

Florida Statewide Quality Assurance Program

**Second Quarter Report
Contract Year 6
October – December 2006**

provided through
Delmarva Foundation
in cooperation with
The Council on Quality and Leadership

**Presented to the Agency for Health Care Administration
and the Agency for Persons with Disabilities**

Table of Contents

Executive Summary	2
Introduction	9
Section One: Data Analysis and Results	10
Volume of Activity-Provider Performance Reviews and Consultations	10
Desk Reviews	13
Core Consultations	16
Distribution by APD Area	17
CRE Evaluation Level by Year	17
CREs by Provider Type	18
Results Element by Element	19
CORE Results Elements by Service	21
Minimum Service Requirements (MSR) Evaluation by Year	25
MSR Evaluation by Element	25
MSR Evaluation by Provider Type	26
CORE Alerts and Recoupments	27
Follow-Up Reviews and Follow-Up with Technical Assistance Reviews	28
Reconsiderations	29
WiSCC Evaluations	30
Distribution by APD Area	30
WiSCC Results Elements (WRE)	31
WiSCC Results Elements by Element	32
Minimum Service Requirements	34
Follow-up with Technical Assistance	35
FOCUS Plan	36
Reconsiderations	37
Personal Outcome Measure Sample Description	37
Demographic Description of the Sample	38
Personal Outcome Measures Volume and Results	40
POM Results by Individual Item	41
POM Results by APD Area	43
Driver Indicators	44
Reason Supports and Outcomes Were Not Met	45
13 or More Outcomes Met and 13 or More Supports Present	46
13 or More Met by Home Type, Area and Age Group	47
13 or More Met Results by Service	48
Foundational Outcomes	49
Foundational Outcome Results by Home Type, Area and Age Group	50
Medical Peer Review Findings	50

Section Two: Summary of Quarterly Compliance Activities	52
Contract Monitoring	52
APD Review	52
Administrative Review	52
Medical Peer Review	52
Contract Amendment	53
Training and Education	53
Education/Training Sessions	53
Tool Revisions	55
CORE	55
WiSCC	56
Staff Changes	56
Liaison/External Communication Modalities	57
Interagency Quality Council	57
Project Status Meetings	58
Small Work Group Sessions	58
Area Quarterly Meetings	58
APD Steering Committee Meetings	59
Florida, National and International Conference Representation	59
Internal Quality Assurance Initiatives	59
Summary of Customer Service Activity	60
Desk Reviews	61
CORE and WiSCC	61
Complaints	61
Interpreting Services	61
Miscellaneous	61
Quality Improvement Initiatives	62
Area Data Reports	62
Quarterly/Annual Reports	62
Quality Improvement Studies	62
Section Three: Discussion of Findings and Recommendations	63

Table of Contents
List of Tables and Figures

Table 1: Number of Provider Performance Reviews and Core Consults (July 2001 – December 2006)	11
Table 2: Number of Provider Follow Up Reviews (July 2001 – June 2005)	12
Figure 1: Desk Review Scores by APD Area (July – December 2006)	13
Figure 2: Desk Review Scores by Provider Type and Year	14
Table 3: Background Screening Alerts by Year for Desk Reviews	14
Table 4: Desk Review Recoupments by Provider Type and Year	15
Table 5: Documentation Follow Up Reviews	16
Table 6: CORE Consults by APD Area	17
Figure 3: CORE Consults by Year; Results Elements	18
Figure 4: CORE Results Elements (CRE) by Provider Type and Year	19
Figure 5: CORE Results Elements (CRE) Evaluation by Element	20
Figure 6: CORE Results Elements (CRE) Evaluation for Adult Day Training Providers	22
Figure 7: CORE Results Elements (CRE) Evaluation for NRSS Providers	22
Figure 8: CORE Results Elements (CRE) Evaluation for Residential Habilitation Providers	23
Figure 9: CORE Results Elements (CRE) Evaluation for Supported Living Coaching Providers	23
Figure 10: CORE Results Elements (CRE) Evaluation for Supported Employment Providers	24
Figure 11: CORE Results Elements (CRE) Evaluation for In-Home Support Services Providers	24
Table 7: CORE Minimum Service Requirements Percent Met by Year	25
Figure 12: CORE Minimum Service Requirements Percent Met by Element	26
Figure 13: CORE MSR Evaluation by Provider Type and Year	27
Figure 14: CORE Alerts	28
Table 10: CORE Follow-up Reviews, Percent of MSR Elements Met at Follow-up—Previously Not Met	29
Table 11: Reconsiderations for Desk and CORE	29
Table 12: Waiver Support Coordinator consultation and Waiver Support Coordinator by APD Area	31
Figure 15: WiSCC Results Elements by Provider Type and Year	32
Table 13: YTD Year 6 Results Elements by Provider Type	33
Figure 16: Number WiSCC MSR Met by Year	34
Figure 17: WiSCC MSR Elements by Year	35
Figure 18: Number of FOCUS Plan Expectations by Year	36
Figure 19: Percent of FOCUS Plan Expectations Met at Follow-up by Year	37
Table 14: Enrolled Population and Sample by APD Area	38

Table 15: Enrolled Population and Sample by Gender	39
Table 16: Enrolled Population and Sample by Age Group	39
Table 17: Enrolled Population and Sample by Living Arrangement	40
Table 18: Personal Outcome Measures, Average and Percent Outcomes Met and Supports Present	40
Figure 20a: Percent Outcomes/Supports Met by POM Item	42
Figure 20: Personal Outcomes Met by APD Area and Year	44
Table 19: Driver Outcomes and Supports by Year	45
Figure 21: 13 or More Outcomes and Supports, Year 2 – YDT Year 6	47
Figure 22: 13 or More Outcomes Met by Service	48
Table 20: Foundational Outcomes, Percent Met by Year	49
Figure 23: Percent POMs with Foundational Outcomes Met by Number Met	50
Table 21: Medical Review Disposition	51
Table 22: Customer Service Contacts	60

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)—the Florida Statewide Quality Assurance Program (FSQAP). In July 2006, individuals receiving services through the Family and Supported Living Waiver (FSL) were added to the QA program. 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 the first two quarters of the current contract year, and comparisons to previous years when possible.

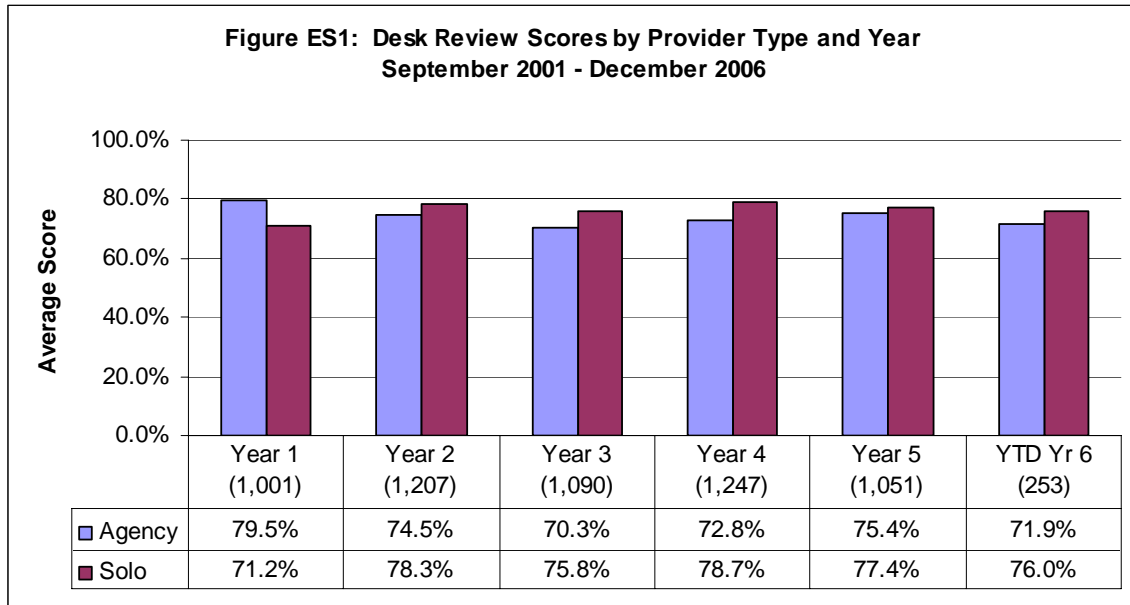
Communication with AHCA, APD, CQL and other stakeholders is of primary importance to Delmarva. Members of the Delmarva staff have actively participated in the Interagency Quality Council (IQC) and other National and International conferences where they consistently present information, conduct panel discussions, and/or lead brainstorming sessions. The Director of Florida Programs, Bob Foley, continues to conduct monthly Status meetings with all participating agencies and partners, bi-weekly manager's meetings and bi-weekly conference calls with all Quality Improvement Consultants (QIC) and managers to ensure communication is consistent among all the various groups involved in the FSQAP. Regional Managers conduct quarterly meetings with Area APD administrators, often attend Steering Committee meetings established by APD to develop quality improvement (QI) initiatives that are Area specific, accompany QICs on many consults, and conduct education/training sessions across the state on topics requested by each Area. These and other contract initiatives are described in Section Two of this report.

In addition to the Personal Outcome Measures (POM) interviews noted above, Delmarva's QICs have conducted Desk Reviews since the first year of the contract. Since July 2004 (Year Four), they have conducted two different types of onsite reviews:

- Waiver Support Coordinators (WSC) participate in a Waiver Support Coordinator Consultation (WiSCC), which includes the POM interviews;
- Providers who render Adult Day Training, Non-Residential Support Services, Residential Habilitation, Supported Employment, Supported Living Coaching, In-Home Support Services or Specialized Medical Home Care participate in a Collaborative Outcomes Review and Enhancement consult (CORE).

QICs have completed 253 Desk Reviews during the six month period ending December 31, 2006. Results for Desk Reviews indicate some differences between agency and solo providers across the years, but fairly consistent annual scores, ranging between approximately 75 percent and 77 percent since the second year of the contract. With the

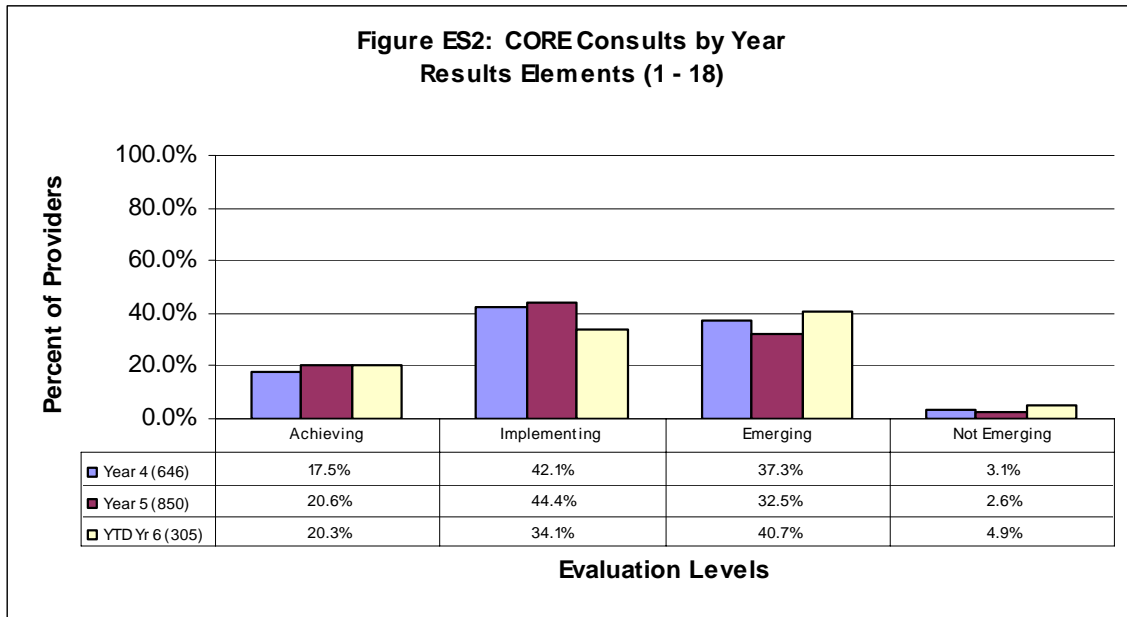
exception of the first year of the contract, solo providers have consistently scored somewhat higher than agency providers.



Desk Review results for the first two quarters of this year also indicate that approximately 23 percent of the providers received at least one Background Screening alert, indicating documentation was not present verifying background screening for one or more employees. This is similar to the previous year and represents an improvement since the first few years of the contract. Approximately 60 percent of these citations are rectified by the time of the Documentation Follow-up Review.

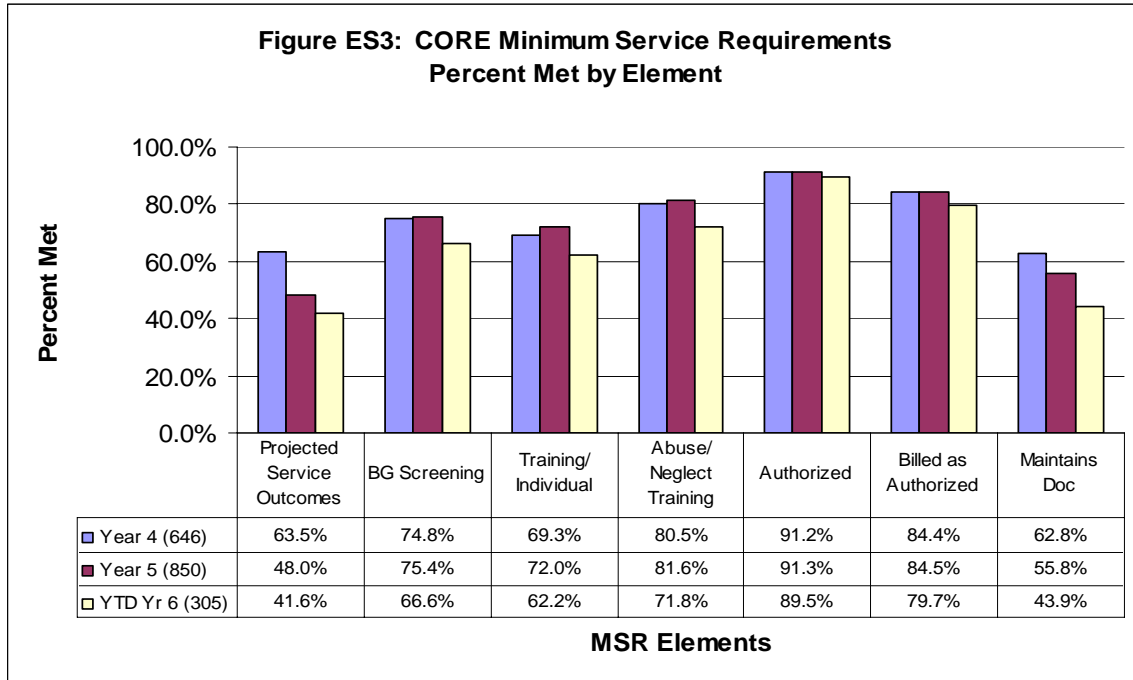
On the CORE and WiSCC processes, providers are evaluated as Achieving, Implementing, Emerging or Not Emerging on elements that are results oriented—ensuring the provider has systems in place and the systems reach all the individuals they serve to help them achieve desired outcomes. There are 18 Core Results Elements (CRE) and six WiSCC Results Elements (WRE). Providers are also scored as Met or Not Met on process elements, the Minimum Service Requirement (MSR) elements that indicate if training, background screening and licensure/billing documentation is complete. There are seven MSR elements in the CORE and five MSR elements as part of the WiSCC process.

Quality Improvement Consultants (QICs) completed 305 CORE consults during the first two quarters of this contract year. The overall Results Element evaluation indicates providers improved somewhat from the first to second year after implementation of the process, but shows a possible downturn thus far in the current contract year. Providers reviewed so far were more likely to be evaluated as Emerging and less likely to be evaluated as Implementing, compared to the previous two years.

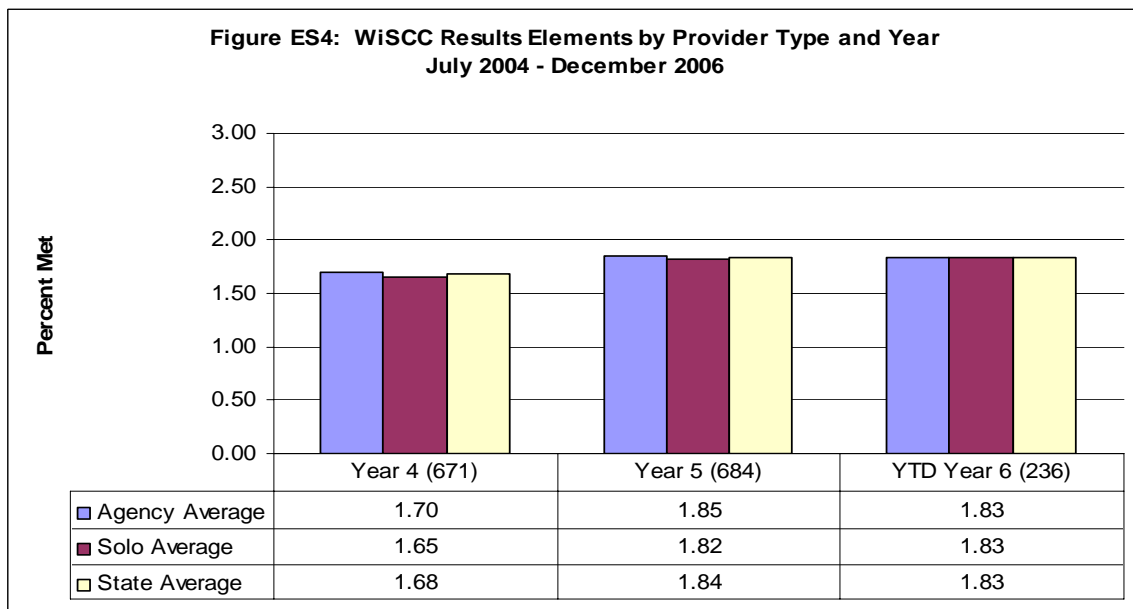


On average, solo providers each year have been much more likely to score as Achieving than agency providers, and less likely to be evaluated as Emerging. Independent CORE Results Elements most likely to be scored as Achieving are the elements indicating organizational systems ensure individuals are safe, they are treated with dignity and respect and that privacy for individuals is ensured. The organizational area with the greatest drop since last year at the Achieving level is the area indicating people are satisfied with their services, and the organizational area most likely to be scored as Not Emerging indicates if individuals routinely review and update their Implementation Plans.

Results on the CORE Minimum Service Requirements reflect a downturn, with a statewide annual score dropping from 75 percent in Year Four (July 2004 – June 2005) to 65 percent for the six month period ending December 31, 2006. Agency providers (N=242) showed a smaller percent of the elements scored as Met in the current year, 63.4 percent compared to 72.1 percent for solo providers (N=63). Providers’ reviewed thus far in this contract year have been least likely to show a decrease in the percent met on the MSR elements measuring service and billing authorization, compared to the previous two years. The greatest drops in performance since Year Four are in the areas of Projected Service Outcomes and Maintaining Documentation for billing.

