

Florida Statewide Quality Assurance Program

**Annual Report
Contract Year 5
July 2005 – June 2006**

provided through
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in cooperation with
The Council on Quality and Leadership

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Executive Summary

Since September of 2001, Delmarva Foundation, in cooperation with the Agency for Persons with Disabilities (APD) and the Agency for Health Care Administration (AHCA), has provided quality assurance, quality improvement and technical assistance to several thousand providers of services under the Developmental Disabilities Home and Community Based Services Waiver (DD). As part of this program, Delmarva consultants have also conducted thousands of interviews with individuals to determine their quality of life as defined by the Personal Outcome Measures developed by The Council on Quality and Leadership (CQL), a partner of Delmarva's in this endeavor. This report includes information, data analysis, results, discussion and recommendations from activities of Year Five of this, the Florida Statewide Quality Assurance Program (FSQAP), July 2005 – June 2006. As in previous years, Delmarva has worked closely with AHCA and APD to meet challenges, improve systems, and modify activities to best address the needs of the individuals receiving services through the Waiver.

Delmarva continues to reach out across the state with training sessions and various types of presentations and contacts within communities. Overall, approximately 1,216 people within the state of Florida attended one of 40 face to face presentation/training sessions with Delmarva this past year, conducted in each APD Area of the state except Area 11. Training sessions were also conducted at National and International conferences. Delmarva staff presented at the annual Family Café conference, annual Florida ARC conference, the annual APSE conference and the annual Alliance for Full Participation Conference in Montreal. In these conferences, regional managers and the Delmarva scientist presented information about the FSQAP quality improvement activities and results from data analysis and quality improvement studies.

In addition to the six web-based training modules completed during Year Four (July 2004 – June 2005) of the contract, three more were developed this year to further enhance Delmarva's ability to reach as many individuals, families and providers as possible. These are available on the Delmarva web site:

1. *Professional Practices* assists providers in anticipating and dealing with ethical issues as they render supports and services.
2. *Medication Highway* provides individuals, family members and providers with a resource to become familiar with the most commonly prescribed drugs, their side effects, indications and special considerations.
3. *Quality Enhancement Planning* was designed to assist providers to develop and implement ongoing enhancement systems, so they can self assess their services and learn how to use data to effect positive change.

Communication with AHCA, APD, CQL and other stakeholders continues to be of primary importance to Delmarva. Representatives from Delmarva consistently attend and present information, conduct panel discussions, and/or lead brainstorming sessions at the Interagency Quality Council (IQC). Status meetings with all participating agencies and partners are held monthly and are well attended. Regional managers conduct quarterly

meetings with every APD Area office where they present and discuss the most recent data analysis results. They have also attended many of the new Steering Committee meetings established by APD to develop quality improvement (QI) initiatives that are Area specific, and the Delmarva scientist has met several times with APD's Area Quality Leaders (AQLs) to revise and update data they use to guide their QI initiatives.

QI initiatives are a constant focus for the project. Over three years, the FSQAP has compiled and analyzed data to support and identify directions for quality improvement initiatives and improved strategies and approaches for supports and services. On going QI initiatives include the quarterly distribution of data reports to each APD Area, based on specific area needs. These reports were updated in Year Four to reflect results from the new consultation processes, and again in Year Five as a result of feedback from APD and AQLs across the state. Further revisions will be completed in the next FY.

One psychotherapeutic drug use study and five QI studies were completed during the fifth contract year:

1. Organizational Practices That Best Predict Percent of Personal Outcome Measures Met
2. Barriers Analysis
3. Waiver Support Coordinator Caseload: Impact on Performance Evaluation
4. Longitudinal Panel Analysis: Impact of Support Coordinator Turnover on Outcomes
5. Outcome Results Analysis: Impact of POM Supports on POM Outcomes Met
6. Evaluation of Use of Selected Psychotherapeutic Drug Profiles in Florida's Developmental Disabilities Home and Community-Based Services Waiver: April 2003 – December 2004

A workgroup consisting of representatives of relevant agencies, families and individuals worked together in Year Four to develop and implement a Public Reporting Website (www.flddresource.com). During Year Five, the work group continued to meet to monitor use of the web site and discuss possible revisions so it would be more user friendly; and to prioritize items members of the group felt to be important future additions to the site. Discussions and plans were also initiated to facilitate transfer of the web site to APD.

The Year Five "Implementation" Support Plan Stakeholder Group convened twice to complete the new Support Plan implementation process. Pilot activities took place during the month of April, generating direct user feedback relative to training, Part A, and Part B implementation. The Stakeholder Group discussed and developed additional recommendations relating to the training of stakeholders on the philosophies, tools, and specific processes associated with the new Support Plan.

Quality Improvement Consultants (QICs) completed 850 CORE consults that included interviews with thousands of individuals.¹ They also conducted 468 WiSCC evaluations that included Personal Outcome Measures (POM) interviews with 687 Waiver Support Coordinators (WSC) and over 1,363 individuals. Providers are evaluated as Achieving, Implementing, Emerging or Not Emerging on elements that are outcome oriented—ensuring the provider has systems in place and that those systems reach all the individuals they serve to help them achieve desired outcomes. Providers are also scored as Met or Not Met on process elements that indicate if training, background screening and licensure/billing documentation is complete.

Providers who received a CORE consult were most likely to be evaluated as Implementing on the outcome elements. Statewide, a greater percent of providers scored as Achieving or Implementing in Year Five than in Year Four, 59.6 percent in Year Four compared to almost 65 percent this past year. Agency providers appear to have improved over the time period, while Solo providers were somewhat less likely to be evaluated as Achieving or Implementing. Independent CORE elements indicating the provider's organizational practices ensure the individual is treated with dignity and respect, the individual is afforded choice of services and supports, and the individual is safe increased by over six percentage points in the Achieving level. On average, providers score Met on approximately 73 percent of the process elements, 75 percent compliant with back ground screening documentation.

WSC also showed improvement from Year Four to Year Five. The six outcome elements were more likely to be evaluated as Implementing than at any other level. This represents an improvement from Year Four when they were most likely to be evaluated as Emerging. Both Agency and Solo Support Coordinators improved in Year Five, increasing the percent of elements scored as Achieving or Implementing by approximately 10 points, while at the same time reducing the percent scored as Emerging. The element indicating the WSC has systems in place to get to know the individuals they serve was most likely to score as Achieving in both Year Four and Year Five, and this improved by close to 10 points over the two year period. On average, WSCs score around 92 percent Met on the five process elements and do fairly well documenting back ground screening, approximately 96 percent Met.

Personal Outcome Measure Interviews results have also been positive this year. The overall percent of outcomes met is up by almost three percentage points (48.6%) and the percent of supports present is up by close to five points (53%). This Improvement comes after a downward trend from Year One to Year Three, the trend leveling off somewhat in Year Four. Each individual POM item showed an improvement with the exception of four that remained relatively unchanged since Year Four. The “driver outcomes”, *Chooses services* and *Chooses work*, improved by 4.5 and 6.8 percentage points respectively. *Realizes personal goals* demonstrated the most improvement in the percent

¹ Providers who render Adult Day Training, Non-Residential Support Services, Residential Habilitation, Supported Employment, Supported Living Coaching, In-Home Support Services or Special Medical Home Care receive a CORE.

of Supports present over the two year period, close to 10 points. *Is treated fairly* demonstrated the greatest increase in outcomes, over eight points.

Over 46.5 percent of the individuals who received a POM interview during the current year had 13 or more outcomes met, and over 50 percent had 13 or more supports present. This represents an increase from 41.6 percent and 46.4 percent respectively since Year Four of the contract. In addition, the percent of individuals with all the Foundational Outcomes met has increased from 6.6 percent in Year Three to 8.5 percent in Year Four and 10.8 percent in Year Five. The percent of individuals with five or more of the Foundational Outcomes met has increased from 36 percent in Year Four to 45 percent in Year Five. These and other positive trends as noted above reflect the ever constant drive of Delmarva, APD and AHCA to ensure a person-directed system focused on outcomes for the individuals served through the DD Waiver.

In addition to the WiSCC, CORE and POM interviews, QICs conducted 1,048 Desk Reviews during Year Five. The average statewide score for Desk Reviews was 77 percent, similar to Year Four and consistent across most of the contract years. For the agency providers, the average score has decreased from over 79 percent to approximately 73.8 percent from Year One to Year Five. The opposite trend has occurred for Solo providers where the average score has improved from 71 percent to close to 76 percent over the same time period.

As a result of the data analysis presented in this report, and constant interaction with stakeholders and APD, Delmarva suggests the following recommendations:

1. It is again recommended that a work group examine the Desk Review process and modify as appropriate. APD should ensure training for all providers is available and reinforce the need for providers to attend required training sessions. Review of licensure elements may be modified and incorporating the outcome-based focus and elements of CORE, as/if possible, may help to enhance the process. Also, a deeper analysis may help determine which elements are most frequently cited for recoupment and if that has changed over the years.
2. Area APD offices and Steering Committees may want to explore the trend among their Area providers, Agencies have improved while Solo's have not. If Solo providers are "losing ground" efforts should be made to determine the source of the problems and address them. If any or all of the Agencies in their Areas have best practices that have improved their organizational systems, these could be shared at local and statewide meetings
3. Because communication with and among providers is a vital component of the program, linked to higher outcomes among individuals, APD should focus efforts on improving communication among all types of service providers. Delmarva has successfully coordinated Collaboratives among hospitals that have resulted in improved service delivery and outcomes for patients. Collaboratives should be explored as an avenue for bringing all DD Waiver service providers together, to enhance their ability to work as a team for each individual served and to improve upon the dissemination of information to providers, families and individuals.

4. Education sessions should be offered that focus on social roles. These should be attended by all providers and should include clear definitions of what valued social roles are as well as a discussion of methods for improving and enhancing social roles for individuals in the program. Individuals and their families/guardians should also attend unless a separate session more focused on their needs would be appropriate. Alternatively, a web based training module could be developed by Delmarva if stakeholders believe it could accomplish the same goals.
5. Solo providers should be closely monitored in the next year to ensure the drop in performance on the MSR elements in Year Five is not a trend.
6. Results from the WiSCC analyzed over the next year should show a continued improvement on Element 6, achieving positive outcomes for individuals. If this is not demonstrated, Delmarva and APD should work together to make any revisions to the process that might enhance the ability of WSCs to organize systems that help generate desired results for individuals.
7. Previous data have indicated relatively low compliance with Level II Background screening requirements. Because this is vital to the safety of the population, Delmarva and APD have worked together to implement a new procedure intended to improve performance of providers in this area. As this is implemented in Year Six, data should be analyzed closely to determine the effectiveness of the new procedure. The procedure should be modified if compliance does not show an increase by the 3rd quarter of the year.
8. Delmarva and APD should closely monitor the outcomes for people living in group homes. Because outcomes are typically low for these individuals, APD and the State should actively pursue the implementation of practices that could improve the lives of these individuals, such as modifying tools used to regularly monitor the homes, making sure they are person-centered. Person-centered monitoring tools should help ensure the development of a person-directed environment. Local APD staff should also regularly and effectively promote positive changes to the homes. Finally, IQC could act as an advocate at the state level to effect policies that could help move more people out of group homes and into more person-centered and integrated environments.
9. Because information on outcomes by service is regularly provided to the legislature to direct policy and budget decisions, a quality improvement study should be done to tease out the complex relationships in the data and help provide a clearer understanding of individuals' POM outcomes across services. Statistical models should be developed that control for other services individuals may be receiving, as well as other relevant variables.
10. Members of IQC have raised some concerns that not all individuals served on the DD waiver are free from abuse and neglect, as measured by the POMs. The Delmarva data captures some reasons for this, but the reasons are quite broad. Because this is an important issue, a quality improvement study should be completed that helps to produce a greater understanding of the extent of the problem, more specific data identifying the type of possible abuse, any issues or problems surrounding the reporting of abuse to the proper state agency, and subsequent action taken by that agency.

As the FSQAP moves into its sixth year, revisions and enhancements to quality improvement processes and protocols are scheduled. The CORE tool will be revised to limit duplication of work and enhance efficiency. It will also reflect information on providers and individuals on the Family and Supported Living Waiver (FSL). The WiSCC will also reflect individuals receiving FSL services and QICs who conduct CORE consults will be trained and reliable on the POM interview techniques. Delmarva will continue to work closely with AHCA and APD to help establish the best processes in order to achieve a DD system where individuals' needs and desires are the focus.

Introduction

This is the annual report for Year Five of the Florida Statewide Quality Assurance Program (FSQAP) contract, July 2005 – June 2006. Information in this report includes fourth quarter activity reports as well as a review of the project across the year. The report is divided into three sections. The first section, **Summary of Quarterly and Annual Project Compliance Activities**, presents information relevant to compliance with contract issues during the fourth quarter of the contract year, with some annual summaries. In this section we detail the activities and accomplishments of the Delmarva Staff and their partners, including:

- Contract Monitoring;
- Education and Training Activities;
- Tool Revisions
- Liaison/External Communication Modalities;
- Internal Quality Assurance Initiatives;
- Summary of Customer Service Activity;
- Quality Improvement Initiatives.

The second section, **Data Analysis and Results**, provides analysis and interpretation of the data collected from July 2005 through June 2006, including annual trends when possible. Data are presented to provide AHCA and APD with information they may utilize to enhance the services provided to the DD population. This section includes:

- Volume of Activity: Desk Reviews and CORE Consultations
- Desk Reviews
- CORE Consultations
- Reconsiderations
- WiSCC Evaluations
- Personal Outcome Measures (POM) Sample Description
- Personal Outcome Measures Volume and Results
- Medical Peer Review Findings

The third section, **Discussion of Findings and Recommendations**, provides a brief summary of the contract activities, interpretation of results and recommendations based on a review of the data and activities for the year.

Section One: Summary of Quarterly and Annual Project Compliance Activities

During this initial year of the second contract period (Year 5) Delmarva continued with several quality improvements efforts that had been initiated in the fourth year of the contract, and modified/updated some procedures. The Collaborative Outcome and Review Enhancement (CORE) and Waiver Support Coordinator Consultation (WiSCC) activities initiated in the fourth year of the contract have been successfully utilized by consultants throughout the fifth year, with no substantive modifications. The Desk Review procedures were updated to reflect changes in the Florida Medicaid Developmental Disabilities Waiver Services coverage and Limitations Handbook.

In addition to consultations and reviews, Delmarva managed a variety of other accomplishments during the past year, including improvements to the Public Reporting website, development of a new Support Plan, modifications to the Area Quarterly Reports, improvements to the FSQAP website, and completion of five Quality Improvement Studies submitted to AHCA and APD. These and other project activities during Year Five are discussed and summarized in the following section of this report.

Contract Monitoring

In July and August of 2005, the Agency for Health Care Administration conducted a monitoring of Delmarva Foundation relative to AHCA Contract #M0225. Carol Burch and Pamela Wainwright of AHCA worked closely with representatives of Delmarva to evaluate Administrative and Medical Peer Review systems. Findings were submitted to Delmarva on October 10, 2005. Delmarva submitted a Performance Improvement Plan (PIP) on November 9, 2005, and revisions to the PIP on January 17, 2006. The PIP was formally approved by AHCA on July 6, 2006.

Administrative Review

Findings from the Administrative review identified several system problems relating to the posting of reports and invoicing data to Delmarva's private website. Reports are now being posted according to established timelines, and new procedures have been established within Delmarva's Internal Quality Assurance Plan (IQAP) to confirm this on a monthly basis. AHCA no longer utilizes the invoicing data, so Delmarva no longer maintains this information on the website.

Delmarva updated confidentiality agreement language, educational materials, and the IQAP in response to AHCA's findings, and initiated a system to communicate production projections to the AHCA contract manager.

Medical Peer Review

Several Medical Peer Review (MPR) standards were cited as requiring PIPs from Delmarva, particularly relating to systems issues, how the MPR relates to the new WiSCC process, and how the Nurse Reviewer makes decisions given the available data.

All system issues have been resolved, and in-depth explanations have been given pertaining to the MPR process and decision making. Several new systems have been put in place by the Nurse Reviewer.

During the monitoring process, it became apparent to the AHCA team the existing monitoring tools were not effective in evaluating Delmarva's activities since the implementation of CORE and WiSCC and the modification of other internal procedures. Pamela Wainwright has since met with Delmarva staff to modify the monitoring tools to better reflect the current processes.

Training and Education Activities

During Year Five, training and educational activities were conducted using the following methodologies:

- Education/Training Sessions
- Website Resources and On-line Training Modules

Education/Training Sessions

During the fourth quarter of contract Year Five, April – June 2006, eight educational sessions were offered to a wide variety of stakeholders. Each session was designed to meet the specific needs of the audience.

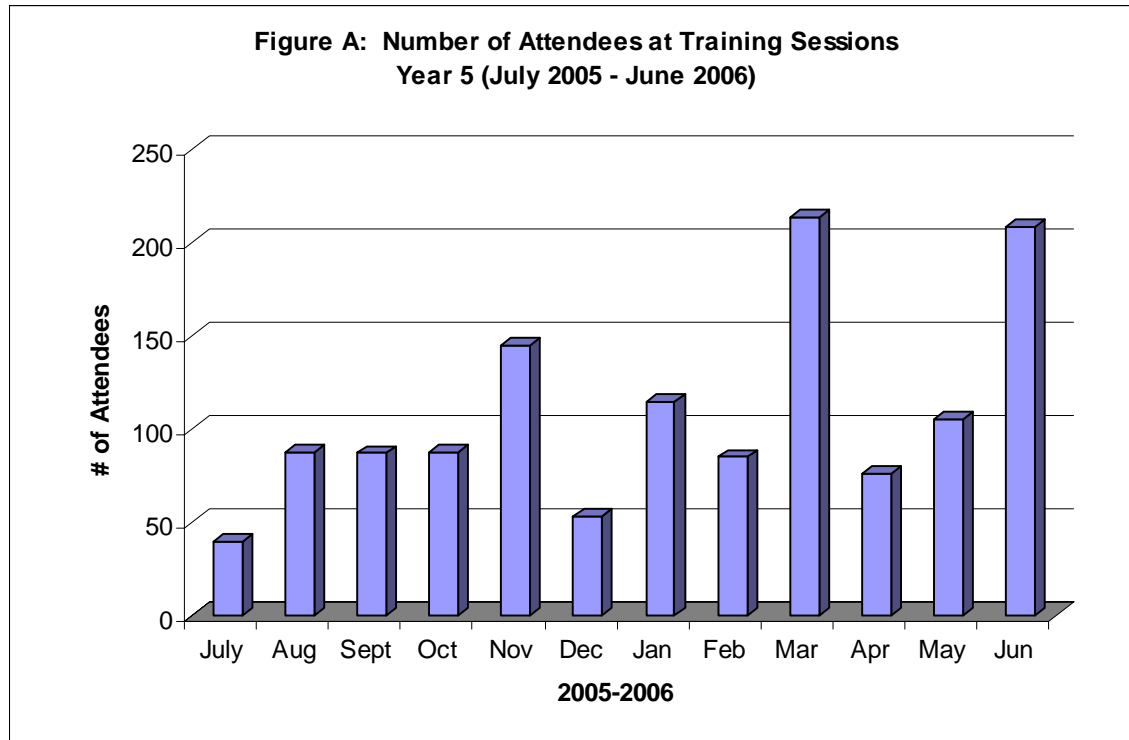
- Training on Implementation Planning was provided in Area 2. The audience consisted of a wide range of service providers. Following a presentation on the role and development of Implementation Plans, four breakout groups were formed, each facilitated by Delmarva staff. Group members participated in the actual development of an Implementation Plan. This hands-on approach was well received.
- Providers in Area 14 were offered training on gathering information and reporting activities related to their services and individuals' outcomes. The focus on functional documentation was twofold in that it assisted providers to streamline their paperwork and to ensure that information on which they report is purposeful.
- In May, three separate sessions were provided in Areas 3, 4 and 9. Each area used multiple sources (data, consultant feedback, area trends, Delmarva reports, and quarterly meetings) to decide on the training that was most needed. All three areas opted for training on Health and Behavioral Risk Indicators. Although the sessions were tailored for the specific audience in each area, the central theme of the sessions included a very detailed discussion of the three risk indicators (Health, Behavioral and Functional). These discussions were accompanied by examples of each type of risk and the possible consequences to an individual's health and safety. Examples were presented by the presenter and also taken from the audience. Since Support Coordinators and other service providers attended the same session, much of the session focused on how they could work together to identify risks and address them effectively.

- At the annual Family Café conference in Orlando, attended by more than 10,000 people, four separate sessions were conducted. In addition to the formal sessions, participants received information disseminated at an information booth.
- At the Quality Symposium in Ft Lauderdale, a power point presentation explaining the driving factors and benefits to all stakeholders of a quality improvement system versus a quality assurance system was followed by a breakout session. Each group was facilitated by a Delmarva staff person who encouraged attendees to consider all sources of support, beginning with natural and community resources. Overall, many creative and unique responses were brought forth by the different stakeholders in attendance.
- At the Florida ARC conference in St Augustine, Delmarva staff provided a detailed description of documentation requirements, including policies and procedures, training requirements for providers, and service logs.

Annual Education/Training Summary

Over the course of the year, a total of 40 formal training sessions were conducted. In addition to these contractual obligations, Delmarva staff has continued to provide education and information at statewide forums and other venues. Feedback surveys are distributed at the conclusion of each training session. On a scale of 1 (not at all satisfied) to 4 (very satisfied), the average feedback score for the year was 3.44.

A total of 1,303 people attended a training session in Year Five. The following bar graph (Figure A) demonstrates the number of people trained each month in one of the 40 formal sessions provided by Delmarva. In November, March and June Delmarva staff completed the most training sessions. Ten sessions focused on Health and Behavioral Risk Indicators conducted by the Nurse Reviewer, Linda Tupper. Other sessions included topics in the areas of Person Centered Planning, Implementation Planning, Overview of CORE and WiSCC, and others. Training sessions were also conducted at National and International conferences. Delmarva staff presented at the annual Family Café conference, annual Florida ARC conference, the annual APSE conference and the annual Alliance for Full Participation Conference in Montreal. Months with the highest number of training sessions were conducted in March 2006 and June 2006.



Website Resources and On-Line Training Modules

Delmarva redesigned the public FSQAP website (www.dfmc-florida.org) to update information, reorganize the homepage, and create a more user-friendly format. The regional manager in charge of Education and Training, Charmaine Pillay, was given the lead responsibility to upgrade the web site, and ensure the most current information is available, particularly on upcoming training sessions and meetings. Modifications included the following:

- The *Resource Center* underwent some revisions that included moving the CORE and WiSCC tools from the Home Page to the Provider Resources section.
- *My Personal Compass* has been updated and moved from the Home Page to the Individual and Family Resources section.
- The sections entitled *Project Description* and *About Delmarva* have been updated to reflect current practices.
- A link to the *Quarterly and Annual Reports* and *Quality Improvement Studies* is now provided on the Home Page.
- Finally, a *Best Practice* section was added to the web site. Best Practices are presented in the bi-weekly consultant conference calls and submitted to the Customer Service Representative for posting. Best practices report on the implementation of processes from a variety of entities that are uniquely designed to improve outcomes for individuals.

During Year Four of the contract, project staff worked with an experienced instructional designer to develop six web-based training modules that were all available through the

Resource Center by June 30, 2004. All of the modules were reviewed by several content experts and coordinated with APD. Each course includes a test for the user to complete. Three additional web-based modules were completed this year, using the same instructional designer and review process.

1. *Professional Practices* assists providers in anticipating and dealing with ethical issues as they render supports and services.
2. *Medication Highway* provides individuals, family members and providers with a resource to become familiar with the most commonly prescribed drugs, their side effects, indications and special considerations.
3. *Quality Enhancement Planning* was designed to assist providers to develop and implement ongoing enhancement systems, so they can self assess their services and learn how to use data to effect positive change.

All of the On-Line Training Modules identify target audiences. However, they do not limit anyone from taking any of the training sessions. Anyone can utilize these training modules.

Tool Revisions

Desk Reviews

Based upon the revised version (June 23, 2005) of the Developmental Disabilities Waiver Services Coverage and Limitation Handbook, the Provider Performance Review (PPR) tools used for providers who receive a desk review were modified. Modifications reflected the changes to the handbook and included qualification and training requirements, service limits, and billing documentation. In December 2005, the revised tools were included as part of an application update, installed onto the consultants' laptops, and posted to the FSQAP website.

CORE

Changes to the CORE application were completed in May 2006. The revised tool allows consultants to input data related to the provider's strengths and barriers identified during the consultation. These data can potentially be used for analysis and identification of trends, similar to barriers as identified in the WiSCC process. In addition, as a part of this modification, consultants are able to identify providers who render services for individuals on the Family and Supported Living Waiver (FSL). The specific services and the number of individuals receiving each service are also included as part of the application.

Liaison/External Communication Modalities

In this last year, Delmarva Foundation continued to ensure that Florida stakeholders had the ability to stay current with FSQAP activities, procedures, and findings. Through a variety of efforts, including the utilization of 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.²

Interagency Quality Council

Four quarterly meetings with the Interagency Quality Council (IQC) were held in a variety of locations throughout Florida in Year Five, and Delmarva Foundation was an active participant and presenter at each of these meetings. Data are routinely presented to update the Council on provider performance across the state and current Personal Outcome Measure trends among individuals receiving services through the waivers. In addition, during the October meeting a summary of the Quality Improvement studies was presented and ideas for new studies discussed.

The IQC meetings also serve as a key forum for sharing and developing future FSQAP initiatives. In the December 2005 meeting, Marion Olivier-Ruelas lead breakout groups in brainstorming solutions to different issues identified by the group. During the March meeting, these issues were further discussed and IQC participants voted on two as topics they felt were most important at the current time: Therapeutic Equipment Specialists Certification and Educating Providers, Families and Consumers Regarding Available Services and/or Program Initiatives. Two committees have been formed to further explore these areas and how they might be positively impacted. Also, Carol McDuff led a panel of individuals receiving services and providers who had been through a CORE consult in a discussion related to the process.