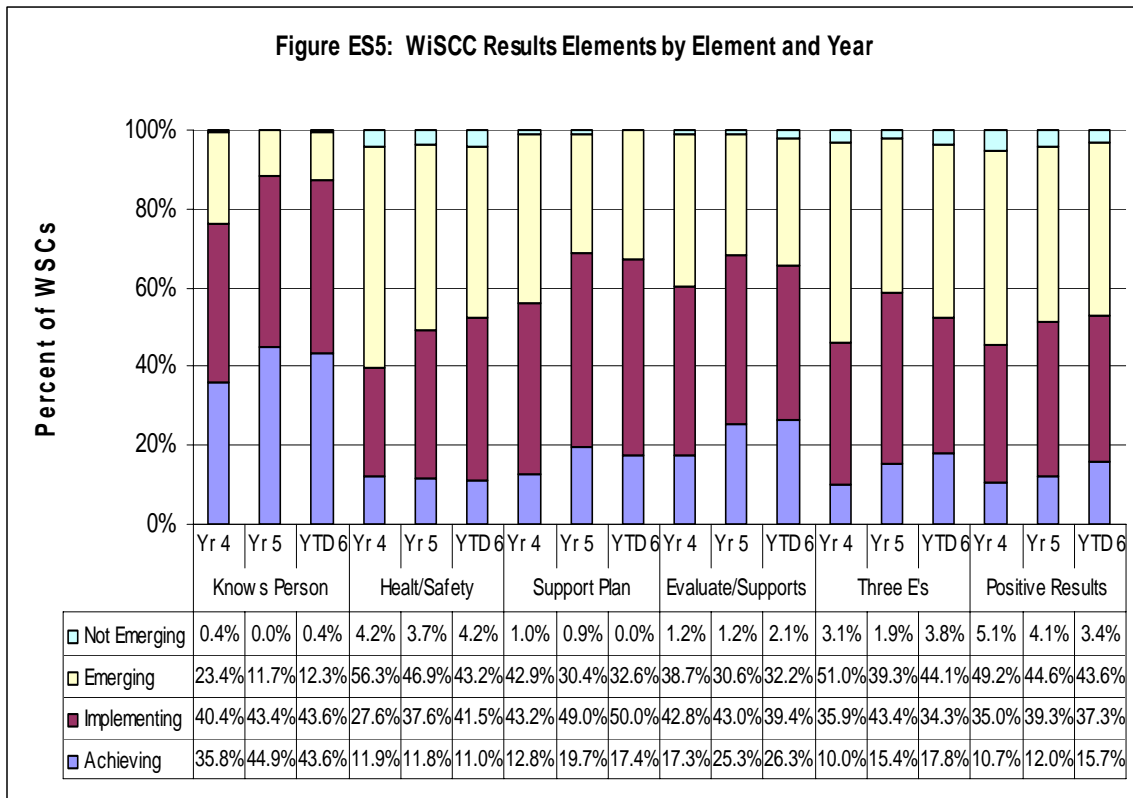


As a result of the 305 CORE consults, 163 alerts were cited. Of these, 102 (62.6%) were for missing or insufficient documentation for background screening. Approximately 77.5 percent of these were corrected at the time of the Follow-up Review, but not all providers had completed a Follow-up review at the time of this analysis. Therefore, at the time this report was compiled approximately 22 percent (37 instances) of Background Screening alerts were unresolved for the first two quarters of Year Six for providers who had a CORE consult.



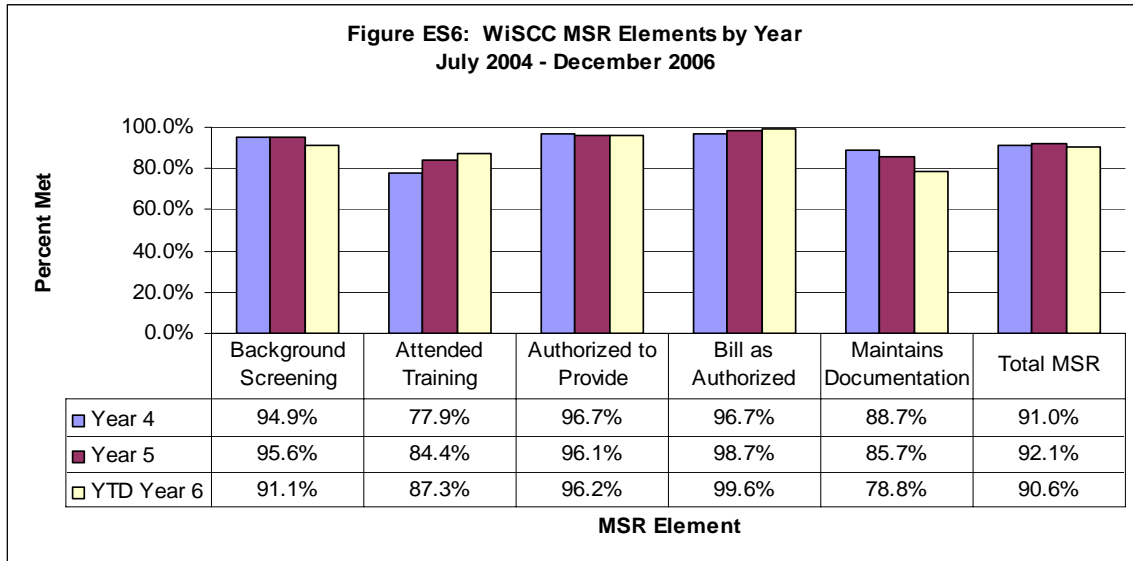
QICs completed 174 WiSCC evaluations that included a review of 236 Waiver Support Coordinators (WSC) and Personal Outcome Measures (POM) interviews with 468 individuals. Using a score ranging from 0 (Not Emerging) to 3 (Achieving) for the six WiSCC Results Elements, findings as demonstrated in the previous graph indicate the WSCs’ performance on the WiSCC Results Elements improved somewhat from the implementation year (July 2004 – June 2005) to the second year, and has remained fairly constant thus far during this contract year.

At the Results Element level for WSC reviewed thus far in Year Six (following graph), most elements were scored as Implementing or Emerging, as indicated in the following graph. WSCs have been most likely to have systems in place that allow them to know the people they serve, close to 44 percent scored this as Achieving. This pattern has persisted since Year Four of the contract. While approximately 11 to 12 percent of WSCs have scored Achieving in the area of Health and Safety, the percent of support coordinators scoring this as Implementing has increased from 27.6 percent in Year Four to over 41 percent thus far in Year Six. WSCs have improved consistently in developing systems that generate positive results for individuals they support.



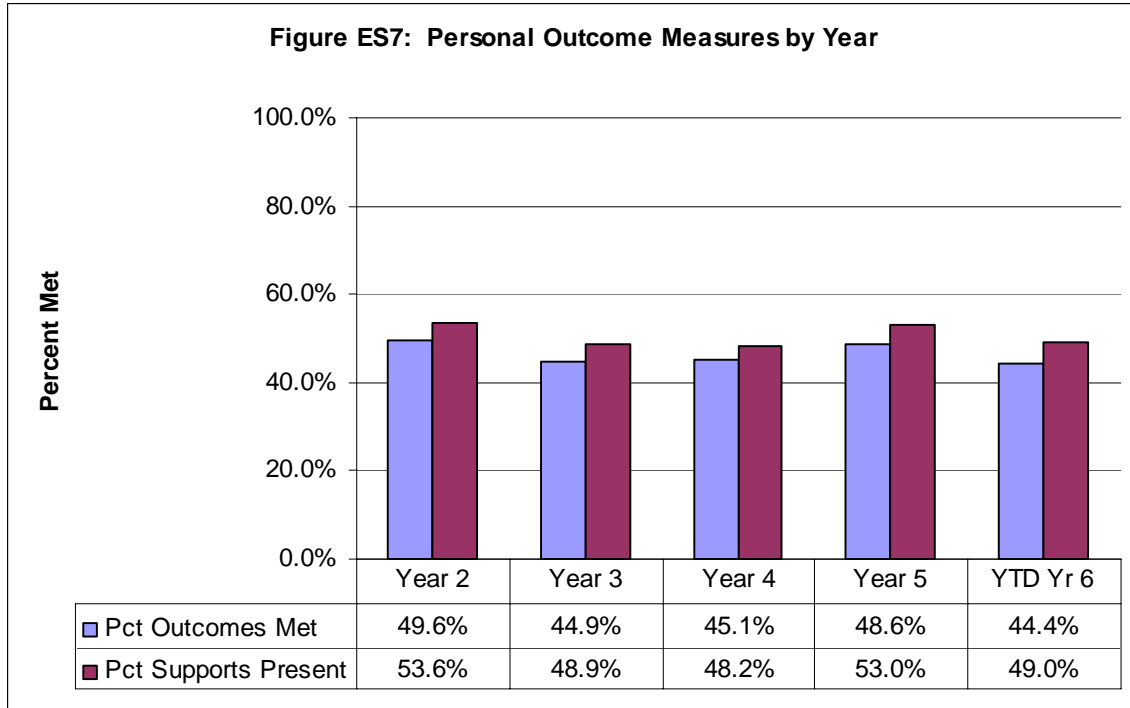
On average, results for agency (N=107) and solo (N=129) support coordinators are similar over the years and close to identical during the first two quarters of the current

year. During the first six months of this year, WSC working for an agency were more likely than solo WSCs to be evaluated as Achieving in the areas of health and safety, developing a support plan with individuals, facilitating Education, Exposure and Experience, and generating positive results for the individuals they serve. WSC working in a solo capacity were more likely to score Achieving in having effective methods to learn about the people they support.



WSCs have had a similar percent of the MSR elements met each year since implementation of the WiSCC process in Year Four. They appear to have improved over the years in attending required training but have dropped some on background screening compliance and maintaining documentation for billing.

During the first few years of the FSQAP contract, results from the individual Personal Outcome Measures (POM) interviews reflected a downward trend in the percent of outcomes and supports present in the lives of people served through the DD Waiver (see following table). In Year Five this trend appeared to shift to the good, with an increased percent of both outcomes and supports present. During the first two quarters of Year Six, results from the POM interviews indicate a possible downward shift. This is apparent across all POM items, with the exception of the item measuring abuse, neglect and exploitation, and is reflected in the criterion of 13 or More Outcomes Met and the Percent of Foundational Outcomes Met, measures reported to the state legislature each year.



When reviewing these and other results in the report, it is important to remember that only a portion of the individuals in the POM sample have been interviewed (468) and only a portion of the service providers and Waiver Support Coordinators have been reviewed. In this report we explore in more detail the results discussed above including analyzing POM results across various demographic characteristics. We posit several possible explanations as to why the POM results seem to have decreased in the first part of the current year and include recommendations to the state regarding various findings and interpretations of the data analysis.

Introduction

This is the second quarterly report for Year Six of the Florida Statewide Quality Assurance Program (FSQAP) contract, October – December 2006. Information in this report includes second quarter activity reports as well as a review of the project across the sixth year. The report is divided into three sections. The first section, **Data Analysis and Results**, provides analysis and interpretation of the data collected from during the quarter, 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 and the achievement of individual outcome expectations. 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 second section, **Summary of Quarterly Project Compliance Activities**, presents information relevant to compliance with contract issues during the second quarter of the contract year. In this section we detail the activities and accomplishments of the Delmarva Staff and partners, including:

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

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: Data Analysis and Results

Volume of Activity-Desk Reviews and CORE Consultations

Providers of Supported Living Coaching, Supported Employment, Adult Day Training, Residential Habilitation, Non Residential Support Services, In Home Support Services and Special Medical Home Care are subject to an Onsite CORE review.¹ Providers of all other DD Waiver services (with the exception of Support Coordination, Adult Dental Services, Consumable Medical Supplies, Adaptive Equipment and Environmental Modifications) receive a Desk Review. There are several categories of providers subject to a Provider Performance Desk Review or a CORE in Year Six of the contract.² The following list identifies the new criteria in place to determine a provider's eligibility for the CORE process, based upon new procedures:

- Any provider rendering at least one of the services listed above for the specified time period.
- Providers who previously received a Desk Review and are now providing at least one of the seven CORE services (Adult Day Training, In Home Supports, Non-Residential Supports and Services, Residential Habilitation, Specialized Medical Home Care, Supported Living Coaching, and Supported Employment) will receive a CORE consultation. The sections for new providers in Elements 21 and 25 will be included in the consultation.
- A provider who received an "Achieving" overall on the outcome elements (no alert or recoupment elements cited) will not be reviewed the following year. At a minimum, every provider will be reviewed no less than once every other year, except for Support Living Coaching services, which will be reviewed using the full CORE tool annually. The other services provided will receive the exemption as stated above.
- Providers who render services in multiple APD Areas will have separate consultations completed for each APD Area.

For new providers who have not had an onsite consultation, the following applies:

- New providers who have never been reviewed, including on Elements 21 and 25 additional requirements for the first year consultation.
- New providers will be identified in narrative summary of the report.

Providers subject to a Desk Review must meet the following criteria:

- Provided services for at least six to 12 months;

¹ It is important to note that providers of Specialized Medical Home Care Services and In Home Support Services are not scored on every CORE element. Elements 12, 13, 14 and 19 are scored as Not Applicable.

² Providers of Support Coordination receive a WiSCC and are required to be reviewed every year. They are included in the WiSCC section of the report.

- Served at least one person in the previous three months;
- Had an alert or recoupment in the previous review;
- Last reviewed prior to two years ago;
- Discontinued the provision of all services which require an onsite consultation;
- Any new providers.

The following table shows the number of annual provider reviews and CORE consultations completed each year during the first five years of the contract, and up through December 31, 2006 of this Year. Delmarva has conducted over 10,000 annual reviews with providers of services on the Medicaid DD Waiver. As indicated in the Table 1, 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, Delmarva completed 5,837 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 1: Number of Provider Performance Reviews and CORE Consults
July 2001 - December 2006

Review Type	Year 1	Year 2	Year 3	Year 4	Year 5	YTD Year 6	Total
Onsite	882	846	940	24	NA	NA	2,692
CORE	0	0	18	639	850	305	1,812
Desk	1,001	1,207	1,090	1,247	1,051	241	5,837
Total	1,883	2,053	2,048	1,910	1,901	546	10,341

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. As part of the revised procedures and amended contract, the regular Follow-up is no longer offered, but Delmarva offers Follow-up with Technical Assistance and Reconsiderations. Follow-up with TA reviews may include the following:

- Assistance in the development of the Quality Enhancement Plan (QEP), as needed.
- Assistance with the development of organizational practices key to the facilitation and 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.

Providers receive a Follow-up with Technical Assistance as follows:

- If the overall outcome score is Not Emerging or Emerging, a Follow-up with Technical Assistance consult will occur within 60 days of the date of the exit.
- If the overall outcome score is Implementing, a request to receive a Follow-up with Technical Assistance consult from Delmarva can be made through the Agency for Persons with Disabilities (APD) Area Office.
- For any outcome score with an Alert (or missing background screening documentation), a Follow-up with Technical Assistance will occur within 30 days of the date of the exit.

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 Implementing 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).

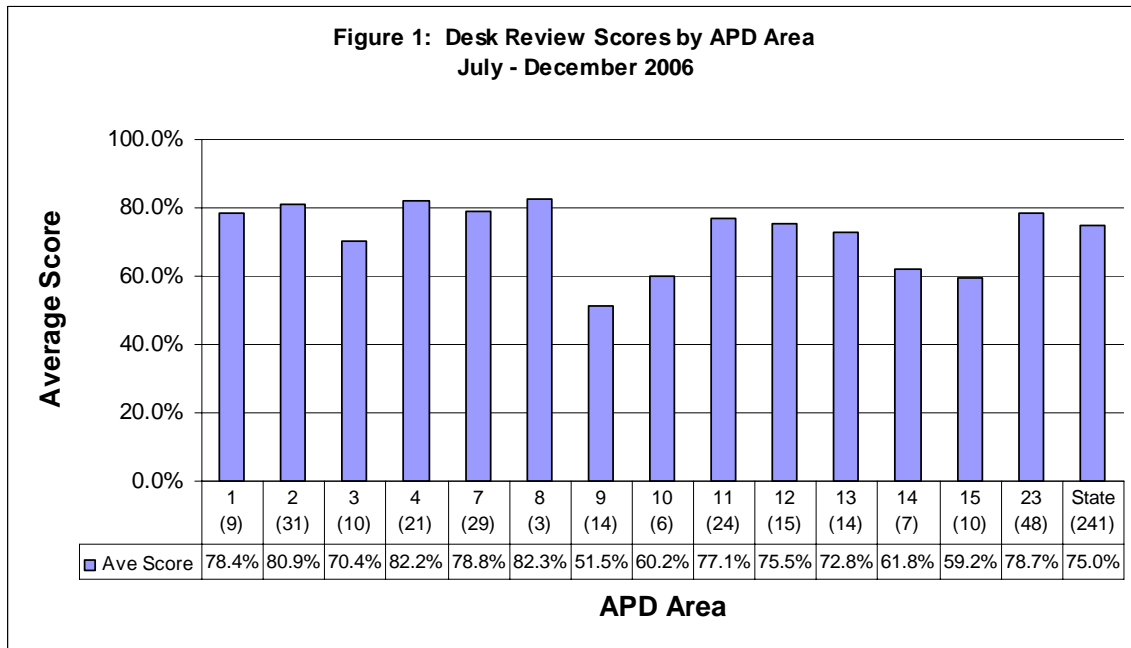
Table 2: Number of Provider Follow-up Reviews
July 2001 - December 2006

Follow-up Type	Year 1	Year 2	Year 3	Year 4	Year 5	YTD Year 6	Total
Follow-up	64	221	180	144	163	13	785
Doc Follow-up	0	277	823	664	663	227	2,654
Follow-up w/ TA	0	140	136	284	359	161	1,080
Reconsideration	92	91	131	89	79	14	496
Total	156	729	1,270	1,181	1,264	415	5,015

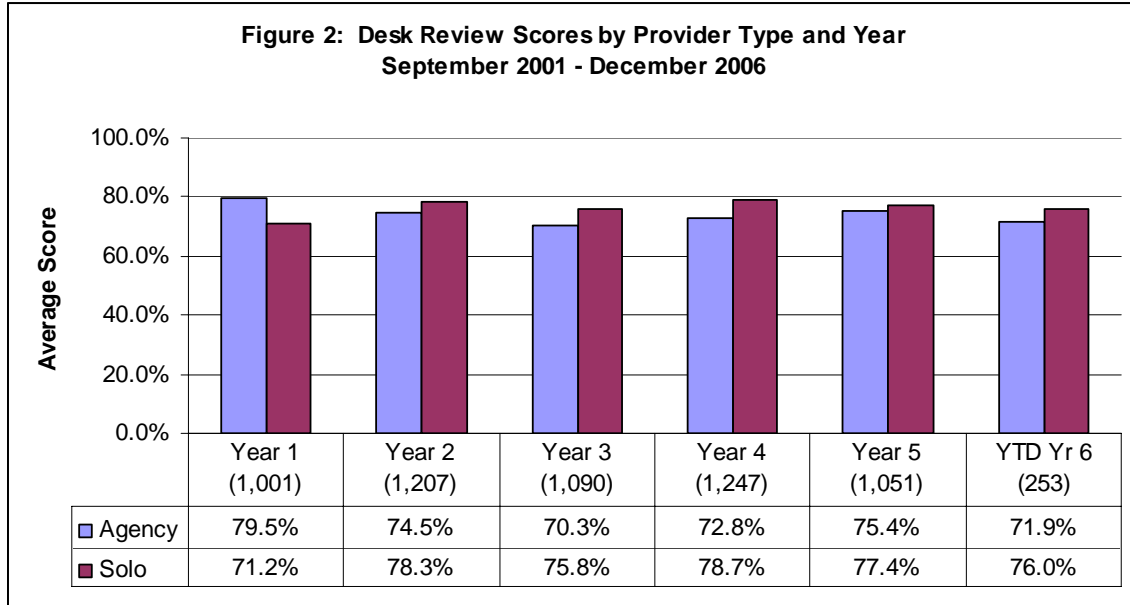
A total of 5,015 follow-up reviews of some type have been completed over the five and one half year period. As indicated in the above table, the number of Follow-up w/ TA reviews has increased considerably since it was first initiated in Year Two. In the six month period ending December 31, 2006, there were three Reconsiderations completed subsequent to a CORE consult and 11 as a result of a Desk Review. Of the 227 Documentation Reviews, 205 were for a Desk Review.

Desk Reviews

In the contract amendment approved this year, provisions were made to reduce the number of Desk Reviews to be completed by Delmarva to a target of 600. The number and percent of desk reviews in each APD Area is presented below. Because the number of reviews in most Areas to date this year is relatively low, comparisons are not yet made to previous years' data. Comparisons of scores across Areas should also be made with caution. The average scores in each Area and for the State are shown in Figure 1. The State score of 75 percent remains fairly consistent with previous years' results.



Over the years, some differences between agency and solo providers have been noted. These are reflected below in Figure 2. Approximately 75 percent of the Desk Reviews completed each of the past several years were for Solo providers. Since the second year of the contract Solo providers have scored somewhat better on the Desk Review than have Agency providers. This difference appears to be continuing in Year Six.



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.

**Table 3: Background Screening Alerts by
Year for Desk Reviews**

Year	Number of Providers w/ Alert	Pct of Providers w/ Alert	Total Number Alerts
1	332	33.2%	616
2	355	29.4%	1,515
3	319	29.3%	2,632
4	332	26.6%	2,009
5	240	22.8%	649
YTD Yr 6	56	23.2%	173
Total	1,634	28.0%	7,594

The information in Table 3 above reflects the number and percent of reviews that were missing documentation for background screening or re-screening, and it was not supplied within the 10 day timeframe. The analysis indicates:

- Over the five and one half year period, 28 percent of providers who had a desk review did not have appropriate background screening documentation;

- The percent of compliance for background screening has increased consistently over the years, with a drop in Year Five that has remained fairly stable thus far in Year Six;

In April 2006, APD implemented a new method for following up on providers who have been found to be non-compliant on their background screening requirements. If a Delmarva Quality Improvement Consultant (QIC) notes a background screening alert, the QIC notifies the appropriate contact person at the Area APD office, who then follows through with contacting the provider. Results of these efforts are noted at the time of the Documentation Follow-Up Review. If the proper documentation has been submitted, the element previously scored as Not Met is recorded as Met, an indication background screening documentation has been verified.

A preliminary analysis of pre (May 2005 – April 2006) and post (July – December 2006) follow up data for Desk Reviews shows some difference in the percent of background screening elements that scored as Met at the time of the Follow-up review. Follow-up reviews in pre time period indicate approximately 62 percent of the background citations for Desk Reviews have been rectified by the time the Follow-up is completed, and in the post time approximately 59 percent had been rectified. However, this analysis will be repeated in three to six months to include more data. In addition, this will allow more time for the new process to be fully incorporated into the system.

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) for the most recent three contract years indicates:³

- The percent of recoupment citations appears to be higher in the first half of Year Six than in the previous two years, for both agencies and solo providers.
- The average number of recoupments per provider is higher among agency providers and appears to be increasing for both provider types.

Table 4: Desk Review Recoupments by Provider Type and Year

July 2004 - December 2006

	Agency Providers			Solo Providers		
	Year 4	Year 5	YTD Yr 6	Year 4	Year 5	YTD Yr 6
Providers Subject to Recoupment	313	275	60	934	772	181
Total Number of Citations	259	236	74	573	483	135
Providers w/ Recoupment	119	102	26	335	289	71
Percent of Providers w/ Citation	38.0%	36.4%	43.3%	35.9%	37.4%	39.2%
Average per Provider w/ Citation	2.18	2.31	2.85	1.71	1.67	1.90

³ Recoupment citations were not recorded in Year One.

Table 5 below shows a summary analysis of Documentation Follow-up Reviews for the past three years of the contract. The Percent Met indicates the percent of elements scored as Met on the Documentation Review that were previously scored as Not Met, on the annual review. Findings reflect the following:

- The percent of provider with 100% of the elements scored as Met during the Documentation Review, from a previously Not Met result, increased over the years but appears to have dropped somewhat thus far in Year Six.
- 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 10 percent in Year Five and close to 13 percent to date in Year Six.

Table 5: Documentation Follow-up Reviews
Percent of Elements Changed to MET from Initial Review

Percent Met	Contract Year				
	Year 2	Year 3	Year 4	Year 5	YTD Yr 6
100%	22.0%	19.8%	22.9%	26.7%	20.0%
>=75%, < 100%	14.1%	14.8%	16.8%	15.5%	12.7%
>=50%, <75%	14.4%	17.5%	17.0%	18.9%	22.0%
>=25%, <50%	16.2%	19.3%	17.0%	17.2%	25.4%
>0%, <25%	26.0%	18.6%	17.0%	11.6%	7.3%
0%	7.2%	10.0%	9.3%	10.1%	12.7%
Reviews	277	823	654	645	205

CORE Consultations

The following section summarizes results from the first six months of Year Six of the Collaborative Outcomes and Review Enhancement (CORE), with comparisons to previous years when appropriate. 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 305 annual CORE consults have been completed and approved during the first two quarters of Year Six of the FSQAP contract. The target for the year is 927. Each provider is evaluated on 25 elements. The first 18 are results-based with a focus on the following areas: rights, choices, community, health and safety, a person-centered approach and communication. Each CORE Results Element (CRE) is evaluated as

Achieving, Implementing, Emerging or Not Emerging.⁴ The provider’s CRE evaluation level is based upon a compilation of CRE 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.

Distribution by APD Area

Table 6 shows the distribution, across APD Area, of the CORE consults completed during the first two and one half years since implementation of the process. Because there are only a small number of CORE that have been completed in each Area thus far in Year Six, comparisons across Areas are not appropriate.⁵

Table 6: CORE Consults by APD Area
July 2004 – December 2006 CORE

APD Area	Year 4	Year 5	YTD Yr 6
1	20	33	15
2	47	90	27
3	48	74	29
4	59	65	19
7	38	62	19
8	19	27	11
9	18	22	3
10	27	63	23
11	64	110	31
12	38	55	0
13	56	55	27
14	31	27	15
15	60	49	4
23	121	118	82
Total	646	850	305

CORE Results Elements (CRE) Evaluation Level by Year

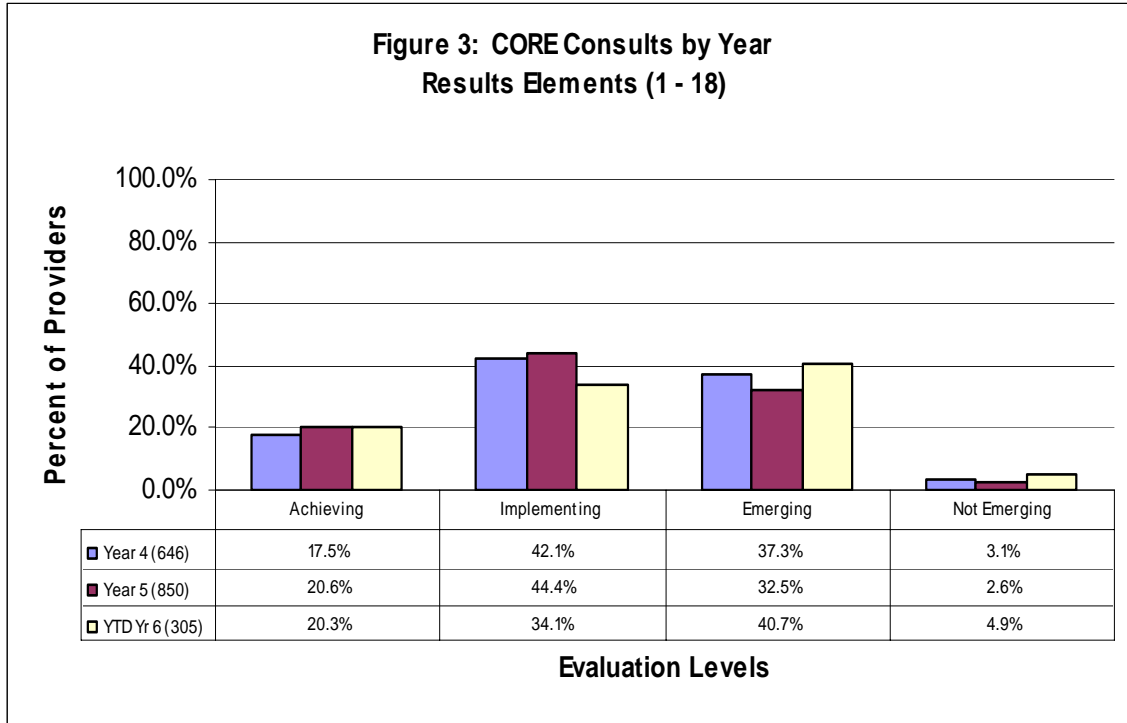
The following chart (Figure 3) displays the percent of CRE evaluation scores by year for providers who had a CORE consult.

- The Percent of providers evaluated as Achieving thus far in Year Six appears to be remaining consistent with the Year Five level, and slightly higher than the baseline year.

⁴ See Appendix 1, Attachment 2, for a description of the levels of evaluation and Attachment 3 for a description of each CORE element.

⁵ Numbers in Year 4 are lower than in Year 5 because it was the start-up year.

- A smaller percentage of providers have been evaluated as Implementing thus far in Year Six, but the percentage scoring as Emerging has increased since Year Five and is greater than in Year Four.

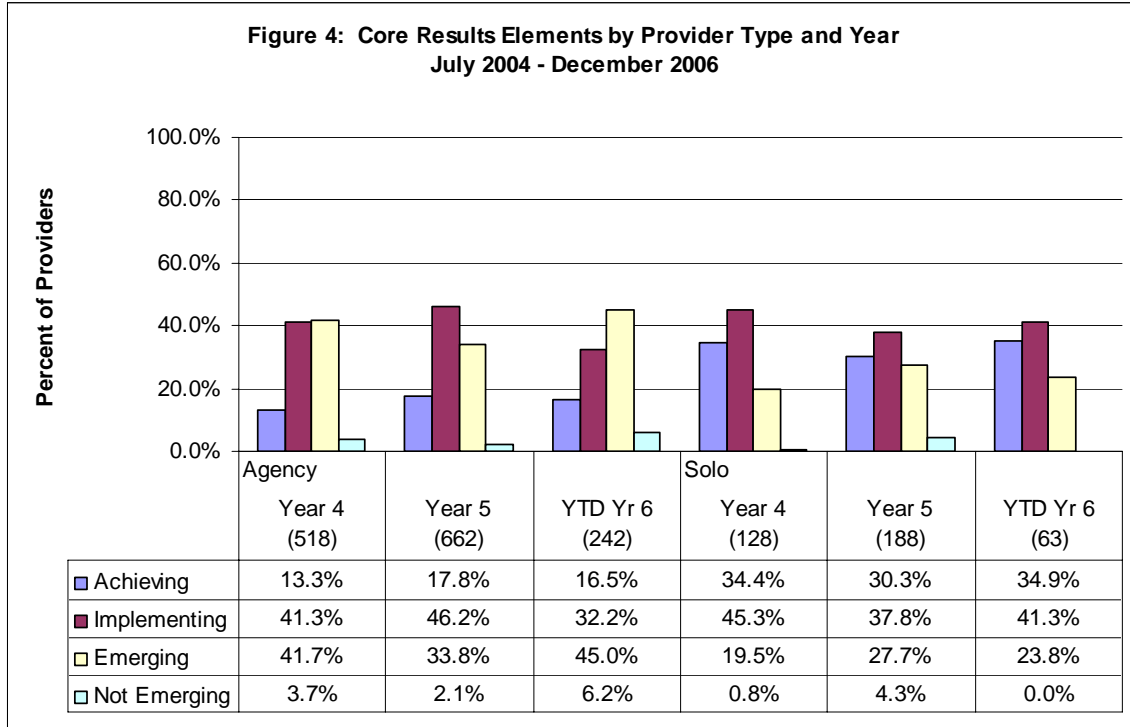


CORE Results Elements (CRE) by Provider Type

The graphic depiction below (Figure 4) shows the distribution of CORE consults by provider type and statewide for this time period. The first three sets of bars represent results for *Agency* providers for Year Four and Five and the first six months of Year Six. The last three sets of bars represent results for *Solo* providers. Information from the chart indicates the following:

- During the first half of the current contract year, for the Results Elements, agency providers were more likely to score as Emerging and less likely to score as implementing than in the previous two years.
- For the first half of the current contract year, over six percent (15) of agency providers were evaluated as Not Emerging and no Solo providers had this evaluation level.
- Solo providers continue to be more likely to score Achieving than agency providers.
- Thus far in Year Six, agency providers have been less likely to be evaluated as Implementing and more likely to be evaluated as Emerging than in Year Five.

- For the first half of the current contract year, a much higher proportion of solo providers scored as Achieving or Implementing than did agency providers, 76.2 percent and 48.8 percent respectively.



CORE Results Elements (CRE) by Element

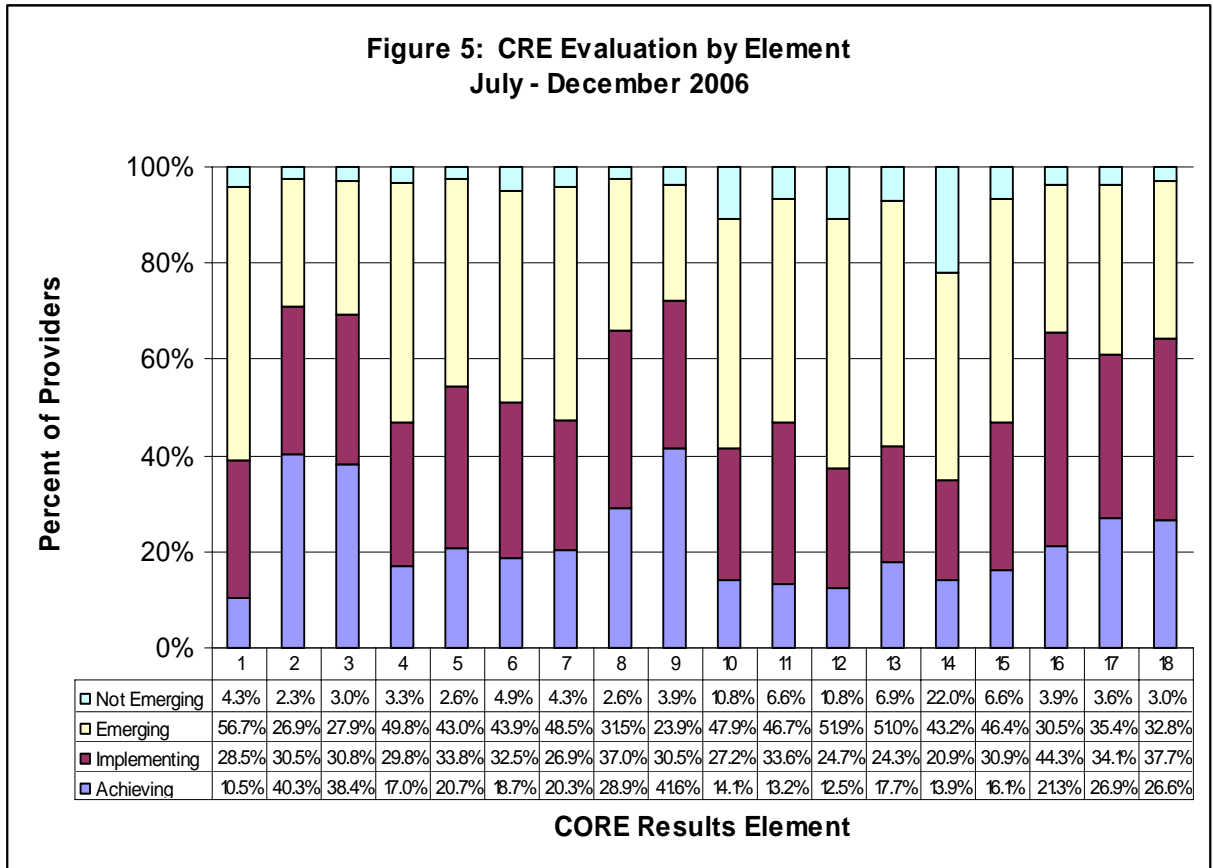
As indicated above, each of the 18 Results Elements are evaluated for every provider.⁶ Figure 5 on the following page shows the evaluation of each element for the first six months of Year Six of the contract. A Key for the elements is provided following Figure 5. A summary of results includes the following:

- Element 9 (Individuals are safe), Element 2 (Individuals are treated with dignity and respect), and Element 3 (Privacy is observed) were most likely to be scored as Achieving.
- Element 10, indicating the provider is helping individuals to develop desired social roles, has been found to be an important indicator of outcomes for individuals. This element has typically been least likely to be scored as Achieving, but is showing a small increase thus far this year, up 3.4 percentage points since Year Five.
- Elements 12 (Individual directs design of Implementation Plan), 15 (Individuals are achieving desired outcomes and goals), 16 (Provider advocates for individuals beyond scope of service) and 18 (Individuals are satisfied with

⁶ See Appendix 1, Attachment 3 for a description of each outcome element.

services) are currently showing over a five percentage point drop in the Achieving level since Year Five. For Element 18, this represents a 12 point drop since Year Four.

- Element 14, indicating if individuals 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, 22 percent of the providers (63) scored in this evaluation level.



Key for Elements:

- 1: Individuals are educated on and fully exercises rights.
- 2: Individuals are treated with dignity and respect.
- 3: Personal privacy is observed.
- 4: Individuals actively participate in their life’s decisions.
- 5: Services are provided in integrated settings.
- 6: Individuals are afforded choice of services and supports.
- 7: Individuals are free from abuse, neglect and exploitation.
- 8: Individuals are healthy.
- 9: Individuals are safe.
- 10: Desired social roles are being developed.
- 11: A personal outcomes approach is used.