Project Status Meetings

The Delmarva Director of Florida Programs, Bob Foley, facilitates regular Project Status Meetings with representatives from AHCA, APD and The Council on Quality and Leadership (CQL). These meetings are a forum for updates, discussion, and decision making relating to the comprehensive and ever-fluid implementation of the FSQAP program. Meetings are held monthly, with the exception being the months most are attending the IQC meeting. Nine meetings were held during Year Five of the contract and all entities were represented in each meeting. Other small group meetings also occur regularly to address specific project areas or implementation issues, such as updating data reports or addressing issues surrounding the public reporting web site.

Area Quarterly Meetings

Regional Managers met quarterly with each Agency for Persons with Disabilities' Area to discuss results from the consultative processes and PPR Desk Reviews, FSQAP impacts to the system, Area and/or Regional initiatives to utilize Delmarva Foundation's results, training and education opportunities, and any other topic that might impact service quality. In addition to the Regional Manager, a consultant from both the CORE and WiSCC often attended these meetings to discuss specific review findings and trends identified within the community. APD participants included the liaison with Delmarva Foundation, staff involved in the QI process, and on occasion, the DD Program Administrator or other representatives.

² See Appendix 1, Attachment 6 for a list of activities.

Area Quality Leader Steering Committee Meetings

With the implementation of the Real Choice Systems Grant awarded to APD, Area Quality Leaders (AQL) were assigned to each APD area. In part, their task was to use the Delmarva data to identify concerns or issues specific to their Area that would benefit from quality improvement efforts. Each AQL has developed a Steering Committee that meets monthly. The Committee is comprised of providers, family members, individuals and Area APD representatives—a mini Interagency Quality Council. Delmarva managers and/or consultants have attended and assisted with approximately 30 Steering Committee meetings during Year Five of this contract. They have attended at least one meeting in each APD Area with the exception of Areas 9 and 11.

Area Quality Leader Bi-monthly Meeting

Sue Kelly has participated in several of the AQL bi-monthly meetings in an effort to further explain the Delmarva data tables sent to each area and to gather feedback from the AQLs on the data as to its usefulness in their quality improvement initiatives. Steve Dunaway arranged an additional meeting with a smaller workgroup of AQLs to discuss data issues. By the end of Year Five, Delmarva had implemented several of the suggested changes. Moving into Year Six, further changes in the format will be discussed and implemented, including graphs and charts utilized to display data results.

National/International Conference Representation

Delmarva had two papers and one poster presentation accepted for presentation at the AAMR Annual Meeting on Social Inclusion in Montreal, May 2-5, 2006. Beth Townsend and Charmaine Pillay jointly presented a paper on the Quality Improvement/Person-Centered focus of the CORE and WiSCC processes. Sue Kelly presented a paper on the impact of different organizational structures, as defined in the CORE process, on outcomes of individuals. Linda Tupper participated in a poster presentation that highlighted parts of the psychotherapeutic drug research Delmarva has completed, identifying individuals on high risk drug profiles.

Other Presentations/Conferences

Delmarva Foundation's outreach efforts went beyond the above information sharing and the Education and Training sessions. Various presentations were made to many stakeholder groups and several Delmarva managers attended relevant conferences.

- August 14, 2005: Bob Foley presented a Delmarva update at the Florida ARF meeting.
- August 2005: Carol McDuff received a Delmarva Foundation scholarship award to attend the North American Association on Customer Management Conference in Orlando.
- September 21, 2005: Linda Tupper attended the National AAMR meeting.
- September 22-23, 2005: Marion Olivier-Ruelas, Anna Quintyne and Linda Tupper attended the National Summit on Full Participation in Washington, DC.
- October 14-16, 2005: Linda Tupper attended, as an incoming officer, the National Developmental Disabilities Nurses Association (DDNA) Board Meeting.
- October 21-22, 2005: Linda Tupper attended the Autism Puzzle Conference.

- February 11-15, 2006: Bob Foley attended the Reinventing Quality conference in San Diego, CA.
- March 22, 2006: Bob Foley and Marion Olivier-Ruelas provided an information booth at DD Awareness Days in Tallahassee.
- April 17-19, 2006: Linda Tupper presented information on the Florida Medication Review Initiative at the Alabama Mental Health/Mental Retardation and SEAAMR Conference.
- June 2-4, 2006: Delmarva provided a booth at the annual Family Café in Orlando. Beth Townsend presented My Personal Compass and Bob Foley teamed with Pamela Wainwright and Ed Rousseau to present information on the new Support Plan process.

Internal Quality Assurance Initiatives³

Annual Consultant Training

Consultants and Delmarva managers attended a five day training retreat in August of 2005. A variety of sessions were offered, covering areas of conflict resolution, communication styles and interviewing techniques. Highlights from the week include the following:

- Sue Kelly discussed the data tables that are distributed to the areas each month, noting when each is updated, interpretations and possible uses of the data. Feedback from the consultants was incorporated into some of the data displays. A presentation of several of the Quality Improvement studies was also offered.
- An all day session with Neil Cerbone Associates was conducted on “Managing Conflict Effectively” and the use of PrioSys, “a tool that enables better communication with more people more of the time.” Feedback from consultants and managers throughout the year has provided support for the positive impact of this program on communicating effectively with different types of people.
- Julie Tyler tied the FSQAP program into the broader Delmarva organization with a presentation on the Four Corners of Delmarva, and the Delmarva CEO Maulik Joshi presented on the Delmarva Dashboards.
- Updates to the Developmental Disabilities Waiver Services Coverage and Limitations Handbook were discussed.
- Consultants were given a presentation from Anne Beuchner on interview techniques. The CORE and WiSCC consultants then teamed up for an interview to allow the CORE consultants time to work with the consultants who are trained and reliable in the POM interview process. This method was well received by all.
- “Facilitated Discussion” work groups for CORE and WiSCC were used by consultants to discuss relevant issues or concerns, brainstorm about best practices, and provide valuable feedback to the Regional Managers on ways to improve the tools/processes.

³ While activities for the year are summarized here, a more complete description is included in Appendix 3, the Internal Quality Assurance Program document.

Bi-Weekly Conference Calls

Conference calls with all consultants on a bi-weekly schedule have continued throughout Year Five of the contract. Through this venue, Regional Managers ensured that consultants received consistent information regarding procedures, interpretations, and system updates. Managers reinforce and supplement this information through telephone and face-to-face contact with the QICs. Consultants are also provided with any additional information or changes related to the CORE and WiSCC processes and, if necessary, clarification on different elements.

The conference calls are used as an avenue to update consultants on key Delmarva initiatives at the corporate level. This may include policy clarification and interpretation, when appropriate. Mandatory corporate training is also accomplished at these times. During one call, a mandatory Ethics Training was completed for all FSQAP personnel.

Formal scenarios are periodically discussed with the consultants after they have had a chance to review them and determine findings. Scenarios focus on one element at a time, and consultants submit their responses to the managers prior to the call. Discussions focus on the key decision making criteria for each element and are designed to improve the reliability of the consultants using each tool.

Another key component of the conference calls is sharing of experiences by the consultants, such as best practices. As a result, Delmarva has established a Best Practices page on the FSQAP web site so the positive experiences/processes identified by consultants can be viewed by the public.

Reliability Assurances

Reliability for QICs conducting Personal Outcome Measures (POM) interviews continues to be maintained through The Council on Quality and Leadership (CQL). This occurred formally through the annual reliability process and through on site monitoring of five percent of the consults throughout the year. Annual reliability was conducted in the use of the POM for adults and for children/youth. All but one WiSCC consultant maintained reliability through the annual observation from CQL. One consultant passed after the second observation. All of the consultants are certified and reliable in both the adult and children/youth interview procedures.

In the past year, reliability activities for the CORE process consisted primarily of the Regional Managers' observation of the consultant conducting a consultation. The Regional Manager accompanied a consultant to an onsite visit, attending all onsite activities. Scenarios distributed to the consultants, as discussed above, were also used to help establish reliability on an element by element basis. Going into Year Six, formal reliability procedures will be developed and implemented to further establish reliability on the CORE and WiSCC processes and on the CORE interview process.

Manager Review

Delmarva Foundation managers continued to review and approve 100% of all WiSCC, CORE and PPR Desk Review reports prior to their distribution. Direct feedback was provided to individual QICs as questions or concerns were identified, and more general concerns were addressed on the bi-weekly conference calls.

Another internal system related to this area was the Medical Peer Review system. Linda Tupper, the Nurse Reviewer, has the opportunity to correct any errors or issues identified with the content or data included in the report. Based on the results of the monitoring process in the early part of the year, Linda Tupper worked with Pamela Wainwright to improve the Medical Peer Review system, implementing new processes to enhance the reviews and better comply with contractual arrangements.

Weekly Manager Meetings

Delmarva managers meet bi-weekly to discuss any new or on going issues related to the FSQAP. IT staff from both Florida and Easton offices also participate, enhancing communications between managers and staff in Easton who provide vital technical and database management support. These meetings provide a valuable forum for managers to track productivity, monitor contractual obligations, discuss any concerns or issues that have developed, and generally share information from across the state.

Manager's Annual Retreat

While the bi-weekly manager's meetings are essential and productive, they do not allow time for in-depth work on strategic planning. The Delmarva managers held a two day retreat in October 2005, to discuss improvements to the current processes and to strategically map out plans that will benefit the FSQAP program over the next several years.

Summary of Customer Service Activity

The Customer Service unit continues to serve as a liaison between Delmarva, DD Waiver service providers, individuals and family members, the districts and the business community. Responses are provided for inquiries about Onsite CORE and WiSCC consultations, Desk Reviews, Person-centered Reviews, related issues on Quality Enhancement Plans, reconsiderations and other required follow up. The Customer Service Representative, Said Sanchez, has completed extensive training on both processes, including observing a CORE and WiSCC, in order to better field questions and concerns about these processes. He also participates on the CORE and WiSCC bi-weekly conference calls.

This active Customer Service component is an integral part of the FSQAP. 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.

During Year Five, a team including the Customer Service Specialist, Managers, and other support staff handled 1,783 contacts during the twelve month period ending June 30, 2006. This continues a downward trend since the second year of the contract, from 1,954 in Year Four, 2,590 in Year Three and 2,009 in Year Two. The following table lists the contacts for Year Five and Year Four.

Table 1: Customer Service Contacts
July 2004 - June 2006

Area	Year 4	Year 5
Desk Reviews	1,460	1,379
CORE	292	132
WiSCC	48	23
Complaints	0	35
Delmarva/Medicaid website	0	68
Interpreting Services	76	35
Miscellaneous	78	111
Total	1,954	1,783

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. There were frequent requests for assistance with explaining what documents need to submit for a desk review and how to address deficiencies in their reports after the reviews have been completed. A total of 1,379 contacts were logged in this area. This area has always generated a large number of calls to customer service, 1,286 in Year Two, 1,926 in Year Three and 1,460 in Year Four. This translates to 1.06, 1.77, 1.17, and 1.32 calls per review respectively.

CORE and WiSCC

There were 132 calls related to the CORE procedure and only 23 related to WiSCC during the year. Many of the CORE related calls were requests for clarification of the different evaluations levels or clarification of the numeric level provided with the WiSCC results, explanation of the minimum service requirement scores, what they need to do next in terms of the follow-up, and interpretation of the results.

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

QICs as requested. This service is arranged for individuals whose primary language is Spanish and also for individuals who communicate through American Sign Language. Services are generally established to facilitate the effective completion of the Personal Outcome Measures interview or to communicate with family members. Requests for this service have dropped from 76 in Year Four to 35 in Year Five.

Complaints

The customer service representative has also fielded several complaints over the course of the year (35).⁴ Only four complaints were logged during the last two quarters of Year Five. Two referred to the same issue which was forwarded to the Regional Manager and pertained to a Personal Outcomes Measure interview.

Miscellaneous

Miscellaneous contacts during the year can be broken down into the following: general information, updates, and best practices.

- General Information has been requested and provided about Medicaid Waiver services, training, and advocacy.
- Updates to provider contact information have been entered into our Delmarva database at the provider's request and reported to the Easton Office to prevent reoccurrence of missing reports, returned reports or other correspondence error.
- The customer service representative has compiled a list of provider Best Practices that is updated frequently and now posted on the Delmarva web site.

One tool extensively utilized in the overall customer service process was the Delmarva Foundation website. Providers, individuals, families, Area staff and others were referred to the website to access the tools, procedures, reconsideration information, and general information about Delmarva Foundation and upcoming training sessions. Individuals and families were also referred to website to access My Personal Compass, the Consumer Road Map, and the Annual and Quarterly reports containing the general activities and findings associated with the FSQAP process. Delmarva worked this past year to simplify and update the information available on this web site.

Quality Improvement Initiatives

Area Quarterly Reports

Statewide data, as well as information specific to each APD Area, continues to be distributed monthly to each area. Some provider information is updated monthly while APD Area data from the WiSCC and CORE review are updated quarterly. Delmarva has worked with the Area Quality Leaders (AQL) to implement some modifications to these tables. Most of the recommended changes were distributed at the end of the Year Five Fiscal Year.

⁴ Complaints were logged and discussed in the Year Four annual report as well, but were incorporated into the Miscellaneous category.

Throughout the year, AQLs have worked with their steering committees in each APD Area to address quality improvement initiatives. They have used the data provided to them by Delmarva to identify Area specific challenges and opportunities to improve. These are reported to the Interagency Quality Council on a quarterly basis.

Stakeholder Workgroups

During the fourth year of the contract a stakeholder group was established to revise the Support Plan. The Support Plan was used to identify the needs and goals of individuals, and also to help determine authorization of services for those individuals. Because this dual purpose was conflicting in nature and reported to be a barrier in terms of providing services to individuals, the stakeholder group was established. Efforts were continued with a Stakeholder Group in Year Five. The purpose of this Support Plan Stakeholder Group was to assist the Agency for Persons with Disabilities (APD) in revising and implementing recommendations from the previous Support Plan Stakeholder Group in Year Four. This activity was directed towards improving the functionality of the Support Plan (SP) Tool and Support Planning processes, as well as to assist APD in establishing a corresponding training curriculum for those charged with developing and utilizing SP's.

The Year Five "Implementation" Support Plan Stakeholder Group convened on two occasions: February 22, 2006, and April 28, 2006. Pilot activities took place during the month of April, generating direct user feedback relative to training, Part A, and Part B implementation. Extensive feedback was provided regarding the electronic application developed by APS Healthcare, Care Connections. A total of 15 different people participated in at least one of the formal meetings, including: a family member, WSCs, a direct service provider, and representatives of the Agency for Health Care Administration (AHCA), APD, Delmarva, Maximus, and APS Healthcare.

The Support Plan Stakeholder Group assisted APD in the initial stages of implementation for the new Support Plan process. Area 2 was designated as the Pilot location, to include one large WSC agency, a small WSC agency, and a solo WSC. Formal training was developed and provided to participating WSCs and other key players in Area 2 by one of the workgroup members, Diane White. As a result of Pilot experiences and feedback from other sources such as APD Area personnel, Interagency Quality Council members, and Family Care Council members, modifications were made to Part A and Part B. Corresponding modifications were made to the Support Plan Instruction documents for individuals and WSCs.

The Stakeholder Group discussed and developed additional recommendations relating to the training of stakeholders on the philosophies, tools, and specific processes associated with the new Support Plan. A guide for establishing a training system can be found in the notes from the April 28th meeting.

Public Reporting Workgroup

A major activity in Year Four of the contract was the development of a public reporting website. A work group consisting of representatives from AHCA, APD, IQC, families and other relevant organizations collaborated with Delmarva on the design and

implementation of the new site, which “went live” in August 2005.⁵ The group determined the primary audience to be individuals with developmental disabilities and their families, and the primary purpose was to disseminate information that would enhance their ability to select a provider that best suits their needs. The site provides demographic information on current providers and performance measures for providers reflecting compliance with background screening and training requirements.

During Year Five, the work group continued to meet to monitor use of the web site and discuss information to be added as the web site expands. Two tasks were initially identified: to revise much of the content language on the site so it would be more user friendly; and to prioritize items members of the group felt to be important additions to the site. To revise the language, several group members focused on different sections of the web site and offered revised language for each section. These revisions are currently under review with AHCA and APD.

The first step in prioritizing items to add to the site was to develop a feedback survey for the web site. A Zoomerang survey was developed and implemented. Results from the survey are to be used to help guide the work group in terms of information users can or can not find, information they would like to have on the site and the ease of using the site itself. Results from the survey have been presented to the work group, APD and IQC.

A subgroup was formed to facilitate the transition of the web site from Delmarva to APD. This group consisted of IT and Application Development staff from Delmarva and APD, Bob Foley, Steve Dunaway and Sue Kelly. At that time it was decided APD could begin the transition process within six months, but this time frame has been extended to a later date.

Quality Improvement Studies

Five quality improvement studies and one psychotherapeutic drug study were completed during the fifth year of the contract. These will be posted on the Delmarva website when approved.

- Organizational Practices That Best Predict Percent of Personal Outcome Measures Met: The focus of this study was to determine which organizational practices, as defined and measured by the CORE elements, were most highly correlated with personal outcomes of individuals served by the provider. Major findings indicated that when providers have organizational systems in place to help individuals develop social roles, people they serve are more likely to have outcomes met. In addition, when providers act as advocates for the individual beyond the scope of their own service, developing a team approach to serving the individual, outcomes are higher for the individuals they serve.
- Barriers Analysis: This study utilized a combination of quantitative data from the WiSCC process and qualitative data from focus groups and interviews to identify and explore barriers present in the system that prevent optimal delivery of

⁵ See two Public Reporting studies, submitted to AHCA by Delmarva, on the research, design and development of the web site. Submitted June 30, 2004, and June 30, 2005.

- services by providers and achievement of outcomes by individuals. Input was provided from Waiver Support Coordinators (WiSCC data), other service providers, family members, self-advocates, ESE (Exceptional Student Education) teachers (focus groups) and Area Quality Leaders (interviews). Several barriers were identified by some or all of the groups including problems with transportation, communication, paper work, transition from high school and service authorization.
- Waiver Support Coordinator Caseload: Impact on Performance Evaluation: The purpose of this study was to explore the potential impact of caseload size on the WSC's capacity to provide optimal support coordination. Results did not show a significant impact of a full-time caseload size (30 to 36) on WSC performance or outcomes for individuals. There was a significant relationship between one of the WiSCC elements and caseload size: WSC with higher caseloads were more likely to have systems in place to allow them to get to know the people they serve.
 - Longitudinal Panel Analysis: Impact of Support Coordinator Turnover on Outcomes: The purpose of this study was to explore changes in the outcomes and supports among the 150 people who had been interviewed every year for four years, and to examine the impact of WSC turnover on those outcomes. Results indicate that one change in a support coordinator over the course of four years is association with lower outcomes for individuals. However, results from the panel data also indicated that a change in WSCs did not impact a change in outcomes over time.
 - Outcome Results Analysis: Impact of POM Supports on POM Outcomes Met: "Driver Outcomes" were identified through statistical analysis and have been tracked by the Legislators for several years: *Chooses Work* and *Chooses Services*. In this study we examined supports to help determine the "driver supports" that facilitate the existence of higher levels of outcomes for individuals. Five POM supports had a strong and statistically significant impact on the likelihood individuals had 13 or more outcomes met in their lives: *Chooses daily routine, Is connected to natural support networks, Chooses where and with whom to live, Decides when to share personal information, and Has intimate relationships.*
 - Evaluation of Use of Selected Psychotherapeutic Drug Profiles in Florida's Developmental Disabilities Home and Community-Based Services Waiver: April 2003 – December 2004: This study presents work documenting the rate of high-risk medication use among persons in Florida's Developmental Disabilities Home and Community Based Services Medicaid Waiver. Analyses use seven drug profiles identified by international experts as indicating high risk of adverse health complications. Important findings indicate half or more of all persons with a drug profile show extended use of medications fitting drug profiles with potentially serious adverse effects from prolonged use. Consequently, we recommend medical guidelines advocating long-term use of these drugs be reviewed. Findings also persons vary in how long they remain on medication. Those who remain on longer are more likely to receive a medication review within six months of receiving a drug.

Section Two: Data Analysis and Results

Volume of Activity-Desk Reviews and CORE Consultations

Providers subject to a Desk Review in Year Five of the contract:⁶

- New providers;
- Established providers who were not reviewed in Year Four (received a 90 percent or above with no Alerts in Year Three);
- Providers reviewed in Year Four who had a review score of less than 90% or who had Alert Elements of Performance (Level II Background Screening) that were Not Met.

Providers of Supported Living Coaching, Supported Employment, Adult Day Training (ADT), Residential Habilitation, Non Residential Support Services (NRSS), In-Home Supports (HIS), or Specialized Medical Care Services are subject to a CORE consult. Those eligible for a consult in Year Five of the contract include:

- New providers;
- Providers who received a CORE in Year Four with an evaluation of Implementing, Emerging or Not Emerging;
- And, providers of Supported Living Coaching who are subject to annual review through State Rule.

The following table shows the number of annual provider reviews and CORE consultations completed each year during the first five years of the contract. Delmarva has conducted 9,792 annual reviews with providers of services on the Medicaid DD Waiver. As indicated in the Table 2, the Onsite reviews during the first three years were replaced with CORE in the fourth year. The 18 CORE conducted during Year Three were part of the pilot study and results from these are excluded from all data analyses. In addition, 5,593 Desk Reviews for providers of all DD Waiver Services that do not require a CORE, with the exception of Adult Dental Services, Consumable Medical Supplies, Adaptive Equipment and Environmental Modifications.

Table 2: Number of Provider Performance Reviews and CORE Consults
July 2001 - June 2006

Review Type	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Onsite	882	846	940	24	NA	2,692
CORE	0	0	18	639	850	1,507
Desk	1,001	1,207	1,090	1,247	1,048	5,593
Total	1,883	2,053	2,048	1,910	1,898	9,792

⁶ Providers of Support Coordination are included in the WiSCC results section.

Delmarva also provides a number of different Follow-up activities to enhance the provider's capacity to assist individuals they serve and to meet documentation requirements. Three potential post onsite Provider Performance Review (PPR)/CORE activities include: Follow-up, Follow-up with Technical Assistance, and Reconsiderations.

With the onsite PPR process utilized in Years 1-3, Follow-ups were generated if providers scored less than 90 percent on the onsite review or did not submit a Quality Improvement Plan (QIP). In the CORE process implemented in Year Four, providers receive a Follow-up if the overall finding from their onsite activity was Implementing and they did not choose to receive a Follow-up with Technical Assistance. Current Follow Up activities may include the following:

- Review of the provider's Quality Enhancement Plan (QEP).
- Review of each element not scored as "achieving" to determine what improvements the provider has made, or what plans the provider has identified to improve organizational practices.
- If deemed necessary, the consultant may interview individuals, staff, and others.

In the PPR process utilized in Years 1-3, Follow-ups with Technical Assistance were generated if an Alert was cited during the onsite, if a submitted QIP was not approved, or if the Quality Assurance Reviewer deemed it necessary at the time of a Follow-up. In the CORE process, providers receive a Follow-up with Technical Assistance if the overall finding from the onsite is Not Emerging or Emerging, if the finding is Implementing and the provider requests that Technical Assistance be attached to the Follow-up, or if the finding is Achieving and the provider requests a Follow-up with Technical Assistance through the APD Area office. Additionally, any CORE in which an Alert is identified generates a Follow-up with Technical Assistance.

Follow Up with TA reviews may include the following:

- Assistance in the development of the QEP, as needed.
- Assistance with the development of organizational practices key to facilitating the achievement of outcomes for the individuals served.
- Review of each of the elements not scored as "achieving" to determine how the provider plans to address or is addressing the area.
- If deemed necessary, the reviewer may interview individuals, staff, and others.

Documentation Reviews are primarily conducted for providers who have received a desk review, to ensure they have corrected elements that were scored as not met or for which correct documentation was not submitted at the time of the original review. Occasionally providers receiving an onsite consult are required to submit information for a documentation review if they scored Achieving but had minimum service requirements

scored as not-met. Providers have 30 days to submit materials for Documentation reviews.

Reconsiderations are conducted when a provider contests the results of the CORE annual onsite consultation or annual desk review. Reconsiderations can only be requested on the minimum service requirement elements in the CORE process (Elements 19-25).

Table 3: Number of Provider Follow-up Reviews

July 2001 - June 2006

Follow-up Type	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Follow-up	64	221	180	144	163	772
Documentation Follow-up	0	277	823	664	663	2,427
Follow-up w/ TA	0	140	136	284	359	919
Reconsideration	92	91	131	89	72	475
Total	156	729	1,270	1,181	1,257	4,593

A total of 4,593 follow-up reviews of some type have been completed over the five year period. As indicated in the above table, the number of Follow-up w/ TA reviews has increased considerably since it was first initiated in Year Two. The percent of Desk Reviews needing a Documentation Follow-up Review has decreased from approximately 75 percent in Year Three to 63 percent in Year Five. However, this is up from 53 percent in Year Four. Of the 72 Reconsiderations completed in Year Five, 20 were for a CORE consult.