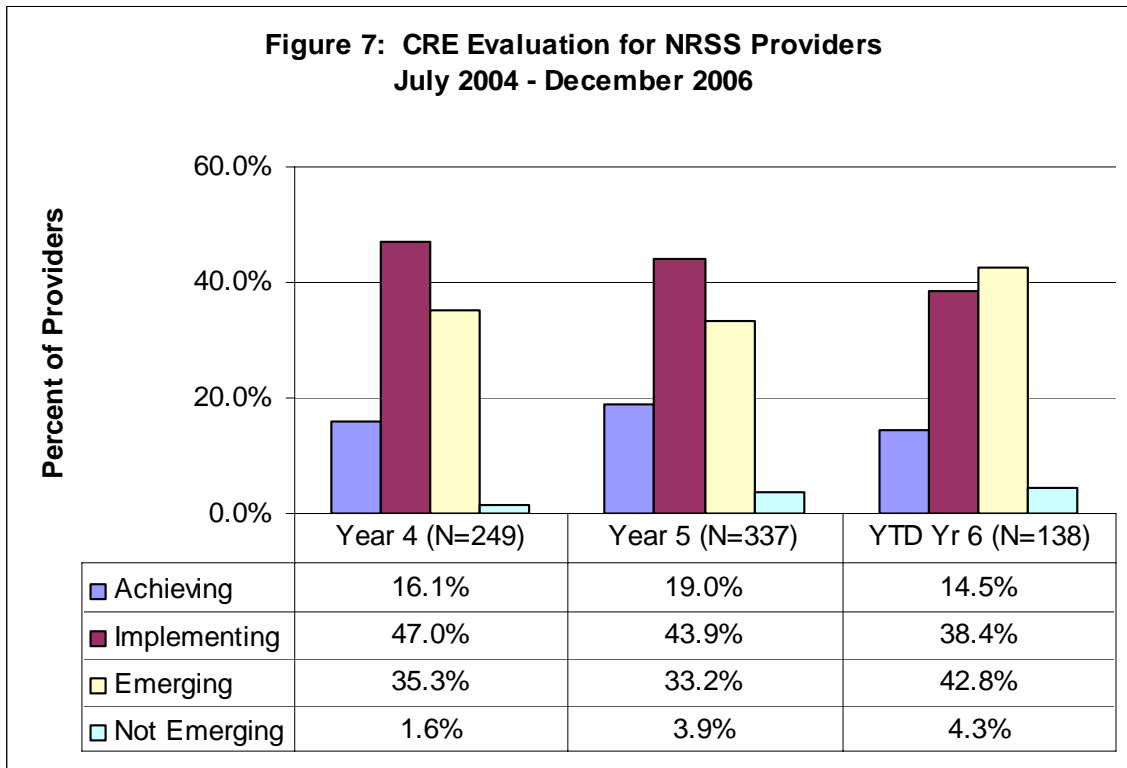
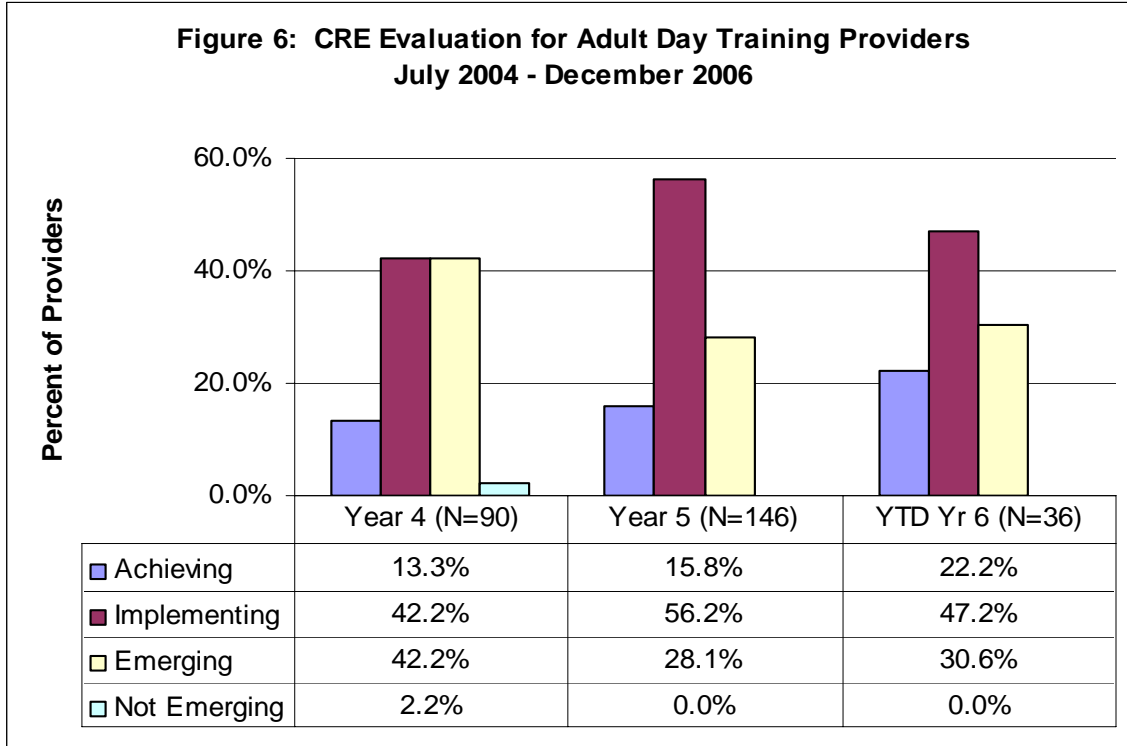
- 12: Individual directs design of Implementation Plan.
- 13: Provider facilitates individuals' outcome achievements.
- 14: Individual routinely reviews the Implementation Plan.
- 15: Individuals are achieving desired outcomes and goals.
- 16: Provider advocates for individuals beyond scope of service.
- 17: Provider coordinates dissemination of information.
- 18: Individuals are satisfied with services.

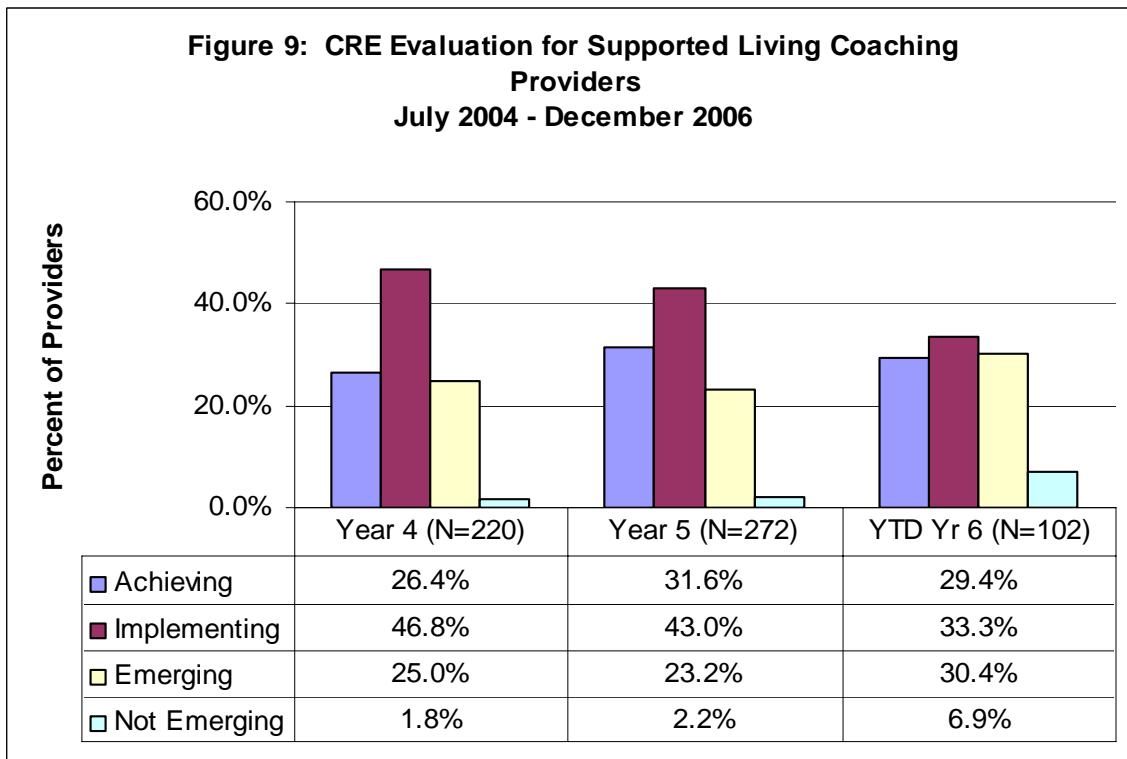
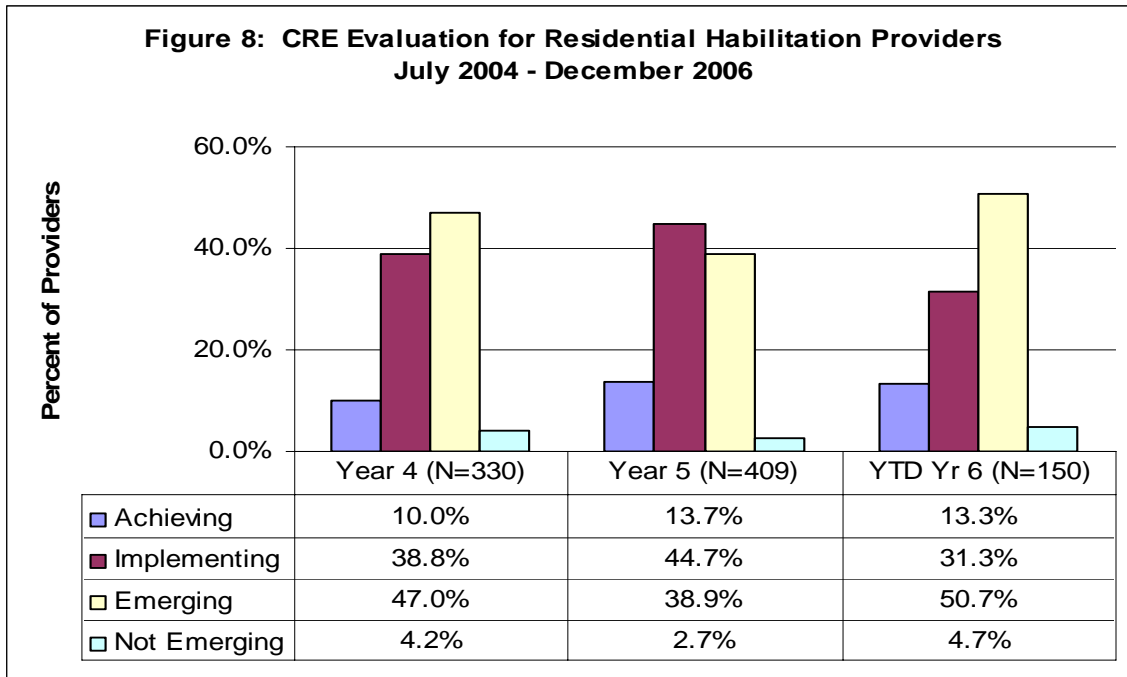
CORE Results Elements by Service

The following series of charts (Figures 6 – 11) shows CORE trends on the Results Elements 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 results for Year Four and Five and the first six months of Year Six. A summary of findings includes the following:

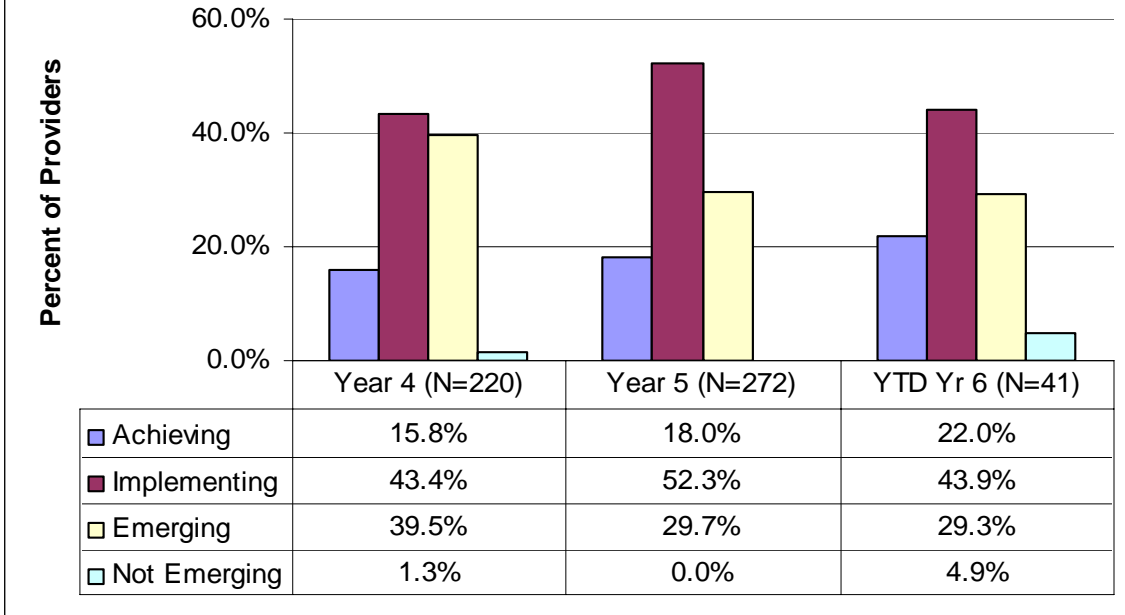
- The Improvement seen among providers of ADT from Year Four to Year Five appears to be continuing in Year Six. The proportion scored as Achieving has increased each year, by almost nine percentage points since Year Four.
- Providers of Supported Employment have also seen a continuous rise in the proportion evaluated as Achieving. However, the estimates in Year Six are based on only 41 CORE consults.
- On average, results for providers of NRSS, Residential Habilitation and Supported Living Coaching reflect a decrease in Achieving and/or Implementing with an increase in Emerging since Year Four.
- Results for In Home Support Services vary somewhat over the years. IHSS was added to the list of services monitored through a CORE consult in Year Five of the contract. Therefore, results in Year Four are for providers who rendered this service along with another service that is subject to a CORE consult.

Specialized Medical Home Care (SMHC) was also added in Year Five to the list of services monitored through the CORE process. There was only one provider of SMHC each year. Results indicate a shift from Emerging to Achieving.

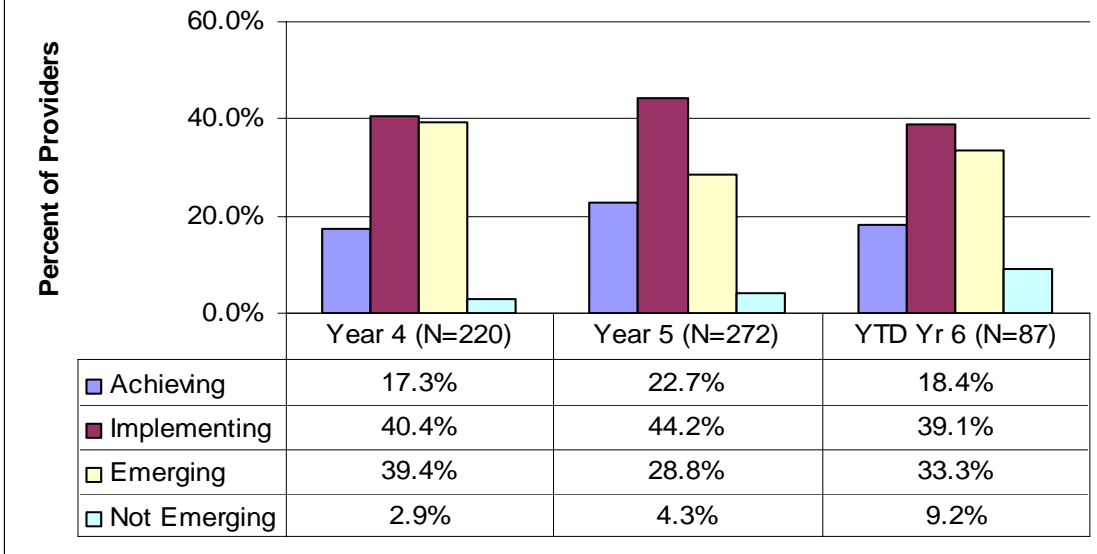




**Figure 10: CRE Evaluation for Supported Employment Providers
July 2004 - December 2006**



**Figure 11: CRE Evaluation for In-Home Support Services
Providers
July 2004 - December 2006**



Minimum Service Requirements (MSR) Evaluation by Year

The last seven of the 25 elements in the CORE are the Minimum Service Requirement (MSR) elements.⁷ Providers must supply documentation of the required background screening, required training, and proper billing procedures. MSR elements are evaluated as Met or Not Met. Table 7 shows the distribution of the percent of MSR elements Met on average by year. The overall percent of MSR elements scored as Met has decreased consistently since implementation of the CORE process. If this pattern persists through the end of Year Six, steps should be taken to address the decrease in compliance with regulatory and licensure requirements.

Table 7: CORE Minimum Service Requirements

Percent Met by Year

July 2004 - December 2006

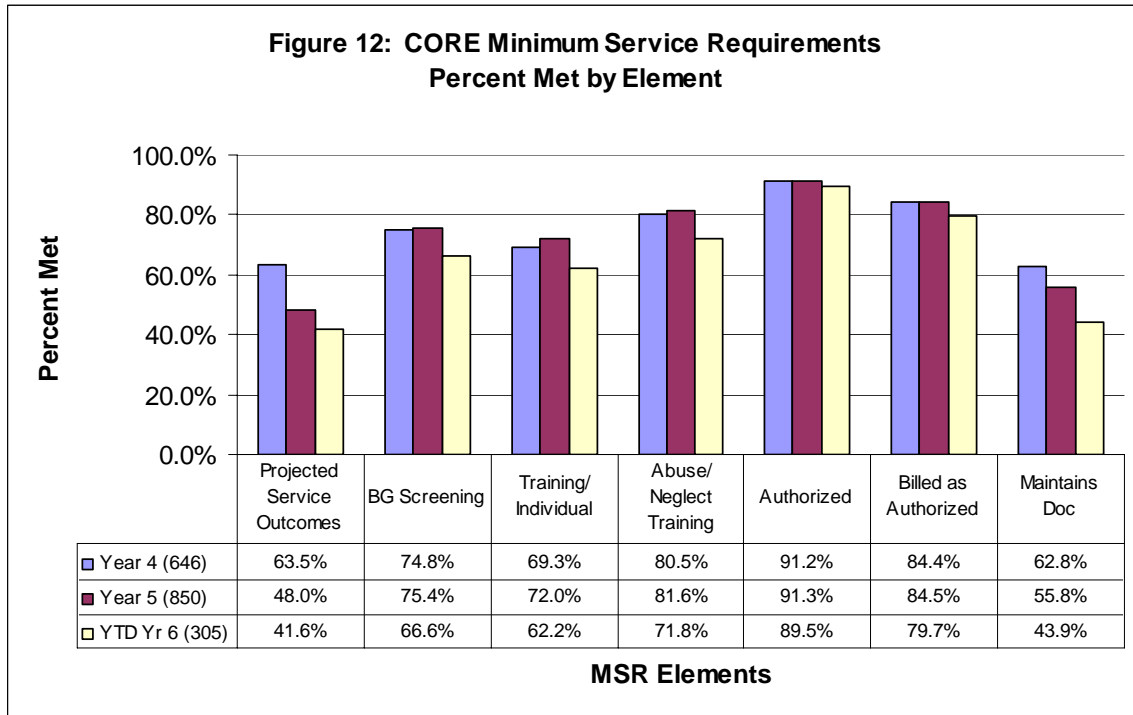
Contract Year	Consults	Percent MSR Met
Year 4	646	75.2%
Year 5	850	72.9%
YTD Yr 6	305	65.2%

MSR Evaluation by Element

Figure 12 shows the percent of MSRs met for each CORE element for Year Four, Year Five and the first six months of Year Six. Results indicate the downward trend is evident among six of the seven elements. The exception is for the element that measures if providers have documentation indicating they are authorized to provide the service, which has remained fairly constant over the years. To summarize:

- Among the other six MSR Elements, the smallest decrease is for Element 24, indicating that for the 305 CORE conducted thus far this year providers are not as likely as in previous years to have documentation indicating they billed as authorized—down almost five points since Year Four.
- Compared to Year Four, results for the six month period ending December 2006 inform us that providers are far less likely to meet service specific projected service outcomes—a drop of nearly 30 points.
- Compared to Year Four, the percent of providers who maintain the required documentation has decreased by close to 20 points.
- Documentation for background screening has decreased by over eight points and the elements measuring training specific to the individual’s characteristics and training on abuse and neglect have dropped by 8.7 and 7.2 points respectively.