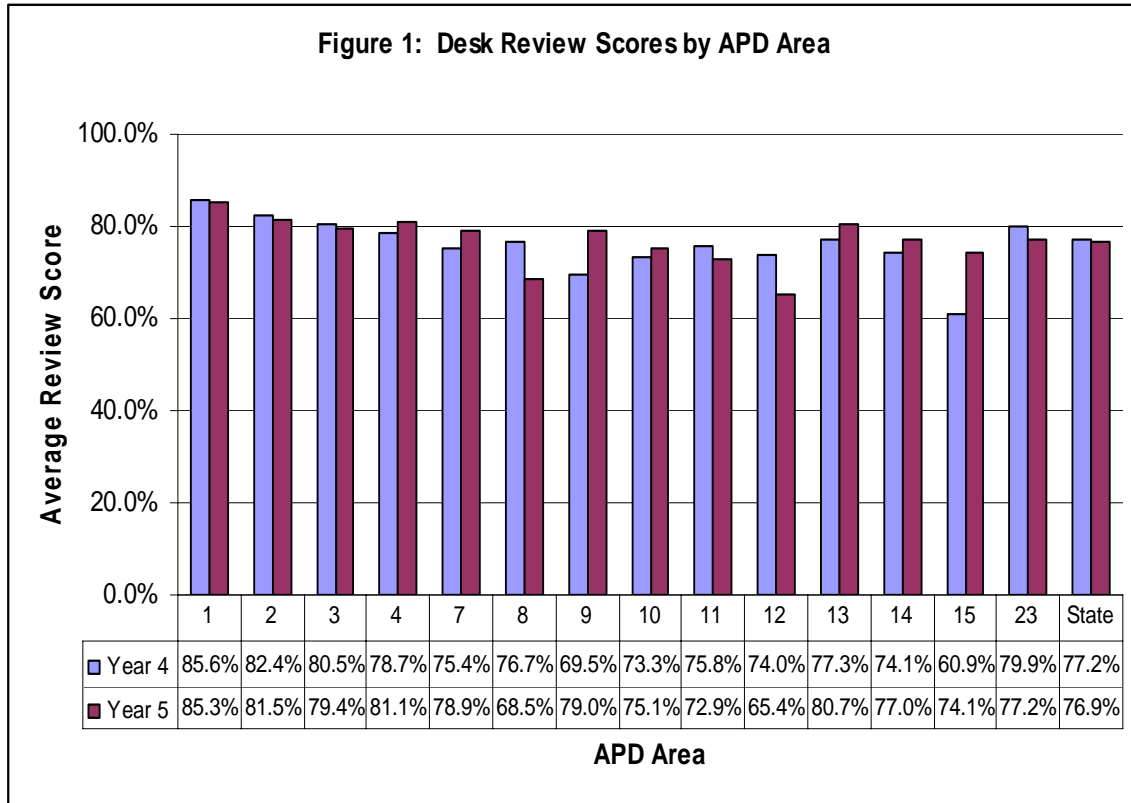
Desk Reviews

The number and percent of desk reviews in each APD Area is presented below. The total number of desk reviews decreased since Year Four. The number of reviews in some Areas each year is relatively low, particularly in Areas 1, 8, 9 and 14.

Table 4: Number of Desk Reviews by Year and APD Area
July 2001 - June 2006

APD Area	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1	16	28	31	25	24	124
2	117	132	112	146	117	624
3	62	70	62	73	52	319
4	63	90	90	116	97	456
7	82	110	104	129	95	520
8	23	24	36	26	30	139
9	29	55	52	43	36	215
10	31	37	56	58	63	245
11	86	98	104	147	116	551
12	51	56	59	71	76	313
13	57	72	54	58	61	302
14	27	27	31	24	20	129
15	48	49	50	50	46	243
23	309	359	249	281	215	1,413
Total	1,001	1,207	1,090	1,247	1,048	5,593

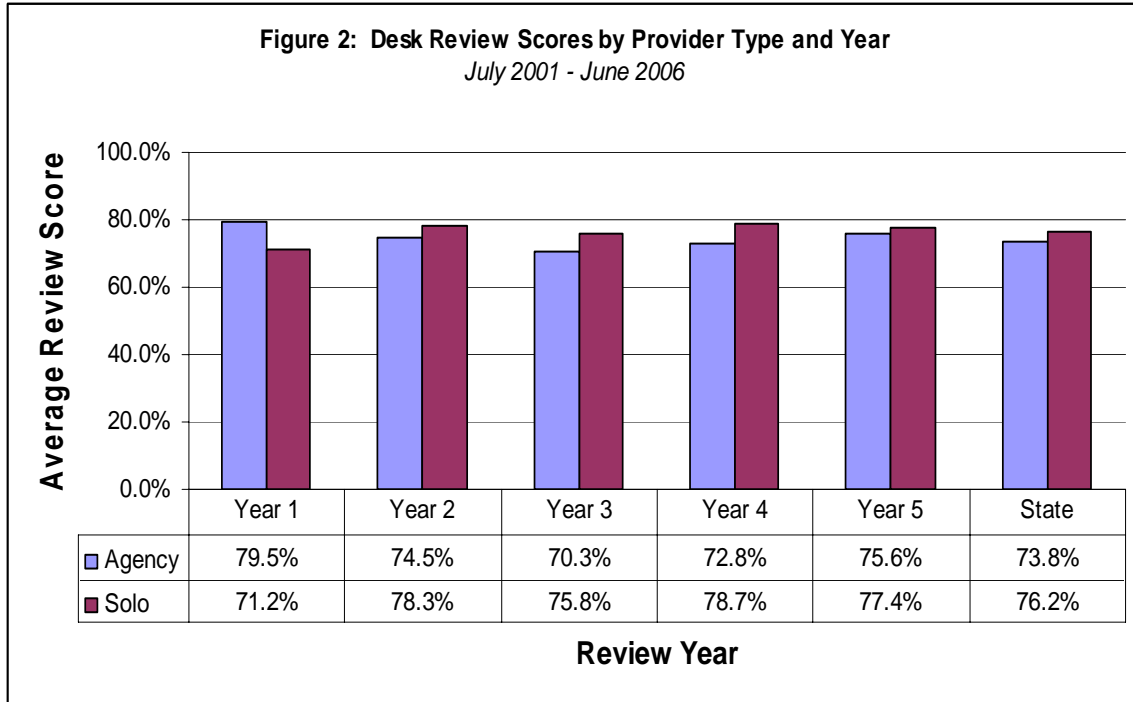
Of greater interest is the trend in Desk Review scores across the years. Because numbers in the APD Areas are often small, as noted above, comparison of scores across areas should be done with caution. As shown in Figure 1, the average score for the state remained consistent since Year Four, and has been fairly consistent throughout the first five years of the FSQAP contract.



The following highlights are evident for Desk Review evaluation scores:

- The average score in Area 15 increased by over 13 percentage points since Year Four and has aligned closer to the state average. This area had consistently posted the lowest average score for the year, each of the first four years of the contract;
- The average scores in Area 9 also show a marked increase, over nine percentage points;
- Areas 1, 2 and 4 had the highest average scores in the state in Year Five.
- Areas 8 and 12 demonstrated the largest decrease in Desk Review scores since Year Four, each over eight percentage points.

Over the years, some differences between agency and solo providers have been noted. These are reflected below in Figure 2.



Comparisons between the two types of providers indicate:

- A majority of Desk Reviews are completed on Solo providers—on average, over 77 percent.
- Scores for Agency providers decreased from Year 1 to Year Four, and have increased somewhat again in Year Five, to 75.6 percent.
- At the same time, scores for Solo providers have increased from 71.2 percent to 77.4 percent.⁷
- The gap between the scores for each provider type has decreased from close to six percentage points in Years Three and Four to just over one point in Year Five.
- The average over the five years shows solo providers with a somewhat higher score, 76.2 percent v 73.8 percent for agency providers.

Documentation for compliance with background screening requirements is the only item for which providers subject to a Desk Review can receive an alert. If Delmarva consultants find missing documentation for these critical screenings, the provider is given 10 days to produce the documentation.

⁷ This trend was noted and discussed in the Quality Improvement study completed during the third year of the contract, Provider Performance Review, Desk Review Procedures, submitted by Delmarva to AHCA, June 30, 2004.

**Table 5: Number and Percent of Providers W/
Background Screening/Re-screening
Documentation: Desk Reviews**

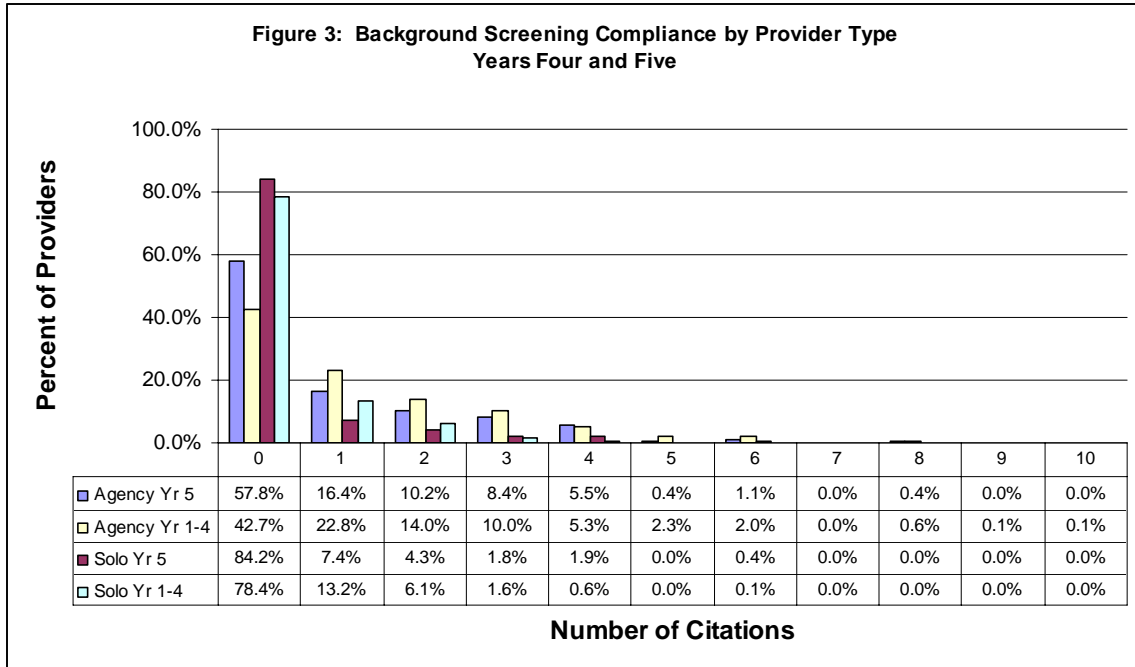
Year	Screening		Re-screening	
	Number	Percent	Number	Percent
1	669	66.8%	N/A	
2	872	72.2%	1,147	95.0%
3	795	72.9%	1,035	95.0%
4	940	75.4%	1,177	94.4%
5	823	78.6%	1,025	97.9%
Total	4,099	73.3%	4,384	95.5%

The information in Table 5 above reflects the number and percent of reviews with the proper documentation for background screening. The analysis indicates:

- Over the five year period, background screening was completed for 73.3 percent of providers who received a Desk Review.
- For 95.5 percent of providers, the required 5-year Level II Background re-screening was documented.
- The percent of compliance for background screening has increased consistently over the years, from 66.8 percent to 78.6 percent.
- Compliance for re-screening has been considerably higher, and close to 98 percent in Year Five.

The following chart (Figure 3) shows background screening/re-screening compliance by provider type. The distribution gives the number of citations per provider on average for Years One through Four, and for Year Five.

- Agency providers have typically been less likely to have no (0) background screening citations than Solo providers.
- However, agencies have improved from an average of 42.7 percent in the first four years of the contract to 57.8 percent in Year Five.
- Agency providers are more likely to have multiple citations.
- Solo providers have also increased the relative number of providers with no background citations, from an average of 78.4 percent in the early years of the contract to 84.2 percent in Year Five.



Elements of Performance for Desk Reviews subject to Recoupment are service specific requirements related to reimbursement documentation. A summary of results for Desk Reviews (below) indicates:⁸

- Recoupment citations have varied more for agencies than for solo providers.
- The average annual percent of providers with a citation has increased somewhat for agency providers and decreased for solo providers over the four years.
- For both provider types combined, the average number of citations per provider has remained fairly consistent in the past two years, close to 0.7 citations per provider.

Table 6: Summary of Desk Reviews Subject to Recoupment by Provider Type
July 2002 - June 2006

	Agency Providers				Solo Providers			
	Year 2	Year 3	Year 4	Year 5	Year 2	Year 3	Year 4	Year 5
Providers Subject to Recoupment	219	267	313	275	950	823	934	772
Total Number of Citations	143	296	259	236	614	608	573	483
Percent of Providers w/ Citation	33.8%	45.7%	38.0%	36.4%	40.3%	42.8%	35.9%	37.4%
Average per Provider	0.65	1.11	0.83	0.86	0.65	0.74	0.61	0.63

⁸ Recoupment citations were not recorded in Year One.

The table below shows a summary analysis of Documentation Follow-up Reviews for the past three years of the contract. Findings indicate the following:

- Of the 663 Desk Reviews requiring a Documentation Follow-up in Year Five, 182 (27.5%) received an evaluation of Met on 100 percent of elements that were previously scored as Not Met. This reflects an increase of four percentage points over the previous year and 7.6 points over Year Three.
- Over 42 Percent of reviews in Year Five requiring a Documentation Follow-up received an evaluation of Met on 75 percent or more of elements that were previously Not Met. This is also relatively greater than for Years Two, Three or Four (36.1%, 34.6% and 40.1% respectively).
- The percent of reviews that had no change in the number of elements scored as Met has increased since the second year, from 7.2 percent to 11.0 percent. The probability this difference could be due to chance or sampling fluctuations is approximately 5.5 percent.

Table 7: Documentation Follow-up Reviews
Percent Changed to MET from Initial Review

Percent Met	Contract Year			
	2	3	4	5
100%	22.0%	19.8%	23.5%	27.5%
>=75%, < 100%	14.1%	14.8%	16.6%	15.1%
>=50%, <75%	14.4%	17.5%	16.9%	18.4%
>=25%, <50%	16.2%	19.3%	16.7%	16.7%
<25%	33.2%	28.6%	26.4%	22.3%
0%	7.2%	10.0%	9.6%	11.0%
Number Reviews	277	823	664	663

CORE Consultations

Because the CORE procedure was implemented in Year Four, trend analyses are possible for two years. The following section summarizes results from the first two years of the CORE, and recommendations from these results are included in the final section of the report. Providers of Adult Day Training (ADT), Non-Residential Support Services (NRSS), Residential Habilitation, Supported Employment, Supported Living Coaching, In-Home Support Services (IHSS) and Specialized Medical Care Services are subject to a CORE consultation.

A total of 850 annual CORE consults have been completed and approved during the fifth year of the FSQAP contract. This falls within the designated range of CORE expected to be completed, between 725 and 1,029. Each provider is evaluated on 25 elements. The first 18 are outcome-based with a focus on the following areas: rights, choices,

community, health and safety, a person-centered approach and communication. Each Outcome Element is evaluated as Achieving, Implementing, Emerging or Not Emerging.⁹ The provider’s CORE outcome evaluation level is based upon a compilation of Outcome Element results (Elements 1-18). Providers are also evaluated on seven process-based elements referred to as the Minimum Service Requirement Elements (MSR). These are scored as Met or Not Met, with a focus on licensure requirements such as background screening and training requirements. Results from the first year were used to establish benchmarks, and comparisons are made to these benchmarks when possible.

Results by APD Area

Table 8 shows the distribution, across APD Area, of the eligible population and the Year Four and Year Five CORE consults.¹⁰ The distribution of CORE consults in Year Five is similar to the distribution of the population. From Year Four to Year Five, there was an increase, or very small decrease (Areas 13, 14, and 23) in the number of CORE in each APD Area with the exception of Area 15 where 11 fewer CORE were completed in Year Five.

Table 8: Enrolled Population and CORE Consults by Area
July 2005 to June 2006 Population
July 2004 - June 2006 CORE

Area	Enrolled Population		CORE Consults		
	Number	Percent	Year 4	Year 5	% Year 5
1	1,245	4.9%	20	33	3.9%
2	1,889	7.4%	47	90	10.6%
3	1,197	4.7%	48	74	8.7%
4	1,978	7.8%	59	65	7.6%
7	2,468	9.7%	38	62	7.3%
8	903	3.6%	19	27	3.2%
9	1,419	5.6%	18	22	2.6%
10	2,180	8.6%	27	63	7.4%
11	3,502	13.8%	64	110	12.9%
12	891	3.5%	38	55	6.5%
13	1,401	5.5%	56	55	6.5%
14	889	3.5%	31	27	3.2%
15	847	3.3%	60	49	5.8%
23	4,585	18.1%	121	118	13.9%
Total	25,394	100.0%	646	850	100.0%

⁹ See Appendix 1, Attachment 2, for a description of the levels of evaluation and Attachment 3 for a description of each CORE element.

¹⁰ Population data were taken from APD’s ABC database. CORE numbers for Year Four vary slightly from the Year Four Annual Report due to approval of consults subsequent to abstraction of data for the report.

The following two charts display the average outcome score and the percent of Minimum Service Requirement elements met by APD Area. The average outcome score is calculated within each area with a simple mean, based upon a scale of zero to three:¹¹

- Achieving = 3
- Implementing = 2
- Emerging = 1
- Not Emerging = 0.

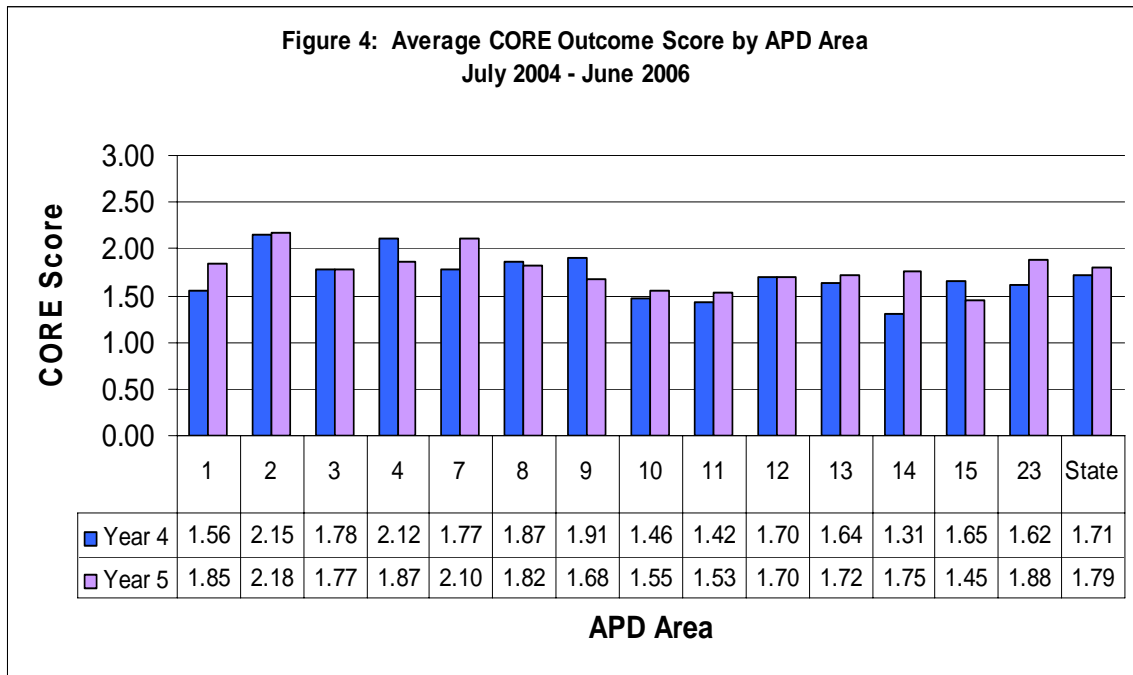


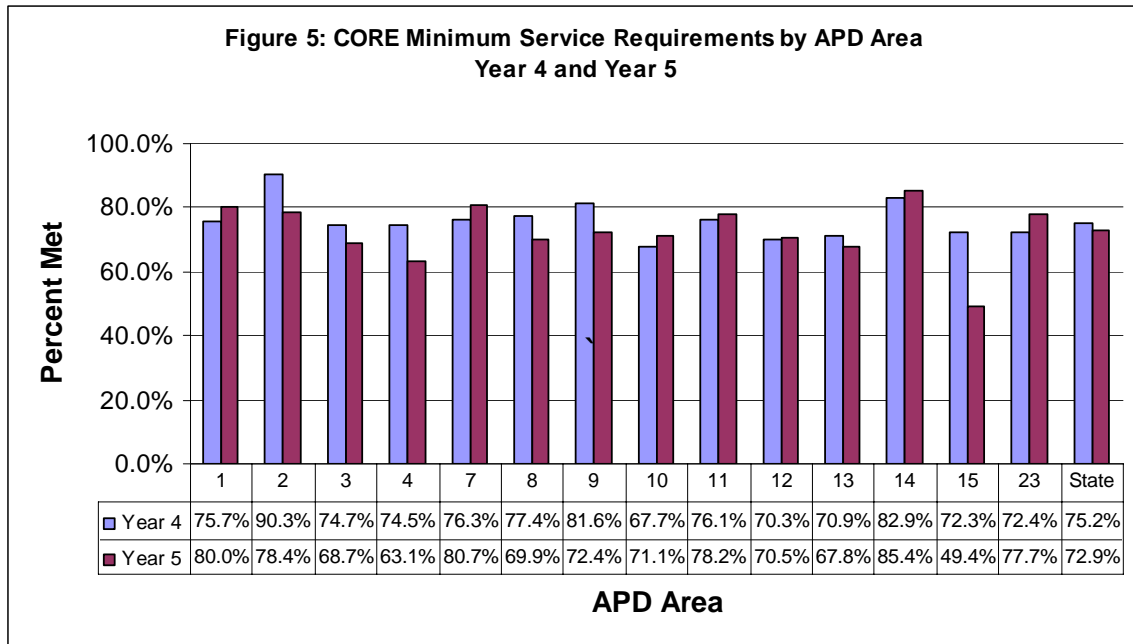
Figure 4 above depicts the outcome score by APD Area for Years Four and Five. Highlights from the chart include the following:

- Overall, the average outcome score statewide has increased somewhat, from 1.71 to 1.79, closer to an overall Implementing level (2).
- APD Areas 1, 7, 14, and 23 showed the greatest improvement from Year Four to Year Five.
- APD Areas 4, 9, and 15 have experienced the greatest decrease in average scores.

In the following chart (Figure 5), the distribution of the percent of Minimum Service Requirement (MSR) elements is shown across APD Areas for Years Four and Five. Highlights from the information given in the chart include the following:

¹¹ See Appendix 2, Exhibit 1 for CORE results by outcome level and area.

- The overall percent of MSR elements that were met in Year Five is somewhat lower than in Year Four, 72.8 percent compared to 75.2 percent.
- APD Area 15 shows a rather dramatic drop of close to 23 percentage points, from 72.3 percent to 49.4 percent.
- APD Areas 2, 4, and 9 also showed a drop in MSR elements met, 11.9, 11.4 and 9.2 points respectively.
- APD Area 23 showed the greatest increase over the two year period, from 72.4 percent to 77.7 percent MSR element met.



Outcome Element Results by Provider Type

During the twelve months ending June 30, 2006, 662 agency and 188 solo providers received a CORE. The graphic depiction below (Figure 5) shows the distribution of CORE consults by provider type and statewide for this time period.¹² Results indicate:

- Both agency and solo providers were most likely to score as Implementing.
- Only 2.6 percent (22 providers) were evaluated as “Not Emerging”.
- Solo providers were much more likely to score Achieving than were agency providers.
- Agency providers were somewhat more likely to score Emerging than solo providers. But this represented only 14 agencies and eight solo providers.
- Statewide, 76.8 percent of providers scored either Implementing or Emerging.

¹² See Appendix 2, Exhibit 2 for Year 4 and 5 results by element.

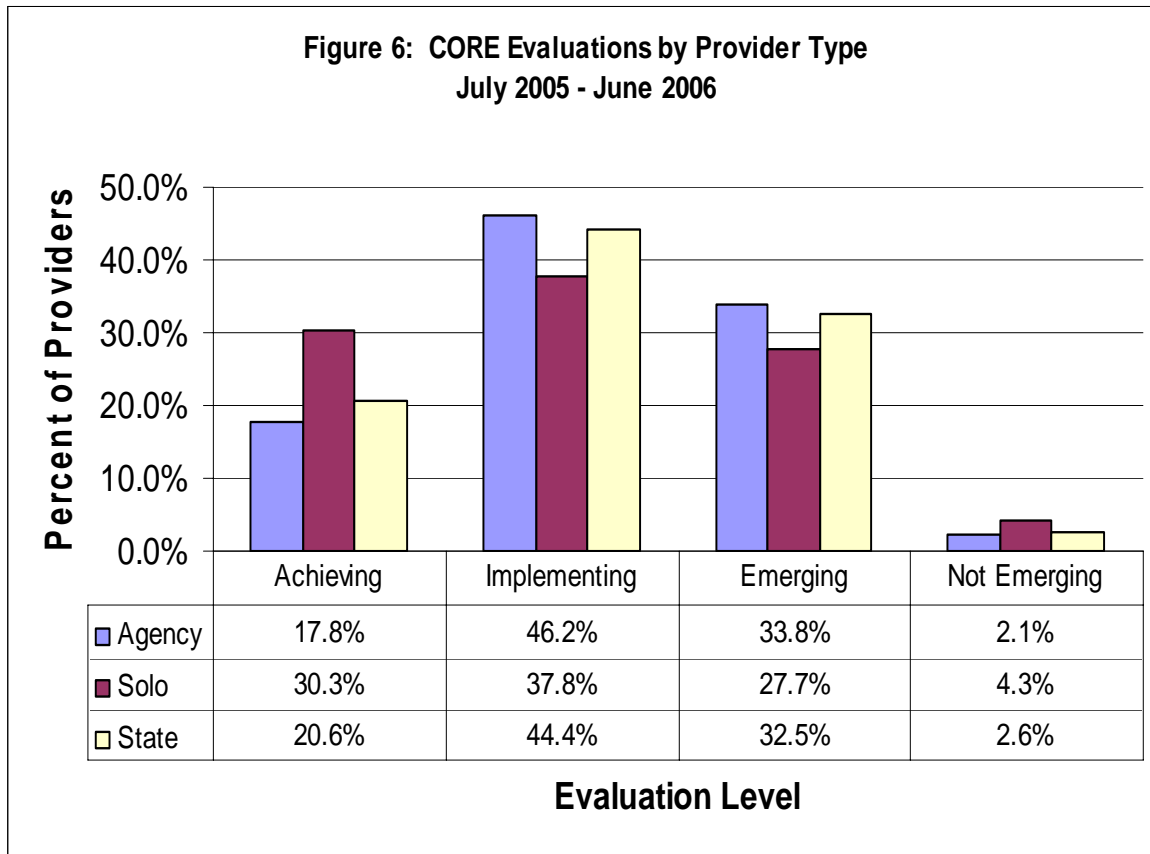


Table 9 provides comparative information of CORE consults by provider type, for Years Four and Five of the contract, the first two years after implementation of the process.