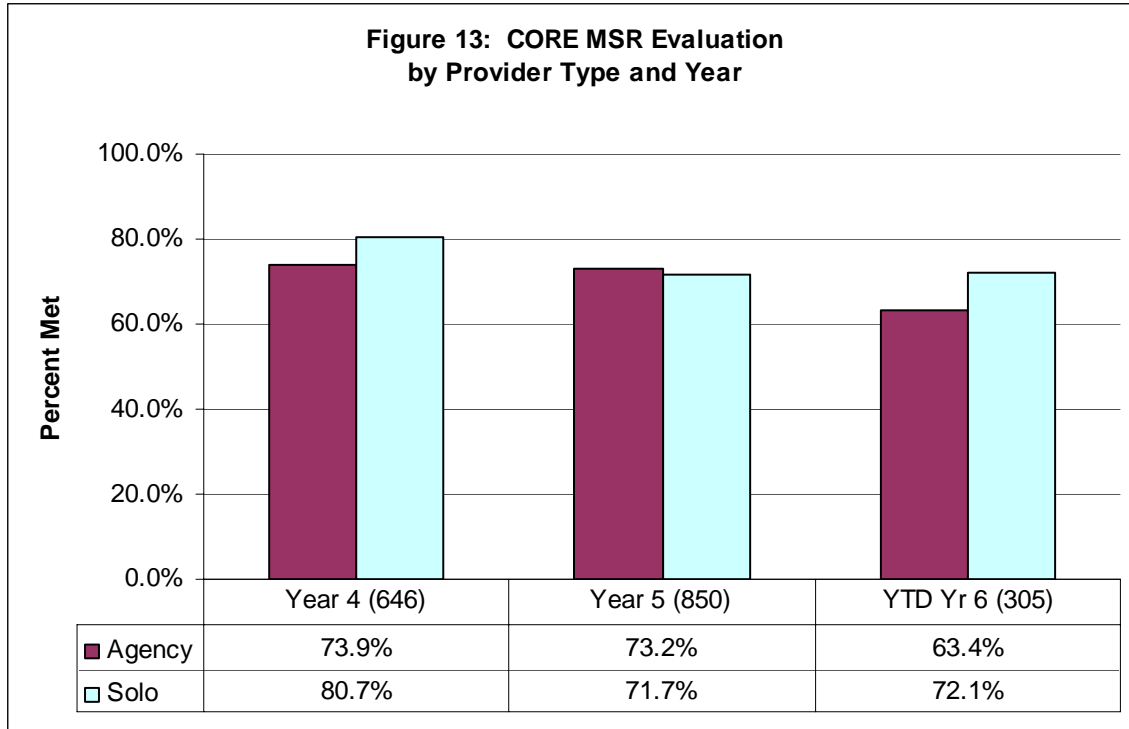
⁷ See Appendix 1, Attachment 3 for a description of each MSR element.



MSR Evaluation by Provider Type

By examining results for the MSR elements by provider type, agency v solo, we see a decrease among both types of providers since Year Four.

- For solo providers, the drop occurred between Year Four and Year Five, and their MSR results have remained fairly consistent with Year Five thus far in Year Six.
- The percent of MSR elements agency providers scored as Met was constant from Year Four to Year Five, but dropped by close to 10 points in the first two quarters in Year Six.
- Solo providers appear to be more likely to have the MSR elements scored as Met than do agency providers.

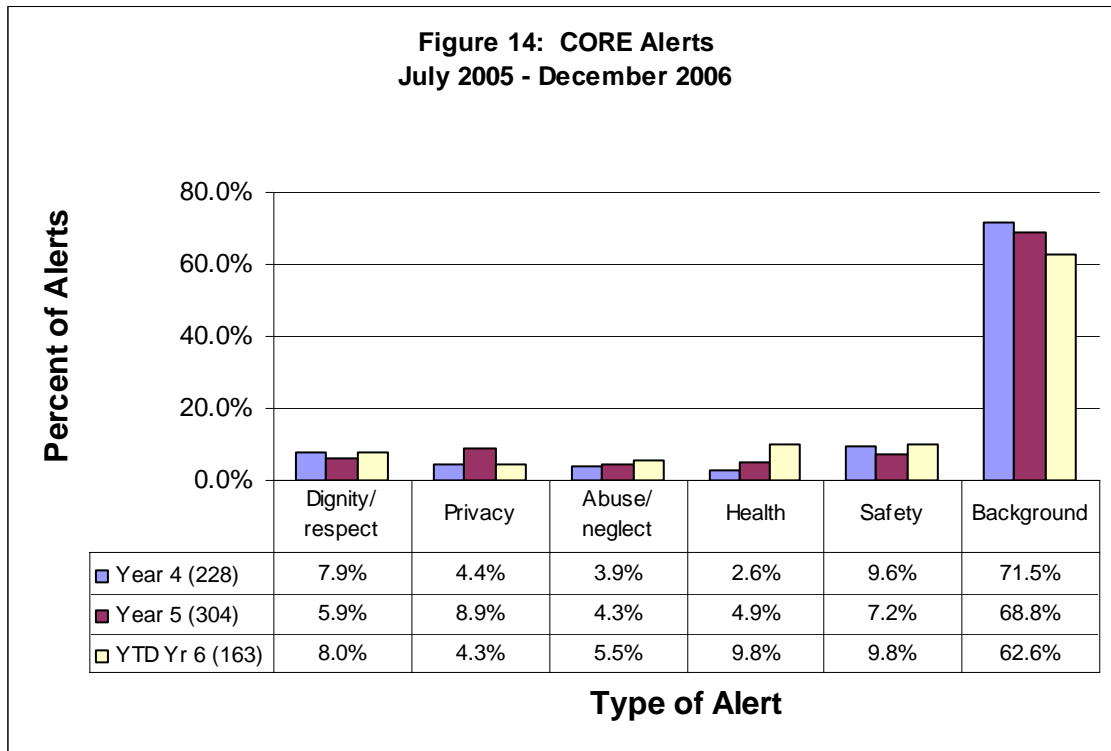


CORE Alerts and Recoupments

Several elements in the CORE evaluation are Recoupment or Alert items.⁸ 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.

There were 163 alerts cited during the first two quarters of Year Six, involving 106 providers. Of these providers, 87 (82%) had only one alert. The percent of each item scored as an alert is depicted in the following chart (Figure 14) by year. While the majority of CORE alerts each year related to background screening, the proportion has dropped somewhat since Year Four, meaning a larger proportion of the alerts pertain to areas of dignity and respect; privacy; abuse, neglect and exploitation; health; and safety. Among these, alerts related to an individual’s health status have risen the most, up over seven percentage points since Year Four. At the same time, the percent of alerts pertaining to privacy has dropped since Year Five.

⁸ 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.



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

- Of the 305 CORE completed in the six-month period ending December 2006, 135 providers (44%) received a total of 197 recoupment citations. This is up from the percent of providers with a recoupment in Year Five (31%).
- A somewhat higher percent of Agency providers have a recoupment than Solo providers, 46 percent and 37 percent respectively.

Follow Up Reviews and Follow Up with Technical Assistance Reviews

While providers may receive a Follow-up or Follow-up with Technical Assistance review for a variety of reasons, the only “scores” that are subject to change in either of the follow up procedures are the seven MSR elements. In addition, either Follow-up review type can be completed for providers who scored all the MSR elements as Met, but needed a follow-up for an outcome element. During the first two quarters of Year Six of the contract a total of 135 providers received a Follow Up review that included an MSR element that had been scored as Not Met during the annual consult. Results of the follow-up activities regarding the MSR elements are shown in Table 10, and indicate the percent of MSR elements that had been scored as Not Met during the annual consult, and were scored as Met during the Follow-up—the elements that were “fixed” at follow-up.

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

Percent Met at FU	Year 4	Year 5	YTD Yr 6	Year 4	Year 5	YTD Yr 6
lt 25%	19	75	30	11.0%	19.7%	22.2%
25% - lt 50%	9	33	23	5.2%	8.7%	17.0%
50% to lt 75%	37	94	25	21.4%	24.7%	18.5%
75% to lt 100%	108	178	57	62.4%	46.8%	42.2%
Total	173	380	135	100.0%	100.0%	100.0%

- Of the 135 Follow Up reviews that were completed thus far in Year Six, close to 47 percent had over 75 percent of their MSR elements scored as Met.
- Over the time period, an increasing proportion of providers have met fewer than 50 percent of the MSR elements previously scored as Not Met, and a smaller proportion have met 75 percent or more.
- In Year Four, over 62 percent of providers scored Met on 75 percent or more of the MSR elements during the Follow-up review. This dropped to under 47 percent in Year Five and is just over 42 percent thus far in Year Six.

Reconsiderations

During the first two quarters of Year Six, 14 Reconsiderations were processed, three for a CORE and 11 as the result of a Desk Review. The 11 Reconsiderations for the Desk Reviews were all approved and the CORE Reconsiderations were all denied. As indicated in Table 11, Reconsiderations for Desk Reviews are much more likely to be approved than are Reconsiderations for the CORE, and this approval rate for Desk Reviews appears to be increasing.

Table 11: Reconsiderations for Desk and CORE

Review Type	Year 4		Year 5		YTD Year 6	
	Number	Percent Accepted	Number	Percent Accepted	Number	Percent Accepted
Desk	70	67.1%	57	78.9%	11	100.0%
CORE	18	44.4%	22	18.2%	3	0.0%
Total	88	62.5%	79	62.0%	14	78.6%

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 (WSC) and Personal Outcome Measure interviews (Person Centered Reviews) with at least two individuals the support coordinator serves. Each WSC is evaluated on six WiSCC Results Elements (WRE) and five Minimum Service Requirements (MSR). For the Results 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.⁹

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.¹⁰ Providers must supply documentation of the required background screening, required training, and proper billing procedures. MSR elements are evaluated as Met or Not Met.

Distribution by APD Area

A total of 174 WiSCCs were completed and approved during the first two quarters of Year Six of the Contract, July – December 2006. The target for the year is 461. As part of these consults, 236 Waiver Support Coordinators (WSC) were reviewed and 468 individuals were interviewed. (Consultants expect to interview approximately 1,416 individuals before June 30, 2007). The WiSCC consults and WSCs were distributed across the APD Areas as shown in the following table. Because only a small number of WiSCCs have been completed in each Area, comparisons of results across Areas are not appropriate.

⁹ See Appendix 1, Attachment 3 and 4 for a description of the evaluation levels and a list of the WiSCC Elements.

¹⁰ See Appendix 1, Attachment 5 for a description of each MSR element.

**Table 12: Waiver Support Coordinator
Consultation and Waiver Support Coordinator
by APD Area**
July - December 2006

Area	WiSCCs	Percent WiSCC	WSCs	Percent WSCs
1	4	2.3%	10	4.2%
2	15	8.6%	20	8.5%
3	12	6.9%	18	7.6%
4	23	13.2%	24	10.2%
7	19	10.9%	22	9.3%
8	3	1.7%	3	1.3%
9	6	3.4%	6	2.5%
10	11	6.3%	16	6.8%
11	27	15.5%	31	13.1%
12	3	1.7%	3	1.3%
13	7	4.0%	16	6.8%
14	7	4.0%	13	5.5%
15	10	5.7%	10	4.2%
23	27	15.5%	44	18.6%
Total	174	100.0%	236	100.0%

WiSCC Results Elements (WRE)

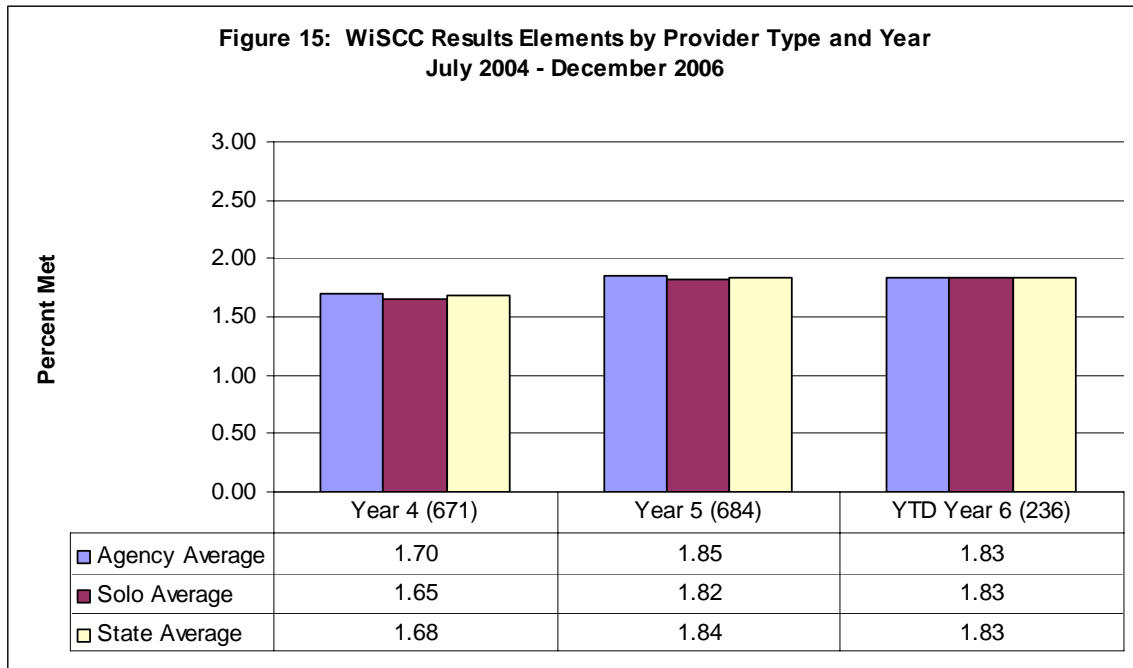
The 236 WSCs received an evaluation of Achieving, Implementing, Emerging or Not Emerging on each of the six Results Elements. Unlike for the CORE Results Elements, the overall results for the WREs for each WiSCC (including all WSCs who are reviewed) are currently not reported as Achieving, Implementing, Emerging or Not Emerging. For analytic purposes an average WRE score is calculated for each Support Coordinator, using the following values:¹¹

- 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 a WSC scores Achieving on all six Results Elements, the overall WRE score is a three.

¹¹ It is important to note 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.

Results for the first two and one half years of WiSCC data are presented in Figure 14, by provider type. There are approximately an equal number of Agency and Solo providers each year. The statewide average for the initial year of the WiSCC process was 1.68, between Emerging and Implementing, somewhat closer to Implementing. This increased somewhat in Year Five to 1.84, and is currently maintaining this level in Year Six. Results for Agency and Solo providers are similar, both improving since Year Four.



WiSCC Results Elements by Element

The distribution of the number and percent for each WRE is displayed in the next table by provider type.¹² While the overall average score for Agencies and Solo providers is the same in Year Six, performance appears to vary somewhat across the elements. Remember to review results as tentative since these include only a portion of the consults that will be completed this year.

Information from the data in the following table (Table 12) indicates the following:

- On average to date in Year Six, Solo providers are more likely than Agency providers to score as Achieving in having systems in place that enable them to learn about the people receiving services and supports from them. This percentage (47.3%) is up 10 points since the Year Four results.

¹² See Appendix 1, Attachment 4 for a description of each evaluation level and Attachment 5 for a description of each element.

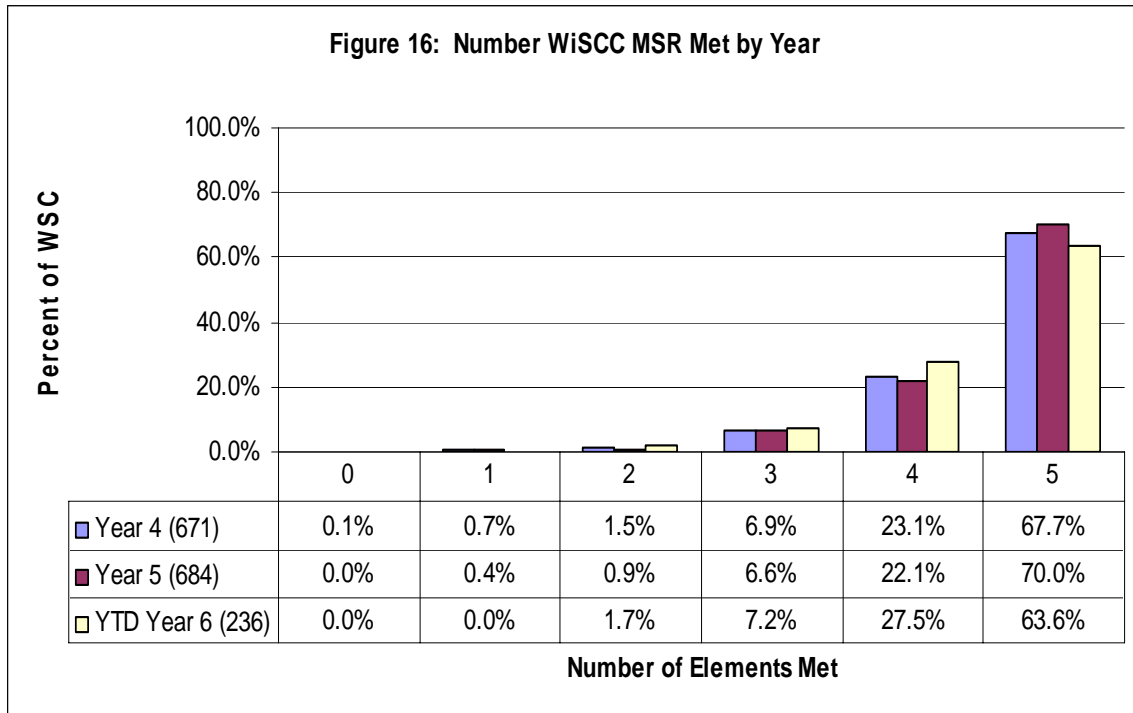
- Agency and Solo providers are both more likely to score achieving on Element 1 (knows the person), than on any other element. This pattern has persisted since implementation of the WiSCC process.
- Thus far in Year Six, Agency providers are more likely to score as Achieving on four of the six WREs; being aware of the Health and Safety of individuals, including the individual in the development of the Support Plan, facilitating Education, Exposure and Experience, and generating positive results for individuals.
- Results also indicate improvement for both types of providers on most elements in the Achieving category since implementation of the WiSCC process in Year Four. The proportion of Agencies scoring Achieving has increased by approximately eight percentage points on Element 3 (Support Plan), seven points on Element 4 (Evaluates Supports), 10 points on Element 5 (three E's) and 10 points on Element 6 (Positive Results).
- The proportion of Solo providers scoring as Achieving has improved since Year Four by over 10 points on Element 1 (Knows Person), 11 points on Element 4 (Evaluates Supports) and six points on Element 5 (Three E's).
- Agency and Solo providers scored in a similar way across elements as Emerging and Not Emerging.
- Solo providers were most likely to score Element 2 (Health and Safety) as Not Emerging.
- Agency providers were most likely to score Element 2 (Health and Safety) and Element 5 (Three E's) as Not Emerging.