- Statewide a greater percent of providers scored as Achieving or Implementing in Year Five, 59.6 percent in Year Four compared to almost 65 percent in Year Five.
- This gain, however, is noted for agencies only. On average, the proportion of agency providers scoring Achieving increased from 13.3 percent to 17.8 percent and the proportion scoring Implementing increased from 41.3 percent to 46.2 percent.
- The proportion of solo providers scoring Achieving decreased from 34.4 percent in Year Four to 30.3 percent in Year Five and the proportion scoring Implementing decreased from 45.3 percent to 37.8 percent.
- The percent of agency providers who scored Emerging decreased by over seven points while their solo counterparts increased by over eight points.

Table 9: CORE Consult Outcome Results by Provider Type*July 2004 - June 2005*

	Year 4			Year 5		
	Agency	Solo	Total	Agency	Solo	Total
Achieving	69	44	113	118	57	175
Implementing	214	58	272	306	71	377
Emerging	216	25	241	224	52	276
Not Emerging	19	1	20	14	8	22
Total	518	128	646	662	188	850
	Agency	Solo	Total	Agency	Solo	Total
Achieving	13.3%	34.4%	17.5%	17.8%	30.3%	20.6%
Implementing	41.3%	45.3%	42.1%	46.2%	37.8%	44.4%
Emerging	41.7%	19.5%	37.3%	33.8%	27.7%	32.5%
Not Emerging	3.7%	0.8%	3.1%	2.1%	4.3%	2.6%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Outcome Results by Element

As indicated above, each of the 18 Outcome Elements is evaluated.¹³ Exhibit 2 in Appendix 2 shows the results by element for Years Four and Five of the contract. A summary of findings follows:

- On average, the percent of outcome elements scored as Achieving or Not Emerging each year has remained fairly constant.
- Relatively more elements scored as Implementing in Year Five and relatively fewer as Emerging, when compared to the Year Four results.
- Providers were most likely to improve from Emerging to Implementing and/or Achieving on four elements: the individual is provided opportunities to receive services in an integrated environment (Element 5); the individual is afforded choice of services and supports (Element 6); a personal outcome approach is used (Element 11); and, providers take responsibility for addressing individual outcomes by advocating for individuals beyond the scope of their own job descriptions (Element 16).
- The measure indicating providers coordinate the dissemination of information with individuals, families and other providers to promote a cohesive person-centered planning and support process (Element 17), showed an increase of 11 points in Implementing, but part of this was a six point drop at Achieving.
- Elements 2, 6 and 9 each demonstrated over a six point increase at the Achieving level: the individual is treated with dignity and respect; the individual is afforded choice of services and supports; and, the individual is safe.

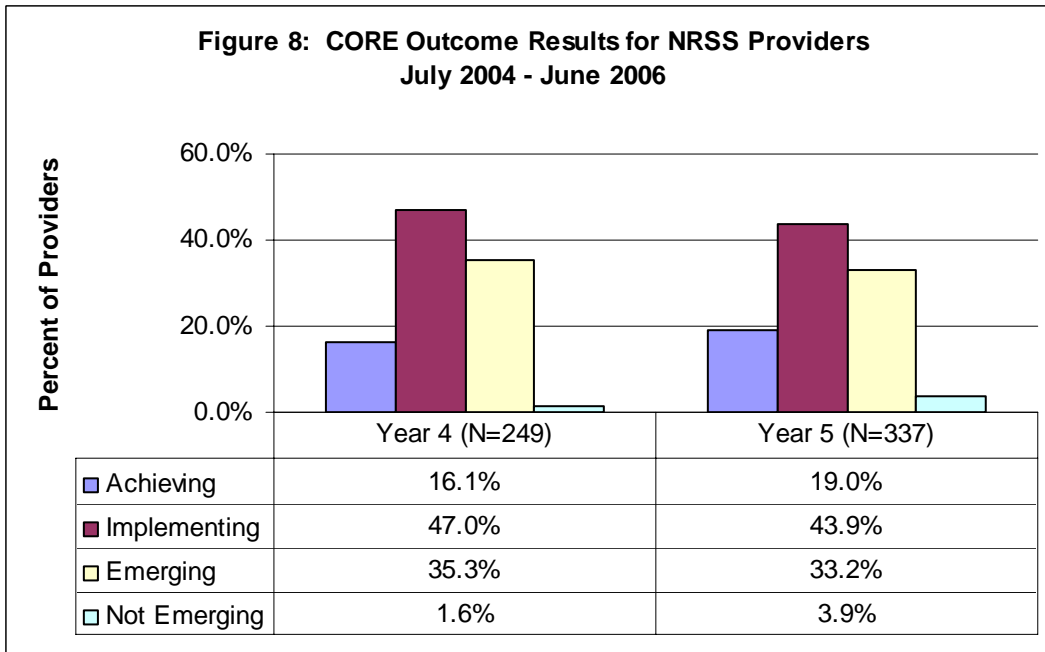
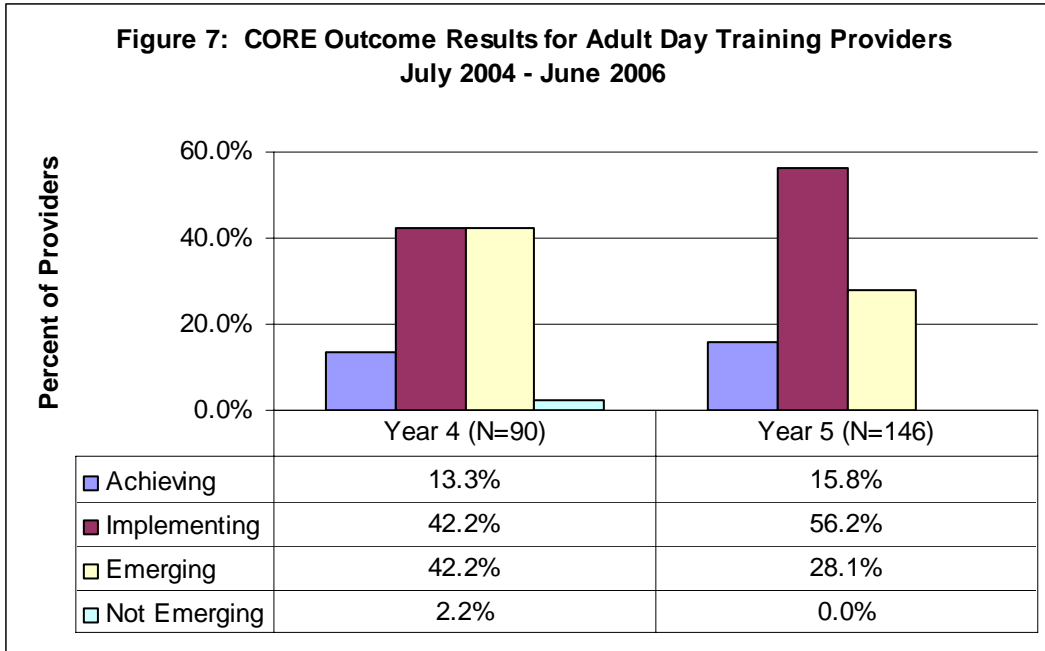
¹³ See Appendix 1, Attachment 3 for a description of each outcome element.

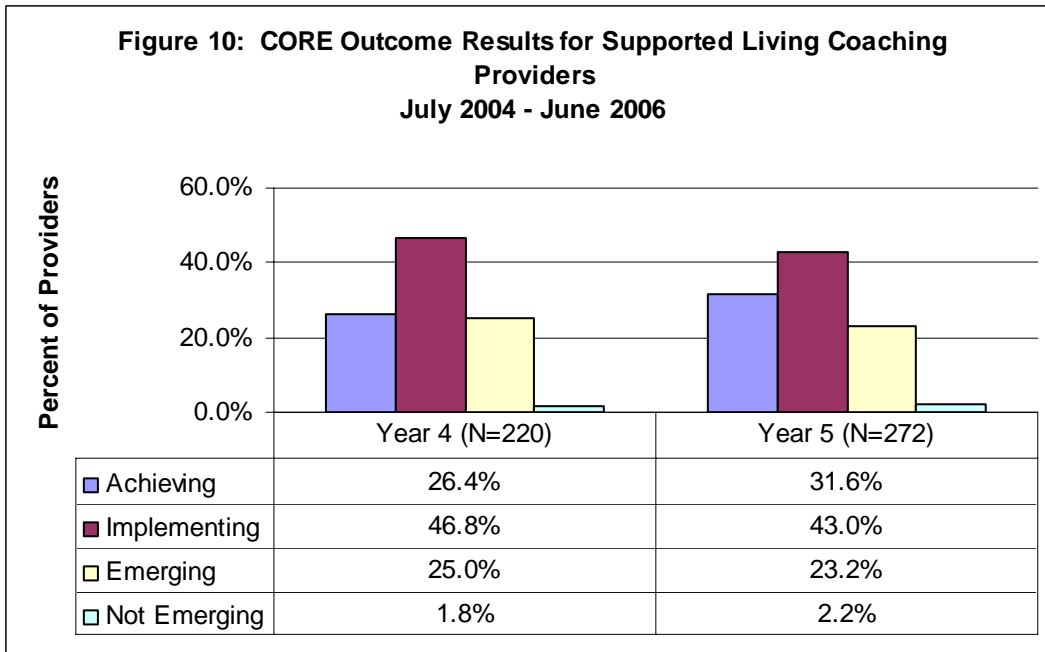
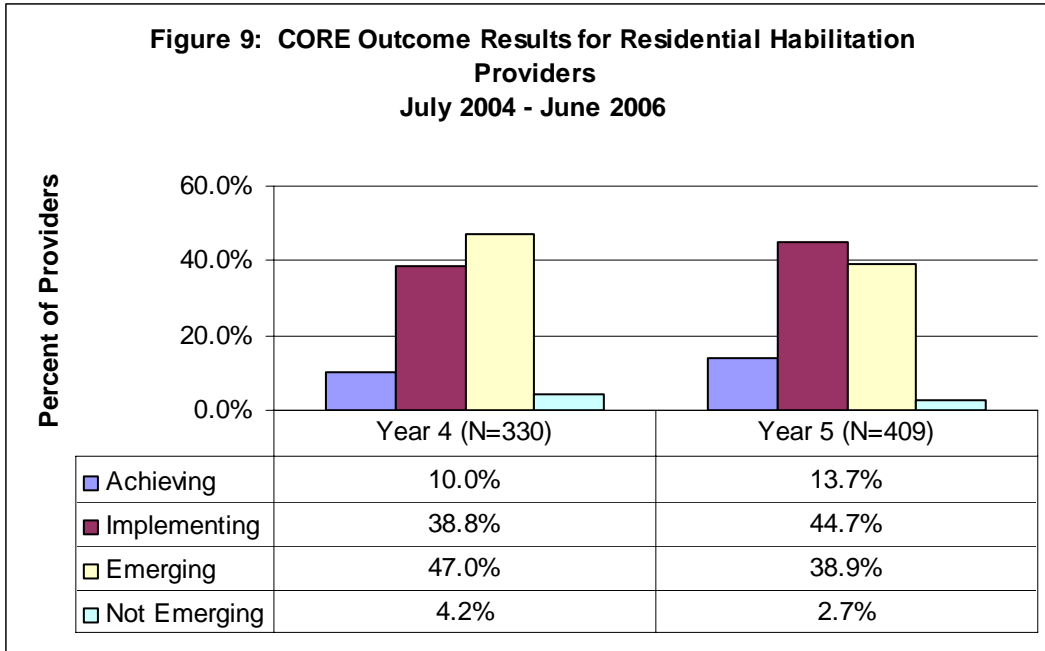
- Element 10 is least likely to be evaluated as Achieving both years, indicating individuals are not adequately developing desired social roles that they value, approximately 11 percent each year.
- Element 14, indicating individuals do not routinely participate in review of the implementation plan or direct changes desired to assure outcomes/goals are met, remains the area most likely to be scored as Not Emerging, 23 percent of the providers (147) in Year Four and close to 17 percent (133) in Year Five.

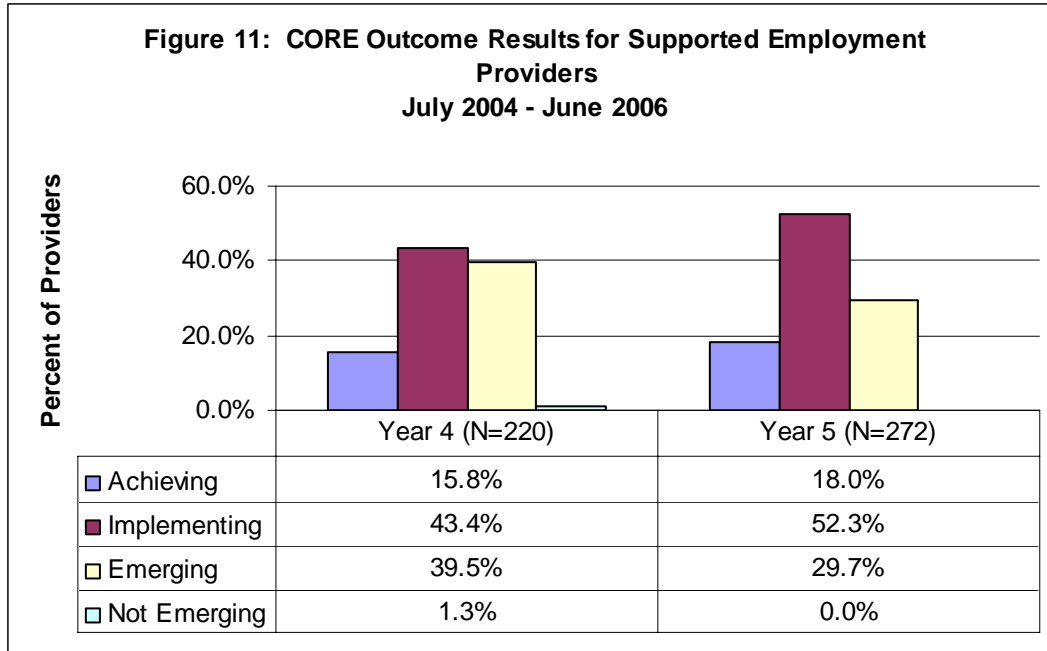
Outcome Results by Service

The following series of charts (Figures 7-11) shows CORE trends by the type of services provided: ADT, NRSS, Residential Habilitation, Supported Living Coaching, Supported Employment, and In-Home Support Services. It is important to note that each provider may render several different services and that CORE consult results are based upon the lowest score for any service that is provided. Therefore, comparing across services at the aggregate level is not appropriate as a low score may be due to a different service that was rendered by the providers. However, comparing the same service over the years includes many of the same providers and is therefore a more acceptable analysis. For comparative purposes, each figure that follows gives the Year Four and Year Five results. A summary of findings includes the following:

- Within every service, there was a small to moderate increase from Year Four to Year Five in the proportion of providers scored as Achieving, from 2.2 points for IHSS and Supported Employment to 5.3 points for providers of Supported Living Coaching.
- Providers of ADT appear to have improved over the two years. The proportion scored as Implementing has increased by almost 14 percentage points. The proportion scored as Emerging has decreased at approximately the same amount.
- On average, providers of NRSS performed fairly consistently from Year Four to Year Five, with an approximately three point shift up at the Achieving level and three point shift down at the Implementing level.
- Residential Habilitation demonstrated an improvement in both Achieving and Implementing, with a smaller proportion of providers in Emerging and Not Emerging.
- Providers of Supported Living showed the greatest increase at the Achieving level.
- Supported Employment providers demonstrated a shift from Not Emerging and Emerging to the Implementing and Achieving levels.







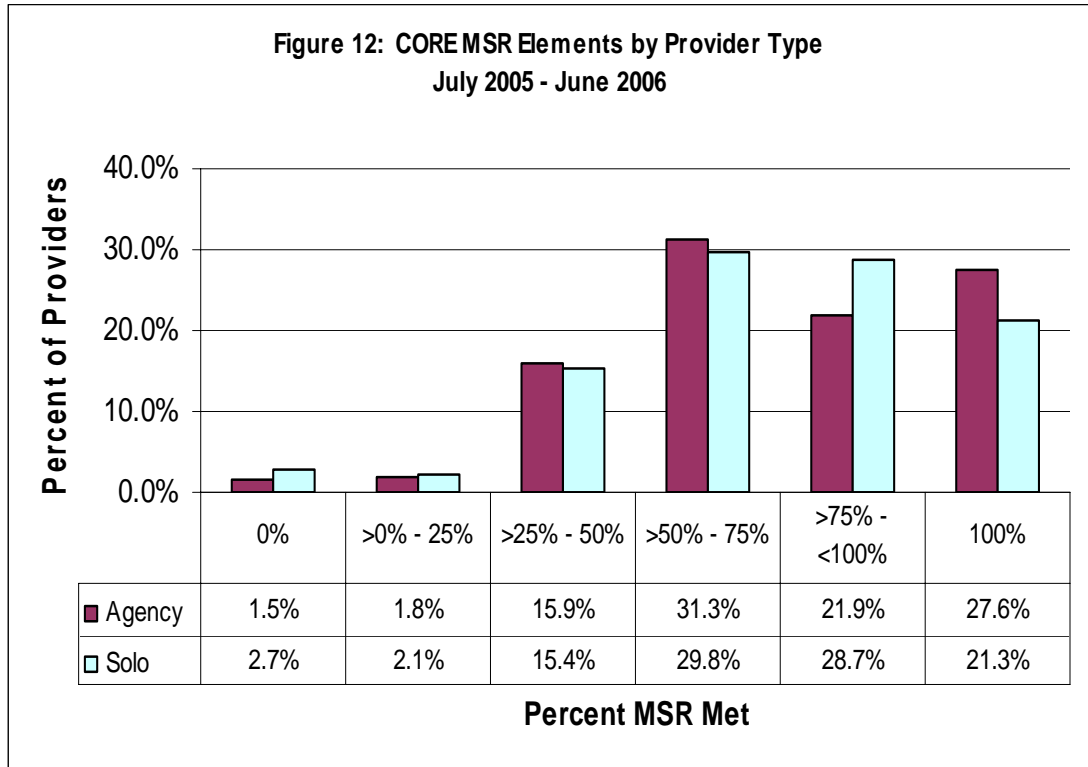
IHSS and Special Medical Home Care (SMHC) were added to the list of services monitored through a CORE consult in Year Five of the contract. Therefore, we can not provide trend data for these services. There was only one provider of SMHC and the providers of IHSS during Year Five were evaluated as:

- Achieving: 22.7%
- Implementing: 44.2%
- Emerging: 28.8%
- Not Emerging: 4.3%

Minimum Service Requirements

The last seven of the 25 elements in the CORE are the Minimum Service Requirement (MSR) elements.¹⁴ Providers must supply documentation of the required background screening, required training, and proper billing procedures. MSR elements are evaluated as Met or Not Met. The following chart shows the percent of consults distributed across the percent of MSR elements that were scored as Met.

¹⁴ See Appendix 1, Attachment 3 for a description of each MSR element.



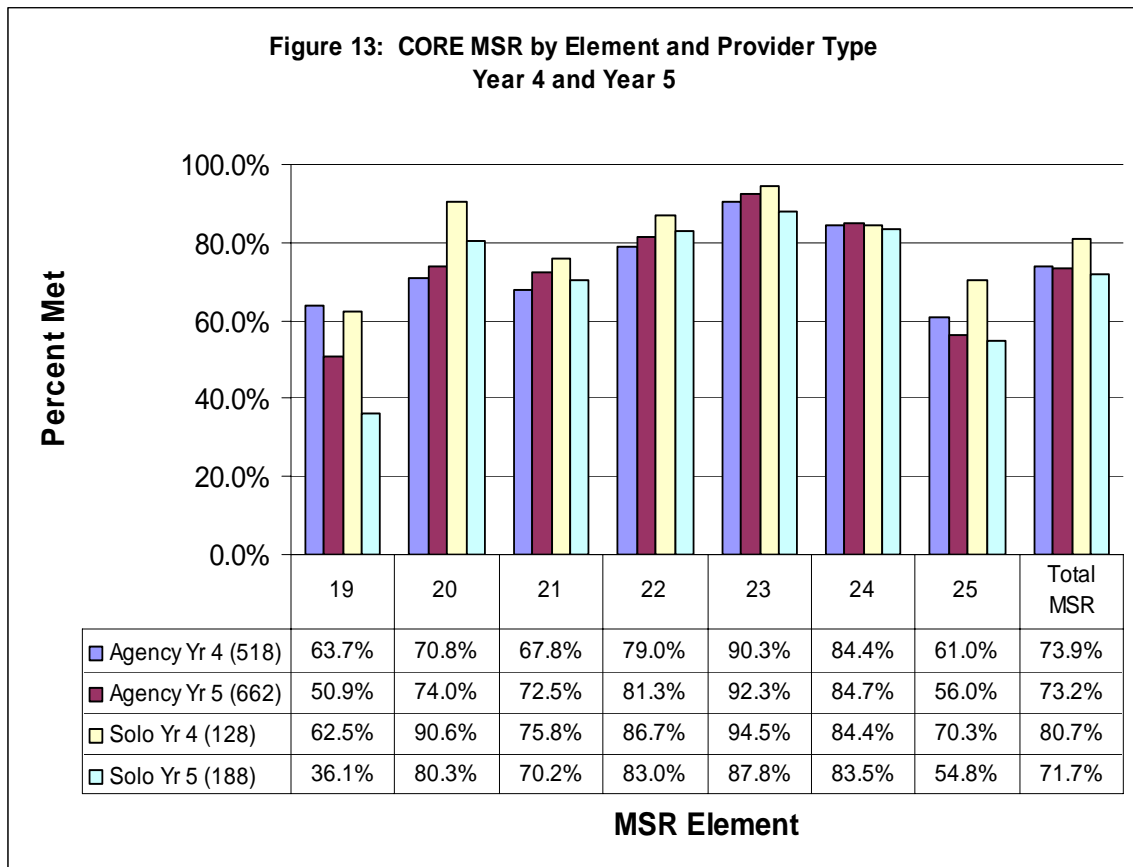
- During Year Five of the contract, agency providers were more likely to have 100% of the CORE MSR elements scored as Met (27.6%) than were solo providers (21.3%). This is opposite the results in Year Four when solo providers were more likely to have 100% of these elements Met (35.2% compared to 27.0%).
- Approximately 50 percent of both agency and solo providers had the required documentation for over 75 percent of the MSRs.
- Approximately 20 percent of both agency and solo providers had the required documentation for 50 percent or less of the MSRs.
- This increase is close to a 10 percentage points over Year Four for solo providers. In Year Four, 12 of 128 providers scored Met on 50 percent or fewer of the MSR elements, compared to 38 of 188 providers in Year Five.
- In Year Five, ten agency providers and five solo providers did not meet the requirements for any of the MSRs, compared to three agencies and zero solo providers in Year Four.

In the following figure, the number and percent of MSR elements scored as met are given at the element level for Years Four and Five. Highlights from the results include the following:

- On average, agency and solo providers appear to be scoring about the same on these elements in Year Five, 73.2 percent to 71.7 percent respectively. For

agency providers this represents about the same percent of MSRs met as in Year Four, but is a drop from 80.7 percent for solo providers.

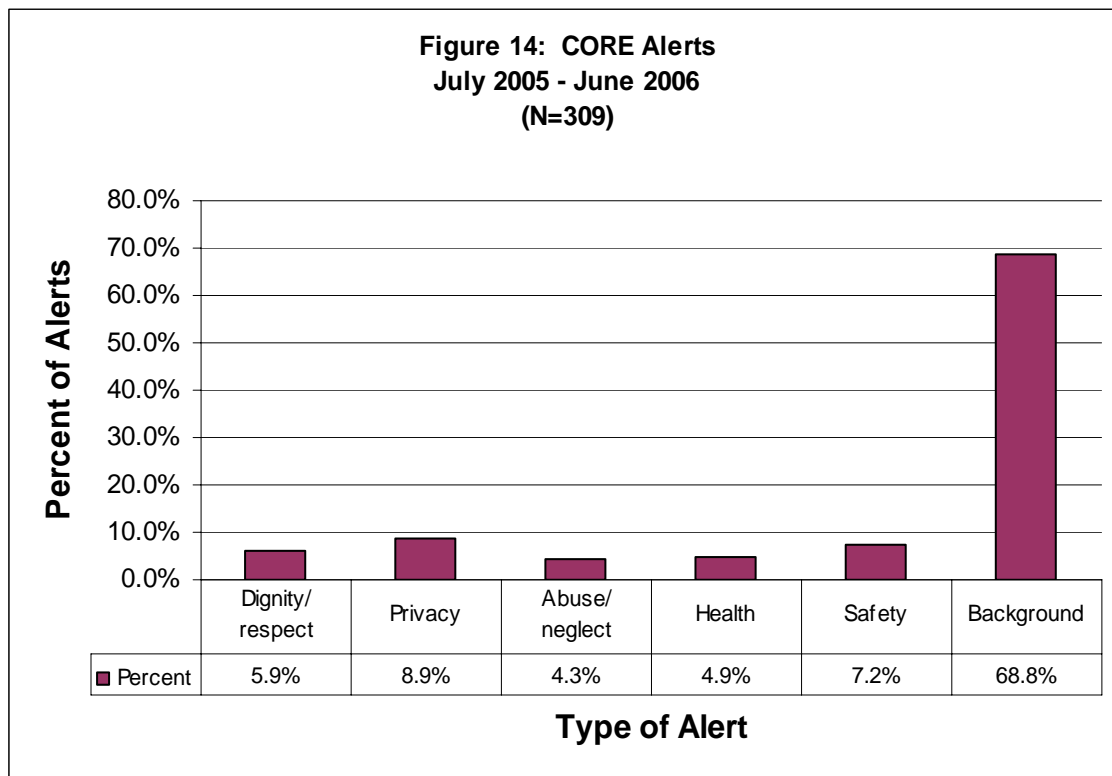
- On average, both types of providers scored worse on Element 19 in Year Five than in Year Four, measuring projected service outcomes. There is also a substantial difference between the two provider types in Year Five. Solo providers were far less likely to score this as Met (only 36%) than were agency providers—a difference of close to 15 percentage points.
- Solo providers continue to do better with documenting background screening (Element 20) than agency providers. However, the difference between them has decreased. Agency providers have improved over the two year period from 70.8 percent to 74 percent, while solo providers dropped from 90.6 percent to just over 80 percent. The current difference between the two is not statistically significant.
- As in Year Four, agency and solo providers were most likely to score Met on Element 23, reflecting proper authorization to provide the service(s).
- Agency and solo providers performed poorly on Element 25 each year, and lower in Year Five than in Year Four, indicating they don't always maintain the required documentation for the service and they have not improved in this area. Solo providers demonstrated over a 15 point drop on this element.



CORE Alerts and Recoupments

Several elements in the CORE evaluation are Recoupment or Alert items.¹⁵ Elements are cited as an alert if it is determined by the consultant that areas of dignity and respect; privacy; abuse, neglect and exploitation; health; or safety warrant immediate corrective action. Failure to meet the requirements for background screening is also cited as an Alert item. Elements are cited as a Recoupment if the provider is not in compliance with the monitoring and billing documentation requirement for the services rendered.

The number and percent of each item scored as an alert are depicted in the following chart (Figure 14). As documented, a majority of CORE alerts relate to background screening. Close to 69 percent of the alerts indicate background screening had not been obtained as required. The remaining 95 alerts are in the areas of dignity and respect; privacy; abuse, neglect and exploitation; health; and safety.¹⁶



The 309 alerts involved 245 different providers. Of these providers:

- 205 had one alert;
- 26 had two alerts;

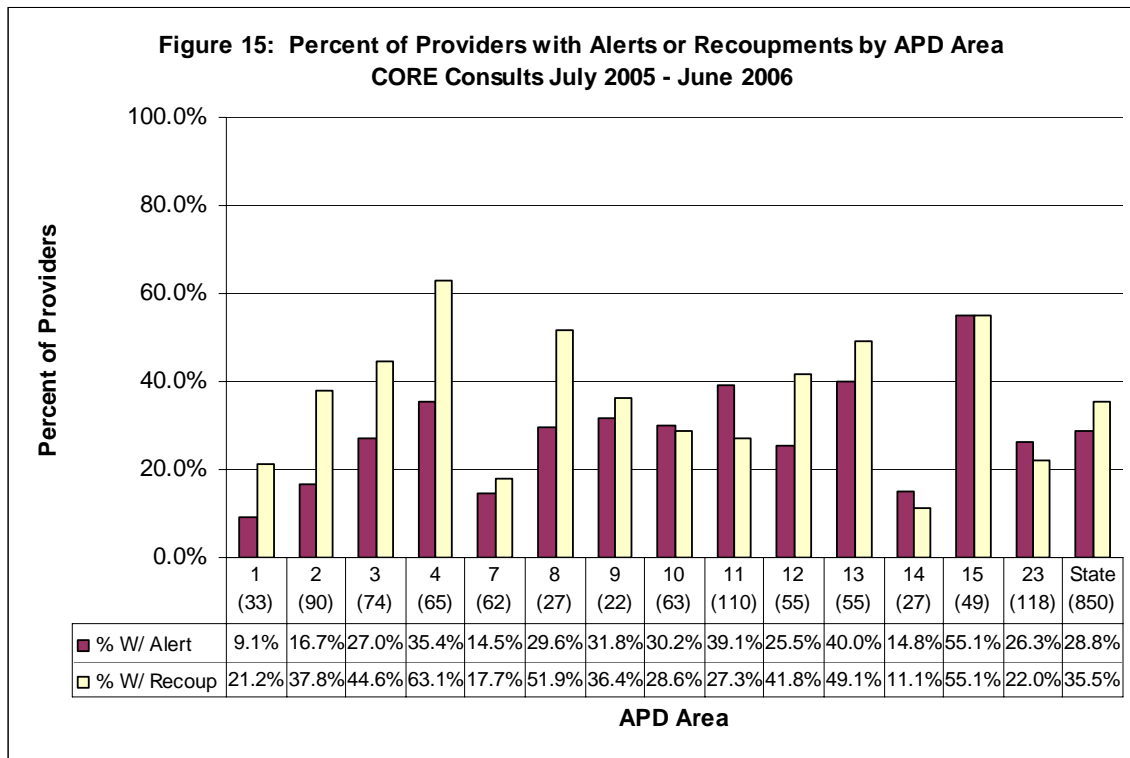
¹⁵ See Outcome Elements Table, Appendix 1, Attachment 3. Alert items are numbers 2, 3, 7, 8 and 9. For the MSR elements, the “level 2 background screening” element (20) is an alert item.

¹⁶ See Appendix 2, Exhibits 3 and 4 for information on alerts and recoupments by APD Area.

- 10 had three alerts;
- 3 had four alerts;
- 1 had five alerts.

Information on alerts and recoupments by APD Area is given in Exhibit 4 (Appendix 2) and includes the following:

- Of the 850 CORE completed in the twelve-month period ending June 2006, 302 providers (35.5%) received a total of 415 recoupment citations. This is up from 274 citations in Year Four, involving 199 (31.1%) of providers who received a CORE consult.
- Solo and agency providers were about equally likely to receive a recoupment citation, 35.8 percent of agencies and 34.6 percent of solo providers.
- On average, providers were more likely to receive a recoupment citation (35.5% of providers or 302) than an alert (28.8 percent of providers or 245).



This last bullet is demonstrated in Figure 15 that shows the percent of providers who received an alert or recoupment by APD Area, during Year Five. The relative number of providers who received an alert ranged from just over nine percent in Area 1 to over 55 percent in Area 15. The proportion of providers who received a recoupment citation ranged from just over 11 percent in Area 14 to over 63 percent in Area 4. In addition,

over 50 percent of providers in APD Areas 8 and 15 were given a recoupment citation and 40 percent of providers in Area 13 were cited with an alert.

Follow Up Reviews and Follow Up with Technical Assistance Reviews

During Year Five of the contract, a total of 163 providers received a Follow Up review and 359 received a Follow Up with Technical Assistance review subsequent to a CORE consult. Of these 352 providers, 380 had at least one MSR element scored as Not Met.¹⁷ The only “scores” that are subject to change in either of the follow up procedures are the seven MSR elements. Results of the follow-up activities are shown in Table 10.

Table 10: CORE Follow UP Reviews
Percent of MSR Elements Met at Follow UP--Previously Not Met
July 2005 - June 2006

Percent Met at FU	Follow Up	FU w/ TA	Total	Follow Up	FU w/ TA	Total
lt 25%	17	58	75	17.0%	20.7%	19.7%
25% - lt 50%	6	27	33	6.0%	9.6%	8.7%
50% to lt 75%	13	81	94	13.0%	28.9%	24.7%
75% to lt 100%	3	14	17	3.0%	5.0%	4.5%
100%	61	100	161	61.0%	35.7%	42.4%
Total	100	280	380	100.0%	100.0%	100.0%

- Of the 163 Follow Up reviews that were completed, 100 providers received a Not Met on one or more of the MSR elements. Of the 359 Follow Up w/ TA reviews, 280 providers received a Not Met on one or more of the MSR elements.
- On average, 161 (42.4%) providers received a Met on 100% of the MSR elements that had been scored as Not Met on their annual CORE consult.
- Providers receiving a regular Follow Up were more likely to score Met on 100% of elements that had been scored as Not Met than providers who received a Follow Up w/ TA, 61percent (61) compared to 35.7 percent (100).
- 69 providers had no change in the MSR elements following either Follow Up review types—all remained Not Met.
- On average, of the 982 MSR elements scored as Not Met during the annual CORE consult, 599 (61%) were scored as Met on the follow-up review.

Reconsiderations

In Year Five, 72 Reconsiderations were processed, 20 for a CORE and 52 for a Desk Review. Of these, 45 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 table below displays the

¹⁷ A follow-up can be completed for providers who scored all the MSR elements as Met, but needed a follow-up for an outcome element.

number of Reconsiderations completed for Desk Reviews and CORE consults for Years Four and Five, the number approved or denied, and the percent approved. Approximately the same percent of providers requested a Reconsideration each year. Four of the 20 CORE Reconsiderations in Year Five were approved (2.4%) and 41 of the Desk Review Reconsiderations were approved (82%).

Table 11: Reconsiderations for Desk and CORE

Year Four: July 2004 - June 2005

Review Type	Number Reviews	Approved	Denied	Percent Recon	Percent Approved
Desk	1247	47	22	5.5%	68.1%
CORE	639	0	8	1.3%	0.0%
Total	1,886	47	30	4.1%	61.0%

Year Five: July 2005 - June 2006

Review Type	Number Reviews	Approved	Denied	Percent Recon	Percent Approved
Desk	1,048	41	9	4.8%	82.0%
CORE	850	4	16	2.4%	20.0%
Total	1,898	45	25	3.7%	64.3%

WiSCC Evaluations

All providers of Support Coordination receive a Waiver Support Coordination Consultation (WiSCC) annually. The WiSCC combines a consultation with the waiver support coordinator and Personal Outcome Measure interviews with at least two individuals the support coordinator supports.

Distribution and Overall Results by APD Area

A total of 468 WiSCCs were completed and approved during Year Five of the Contract, July 2005 – June 2006. This is somewhat more than the target for the year of 406. As part of these consults, 687 Waiver Support Coordinators (WSC) were reviewed and 1,454 individuals were interviewed.¹⁸ (Consultants expected to interview approximately 1,572 individuals before June 30, 2006). The WiSCC consults and WSCs were distributed across the APD Areas as shown in the following table.

¹⁸ Of the 1,454 Personal Outcome Measures (POM) interviews, 91 were not part of the random sample for and are not included in the data analysis. Most of these were interviews for the Longitudinal sample that were not completed in Year Four. Others were selected for POM reliability.

Table 12: WiSCC and WSCs by APD Area

July 2005 - June 2006

Area	WiSCCs	WSCs	Percent WSCs
1	15	32	4.7%
2	41	51	7.4%
3	20	32	4.7%
4	55	63	9.2%
7	72	83	12.1%
8	19	25	3.6%
9	19	32	4.7%
10	32	49	7.1%
11	55	84	12.2%
12	17	29	4.2%
13	13	32	4.7%
14	16	25	3.6%
15	19	25	3.6%
23	75	125	18.2%
Total	468	687	100.0%

Each Waiver Support Coordinator (WSC) is evaluated on six Outcome Elements and five Minimum Service Requirements (MSR). With the Outcome Elements, consultants determine if organizational systems are in place that help individuals being served achieve outcomes that are important to them. For example, is the WSC learning about the people served and aware of their health, safety and well-being? Is the individual helping with the development of a support plan? The WSCs are evaluated on these six elements similar to the way CORE providers are evaluated, as Achieving, Implementing, Emerging and Not Emerging.¹⁹

An outcome score is calculated for each Support Coordinator using the same values for each evaluation level as described earlier for CORE:²⁰

- Achieving = 3
- Implementing = 2
- Emerging = 1
- Not Emerging = 0

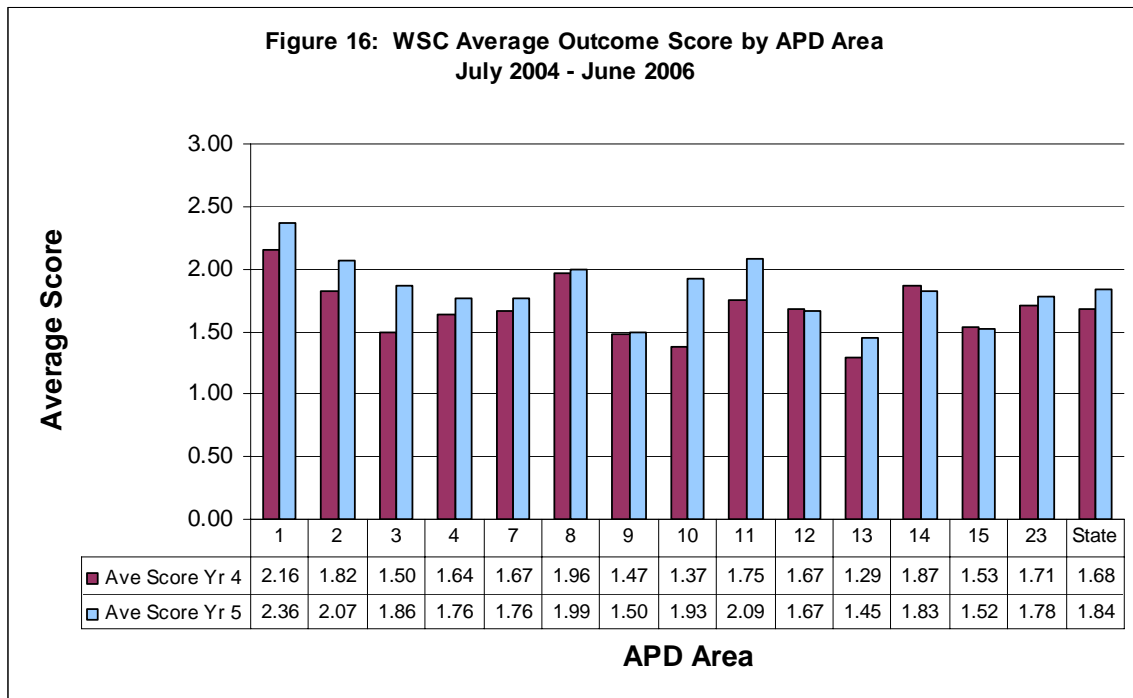
A score, between zero and three, is calculated for each WSC, based upon the element level evaluations. Therefore, if WSCs score Achieving on all six Outcome Elements,

¹⁹ See Appendix 1, Attachment 3 and 4 for a description of the evaluation levels and a list of the WiSCC Elements.

²⁰ As with the CORE scores, it is important to note here that we are calculating an “average” from what is essentially qualitative (ordinal) data. While often used for analytic purposes, the “distance between” each value is not a standard unit, such as with age.

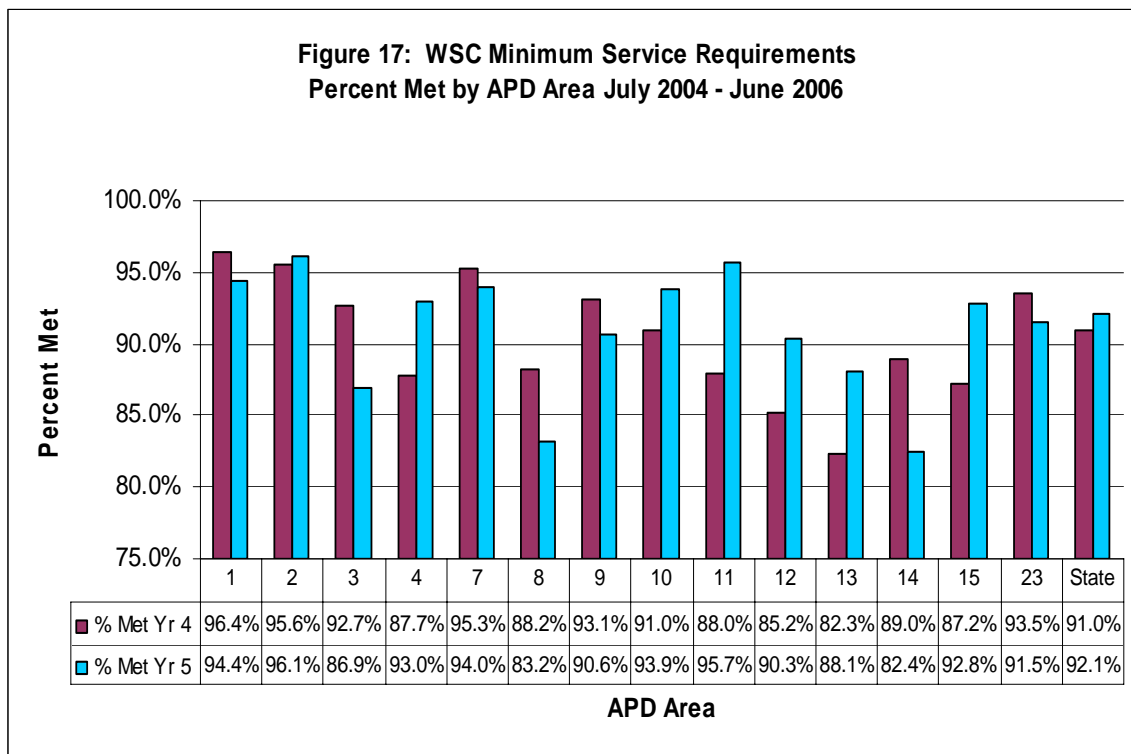
their outcome score is a three. These are then summed and divided by the number of elements scored in each APD Area for an average WSC score per Area. Results for the first two years of WiSCC data are presented in Figure 16.

- The statewide average for the initial year of the WiSCC process was 1.68, between Emerging and Implementing, somewhat closer to Implementing. This has increased somewhat in Year Five to 1.84.
- The average score in each Area has remained fairly constant or improved since Year Four.
- APD Area 10 demonstrated the greatest improvement with an increase from Year Four to Year Five of over ½ point (0.56). Thinking in terms of a “one point” difference between each evaluation level, this appears to be a relatively large increase.
- Areas 3, 11, 2, and 1 also showed improvement of 0.36, 0.34, 0.25 and 0.21 respectively.



The five MSRs are process elements and are similar to those discussed in the CORE section of this report. These are scored as Met or Not Met. The average percent of MSRs scored as Met in each APD Area for the first two years of CORE utilization is shown in Figure 17.

- The state average has remained fairly consistent over the two year period, moving from 91.0 percent in Year Four to 92.1 percent in Year Five.
- The scores in Year Five ranged from a low of 82.4 percent in Area 14 to a high of 96.1 percent in Area 2.
- Area 11 demonstrated the greatest increase in the percent of MSR elements scored as Met, a 7.7 percentage point improvement.
- Area 14 showed the greatest decrease in the percent of MSR elements scored as Met, a 6.6 point drop.
- Areas 4, 12, 13, and 15 also showed improvement of over five percentage points.
- Areas 3 and 8 dropped by at least five points.



Outcome Elements

Each of the 687 WSCs received an evaluation of Achieving, Implementing, Emerging or Not Emerging on the six Outcome elements. The distribution of the number and percent for each element is displayed in the next table.²¹ Year Four statewide averages are presented in the bottom row for comparative purposes.

²¹ See Appendix 1, Attachment 4 for a description of each evaluation level and Attachment 5 for a description of each element.

Table 13: WiSCC Outcome Elements by Level of Evaluation
Year 5 - July 2005 - June 2006

Outcome Elements	Achieving		Implementing		Emerging		Not Emerging	
	Number	Pct	Number	Pct	Number	Pct	Number	Pct
1	311	45.3%	297	43.2%	79	11.5%	0	0.0%
2	84	12.2%	258	37.6%	320	46.6%	25	3.6%
3	136	19.8%	338	49.2%	207	30.1%	6	0.9%
4	177	25.8%	294	42.8%	208	30.3%	8	1.2%
5	107	15.6%	299	43.5%	268	39.0%	13	1.9%
6	85	12.4%	270	39.3%	304	44.3%	28	4.1%
Year Five	900	21.8%	1,756	42.6%	1,386	33.6%	80	1.9%
Year Four	661	16.4%	1,509	37.5%	1,755	43.6%	101	2.5%

Information from the data in Table 13 indicates the following:

- On average, in Year Five outcome elements were more likely to be evaluated as Implementing than at any other level. This represents an improvement from Year Four when they were most likely to be evaluated as Emerging.
- Relatively more of the outcome elements were evaluated as Achieving in Year Five and fewer evaluated as Emerging, compared to Year Four. This represented an increase at the Achieving level on every element, with Element 2 (Health and safety issues) remaining the same as in Year Four.
- Providers were most likely to score Achieving on Element 1 (45.3%), indicating they often have an effective method for learning about the people they serve. This is up from just over 35 percent in Year Four, the greatest gain among all the outcome elements at the Achieving level;
- Providers were least likely to score Achieving on Element 2 (12.2%) indicating they are not fully aware of the health, safety and well-being of the people they serve and Element 6 (12.4%), indicating the accomplishment of positive results;
- Elements 2 and 6 were more likely than the other elements to be scored as Not Emerging, indicating that some WSCs (25) exhibit a total lack of awareness for the health, safety and well-being of individuals and some WSCs (28) have not facilitated positive results reflective of the preferences that matter most to the individual.

Outcome Elements by Provider Type

A comparison across provider types reveals small differences between support coordinators working for an agency or operating as a solo provider. During Year Five, there were 342 support coordinators working with an agency and 345 working as solo providers. Results of the evaluations on the WiSCC elements for WSCs are presented for Agency and Solo providers in the following three charts: Figure 18 shows the results in Year Five by provider type; Figure 19 shows results for Agency providers for Year Four and Year Five; Figure 20 shows Year Four/Five results for Solo providers. Percents

represent the percent of elements scored at the various levels, i.e., Achieving, Implementing, Emerging or Not Emerging.

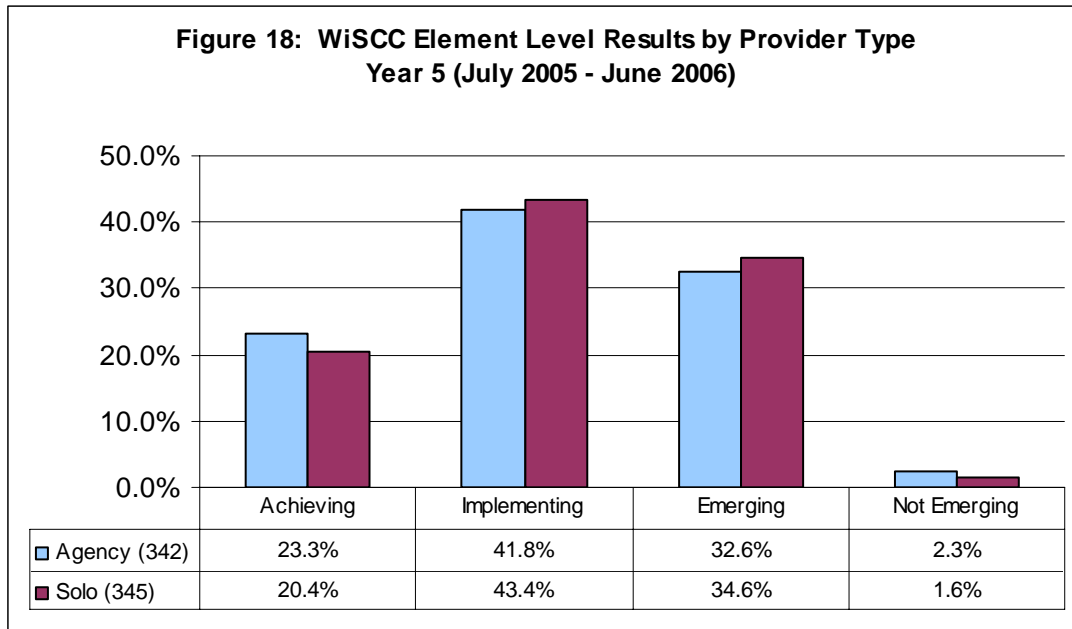
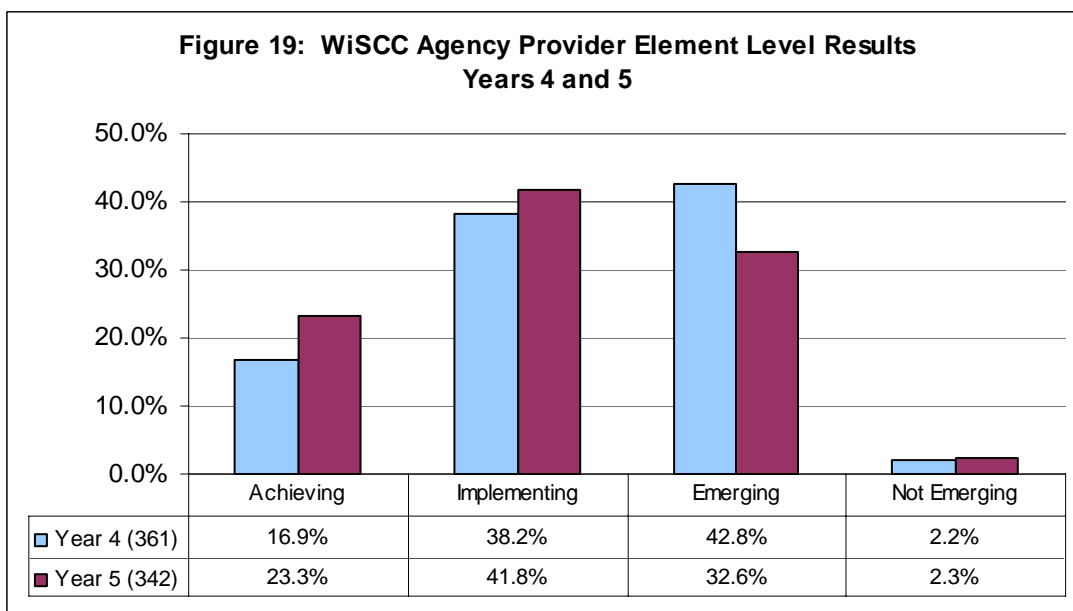
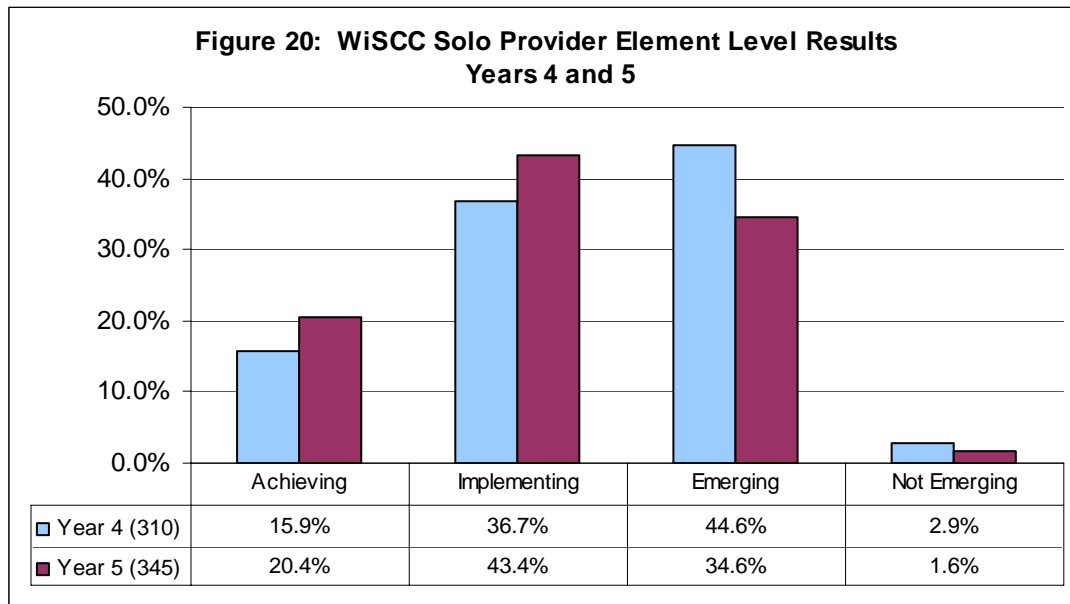


Figure 18 above pictures the difference between Agency and Solo providers for the 12 month period ending June 2006. They appear to be performing at about the same level, with Agency providers slightly more likely to have elements scored as Achieving. Approximately 64 percent of the outcome elements for Solo providers were evaluated as Implementing or Achieving, compared to approximately 65 percent for Agencies.