Table 13: YTD Year 6 Results Elements by Provider Type
July - December 2006
Agency (N = 107); Solo (N = 129)

	Achieving		Implementing		Emerging		Not Emerging	
	Agency	Solo	Agency	Solo	Agency	Solo	Agency	Solo
Knows Person	39.3%	47.3%	45.8%	41.9%	10.9%	14.0%	0.0%	0.9%
Health/Safety	14.0%	8.5%	37.4%	45.0%	42.6%	43.9%	3.9%	4.7%
Support Plan	20.6%	14.7%	45.8%	53.5%	31.8%	33.6%	0.0%	0.0%
Evaluates Supports	26.2%	26.4%	38.3%	40.3%	31.8%	32.7%	1.6%	2.8%
Three E's	21.5%	14.7%	27.1%	40.3%	41.1%	47.7%	3.9%	3.7%
Positive Results	21.5%	10.9%	31.8%	41.9%	44.2%	43.0%	3.1%	3.7%

Minimum Service Requirements (MSR)

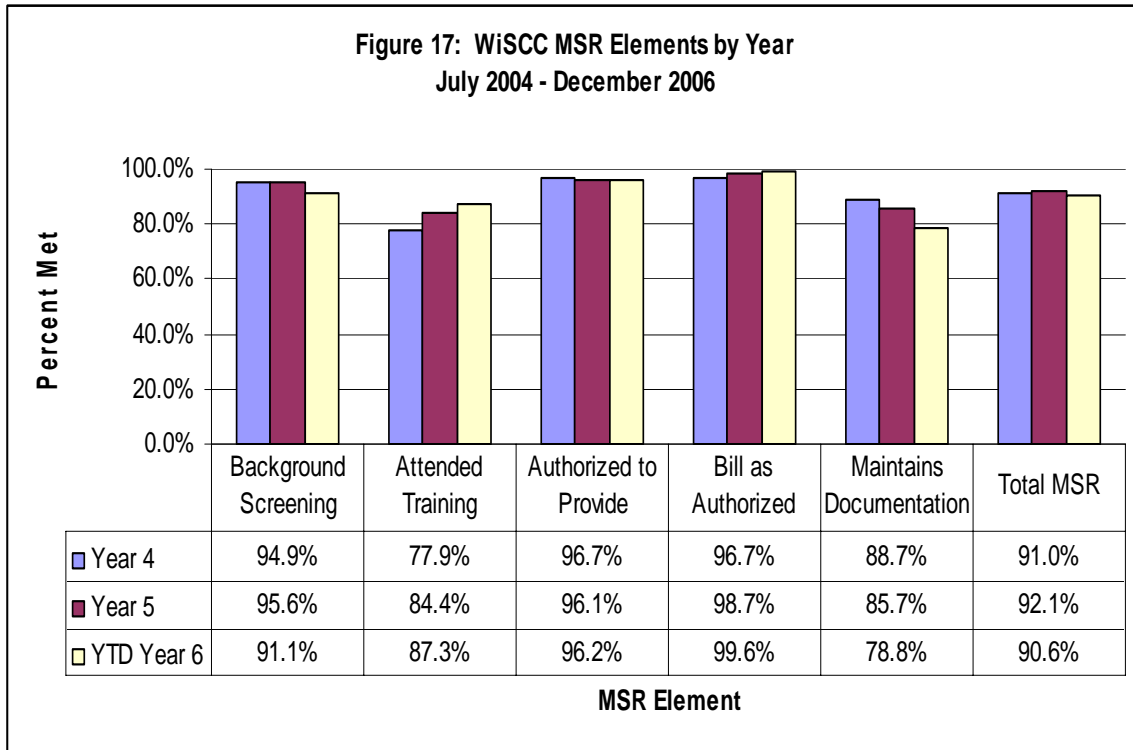
The five MSRs are process elements and are similar to those discussed in the CORE section of this report. These are scored as Met or Not Met. The following graph portrays the percent of Waiver Support Coordinators distributed across the number of MSR elements that were scored as Met for Year Four (July 2004 – June 2005) and Year Five (July 2005 – June 2006) and the first two quarters of Year Six (July – December 2006). The numbers zero through five represent the number of MSR elements and the percent is the percent of providers for each number Met.



- Only one WSC over the two and one half year time period scored all of the MSR elements as Not Met.
- A majority of providers have scored all five MSR elements as Met in each time period. However, thus far in Year Six, a greater proportion of support coordinators have scored Met on four of the elements and a smaller proportion on all five.

In the following graph (Figure 17), the number and percent of MSR elements scored as met is given at the element level year.¹³ On average, the total Percent Met has remained fairly consistent, 91.0 percent in Year Four and 92.1 percent in Year Five and 90.6 percent thus far in Year Six.

¹³ See Appendix 1, Attachment 5 for a description of the WiSCC MSR elements.



Highlights from Figure 17 include:

- A somewhat smaller proportion of WSCs had documentation of required background screening thus far in Year Six than in the previous two years.
- Over the same time period, WSCs have consistently improved in respect to attending required training. Results in the first two quarters of Year Six indicate an apparent nine point increase since Year Four.
- Authorization to provide the specific service and billing for the service as authorized are two areas that have remained consistently high, with results for billing authorization currently near 100 percent.
- However, WSCs are now less likely to maintain documentation required for billing. The percent of support coordinators who scored this as Met is down by close to 10 points since Year Four.

Follow-up With Technical Assistance

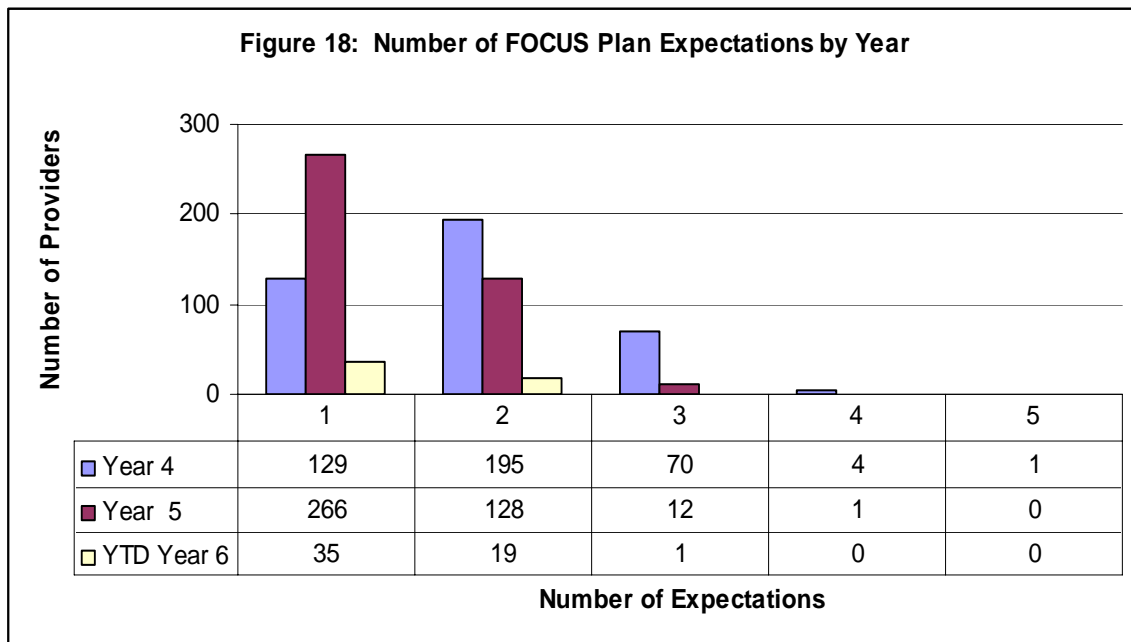
Prior to departing the WiSCC, the Quality Improvement Coordinator (QIC) and WSC agree upon a date on which the QIC can return to provide Follow-up with Technical Assistance. This takes place between 10 and 90 days for solo WSCs and small WSC agencies. Follow-up with Technical Assistance for large WSC agencies may occur between 10 and 180 days following the WiSCC. These follow-up activities determine the effectiveness of the FOCUS plan initiatives (Formula Offering Cooperative and Unified

Success), 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.

Beginning with the release of the new WiSCC application in mid December, data have been collected on the MSR elements at the Follow-up consult. These will be analyzed and included in the annual report at the completion of year’s review activities.

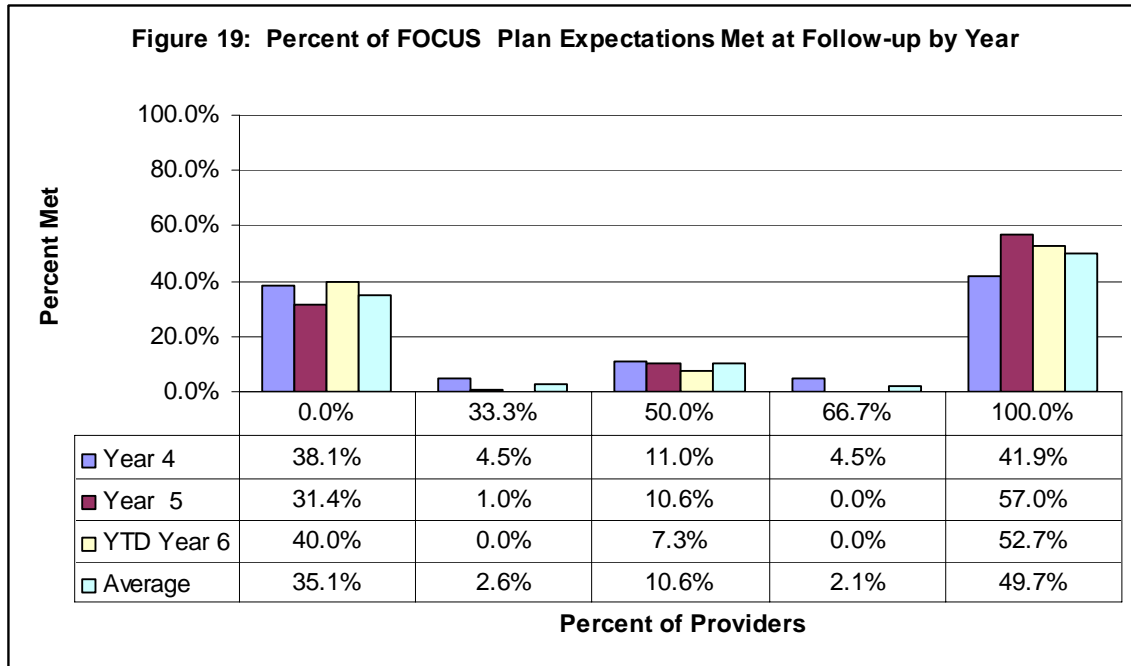
FOCUS Plan

As part of the WiSCC, the Delmarva Consultant helps the WSC agency or solo provider develop a FOCUS plan. This includes expectations for the WSC that will enhance performance and increase outcomes for individuals. For each WiSCC, one or more expectations are developed. The following graph shows the number of expectations per WiSCC for the first two and one half years since implementation of the process. Because the expectations are determined to be Met or Not Met during the Follow-up Review, results are included only if the Follow-up has been completed. A majority of the WSC entities have one or two expectations in the FOCUS Plan each year.



The following graph (Figure 19) shows the percent of expectation that were completed at the time of the Follow-up review. On average across the years, about 35 percent of providers had not met any of the expectations delineated in the FOCUS Plan (0.0%), but close to half of the providers had addressed all of them (100%). The proportion of providers meeting all the expectations increased from around 42 percent in Year Four to

57 percent in Year Five. Results for Year Six are based on only 55 WiSCC so may or may not indicate a downward trend.



Reconsiderations

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 second quarter of Year Six.

Personal Outcome Measure Sample Description

The Florida Developmental Disabilities Program uses the Personal Outcomes Measures (POMs) developed and published by The Council on Quality and Leadership (CQL) to determine the extent outcomes and supports are present in the lives of people on the waivers.¹⁴ Results from these are reported as performance indicators to the State of Florida. The POM is incorporated into a Person Centered Review (PCR) and is a primary component of the WiSCC process, conducted as part of the FSQAP review functions. The focus of the POM is on measures that emphasize values-based supports and services, individualized planning, and personal outcomes. Other components of the PCR include follow-up interviews and a central record review with the WSC, and a Medical Peer Review.

¹⁴ Go to <http://www.thecouncil.org> for information on the history of the Council, their mission statement and the development of the POM tool.

The POM 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. During the first four years of the contract, if the individual had completed a POM interview at any time during the first four years, that person was excluded from the sample. Since that time, individuals have been excluded if they had participated in a POM during the previous 12 months.

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

Demographic Distribution of the Sample

The following table provides information by APD Area for the enrolled population and for the sample of individuals who received a POM interview in the six month period ending December 31, 2006. While the proportion of individuals in the sample varies somewhat from the population, the variances are generally quite small, no greater than three percentage points. The 468 people interviewed thus far this contract year represent only a portion of the entire sample, expected to be approximately 1,416 individuals.

Table 14: Enrolled Population and Sample by APD Area
July - December 2006

District	Enrolled Individuals		Individuals in Sample	
	Number	Percent	Number	Percent
1	1,237	4.9%	20	4.3%
2	1,879	7.4%	40	8.5%
3	1,211	4.8%	36	7.7%
4	1,968	7.8%	48	10.3%
7	2,418	9.5%	43	9.2%
8	910	3.6%	6	1.3%
9	1,403	5.5%	12	2.6%
10	2,223	8.8%	30	6.4%
11	3,462	13.7%	60	12.8%
12	888	3.5%	6	1.3%
13	1,417	5.6%	32	6.8%
14	907	3.6%	25	5.3%
15	854	3.4%	20	4.3%
23	4,552	18.0%	90	19.2%
Total	25,329	100.0%	468	100.0%

Gender information for the population and sample indicates close to 60 percent of the consumers reviewed were male. This distribution is slightly different from demographic information for the enrolled Waiver population, but the difference is less than five percentage points and therefore consistent with some degree of sampling fluctuation.

Table 15: Enrolled Population and Sample by Gender

July 2005 - June 2006

Gender	Population		Sample	
	Number	Percent	Number	Percent
Female	10,797	42.6%	188	40.2%
Male	14,531	57.4%	280	59.8%
Total	25,328	100.0%	468	100.0%

The population and sample distributions by age group are shown below in Table 16. Differences within age groups appear to be minimal and the sample thus far this year represents the population fairly well in terms of age distribution.

Table 16: Enrolled Population and POM Sample by Age Group

Year 6 - July - December 2006

Age Group	Population		Sample	
	Number	Percent	Number	Percent
< 18	3,777	14.9%	65	13.9%
18 - 21	2,143	8.5%	37	7.9%
22 - 25	2,344	9.3%	52	11.1%
26 - 44	10,685	42.2%	200	42.7%
45 - 54	3,948	15.6%	69	14.7%
55 - 64	1,762	7.0%	33	7.1%
65+	592	2.3%	11	2.4%
Unknown	78	0.3%	1	0.2%
Total	25,329	100.0%	468	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 sample for the first two quarters of Year Six. Almost 49 percent of the individuals in the sample lived in a family home at the time of their interview, compared to 59 percent of the population. There was also 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 6 - July - December 2006

Type of Living Arrangement	Enrolled Individuals		Individuals in Sample	
	Number	Percent	Number	Percent
Family home Independent/supported living	14,956	59.0%	229	48.9%
Small group home (6 or less)	3,433	13.6%	88	18.8%
Assisted Living Facility	4,483	17.7%	109	23.3%
Foster home	0	0.0%	10	2.1%
Large group home (> 6)	465	1.8%	7	1.5%
Other	1,581	6.2%	21	4.5%
	411	1.6%	4	0.9%
Total	25,329	100.0%	468	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. Consultants 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	YTD Year 6
Number of Person Centered Reviews	1,907	2,539	2,456	1,355	1,363	468
Average Number of Outcomes Met per Consumer	13.2	12.4	11.2	11.3	12.1	11.1
Average Percent of Outcomes Met	52.8%	49.6%	44.9%	45.0%	48.4%	44.5%
Average Number of Supports Present per Consumer	14.9	13.4	12.2	12.1	13.2	12.2
Average Percent of Supports Present	59.5%	53.6%	48.9%	48.2%	53.0%	49.0%

The table above provides data indicating the Outcomes and Supports for individuals decreased over the first three years, leveled off during the fourth year and increased somewhat during Year Five. However, for the first two quarters in Year Six there is a drop in both Outcomes and Supports. The number of individuals interviewed to date in Year Six is only a portion of the total sample, so results are tentative and at the completion of the year may not indicate any statistically significant changes.

POM Results by Individual Item

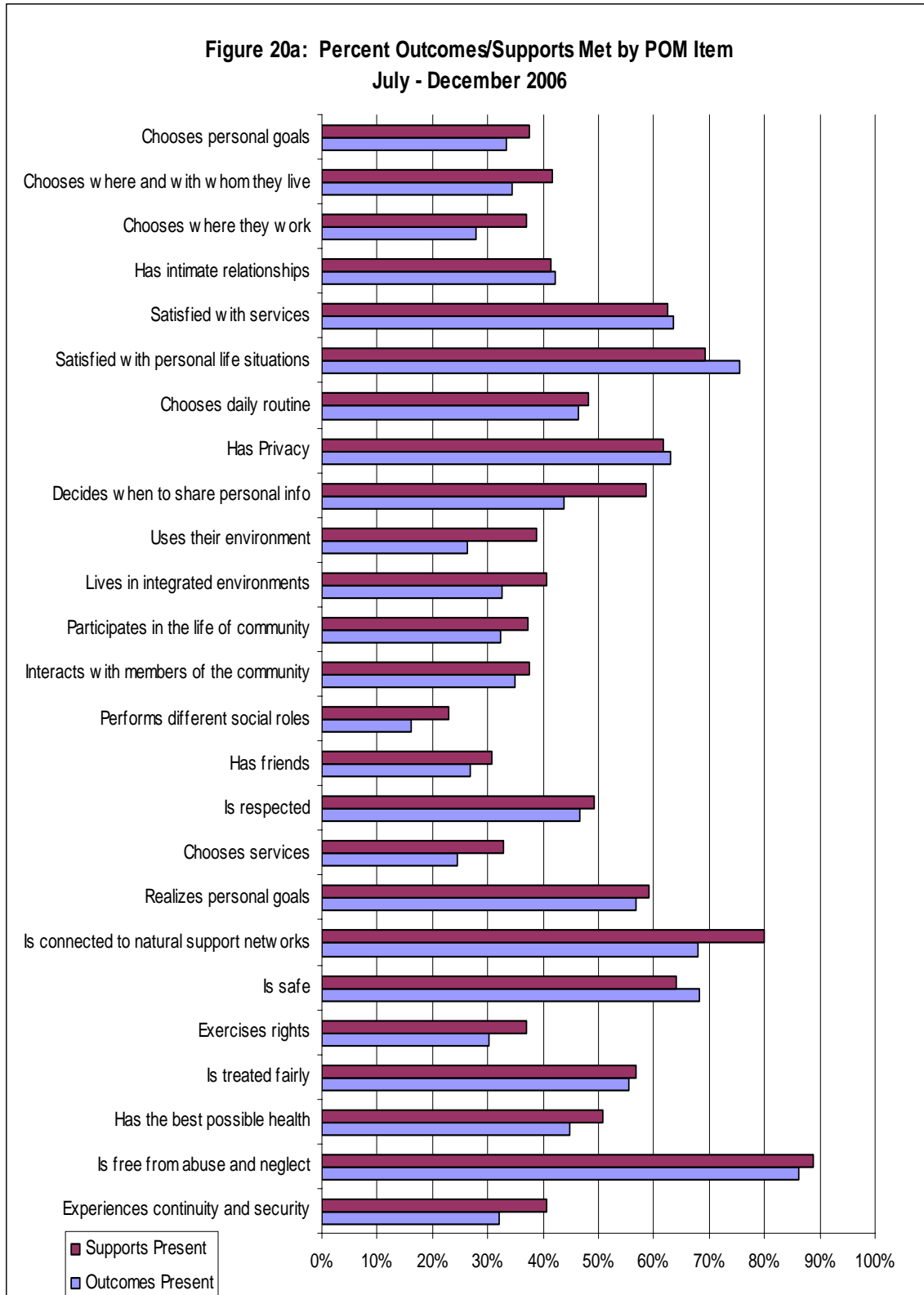
The POM interview is a 25-item assessment tool that determines if for the individual a personal outcome is present and/or the supports are present for each item, regardless of the service received. Quality improvement studies have statistically linked the increased presence of Supports with increased Outcomes for individuals.¹⁵ Figure 19 on the following page provides the percentage of Outcomes Met and Supports Present by POM item for the sample of individuals who received a POM interview (N=468) during the first two quarters of Year Six.¹⁶ It is important to reiterate that results presented here represent only a portion of the total sample and may change by year's end.

Data indicate the following:

- *Is free from abuse and neglect* continues to show the highest percent Present for both outcomes and supports, and each has increased by two percentage points since Year Five.
- *Performs different social roles* remains the lowest among all the POM items on both outcomes and supports, at 16.2 percent and 22.9 percent respectively. Based on the partial sample to date, this reflects a decrease in both areas by approximately three percentage points since Year Five.
- The percent of outcomes met has decreased by five or more points since Year Five on eleven POM items. The largest decrease, close to 10 points, is for POM 25 indicating if *people experience continuity and security* in their lives.
- *People live in integrated environments* and *people interact with other members of the community* each show over an eight point decrease since Year Five.
- The percent of individuals with outcomes met on *chooses work* and *chooses services* has decreased by 7.7 and 5.1 points respectively since Year Five.
- With the exception of being free from abuse and neglect, each item has remained the same as in Year Five or has a lower proportion of outcomes and supports met.

¹⁵ 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.

¹⁶ The Year Four and Year Five results are provided in Appendix 3.



The top five POM items for which the Outcome is most frequently Met and the Support is most frequently Present have remained consistent from Year One through Year Five.¹⁷

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

The lowest levels of both supports provided and outcomes achieved have remained consistent on three items.

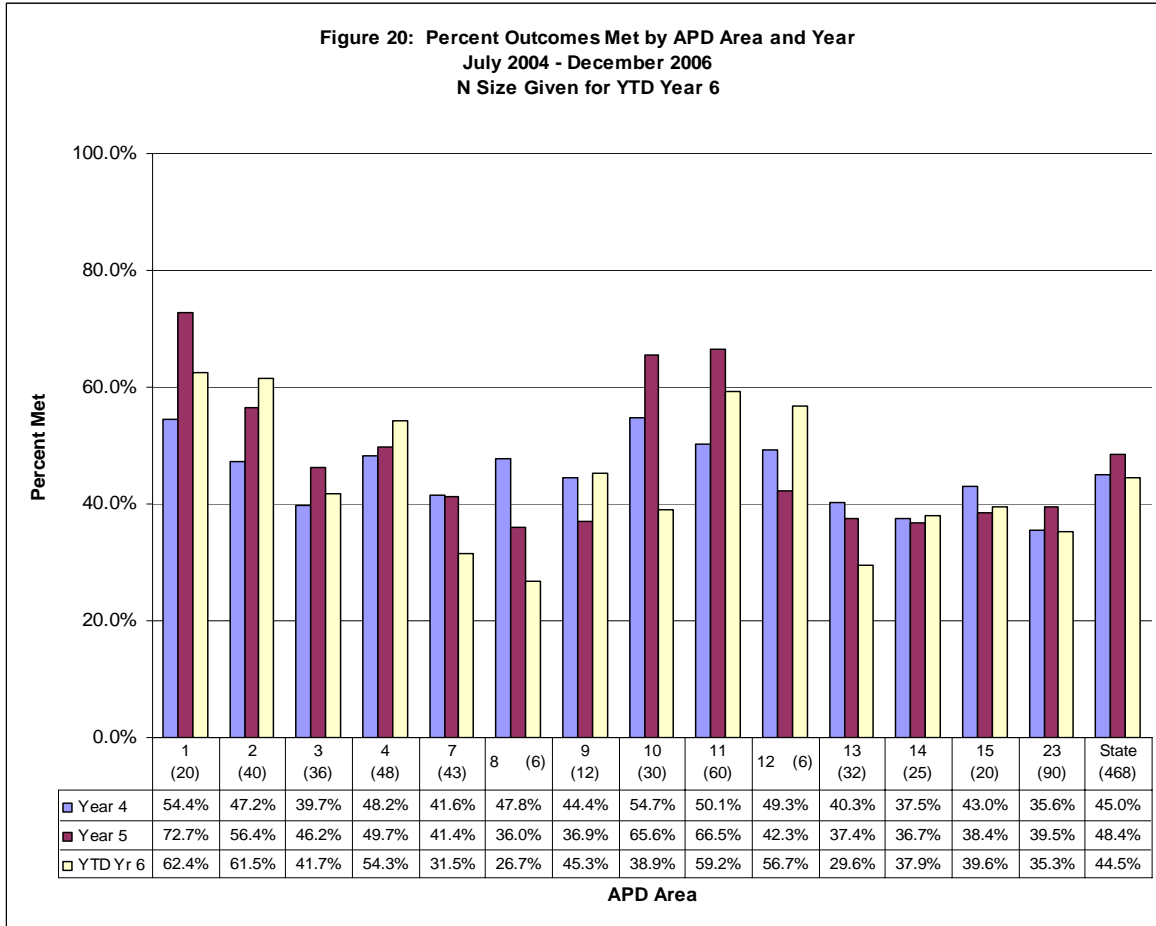
- Performs different social roles
- Chooses services
- Has friends

POM Results by APD Area

Because there are so few interviews in each Area, comparisons across Areas are not appropriate. The following chart (Figure 20) is for informational purposes and should not be used to draw comparisons between or among the separate Areas. Comparisons by years should also be viewed with caution as most Areas have fewer than 50 interviews.

In Figure 20, the number in parentheses below each Area represents the number of POM interviews completed during the first two quarters of Year Six. Currently, results in Year Six show an increase over Year Five in Areas 2, 4, 9, 12, 14, and 15. In Areas 2 and 4 this reflects an increase each year since Year Four. Results by Area will be presented in the Annual Report and analyzed in depth at that time.

¹⁷ See Appendix 2, Exhibit 5 for a list of the reasons outcome/supports are not present.



Driver Indicators

Two Personal Outcome Measures were 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 and 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*.¹⁸ 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*

¹⁸ Outcome Results Analysis: Best Predictors of Percent of Outcomes Met, submitted by Delmarva to AHCA and APD, June 30, 2005.

*information and Has intimate relationships.*¹⁹ Results for these driver outcomes and driver supports are presented in the following table.

Table 19: Driver Outcomes and Supports by Year

Personal Outcome	Year 2	Year 3	Year 4	Year 5	YTD Yr 6
Driver Outcomes	Percent Outcomes Met				
Chooses work	30%	23%	29%	36%	28%
Chooses services	27%	22%	26%	30%	25%
Feel respected	55%	48%	49%	54%	47%
Exercise rights	40%	34%	35%	38%	30%
Driver Supports	Percent Supports Present				
Chooses daily routine	61%	49%	52%	55%	48%
Is connected to natural support networks	85%	78%	73%	82%	80%
Chooses where/with whom to live	56%	42%	41%	48%	42%
Decides when to share personal information	66%	61%	60%	62%	59%
Has intimate relationships	62%	45%	43%	45%	42%

Results indicate the driver outcomes had all improved from Year Three through Year Five and have all dropped thus far in Year Six. *Chooses work* and *Exercises rights* show the biggest decrease, eight points each. The percent of support present for the Driver Supports varies somewhat across the items and the years. From Year Three to Year Five, *chooses daily routine*, *is connected to natural supports* and *chooses where and with whom to live* all show an increase in the percent of supports present, while results for the remaining two items remained fairly flat. Results thus far in Year Six reflect a decrease on each item, from between two and seven points.

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.²⁰

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, or

¹⁹ Outcome Results Analysis: Impact of POM Supports on POM Outcomes Met, submitted by Delmarva to AHCA and APD, June 30, 2006.

²⁰ 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.

making an effort to learn about the individual's preferences. In terms of *Choosing services*, choices are often made by the family or others without the individual's input, or service choices are simply limited, and supports need to help increase individuals' awareness of different service.

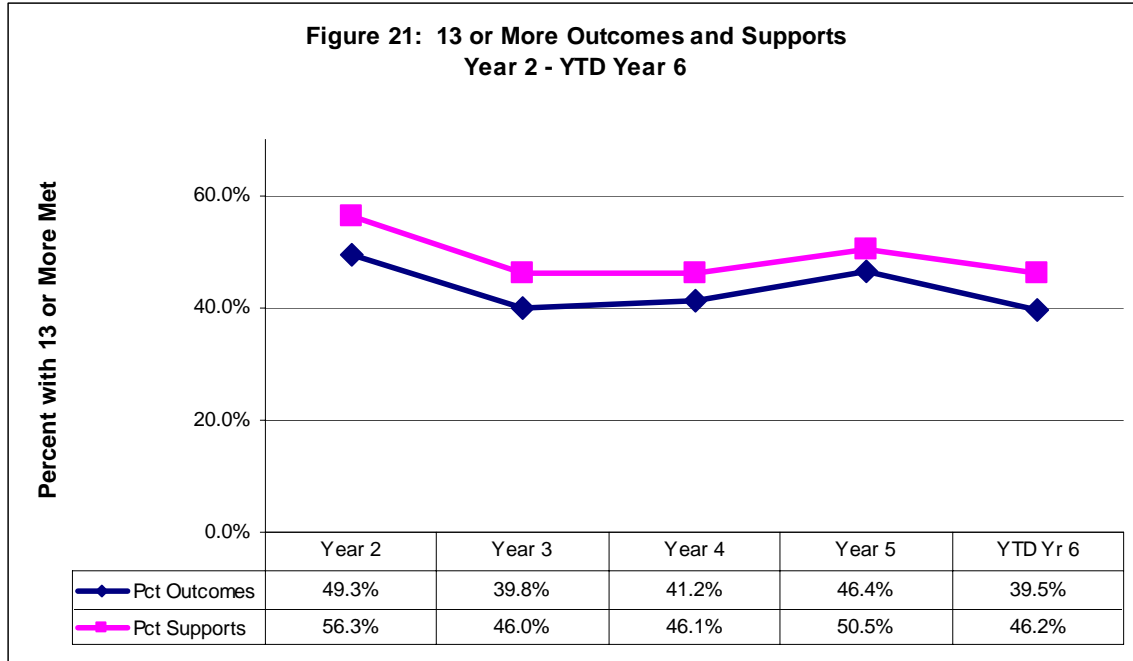
While individuals most often have outcomes and supports present on *Freedom from abuse and neglect*, 65 individuals served in the program were not achieving this important outcome when interviewed during the first two quarters of Year Six, and 52 had no supports in place to address issues of abuse and neglect. A majority of individuals were "out" on this outcome due to distress over past abuse (51.4%). This is similar to results from Years Four (60%) and Five (55.6%). Among supports, counseling and training for protection are not being addressed and Reporting Training is missing.²¹

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 and one half years of the contract (Figure 21). As seen for outcomes and supports in general, thus far in Year Six the percent of individuals with 13 or More outcomes met or supports present has dropped since Year Five, close to the Year Three and Year Four levels.

²¹ See Appendix 2, Exhibit 5 for a list of the top three reasons outcomes and supports are not present for all 25 POM items.



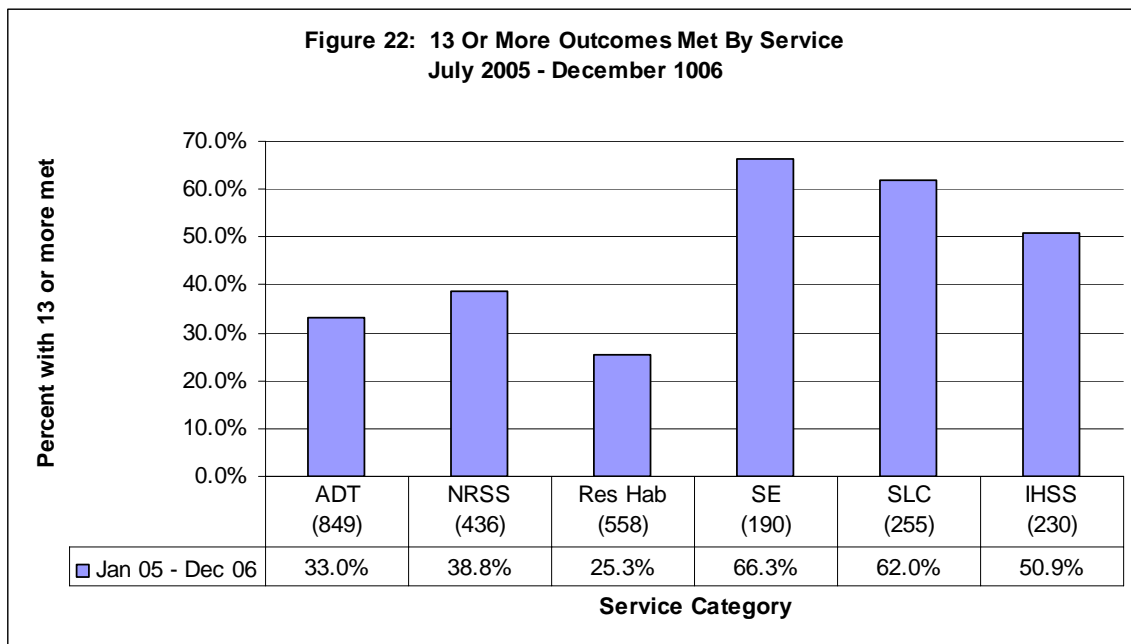
13 or More Met by Home Type, Area, and Age Group

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 the first two quarters in Year Six. 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 63.6 percent and 68.2 percent respectively, the same as in Year Five and consistent with findings over the previous four years.
- The percent of residents in small group homes that met the criterion of 13 or more outcomes met appears to be dropping in Year Six, compared to Year Five, from 25.8 percent to 19.3.
- The percent of residents in family homes meeting this criterion also appears to be declining, from 53.2 percent in Year Five to 42.8 percent for the first two quarters in Year Six.
- The data suggest fairly large variations across areas on the percent of 13 or more outcomes met, from a high of 86.7 percent in Area 11 to a low of 0 percent in Area 8 (N=6). Most of the areas have a small number of participants in the sample, which lends itself to large fluctuations in point estimates.
- Children age 17 and under continue to be most likely to have this criterion met for both outcomes and supports. The percent of children who meet this criterion appears to be higher thus far in Year Six, compared to Year Five, 66.2 percent and 61.3 percent respectively.

13 or More Met Results by Service

Figure 22 displays the distribution of the percent of individuals who had 13 or more outcomes met, by service for individuals who received a POM between July 2005 and December 2006, and successfully linked to the claims data to identify the services they received. Services included in this analysis are subject to an Onsite CORE consult (CORE service).²² When reviewing these results it is important to note that individuals may have received more than one of these CORE 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.



There were a total of 1,736 interviews included in the service level analysis. Of these 1,736 people, 21 percent (364) received only one CORE service. Approximately 30 percent (518) received two CORE services and 31 percent (539) received three. Figure 22 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 CORE services.
- Among the “day services”, ADT, NRSS and SE, people receiving Supported Employment are much more likely to achieve 13 or more outcomes.

²² In Home Support Services and Special Medical Home Care were reviewed Onsite beginning in Year Five. Only one person interviewed received Special Medical Home Care.