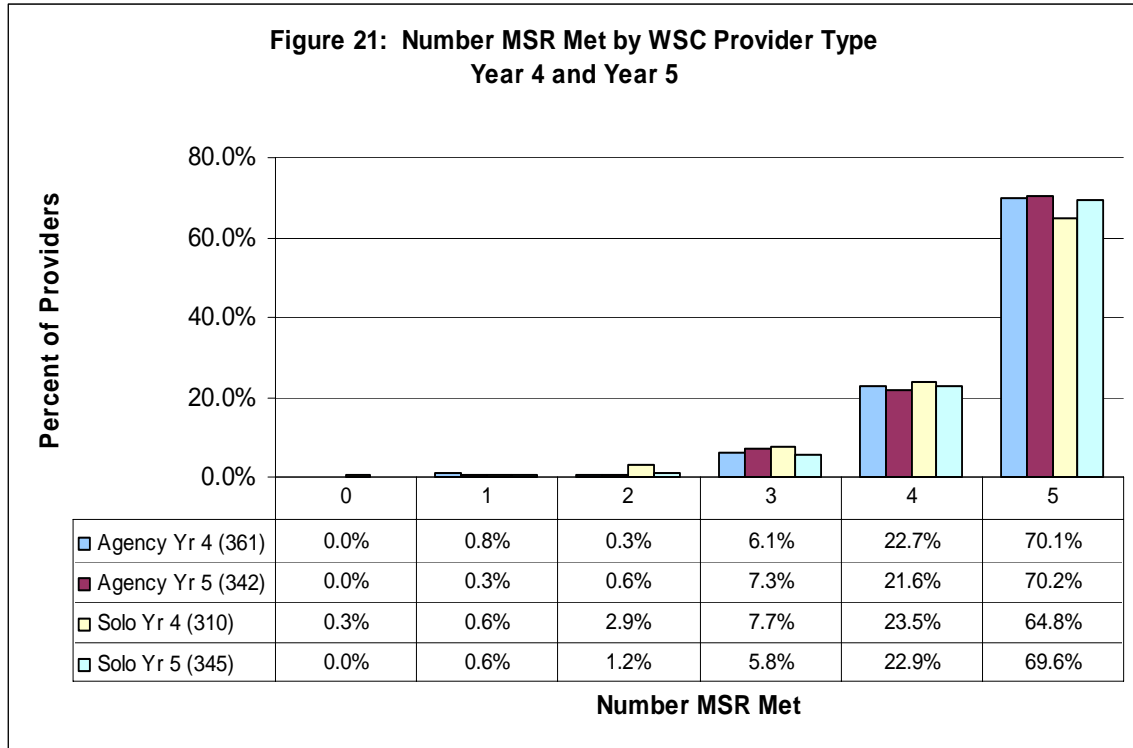


Outcome element results for Years Four and Five for the two different provider types are shown separately in Figures 19 (Agency) and 20 (Solo) above. On average, both types of providers improved in Year Five, increasing the percent of elements scored as Achieving and as Implementing by approximately 10 points, while at the same time reducing the percent scored as Emerging.

Minimum Service Requirements

As noted previously, the Minimum Service Requirement (MSR) elements are process related and are similar to elements scored during the first three years of the contract.²² Providers must supply documentation of the required background screening, required training, and proper billing procedures. MSR elements are evaluated as Met or Not Met. The following graph portrays the percent of Waiver Support Coordinators distributed across the number of MSR elements that were scored as Met for Year Four (July 2004 – June 2005) and Year Five (July 2005 – June 2006). The numbers zero through five represent the number of MSR elements and the percent is the percent of providers for each number Met. The first two columns represent Agency providers in Year Four and Year Five and the second two columns represent Solo providers.

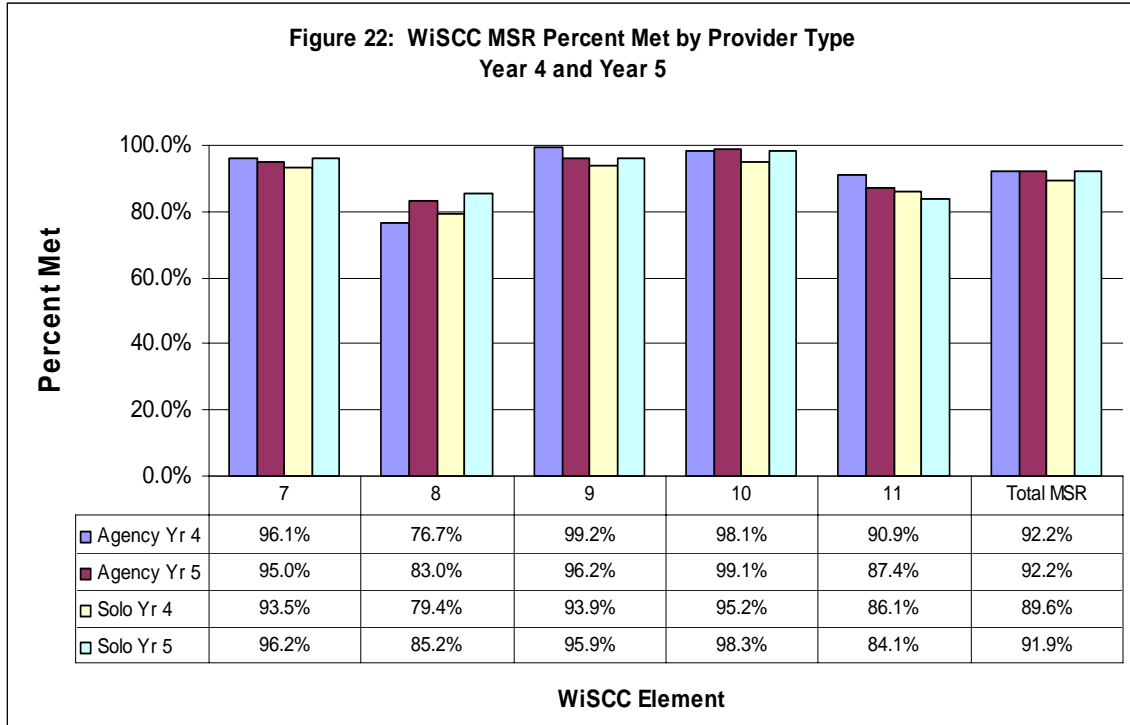
²² See Appendix 1, Attachment 5 for a description of each MSR element.



- Of the 1,358 WSCs who participated in a WiSCC in this two year time period (many in both years), only one is shown as having none of the MSR elements scored as Met—one Solo provider in Year Four (0.3%).
- A majority of both types of providers scored all five MSR elements as Met in both years.
- On average, the percent of providers who scored Met on all five MSR elements has moved up slightly from around 68 percent to close to 70 percent.
- The trend for Agencies over the two years has been fairly consistent but Solo providers have shown improvement, with close to a five percentage point increase for providers who scored all five of these elements as met.
- The percent of Agency providers who scored met on three or fewer MSRs also remained somewhat consistent (increase of only one point), but decreased just over four points for Solo providers (11.6% to 7.5%).

In the following figure, the number and percent MSR elements scored as met is given at the element level by provider type and year.²³ The first two columns represent Agencies and the second two columns represent Solo providers. On average, the total Percent Met has remained fairly consistent, 91 percent in Year Four and 92 percent in Year Five.

²³ See Appendix 1, Attachment 5 for a description of the WiSCC MSR elements.



Highlights from Figure 22 include:

- The average Percent Met for both types of providers has remained constant over the two years, slightly up for Solo providers.
- Both Agency and Solo providers showed a downward shift on Element 11, maintaining the required documentation for billing.
- Both types of providers showed improvement on Element 8, showing they have attended the required training, but are performing relatively poorly in this area compared to the other MSRs.
- Solo providers showed some improvement on every element with the exception of Element 11, as noted above.
- On average, both agency and solo support coordinators have good documentation of background screening (Element 7), 95 percent and 96 percent met respectively.

Follow-up With Technical Assistance

Prior to departing the WiSCC, the Quality Improvement Coordinator (QIC) and WSC agree upon a date on which the QIC can return to provide Follow-up with Technical Assistance. This takes place between 10 and 90 days for solo WSCs and small WSC agencies. Follow-up with Technical Assistance for large WSC agencies may occur between 10 and 180 days following the WiSCC. These follow-up activities determine the effectiveness of the FOCUS plan initiatives, as well as provide an opportunity to review any follow-up to individual recommendations. Technical Assistance is directed toward maintaining the momentum of the WSC entity, and ensuring that WSC efforts are still on

target to assist individuals toward achieving results that reflect communicated choices and preferences that matter most to them.

WiSCC Reconsiderations are conducted when a provider contests the results of the annual onsite consultation. Reconsiderations can only be requested on the minimum service requirement elements in the WiSCC process (Elements 7-11). There were no reconsiderations during the first two years of implementation of the WiSCC process.

Personal Outcome Measure Sample Description

The Florida Developmental Disabilities Program has been in the forefront of efforts to provide a community-based person centered/outcomes approach to delivery of services to persons with developmental disabilities. They have adopted the use of the Personal Outcomes Measures (POMs) developed and published by The Council on Quality and Leadership (CQL) to report Performance Indicators to the State of Florida.²⁴ The POM is a primary component of the WiSCC process, 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 POM include follow-up interviews and a central record review with the WSC, and a Medical Peer Review.

POM Interviews were completed on 1,363 randomly selected consumers of DD Waiver services in Year Five of the contract.²⁵ The sample is a random cluster design, stratified by provider type. For all solo WSCs, two individuals they served at the time of their consultations were randomly selected for the POM interview. Each individual was assigned a number, and computer generated random numbers were used to identify individuals selected for the sample. If the individual had completed a POM interview at any time during the first four years of the contract, that person was excluded from the sample. During Year Five, individuals were excluded if they had participated in a POM during the previous 12 months.

For agencies with more than four WSCs, two different consultations were completed, with the second one at least six months after the first. A two step sampling process was followed. First, four WSCs were randomly selected for the first consultation, using the same process as described above. Second, two individuals were randomly selected from each WSC. For the second consultation, the process was completed again, eliminating the WSCs already selected. A maximum of eight WSCs from any agency were selected to participate in the WiSCC, four with each consultation. Individuals who had previously completed a POM were excluded from the sample.

²⁴ Go to <http://www.thecouncil.org> for information on the history of the Council, their mission statement and the development of the POM tool.

²⁵ An additional 91 POMs were completed with individuals who were not part of the random sample.

Demographic Distribution of the Sample

The following table provides information by APD Area on the enrolled population and sample of individuals who received a POM interview in the twelve month period ending June 30, 2006. While the proportion of individuals in the sample varies somewhat from the population, the variances are generally quite small, no greater than 2.4 percentage points. Therefore, the sample appears to be a good representation of the population across the areas in the state.

Table 14: Enrolled Population and POM Sample by APD Area
July 2005 - June 2006

District	Enrolled Individuals		Individuals in Sample	
	Number	Percent	Number	Percent
1	1,240	4.9%	66	4.8%
2	1,886	7.4%	102	7.5%
3	1,197	4.7%	64	4.7%
4	1,976	7.8%	126	9.2%
7	2,463	9.7%	165	12.1%
8	902	3.6%	50	3.7%
9	1,409	5.6%	63	4.6%
10	2,179	8.6%	96	7.0%
11	3,499	13.8%	161	11.8%
12	889	3.5%	58	4.3%
13	1,400	5.5%	64	4.7%
14	887	3.5%	50	3.7%
15	844	3.3%	50	3.7%
23	4,579	18.1%	248	18.2%
Total	25,350	100.0%	1,363	100.0%

Gender information for the population and sample in Year Five indicates that 53.9 percent of the consumers reviewed were male, and 46.1 percent were female. This distribution is slightly different from demographic information for the enrolled DD Waiver population. There is a slightly higher percentage of females in the population, but the difference is less than five percentage points and therefore consistent with some degree of sampling fluctuation.

Table 15: Enrolled Population and POM Sample by Gender
July 2005 - June 2006

Gender	Enrolled Individuals		Individuals in Sample	
	Number	Percent	Number	Percent
Female	10,849	42.8%	627	46.1%
Male	14,500	57.2%	734	53.9%
Total	25,349	100.0%	1,361	100.0%

The population and sample distributions by age group are shown below in Table 16. In previous years, the proportion of children age three to 17 in the sample has been somewhat lower than the proportion in the population. In Year five, however, this difference is minimal. The sample appears to represent the population fairly well in terms of age distribution.

Table 16: Enrolled Population and POM Sample by Age Group
Year 5 - July 2005 - June 2006

Age Group	Population		Sample	
	Number	Percent	Number	Percent
< 18	4,224	16.7%	194	14.2%
18 - 21	2,129	8.4%	86	6.3%
22 - 25	2,369	9.3%	130	9.5%
26 - 44	10,693	42.2%	598	43.9%
45 - 54	3,753	14.8%	215	15.8%
55 - 64	1,631	6.4%	99	7.3%
65+	528	2.1%	26	1.9%
Unknown	22	0.1%	15	1.1%
Total	25,349	100.0%	1,363	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. The table below provides information identifying the living arrangement for the enrolled population and the fifth year sample at the time of the interview. Almost 59 percent of the enrolled population lived in a family home, compared to around 49 percent of the sample. There was a somewhat larger percent of individuals interviewed who lived in Independent or Supported Living. There are no Assisted Living Facility residents listed for the eligible population because the ABC database captures this information under a group home setting.

Table 17: Enrolled Population and Sample by Living Arrangement

Year 5 - July 2004 - June 2005

Type of Living Arrangement	Enrolled Individuals		Individuals in Sample	
	Number	Percent	Number	Percent
Family home	14,900	58.8%	665	48.8%
Independent/supported living	3,492	13.8%	260	19.1%
Small group home (6 or less)	4,550	17.9%	310	22.7%
Assisted Living Facility	0	0.0%	40	2.9%
Foster home	501	2.0%	12	0.9%
Large group home (> 6)	1,614	6.4%	64	4.7%
Other	293	1.2%	12	0.9%
Total	25,350	100.0%	1,363	100.0%

Personal Outcome Measures Volume and Results

The POM interview is a valid assessment tool that determines if personal outcomes are met and if supports are present in 25 areas found to be important to all people. Reviewers who have established reliability in the use of the interview tool conduct POM interviews. A random sample of two individuals was selected for each Waiver Support Coordinator participating in a WiSCC.

Table 18: Personal Outcome Measures*Average and Percent Outcomes Met and Supports Present*

	Year One	Year Two	Year Three	Year Four	Year Five
Number of Person Centered Reviews	1,907	2,539	2,456	1,355	1,363
Average Number of Outcomes Met per Consumer	13.2	12.4	11.2	11.3	12.1
Average Percent of Outcomes Met	52.8%	49.6%	44.9%	45.1%	48.6%
Average Number of Supports Present per Consumer	14.9	13.4	12.2	12.1	13.2
Average Percent of Supports Present	59.5%	53.6%	48.9%	48.2%	53.0%

The table above provides data indicating the Outcomes and Supports for individuals decreased over the first three years but appear to have leveled off during the fourth year and have increased somewhat during Year Five. The implementation of the two new review processes, use of Area Quality Leaders and Steering Committees to identify area specific issues needing quality improvement, and efforts to improve the Prior Service Authorization process may have all contributed to this positive shift.

POM Results by Individual Item

The POM interview is a 25-item assessment tool that determines if for the individual a personal outcome is Present and/or the supports are Present for each item, regardless of the service received. Quality improvement studies have statistically linked the increased presence of Supports with increased Outcomes for individuals.²⁶ It is therefore encouraging to find an increase in the percent of Supports Present in Year Five on every POM item, with the exception of one that remained the same as in Year Four.

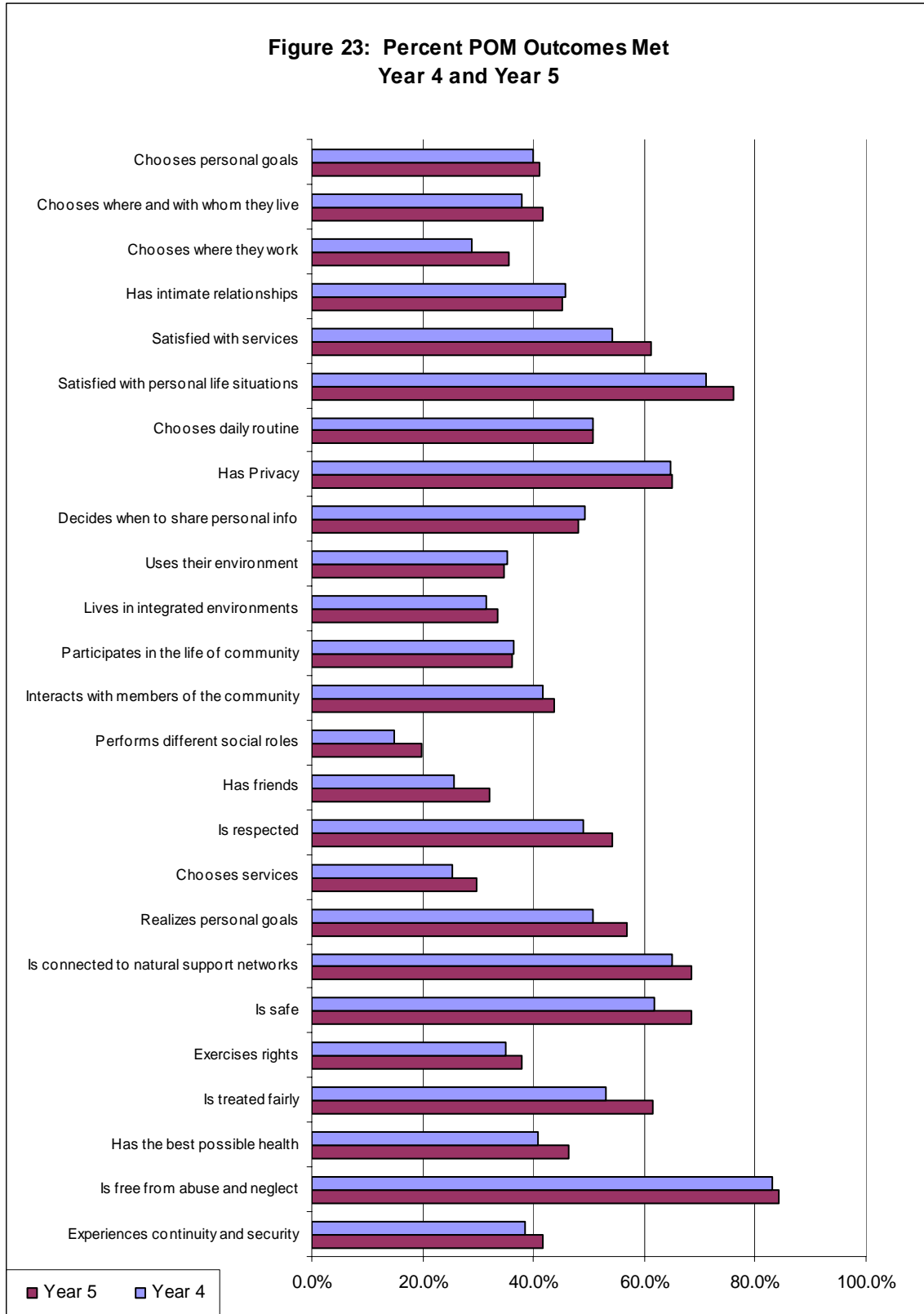
Figures 23 and 24 on the following pages provide the percentage of Outcomes Met and Supports Present by POM item for the sample of individuals who received a POM interview in Years Four and Five of the contract. Figure 25 provides a graphic description of the change in the percent met from Year Four to Year Five. Any columns to the right of the center line indicate an improvement.

Data indicate:

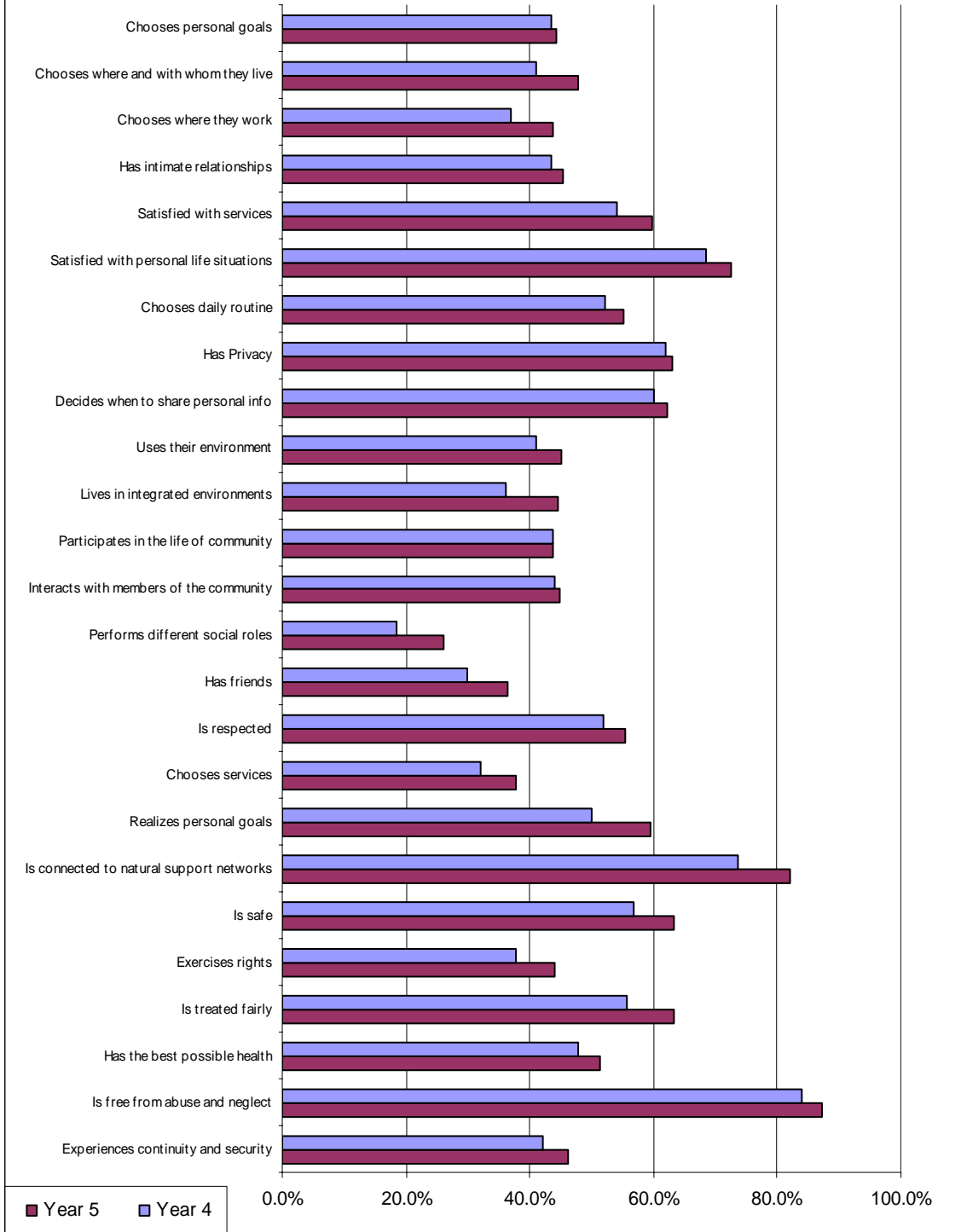
- *Is free from abuse and neglect* shows the highest percent Present for both outcomes and supports each year, at 84 percent and 87 percent respectively in Year Five.
- *Performs different social roles* remains the lowest among all the POM items on both outcomes and supports, although supports in this area improved by close to 7.5 percentage points since Year Four and outcomes by almost five points.
- Only two POM items show fewer than 30 percent of individuals with Outcomes Present: *Perform different social roles* and *Chooses services*.
- *Performs social roles* is the only POM item showing less than 30 percent of individuals with Supports Present.
- Twelve POM items have close to 50 percent or higher on both Outcomes Present and Supports Present, two more than in Year Four.
- *Realizes personal goals* demonstrated the most improvement in the percent of Supports present over the two year period, close to 10 points.
- *Is connected to natural supports* and *Lives in an integrated environment* each improved on the percent of supports present by over eight points. An additional eight items increased supports by five points or more, including *Chooses work* and *Chooses services*, the outcome driver elements.
- *Is treated fairly* demonstrated the greatest increase in outcomes, over eight points. An additional six items improved by over five points, including *Chooses work*.

²⁶ POM Outcomes Analysis: Impact of POM Supports on POM Outcomes Met, submitted to AHCA and APD by Delmarva on June 30, 2006, and awaiting final approval.

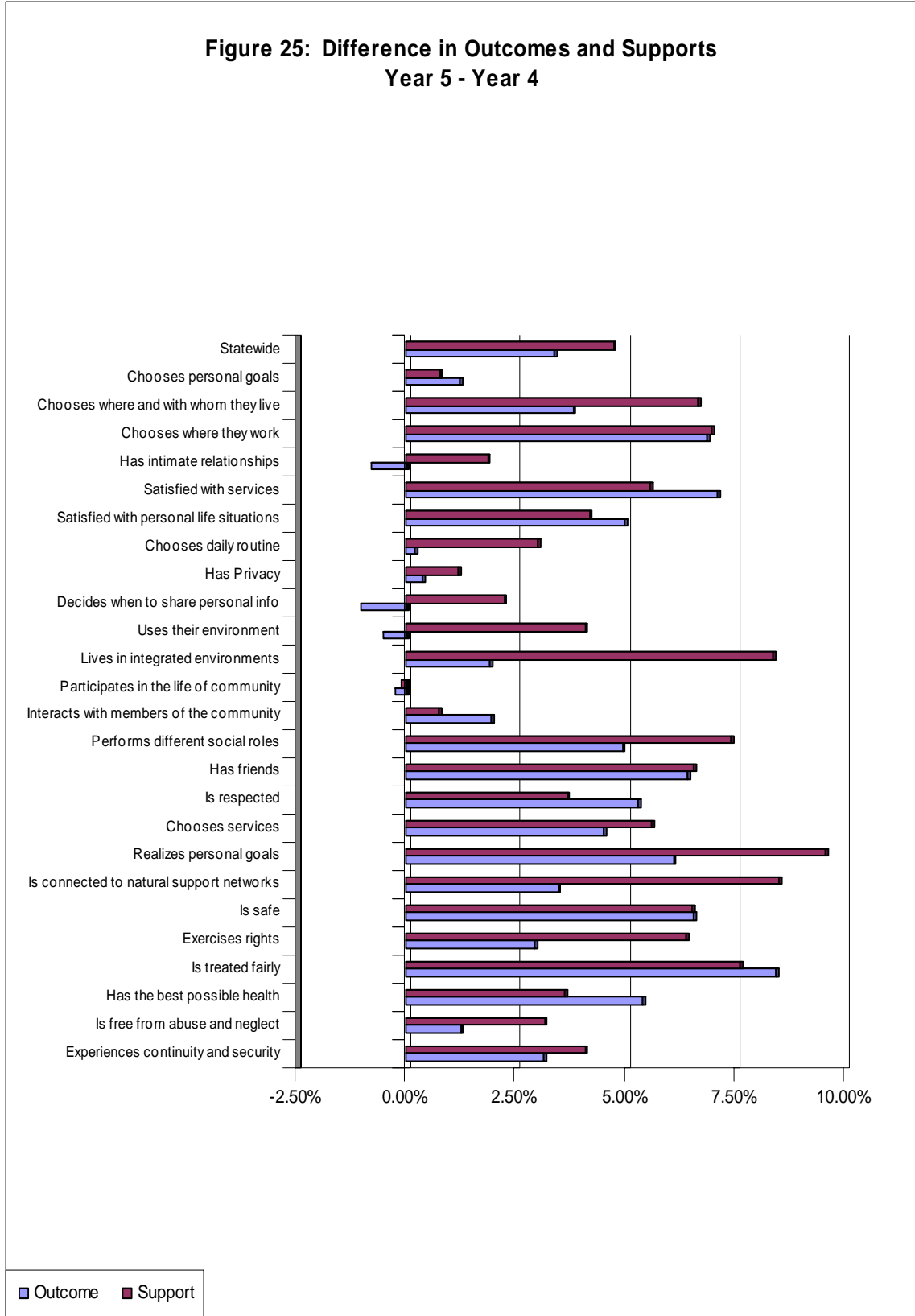
**Figure 23: Percent POM Outcomes Met
Year 4 and Year 5**



**Figure 24: Percent POM Supports Present
Year 4 and Year 5**



**Figure 25: Difference in Outcomes and Supports
Year 5 - Year 4**



As mentioned above, the results reflect a shift from the downward trend established over the first three years of POM interviews. The current year's results presented in this report have not been weighted for the cluster sample design. However, the nature of a complex design such as used in Years Four and Five affects standard errors and statistical manipulations. The statewide results, displayed for descriptive purposes such as in the tables above, should not be greatly impacted as the sample is a good demographic representation of the population (see demographic section).

The top five POM items for which the outcome is most frequently Present and the support is most frequently Present have remained consistent from Year One through Year Five.²⁷

- 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 remained consistent on three items.

- Performs different social roles
- Chooses services
- Has friends

Table 19 presents an analysis on a case by case basis of the 25 POM items, illustrating the strong association between outcomes and supports. Information provided gives the number and percent of times POM items had both outcomes and supports Not Present and the number and percent of times the items had both outcomes and supports Present. In other words, in Year Five (July 2005 – June 2006), 1,363 individuals were interviewed on a total of 34,075 POM questions. On 14,718 (43.2%) questions (items), neither outcomes nor supports were present and on 15,242 (44.7%) items both were Present.

Data from the following table indicate:

- There had 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 and 41 percent in Year Four. This has increased to 44.7 percent in Year Five.
- At the same time, there had been a steady increase in the percent where both are Not Met, dropping by 4.5 points in Year Five.²⁸
- The percent of POM items with a different result, one Met and one Not Met, has remained fairly constant.

²⁷ See Appendix 2, Exhibit 5 for a list of the reasons outcome/supports are not present.

²⁸ 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.

- Each year a high percentage of cases (around 88%) show a direct correlation between outcomes and supports—both Met or both Not Met.

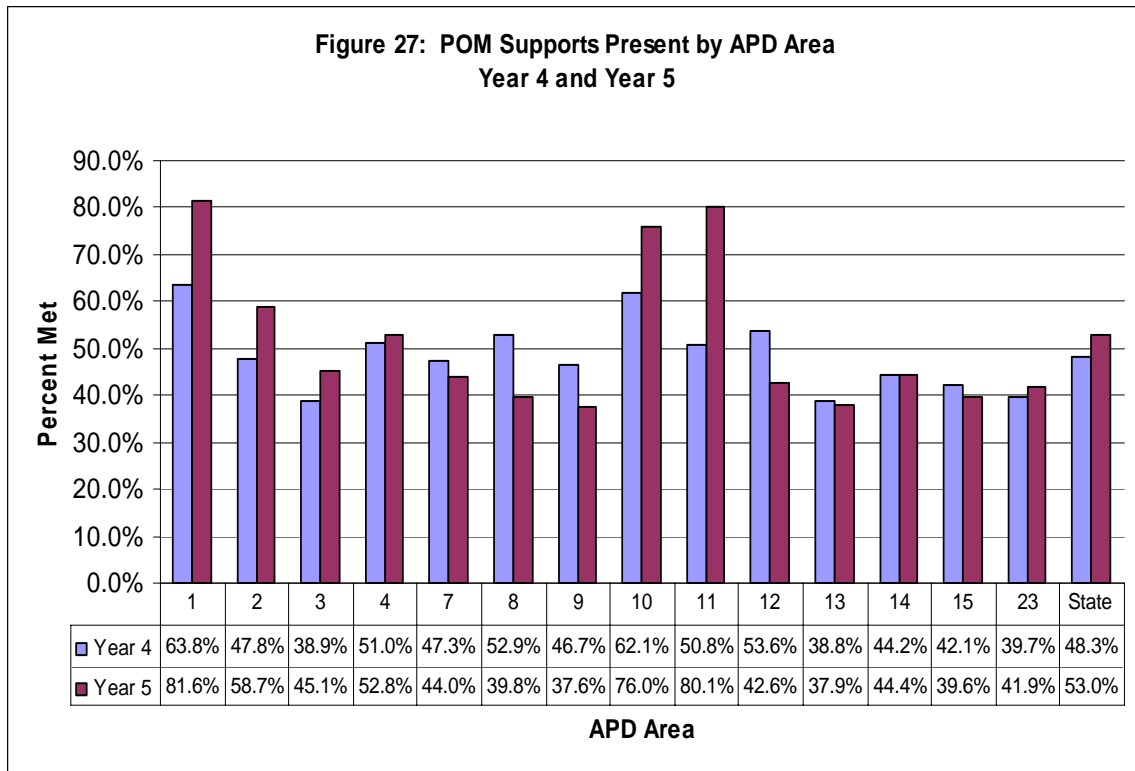
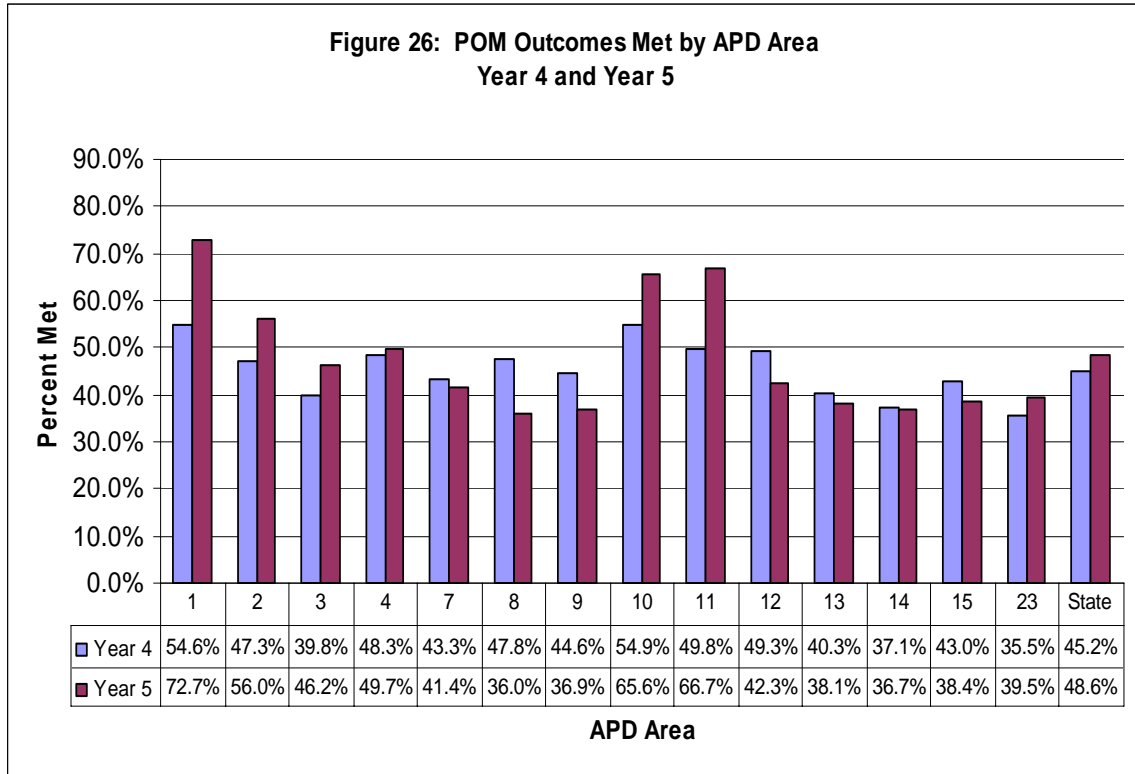
Table 19: Outcomes and Supports Both Met or Not Met

Contract Year	Number With Both			Percent With Both	
	Not Met	Met	Total	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%
Jul 04 - Jun 05	16,147	13,926	30,073	47.6%	41.0%
Jul 05 - Jun 06	14,718	15,242	29,960	43.2%	44.7%
<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%			
Jul 04 - Jun 05	3,852	11.4%			
Jul 05 - Jun 06	4,115	12.1%			

POM Results by APD Area

The following two charts display the average percent of POM outcomes met (Figure 26) and supports present (Figure 27), by APD Area for Years Four and Five of the contract. Highlights from these include the following:

- As expected, the pattern across the Areas is similar for both outcomes and supports.
- APD Areas 1, 10 and 11 showed the greatest gains on both measures.
- Eight Areas remained virtually the same or improved outcomes over the two years.
- Nine Areas remained virtually the same or improved supports over the two years.
- Providers in Area 8 experienced the greatest drop in both outcomes and supports.
- Area 11 providers showed close to a 30 percent increase in supports in the two year time period.



Driver Indicators

Two Personal Outcome Measures have been identified as “driver” indicators. A driver indicator has been defined as a Personal Outcome Measure that if Present, increases the likelihood that at least 13 or more Outcomes will be present. Through a series of analyses, the POMs with the highest predictive value were identified; two were selected by the IQC - *Chooses services* and *Chooses where they work* as indicators to be targeted and tracked for Quality Improvement initiatives.

Two separate quality improvement studies have been completed, using more recent data, to explore the outcomes and supports that are the best predictors of having more outcomes met in individuals’ lives. The first study, completed June 30, 2005, identified two additional outcomes that, when present, improve the overall outcomes in individuals’ lives: *Feels respected* and *Exercises rights*.²⁹ The second study identified five POM items, that when the supports for these were present, individuals were more likely to have 13 or more outcomes present in their lives: *Chooses daily routine*, *Is connected to natural supports*, *Chooses where and with whom to live*, *Decides when to share personal information* and *Has intimate relationships*.³⁰ Results for these driver outcomes and driver supports, for the previous four years of the contract, are presented in the following table.

Table 20: Driver Outcomes and Supports by Year

Personal Outcome	Year 2	Year 3	Year 4	Year 5
Driver Outcomes				
Chooses work	30%	23%	29%	36%
Chooses services	27%	22%	25%	30%
Feel respected	55%	48%	49%	54%
Exercise rights	40%	34%	35%	38%
Driver Supports				
Chooses daily routine	55%	47%	51%	51%
Is connected to natural support networks	74%	65%	65%	69%
Chooses where/with whom to live	50%	36%	38%	42%
Decides when to share personal information	48%	46%	49%	48%
Has intimate relationships	59%	45%	46%	45%

Results indicate the driver outcomes have all improved since Year Three, and that *Chooses work* and *Chooses services* are higher than levels in Year Two as well. The driver supports have not improved at the same level and in fact, only *Decides when to share personal information* has equaled Year Two levels. Among the driver supports, *Is connected to natural supports* and *Chooses where and with whom to live* demonstrated

²⁹ Outcome Results Analysis: Best Predictors of Percent of Outcomes Met, submitted by Delmarva to AHCA and APD, June 30, 2005.

³⁰ Outcome Results Analysis: Impact of POM Supports on POM Outcomes Met, submitted by Delmarva to AHCA and APD, June 30, 2006.

the most improvement in the past two years. The remaining three driver supports remained relatively flat from Year Four to Year Five.

Reasons Supports and Outcomes were Not Met

For several years, the QICs have collected information on the reasons outcomes and supports are not met for each individual. These are collected in the form of “drop down” menus. Two quality improvement studies have been completed examining these reasons for both outcomes and supports.³¹

Individuals were most often not able to choose their own work venue (a driver outcome) due to having limited or no options available to them, or having no opportunity to experience different work options or because choices are made for them by others. Supports are not offering varied experiences or addressing barriers to this outcome. In terms of *Choosing services*, choices are often made by others or are simply limited, and support need to help increase individuals’ awareness of different service.

While individuals most often have outcomes and supports present on *Freedom from abuse and neglect*, 214 individuals served in the program were not achieving this important outcome when interviewed in Year Five, and 223 had no supports in place to address issues of abuse and neglect. A majority of individuals were “out” on this outcome due to distress over past abuse (55.6%). This is similar to results from Year Four when 60 percent were “out” on abuse and neglect due to distress over previous abuse issues. Among supports, counseling and training for protection are not being addressed and Reporting Training is missing.³²

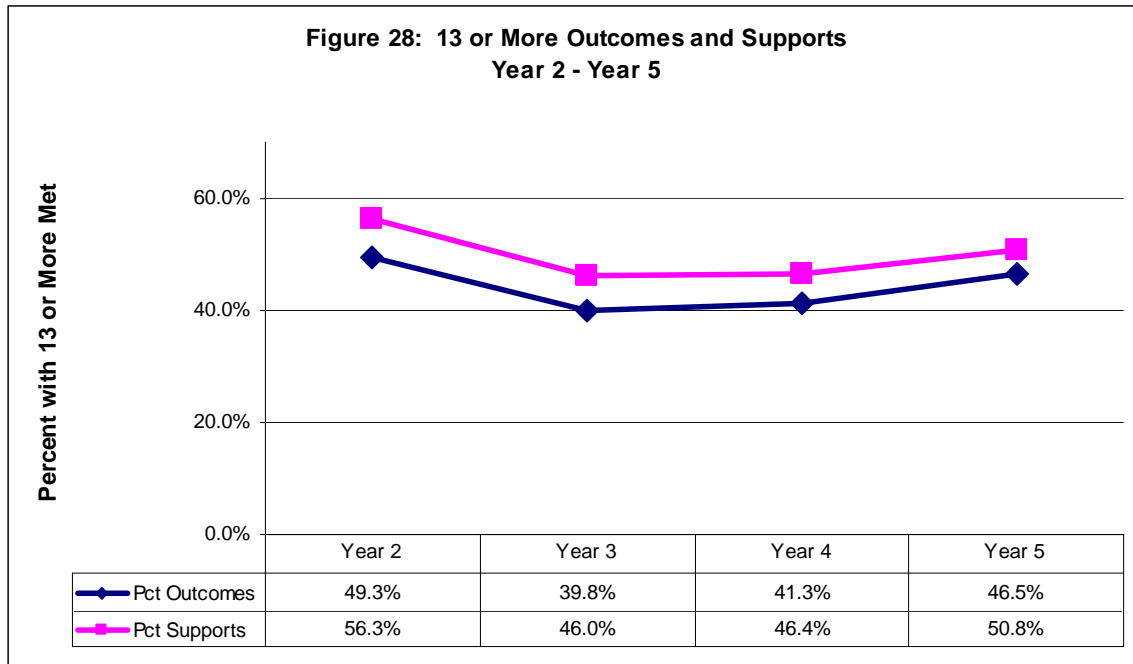
13 or More Outcomes Met and 13 or More Supports Present

The Personal Outcome Measures have been used by the Agency for Persons with Disabilities to measure outcomes for people with developmental disabilities since 1998. POM results are a Performance Indicator that APD reports to the Governor and State Legislature. Based upon 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 below for the last four years of the contract. Over this four year period, July 2002 – June 2006, on average 44.3 percent of individuals had 13 or more outcomes Met and 50.3 percent had 13 or more supports Present. In both areas, this decreased from Year Two to Year Three but has slowly increased since that time. In Year Five, 46.5 percent of individuals achieved 13 or more outcomes and close to 51 percent had 13 or more supports present in their lives.

³¹ Personal Outcome Measures: Reasons Outcomes are Not Met, submitted by Delmarva to AHCA and APD, June 30, 2004. Personal Outcome Measures: Reasons Supports are Not Present, submitted to AHCA and APD, June 30, 2005.

³² See Appendix 2, Exhibit 5 for a list of the top three reasons outcomes and supports are not present for all 25 POM items.



13 or More Met Results by Home Type, Area, and Age Group

Exhibit 6 (Appendix 2) shows the distribution of individuals who had 13 or more outcomes met or supports present across APD Areas, age groups and type of living arrangement for Year Five. When reviewing the data, be aware that many categories have small numbers of individuals who received a POM interview. Therefore, the point estimates may be fairly unstable and the results should be interpreted with caution. Some highlights from the information include the following:

- Residents in Independent or Supported Living continue to have the largest proportion of individuals with both outcomes and supports met, with 63.5 percent and 68.1 percent respectively, up from 56.4 percent and 58.7 percent in Year Four. This is consistent with findings over the previous four years.
- The percent of residents in large group homes that met the criterion of 13 or more outcomes met decreased from 29.6 percent in Year Three to 19.7 percent in Year Four. This has increased slightly, to approximately 22 percent in Year Five.
- The data suggest fairly large variations across areas on the percent of 13 or more outcomes met, from a high of 84.8 percent in Area 1 to a low of 18 percent in Area 14. Several areas have a small number of participants in the sample, which lends itself to large fluctuations in point estimates. This also produces variation from one year to the next. Differences across Areas from Year Four to Year Five range from an increase of 29 percent in Area 11 to a decrease of 18 percent in Area 8.³³

³³ See Appendix 2 Exhibit 7 for 13 or more outcomes/support met by area (district) and year.

- Children age 17 and under continue to be most likely to have this criterion met for both outcomes and supports. The percent met for Year Five is only slightly higher than for Years Three and Four, at approximately 61 percent.
- People age 26 to 44 have the highest level of 13 or more Outcomes met (49.3%) and 13 or more Supports present (54.8%) among the adult age groups.

13 or More Met Results by Service

Figure 29 displays the distribution of the percent of individuals who had 13 or more outcomes met, by services for Year Four and Year Five. Services included are subject to an Onsite CORE consult.³⁴ When reviewing these results it is important to note that individuals may have received more than one of these services and may have received any number of other services as well. In addition, claims data were used to identify services received by the individuals and not all POM results were successfully linked to the claims data.

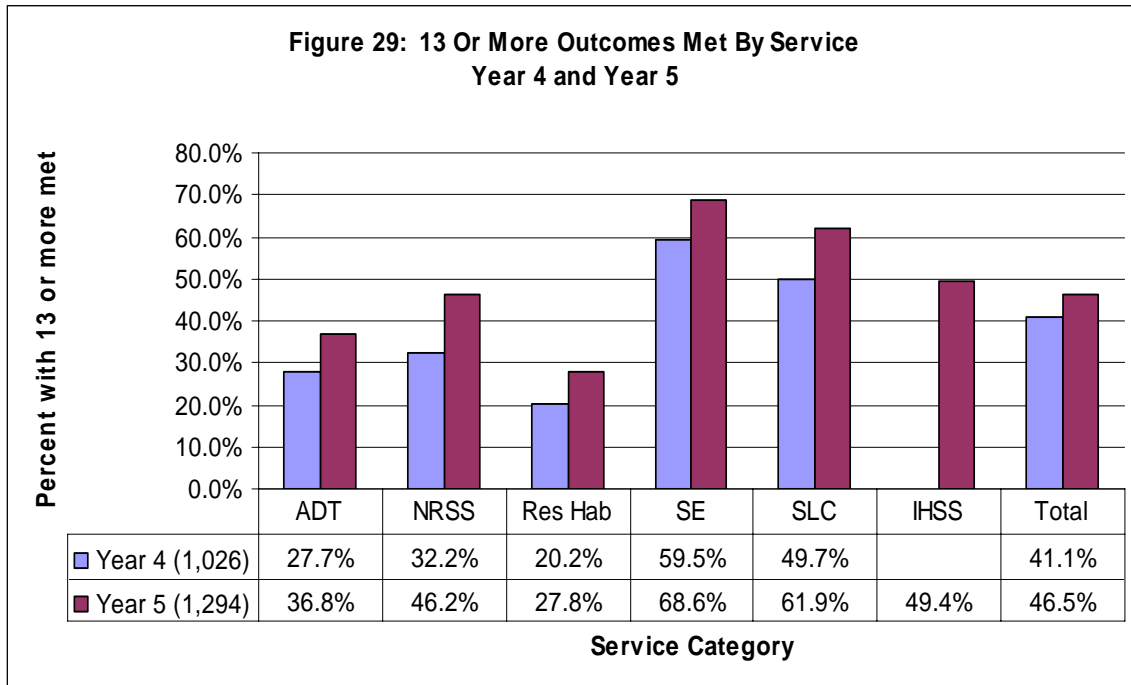


Figure 29 provides graphic evidence that:

- Individuals receiving Supported Employment (SE) or Supported Living Coaching (SLC) were more likely to have 13 or more outcomes met than individuals receiving the other services displayed, and this was true both in Year Four and Year Five.

³⁴ In Home Support Services and Special Medical Home Care were reviewed Onsite beginning in Year Five so no data exist for the Year Four comparison. Only one person interviewed received IHSS.

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- Among the “day services”, ADT, NRSS and SE, people receiving Supported Employment are much more likely to achieve 13 or more outcomes.
- Improvement among all the services is evident over the two year period.
- The greatest increase is seen for individuals receiving NRSS, up 14 points since Year Four.

Foundational Outcomes

The last seven Personal Outcome Measures 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 should 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.

The seven Foundational Outcomes are listed in the following table for Year Two – Year Five. After a decline since Year Two, each outcome has improved since Year Four. *Is connected to natural supports*, *Has the best possible health*, and *Experiences continuity and security* are not yet back to the level attained in Year Two. *Is treated fairly* and *Is safe* have made the greatest gains since Year Four and have passed Year Two levels.

Table 21: Foundational Outcomes
Percent Met by Year

Foundational Performance Outcome Measures	Year 2	Year 3	Year 4	Year 5
	Percent of Total Reviews			
19 - Is connected to natural support networks	70.5%	64.6%	65.1%	68.5%
20 - Is safe	67.7%	67.3%	61.9%	68.5%
21 - Exercises rights	36.6%	33.9%	34.9%	37.8%
22 - Is treated fairly	60.5%	60.1%	53.1%	61.6%
23 - Has the best possible health	50.2%	39.5%	40.8%	46.2%
24 - Is free from abuse and neglect	84.6%	83.0%	83.0%	84.2%
25 - Experiences continuity and security	49.2%	37.2%	38.5%	41.7%

The following two charts show the distribution of POMs across the number of Foundational Outcomes scored as Met--individuals who have zero to seven of the foundational outcomes met. The overall rate that All Foundational Outcomes were met during the twelve month period ending June 30, 2006, (Figure 30) was 10.8 percent (147 individuals). This shows an increase from 6.6 percent in Year Three and from 8.3 percent in Year Four. An overall increase is noted, with an increase of 2.5 points among individuals who had all seven outcomes met, an increase of 4.2 points for those with six met and an increase of 2.3 points for those with five met. Decreases are noted among POMs with fewer than five of the Foundational Outcomes met.

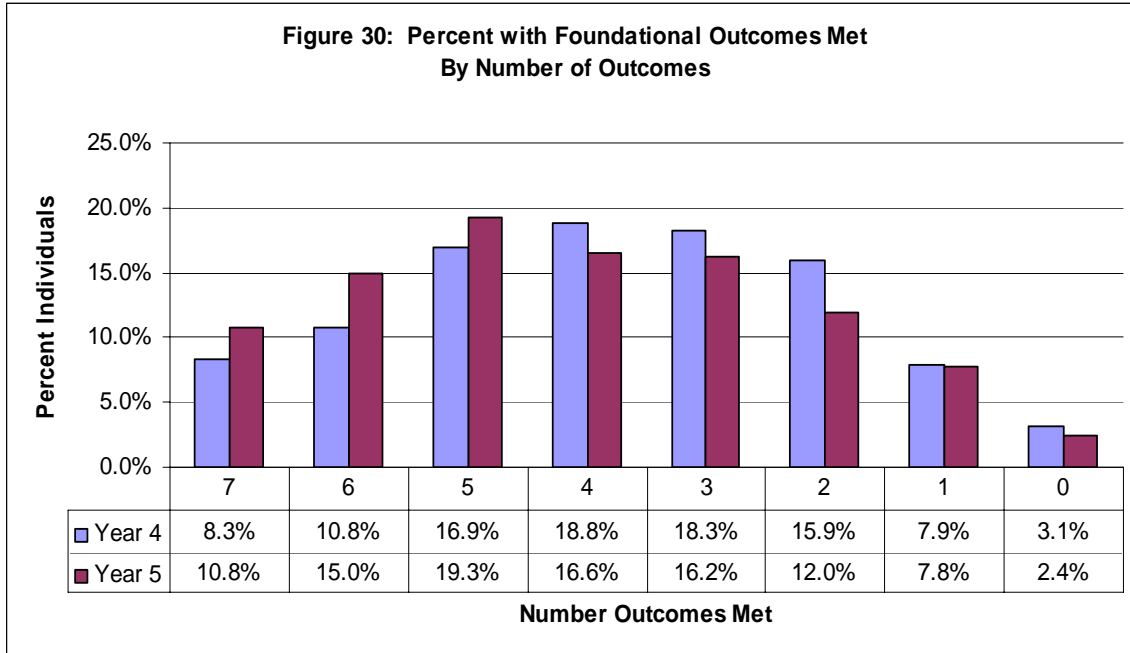
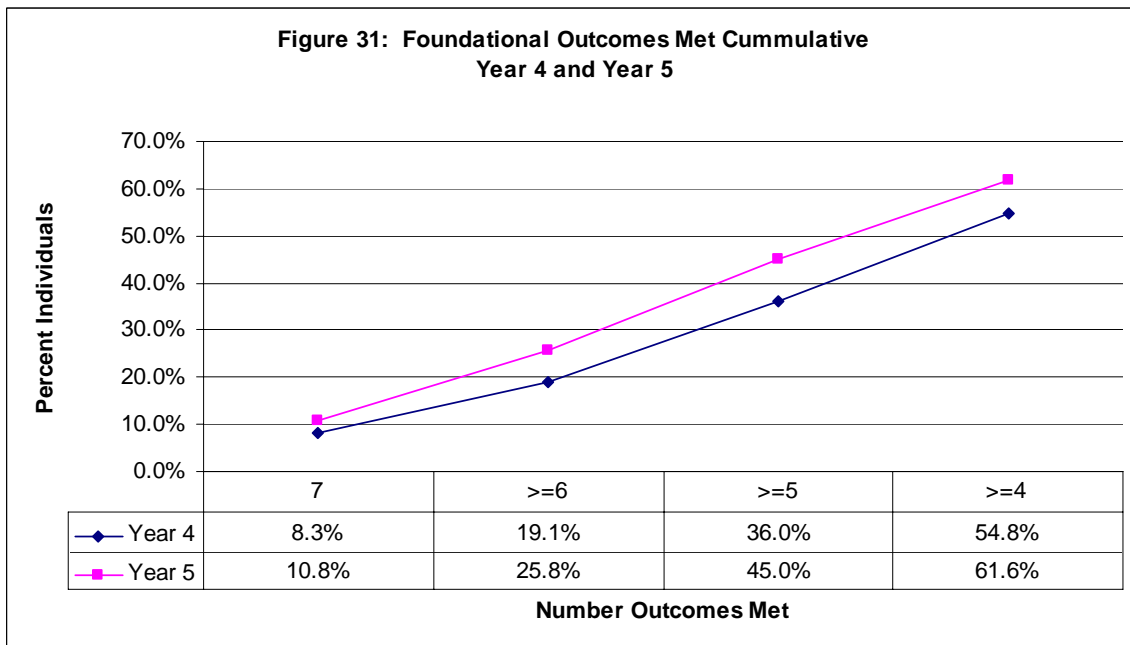


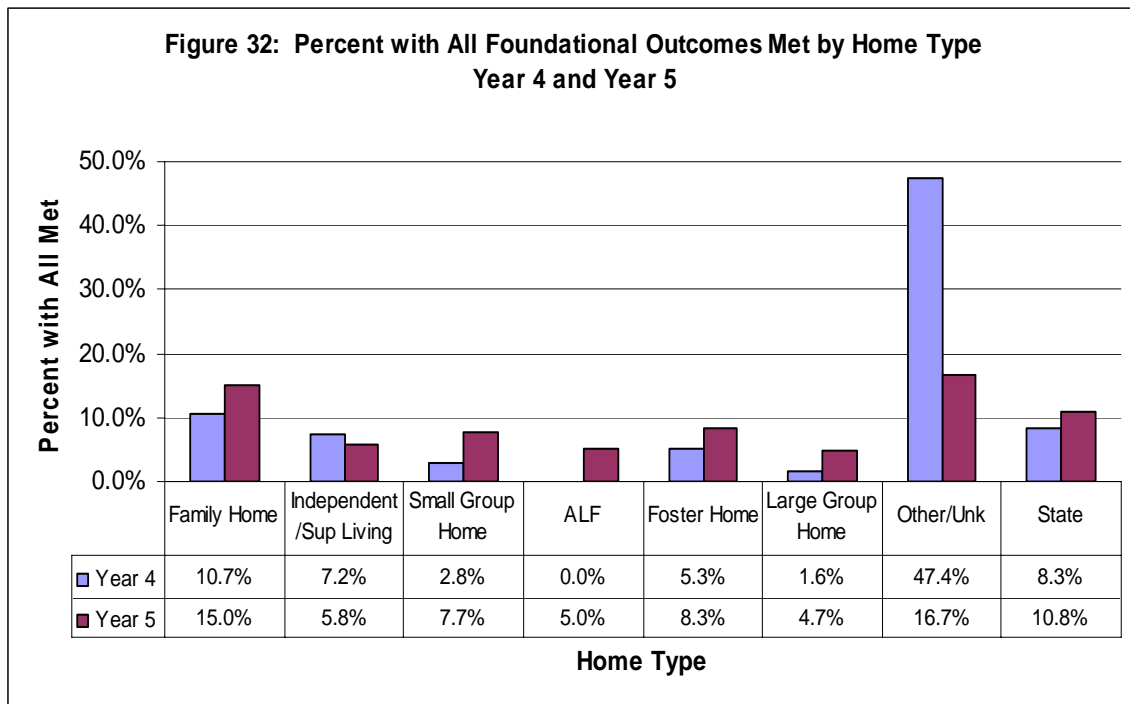
Figure 31 displays the Percent of POMs (individuals) with a cumulative number of the Foundational Outcomes met, 7, 6 or more, 5 or more, and 4 or more. Results in Year Five show an increase in all of the categories.



Foundational Outcome Results by Home Type, Area, and Age Group

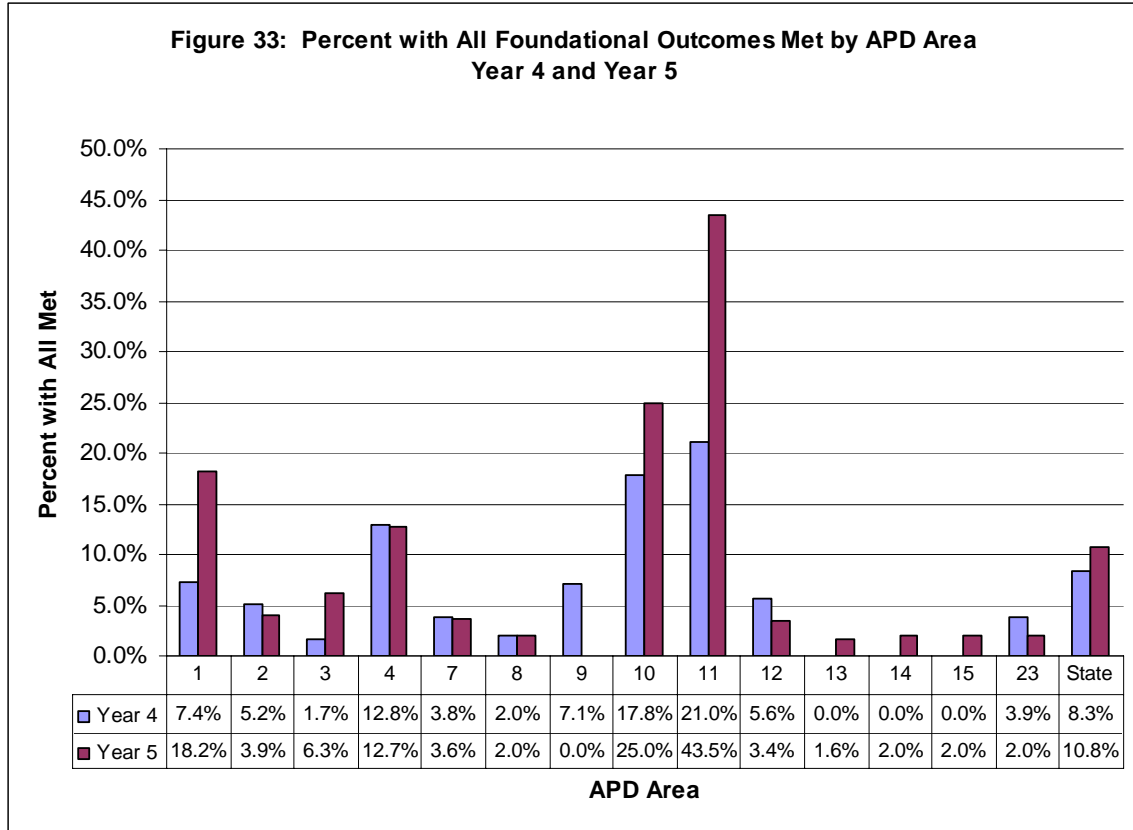
Results in Exhibit 9 (Appendix 2) display the number and percent of individuals for whom a Person-centered Review was completed who met all seven Foundational Outcomes, displayed for each home type, APD Area and age group, for Year Four and Year Five.³⁵ In addition, Figures 32 and 33 present a graphic display of the results by home type and APD Areas. The number of POM interviews completed in several areas and within some hone types and age groups is relatively small, which can produce unstable point estimates.

- The youngest age group was most likely to have all of the foundational outcomes met each year.
- Each year, the percent with all of the foundational outcomes met is highest for people living in a family home, with the exception of the “other/unk” category.³⁶ The proportion Met in family homes is up five points since Year Four.
- There is quite a bit of variation across APD Areas as well as within some areas over time. However, because the numbers in most areas are generally small, eight with fewer than 70, this is expected. Areas 1 and 11 showed the greatest improvement over time, 10.8 and 22.5 point increase respectively.



³⁵ See Appendix 2, Exhibit 8 for summary information on Foundational Outcomes by district, age group and home type for Years 1, 2, and 3.

³⁶ This category consists of 14 people in Residential Treatment Facilities and five Unknown in Year Four and 10 in Residential Treatment and two Unknown in Year Five.



Medical Peer Review Findings

New Medical Review procedures were implemented when QICs began doing WiSCC. For the review, the Nurse Reviewer is responsible for overseeing the recommendations that are automatically generated by the QIC through the utilization of the Health/Behavioral Data Collection Form-Attachment five. As part of the approval process for the report, the Nurse Reviewer evaluates the appropriateness of recommendations, and compares the findings to information contained in the claims data. If discrepancies exist in any of the findings, the Nurse Reviewer may initiate a Focused Review or request Medical Records. Any significant findings are reported to the WSC and possibly to the local Medical Case Manager, if appropriate.

The Nurse Reviewer is additionally notified of the existence of any critical health issues that have been encountered by the QICs at the time of the review. The Nurse Reviewer will take a lead on communicating these concerns to the Medical Case Manager. It is not the intent of this disposition for follow up action related to any health, safety, or behavioral recommendation to be specifically assigned to the District DD Case Management Team. The intent is to make the District DD Medical Case Management Team aware of any health, safety or behavioral concerns and to be available to provide

assistance or intervention, if requested, to the individual, family, or waiver support coordinator in securing or arranging needed supports and services.

The distribution of Medical Dispositions is presented in the next table.³⁷ The overwhelming majority show no additional concerns were noted (91.5%). The change in procedures with the implementation of WiSCC has allowed input from the Nurse Reviewer during the WiSCC process. For this reason, most concerns are addressed on site rather than sent to the WSC or Medical Case Manager.

Table 22: Medical Review Disposition
Year 5 - July 2005 - June 2006

Disposition	Number	Percent
Requesting Medical Records	26	1.9%
Done - no additional concerns	1,253	91.9%
Done - additional concerns to WSC	63	4.6%
Done - no concern/no claims	3	0.2%
Done - concern yes/no claims	0	0.0%
Done - ancillary claims only	0	0.0%
Done - additional concerns to MCM	18	1.3%
Total	1,363	100.0%

³⁷ Additional information about the recommendations and a summary of the frequency and types of specific health or behavioral health recommendations is provided in Exhibit 10, Appendix 2.

Section Three: Discussion of Findings and Recommendations

Through June 30, 2006, the Florida Statewide Quality Assurance Program (FSQAP) has conducted close to 10,000 Personal Outcome Measure interviews with individuals who were receiving services and supports through the Developmental Disabilities Home and Community Based Services Waiver. Close to 9,800 annual Provider Performance Reviews/CORE have been completed along with 4,600 follow up reviews/consultations. This number does not include the number of follow-up visits QICs conducted subsequent to a WiSCC. Over the past two years consultants conducted 900 WiSCC that included an interview with 1,359 Waiver Support Coordinators.

Review/Consult results from these activities have been reported on a regular basis through quarterly reports and presentations at state and local meetings. As project staff have shared the data and worked with the State and APD Areas 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. Results from the quality improvement studies have also been reported and used to help implement quality improvement initiatives or a shift in focus. For example, a lack of training has surfaced in several studies as a barrier to quality performance. APD is currently undergoing efforts to increase training opportunities available throughout each Area.

The average score for Desk Reviews, a procedure that has changed very little over the five years of the contract, has increased somewhat since Year One but has remained fairly consistent since Year Two, with a current score of around 77 percent. The percent of Desk Reviewed providers who had documentation for their Level 2 Background screening has improved every year, but remains under 80 percent. The percent of Recoupment Citations has remained fairly constant. From this evidence, it seems apparent the process used for providers of services who receive a Desk Review are not improving performance evaluations for these providers.

In the annual report for Year Four, it was recommended that a work group representing all relevant parties examine the Desk Review process and suggest modifications where appropriate. Further, results from the Desk Review Quality Improvement study should be used to guide modifications to the process. This study indicated that elements pertaining to training were most often cited as Not Met, across all services. Providers were most often compliant on elements pertaining to licensure.

Recommendation: It is again recommended that a work group examine the Desk Review process and modify as appropriate. APD should ensure training for all providers is available and reinforce the need for providers to attend required training sessions. Review of licensure elements may be modified and incorporating the outcome-based focus and elements of CORE, as/if possible, may help to enhance the process. Also, a deeper analysis may help determine which elements are most frequently cited for recoupment and if that has changed over the years.

Outcome results for providers who received a CORE consult (the first 18 elements) appear to be better than in Year Four. This is due to the improved performance of Agency providers only. However, close to 78 percent of the onsite consults were with Agencies. The percent of Agencies evaluated as Achieving or Implementing increased from 55 percent in Year Four to 64 percent in Year Five. At the same time, Solo provider evaluations at these levels decreased from 80 percent to 68 percent. Solo providers were still performing somewhat better than Agencies, but the gap had lessened.

Recommendation: Area APD offices and Steering Committees may want to explore this trend among their Area providers. If Solo providers are “losing ground” efforts should be made to determine the source of the problems and address them. If any or all of the Agencies in their Areas have best practices that have improved their organizational systems, these could be shared at local and statewide meetings.

At the element level, CORE results inform us that providers of services other than Support Coordination who are reviewed onsite have made improvements in the critical areas of offering services in an integrated environment, providing choice of services/supports, using a personal outcome approach and advocating for individuals with a “team approach” to service delivery. Advocating for the individual beyond the scope of the provider’s immediate service responsibilities, in combination with effectively disseminating information to families and other providers (Communication Affiliation component of the CORE tool) has been shown to be significantly associated with outcomes for individuals.³⁸ Unfortunately, Element 17 (coordinating the dissemination of information) showed the largest drop at the Achieving level in Year Five, down over six points compared to Year Four results. Communication has also been identified as a key barrier in some Areas.³⁹

Recommendation: Because communication with and among providers is a vital component of the program, linked to higher outcomes among individuals, APD should focus efforts on improving communication among all types of service providers. Delmarva has successfully coordinated Collaboratives among hospitals that have resulted in improved service delivery and outcomes for patients. Collaboratives should be explored as an avenue for bringing all DD Waiver service providers together, to enhance their ability to work as a team for each individual served and to improve upon the dissemination of information to providers, families and individuals.

Having organizational systems in place to enhance the development of valued social roles for individuals has also been shown to be an important predictor of outcomes for individuals. Unfortunately, CORE results (Element 10) indicate this is least often evaluated as Achieving, and 60 providers scored this as Not Emerging during Year Five. In addition, outcomes and supports for individuals on the POM *Having desired social roles* are lower than for any other POM, at only 20 percent outcomes met in Year Five.

³⁸ Organizational Practices That Best Predict Outcomes for Individuals, submitted by Delmarva Foundation to AHCA and APD, June 30, 2006. Awaiting approval.

³⁹ Barriers Analysis, submitted by Delmarva Foundation to AHCA and APD, June 30, 2006. Awaiting approval.

Recommendation: Education sessions should be offered that focus on social roles. These should be attended by all providers and should include clear definitions of what valued social roles are as well as a discussion of methods for improving and enhancing social roles for individuals in the program. Individuals and their families/guardians should also attend unless a separate session more focused on their needs would be appropriate. Alternatively, a web based training module could be developed by Delmarva if stakeholders believe it could accomplish the same goals.

Both Agency and Solo providers demonstrated a drop in performance on CORE Element 19, the MSR measuring projected service outcomes. This has been discussed by Delmarva and APD, and revisions to the CORE tool have been developed to specifically address providers' needs to improve in this area. These revisions are scheduled to be implemented in January 2007. Overall, providers' scores on the MSR (process) elements decreased by about two points from Year Four to Year Five. Agency providers, on average, remained at about the same level of the percent of MSR elements that were met. However, Solo providers saw a decrease in these elements of close to 10 percentage points.

Recommendation: Solo providers should be closely monitored in the next year to ensure the drop in performance on the MSR elements in Year Five is not a trend.

Outcome results for providers of Support Coordination (WiSCC, first six elements) indicate Agency and Solo providers were evaluated at similar levels, with Agency WSCs only slightly more likely to have elements scored as Achieving and Implementing. Both types of providers improved by approximately 10 points at these evaluation levels from Year Four to Year Five.

At the element level, almost every outcome element showed an increase at the Achieving level. From Element 1 to Element 6, increases were as follows: percentage points of 9.5, 0.3, 8.5, 5.6, and 1.6 respectively. However, organizational practices pertaining to health and safety (Element 2) and the accomplishment of positive results for individuals (Element 6), remain areas least likely to be evaluated as Achieving and most likely to be evaluated as Not Emerging. At the same time, WSCs appear to be improving their systems in many areas such as getting to know the individuals they serve (Element 1), evaluating supports and addressing barriers, developing support plans with individuals. Because the elements in the tool are somewhat progressive from 1 to 6, as Support Coordinators improve on the first elements they should begin to see improvement in terms of accomplishing positive results as well (Element 6).

Recommendation: Results from the WiSCC analyzed over the next year should show a continued improvement on Element 6, achieving positive outcomes for individuals. If this is not demonstrated, Delmarva and APD should work together to make any revisions to the process that might enhance the ability of WSCs to organize systems that help generate desired results for individuals.

On average, Waiver Support Coordinators, either with an agency or solo, are performing well on the MSR elements, both at around 92 percent. This is much higher than the average for providers of other services, with around 73 percent of the MSRs met in Year Five. One caveat is the CORE tool has seven MSRs while WiSCC only has five. In addition, close to 80 percent of the providers who participated in a CORE were Agencies. Monitoring the “paper work” and process requirements for a large staff is much more difficult than for one Solo provider. This will tend to drive the MSR results down. There were an equal number of Agency and Solo WSCs who participated in a WiSCC.

Background screening results for WSCs are generally good, with an average of close to 96 percent met in Year Five. This is quite a bit higher than the average for CORE consults of approximately 75 percent for the year. Again, this may be due to the fact that most are Agency providers and have more challenges in maintaining documentation for a multiple number of staff in various locations.

Recommendation: Previous data have indicated relatively low compliance with Level II Background screening requirements. Because this is vital to the safety of the population, Delmarva and APD have worked together to implement a new procedure intended to improve performance of providers in this area. As this is implemented in Year Six, data should be analyzed closely to determine the effectiveness of the new procedure. The procedure should be modified if compliance does not show an increase by the 3rd quarter of the year.

Personal Outcome Measures data are provided in this report and where appropriate, displayed by project year. Results reported over the past three years have reflected a decline in the number of Outcomes Met and Supports Present. A comparison of Year Three to Year One results reflected 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 from Year One to Year Three (13.4 to 6.6 percent Met). The percent of individuals with Outcomes Met and Supports Present by individual POM item had also declined each year.

However, results for Years Four and Five suggest this trend may have shifted. The percent of individuals with all of the foundational outcomes met has increased to nearly 11 percent and all but four of the POM items showed improvement from Year Four to Year Five. It is also encouraging to note the percent of individuals with 13 or more outcomes met has come back up, after a slight decline last year.

The data from Year Four indicated a rather substantial decrease in the criterion measuring 13 or more outcomes for residents in large group homes, from 29.6 percent in Year Three to 19.7 percent in Year Four. While this has improved somewhat in Year Five, closer to 22 percent, it remains quite low compared to people living in other types of homes. Individuals in small group homes do slightly better at around 26 percent with 13 or more outcomes met.

Recommendation: Delmarva and APD should closely monitor the outcomes for people living in group homes. Because outcomes are typically low for these individuals, APD and the State should actively pursue the implementation of practices that could improve the lives of these individuals, such as modifying tools used to regularly monitor the homes, making sure they are person-centered. Person-centered monitoring tools should help ensure the development of a person-directed environment. Local APD staff should also regularly and effectively promote positive changes to the homes. Finally, IQC could act as an advocate at the state level to effect policies that could help move more people out of group homes and into more person-centered and integrated environments.

In this report, and in reports regularly presented to the legislature, POM outcome results are calculated by service, for the services that are subject to a CORE consult. Results generally indicate, as in this report, that among people receiving day services—ADT, NRSS, and Supported Employment, individuals receiving Supported Employment are much more likely to have outcomes met. While this information is useful there are some limitations in this analysis. In particular, individuals receive more than one service. It is not clear how different services may impact their outcomes, regardless of the day service they also receive. In other words, an individual may receive ADT and have 60 percent of outcomes met. However, it might be other supports and services enhancing the outcomes, not just ADT. An individual may have 60 percent of outcomes met, and only receive SE. This confounds the results.

Recommendation: Because this information is regularly provided to the legislature to direct policy and budget decisions, a quality improvement study should be done to tease out the complex relationships in the data and help provide a clearer understanding of individuals' POM outcomes across services. Statistical models should be developed that control for other services individuals may be receiving, as well as other relevant variables.

The personal outcome measuring abuse and neglect has always been the one most often met by individuals in the DD program, around 85 percent this year. However, clearly not all individuals have this scored as met. During Year Five, 214 individuals were scored as Not Met on this outcome and 223 did not have supports in place to ensure they are free from abuse and neglect. The reason cited most often (55.6%) as to why this was not met indicates “the person is distressed over past abuse”. Other reasons include “possible abuse issues indicated” and “possible exploitation issues indicated”.

Recommendation: Members of IQC have raised some concerns that not all individuals served on the DD waiver are free from abuse and neglect, as measured by the POMs. The Delmarva data captures some reasons for this, but the reasons are quite broad. Because this is an important issue, a quality improvement study should be completed that helps to produce a greater understanding of the extent of the problem, more specific data identifying the type of possible abuse, any issues or problems surrounding the reporting of abuse to the proper state agency, and subsequent action taken by that agency.

Results in this report indicate some improvements are evident in provider performance and in the outcomes present in individuals' lives. These and other positive trends as noted in the report reflect the ever constant drive of Delmarva, APD and AHCA to ensure a person-directed system focused on outcomes for the individuals served through the DD Waiver. This drive has resulted in improved provider "monitoring" tools that are outcome based, in the employment of Area Quality Leaders to direct QI initiatives in each APD Area, and in developing better communication with Maximus and APS to improve the service authorization process for providers and individuals.