Foundational Outcomes

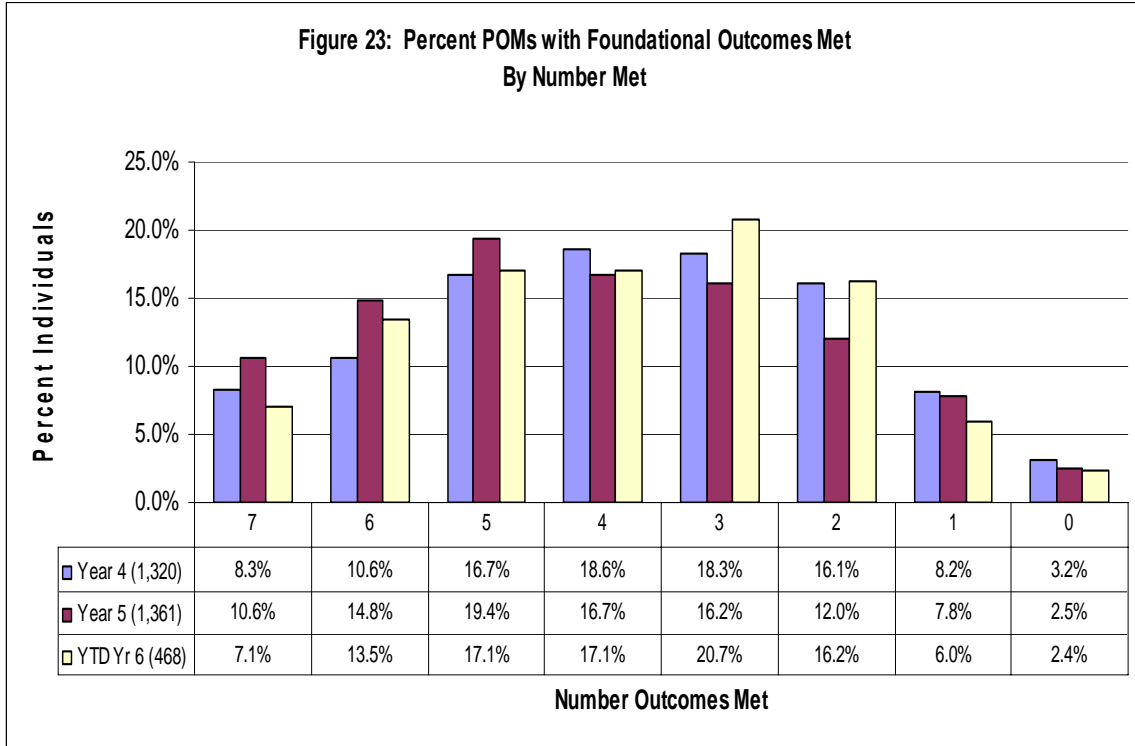
The last seven Personal Outcome Measures include the items measuring Safeguards, Rights, and Health and Wellness. These are the Foundational Outcomes and are considered to be basic outcomes that most people with developmental disabilities should expect to have met most of the time. The percent of reviews 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 and through the first two quarters of Year Six. *Is connected to natural supports*, *Is safe*, and *Has the best possible health* are similar thus far in Year Six as results indicated for Year Five. However, *Experiences continuity and security*, *Is treated fairly*, and *Exercises rights* have dropped since Year Five. Only one, *Is free from abuse and neglect*, has slightly improved, and is higher than any year since Year Two of the contract.

Table 20: Foundational Outcomes
Percent Met by Year

Foundational Performance Outcome Measures	Year 2	Year 3	Year 4	Year 5	YTD Yr 6
	Percent of Total Reviews				
19 - Is connected to natural support networks	70.5%	64.6%	64.4%	68.4%	67.9%
20 - Is safe	67.7%	67.3%	61.3%	68.1%	68.2%
21 - Exercises rights	36.6%	33.9%	34.9%	37.8%	30.1%
22 - Is treated fairly	60.5%	60.1%	52.6%	61.6%	55.3%
23 - Has the best possible health	50.2%	39.5%	40.8%	45.8%	44.9%
24 - Is free from abuse and neglect	84.6%	83.0%	83.1%	84.0%	86.1%
25 - Experiences continuity and security	49.2%	37.2%	38.1%	41.5%	32.1%

The following chart (Figure 23) shows 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 six month period ending December 31, 2006, was 7.1 percent (33 individuals). This shows a decrease from 10.6 percent in Year Five and 8.3 percent in Year Four. The greatest increases are seen for individuals with two or three of the Foundational Outcomes met.



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

Results in Exhibit 8 (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 Years Three through the first two quarters in Year Six. Because most of the categories in the table have only a small number of results for the Year Six time period, analysis and comparisons are not beneficial. Trends will be analyzed in the Annual Report.

Medical Peer Review Findings

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.²³ The overwhelming majority show no additional concerns were noted (95.7%), consistent with previous years. 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 21: Medical Review Disposition
July - December 2006

Disposition	Number	Percent
Requesting Medical Records	4	0.9%
Waiting for Support Plan Review	1	0.2%
Done - no additional concerns	448	95.7%
Done - additional concerns to WSC	11	2.4%
Done - no concern/no claims	0	0.0%
Done - concern yes/no claims	0	0.0%
Done - ancillary claims only	0	0.0%
Done - additional concerns to MCM	1	0.2%
Pending	3	0.6%
Total	468	100.0%

²³ Additional information about the recommendations and a summary of the frequency and types of specific health or behavioral health recommendations is provided in Exhibit 9, Appendix 2.

Section Two: Summary of Quarterly Compliance Activities

During the first two quarters of the sixth year of the contract Delmarva has continued with the Collaborative Outcome and Review Enhancement (CORE), Waiver Support Coordinator Consultation (WiSCC), and Desk Review activities, with no substantive modifications. Delmarva has managed a variety of accomplishments during the first half of this year, including updates and modifications to the CORE and WiSCC applications and procedures that are currently being implemented. These and other project activities are discussed and summarized in the following section of this report.

Contract Monitoring

APD Review

During the first part of this contract year, APD developed a monitoring tool to use when observing Delmarva's QICs while conducting a CORE or WiSCC. Formal observations began this quarter by Ed Rousseau and Steve Dunaway. They monitor the activities and provide feedback to the consultant and the Delmarva Manager. Mario Arreaga and Christine Stevens have been observed this quarter during a CORE consult, with positive results reflected in the feedback from APD.

Administrative Review

Pamela Wainwright met with Marion Olivia-Ruelas and completed the administrative review on November 27. At this time, Delmarva has no feedback from that activity.

Medical Peer Review

During the monitoring process in Year Five, it became apparent to the AHCA team the existing monitoring tools were not effective in evaluating Delmarva's Medical Peer Review activities since the implementation of CORE and WiSCC and the modification of other internal procedures. Pamela Wainwright met with Linda Tupper, the Delmarva nurse reviewer, to develop a new monitoring tool that would better reflect the current processes. The MPR Monitoring Tool and Data Collection Tool were revised and implemented in September 2006.

Major changes in the new processes included a quarterly on-site review of the WiSCC electronic application process, and a quarterly on-site review of the MPR electronic application process. These modifications allow the monitor to access randomly selected individual records and to examine each screen of the MPR application to ensure compliance with the Performance Standards. The monitor is given immediate access to any medical records that are to be reviewed, with the Nurse Reviewer present to explain and or clarify any questions in the medical record. The monitor is also able to access claims data to ensure the appropriate recommendations have been made and again the process is enhanced with the Nurse Reviewer present to answer any questions. The new process was used in September and results are still pending.

Contract Amendment

The contract amendment, submitted to AHCA in Year 5, was approved. Modifications include the addition of Family and Supported Living Waiver activities, a change in rates for the CORE process and revisions to the expected number of Desk Reviews and Follow-up Reviews. The targeted number of training sessions was reduced to 14 and the targeted number of Quality Improvement Studies was reduced to three.

Training and Education Activities

Education/Training Sessions

During the second quarter of the year, five formal training and educational sessions were conducted. Topics were decided upon by Area staff in collaboration with Delmarva managers and a review of quarterly data.

FASC Conference, Area 7

In October, providers and support coordinators at the FASC conference were presented with an educational session on Person Directed Planning enhanced by Quality Management. Key concepts of Person Directed Planning along with practical applications of quality management systems were presented to support coordinators and providers of other services, using a results oriented approach to service delivery. This approach encouraged attendees to recognize that focusing on collecting, analyzing and acting on feedback from individuals served also benefits every provider who works with individuals receiving services.

A discussion on self assessment methodologies and the administrative process of tracking projected service outcomes was presented with concrete examples from a variety of services. The session included a step by step approach to using quality management to enhance services. Each step, from having a method to collect data to the analysis and use of such data, was presented with examples. Questions and discussion were entertained throughout the presentation. Attendees were given handouts to assist with continuous enhancement of services. Support Coordinators were also provided with training on upcoming support plan changes, including discussion of the different parts of the new support plan and the types of documentation appropriate to parts A and B.

Documentation Training, Area 10

In Area 10 an educational session was provided covering documentation, per Medicaid Waiver requirements, for a variety of services. Attendees included support coordinators as well as providers of other services. This proved to be a great opportunity to ensure that each provider not only understood documentation requirements for each service but also how critical it is to use documentation as a method of communication, as a tool to evaluate progress and effectiveness of supports, and as a way to maintain historical information. The session was delivered in 4 parts:

- The first section guided providers through specific documentation requirements as dictated by the service and included discussion on service logs, monthly summaries, implementation plans, annual reports, service authorizations, satisfaction surveys, progress notes, self assessments, projected service outcomes, and behavior service plans.
- Second, we provided a detailed explanation of required training such as Core Assurances, Zero Tolerance, Choice and Rights, Health and Safety, Personal Outcome Process, Direct Care Competency, Service Specific, Required Documentation, CPR, HIV/Aids, Infection Control and the Needs and Characteristics of Individuals. Discussion on training was followed by information on Policies and Procedures which included topics such as Health and Safety, Personal Outcome process, Rights, Abuse and Neglect, Marketing Practices, Medication Administration and Grievance Procedures.
- The third part of the training focused on the use of documentation as a method of communicating information on progress toward outcomes, strengths, barriers, referral systems, follow up method, advocacy, empowerment, and coordination of information. In this portion of the training we also examined the role of documentation as an historical tool, able to capture people's experiences, past experiences, likes, dislikes, past abuse, and current activity. The use of documentation as an evaluation tool to assist in data comparison, next steps, and tracking systems was covered with participation from attendees being encouraged throughout.
- The fourth portion of the session involved four small breakout groups, each facilitated by a Delmarva staff person. Each group was given examples of documentation from a service and asked to brainstorm ideas for rewriting the service log/progress note or summary to reflect the essence of the entire training session: service specific requirements along with information related to communication, history and evaluation. A spokesperson from each group presented the rewritten documentation to the entire audience. Overall, the session was very interactive and well received.

Person Centered Planning, Areas 7 and 9

In Area 9 training and education was provided in two sessions to support coordinators and providers of other services. The first session covered the concepts of Person Centered Planning, including a discussion among the participants. Real life scenarios were used to illustrate each key point. Many participants presented their own challenges, and brainstorming occurred to assist in resolving them which enhanced networking among the providers. A very interesting development centered on providers supplying other providers with potential solutions to challenges based upon their own experiences.

In the second session we presented providers with education on health, behavioral and functional risk indicators. Attendees not only participated throughout the session, but were also put into situations where they had to experience, if only for a short time, the challenges one faces when one has a disability. Per providers, this was an enlightening experience for them. The session ended with providers asking and answering key

questions regarding the different types of indicators. Their responses revealed that most of the material covered was understood and relevant to enhancing service delivery.

In Area 7 training and education was provided on the concepts of Person Driven Planning in two parts. The first session covered the concepts of Person Driven Planning that included discussion among the participants. Woven throughout the discussion were the concepts of self determination, a people first focus and practical ways to apply these concepts. Real life scenarios presented by the trainers and the audience were used to brainstorm potential applications of each concept. Providers were encouraged to keep the individual as the primary authority over all decisions. The use of person directed approaches were discussed as they pertain to health, safety, rights, choice, communication and community life.

The second session was a practical application of some of the concepts discussed earlier. Providers were divided into four groups and given scenarios as well as tools to aid in the collection of information. They were asked to answer specific questions about how they go about assisting individuals to develop their own person centered plan. A representative from each group presented the results of the group's efforts to the audience at large. Overall, the session was very well attended and received.

Person Centered Planning and Quality Management, Area 3

In December an educational session was conducted in Area 3 on Person Driven Planning enhanced by Quality Management. A results oriented approach to service delivery was emphasized, which encouraged all attendees to recognize that focusing on collecting, analyzing and acting on feedback from individuals served also benefits every provider who works with individuals receiving services. A discussion on self assessment methodologies and the administrative process of tracking projected service outcomes was presented with concrete examples from a variety of services. Discussion included practical ways to develop, maintain and use both quality management systems. The session included a step by step approach to using quality management to enhance services. Each step, from having a method to collecting data to the analysis and use of such data, was presented with examples. Question and discussion were entertained throughout the presentation, including questions related to satisfaction surveys.

Personal Outcome Measures Training, CORE Consultants

During the week of December 4th, all the CORE Quality Improvement Consultants (QIC), one WiSCC QIC and one Regional Manager participated in a week long POM training, conducted by the Council on Quality and Leadership. Three participants have already completed and passed the reliability test, with the remaining consultants to be tested on reliability in January.

Tool Revisions

CORE

In October, a workgroup was developed to examine the current CORE tool and determine ways to create a more efficient and effective process by combining similar topics and

elements. The work group consisted of one Regional Manager and three Quality Improvement Consultants (QIC) who conduct CORE consults on a regular basis. Initially, the group developed a tool with 11 CORE Results Elements (CRE) versus the current 25 CREs. A draft of this tool was completed in July and distributed for feedback from other QICs, managers, and APD. The workgroup met again to discuss and review feedback given to prepare for a formal revision meeting with APD. In October, these revisions were incorporated into the documents.

In November, the modifications to the tool were presented at IQC. Based on discussion at the meeting, an additional element measuring abuse, neglect and exploitation, was added. While this information was captured in combination with another element, several IQC members felt it was important to track and needed to be a “stand alone” element. Therefore, the tool was revised and contains 12 CREs versus the current 25.

Members of the workgroup met with APD twice to work on additional modifications for each element. The tool was resubmitted to APD who then sent it out to stakeholders, including self-advocates, family members, APD Area administrators, AHCA, Area Quality Leaders, Family organizations and Provider Organizations for additional feedback. The tool was also resubmitted to the CORE Quality Improvement Consultants and Regional Managers for any additional comments to the modifications. The workgroup met again to discuss and review feedback from this last distribution and to prepare for a formal revision meeting with APD. In December, all of the feedback received was incorporated into the revised CORE tool and reviewed with the workgroup. The final draft for approval was submitted to APD and AHCA on December 15, 2006. We are currently waiting for approval from AHCA, with an expected implementation date in March.

WiSCC

Carol McDuff has worked closely with the Application Development and Data Management groups within Delmarva’s IT section to upgrade the Waiver Support Coordination Consultation (WiSCC) application. The application was enhanced to encompass the recent additions of the Family and Supported Living Waiver (FSL) to the Delmarva contract, and to capture additional information concerning the alert for Health and Safety (WiSCC Element 2) and the alert for Background Screening (WiSCC Element 7). Testing of the enhanced application began in October and was completed in December. The application was successfully downloaded to the WiSCC Quality Improvement Consultants during the week of December 11th.

Staff Changes

During this past quarter two QICs left Delmarva, Carol Taylor and Sharon Searcy.

Trudy Acevedo started with Delmarva October 10, 2006, as a CORE consultant in Area 23. She received training on the CORE procedures from Charmaine Pillay and Anna

Delmarva Foundation

Quintyne, shadowed three CORE consults, received training on the Desk Review process from Susan Von Fossen, and POM training through CQL in December.

Dena Johnson, the WiSCC QIC in Area 1, has agreed to expand to full time and also conduct CORE consults. She was trained on the process by Marion Olivia-Ruelas and Anna Quintyne and observed several CORE consults prior to conducting one on her own.

Janet Tynes is a new CORE consultant in Area 11. She began December 4, 2006, by attending the POM training with CQL. She has been oriented to the CORE process by Carol McDuff and has observed three other consultants conducting CORE consults.

Regina Tumelty is a new consultant in Area 7 for the WiSCC. She attended the POM training in December and has passed reliability. She received two days of training from Beth Townsend and observed Cheryl King on two different WiSCCs.

Liaison/External Communication Modalities

During the second quarter of this 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.²⁴

Interagency Quality Council

Several Delmarva managers attended the Interagency Quality Council (IQC) in Orlando on December 6 and 7, 2006. The IQC meetings serve as a key forum for sharing and developing future FSQAP initiatives. In response to concerns raised during the September IQC meeting regarding the percent (about 15%) of individuals who scored “Not Met” on the POM item measuring abuse, neglect and exploitation, Delmarva teamed with The Council on Quality and Leadership (CQL) for a joint presentation on the subject. Anne Beuchner presented information on how people are trained on this item and how it is measured—what constitutes a Met or Not Met. Charmaine Pillay followed with a presentation on how the QICs address issues of abuse, neglect and exploitation within the context of the CORE and WiSCC, as well as follow through with APD and calls to the hot line when appropriate. Sue Kelly then presented current data patterns for people with the item scored as Not Met.

Bob Foley presented an update on Delmarva activities, including current WiSCC and CORE tool revisions, and Sue Kelly presented results and recommendations from the Barriers study that was completed last year.

²⁴ See Appendix 1, Attachment 6 for a detailed list of activities—dates, activity, participants and audience.

Project Status Meetings

The Delmarva Director of Florida Programs facilitates regular Project Status Meetings with representatives from AHCA, APD, The Council on Quality and Leadership (CQL), Delmarva managers and Delmarva's IT staff. The Executive Vice President in charge of the Florida project also often attends. 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 of the months most are attending the IQC meeting. During this quarter, status meetings were held October 19 and November 16.

Small Work Group Sessions

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. Steve Dunaway met with Sue Kelly on October 6th to review each Quality Improvement Study, offer suggestions for changes and address recommendations.

Steve Dunaway, Linda Mabile, Pamela Wainwright, Marion Olivia-Ruelas and Sue Kelly met on December 5th to discuss revisions to the annual reports (and second quarterly reports). The group reviewed all tables and charts in the Year 5 Annual Report, suggested some revisions, deletions and additions. In particular, the participants developed a new format for the Executive Summary that will provide APD with a more condensed "at a glance" format suitable for APD and Legislative review.

Prior to the September IQC meeting, Bob Foley participated in the Employment Work Group conducted by J.B. Black, with approximately 10 other members in the group. Discussion evolved around the need for all players in the service delivery system to truly understand the impact of employment on benefits, and to avoid keeping people in an under-employed situation because of the fear of losing Medicaid. Individuals with incomes in the \$20,000 range are still eligible for benefits.

On October 30, Charmaine Pillay met with members of an IQC workgroup on Training and Education. The primary purpose was to discuss strategies for improving educational materials and delivery systems.

Area Quarterly Meetings

Regional Managers met quarterly with each Agency for Persons with Disabilities' Area representatives 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. Consultants discuss the data Delmarva distributes monthly to each Area in order to provide clarity, interpretations, and possible uses of the results. In addition to the Regional Manager, a consultant from both the CORE and WiSCC often attend these meetings to discuss specific review findings and trends identified within the community. APD participants include the liaison with Delmarva Foundation, staff involved in the QI process, and on occasion, the DD Program Administrator or other

representatives. Quarterly meetings were held in all the Areas this past quarter with the exception of Area 9 where the meeting was rescheduled due to bad weather.

APD 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 eight Steering Committee meetings during the second quarter of this year, in Areas 4, 7, 8, and 13.

Florida, National and International Conference Representation

Charmaine Pillay and Beth Townsend presented at the annual Home and Community Based Services conference in Minneapolis, on October 4th and 5th. Their presentation focused on the shift from a process centered to an outcome centered system, starting with interviews of individuals. They also presented jointly with Steve Dunaway (APD) on the new Support Plan process: how and why it was developed.²⁵

On October 13, Bob Foley presented with Janice Phillips at the Florida Association of Support Coordinators conference. Over 100 Waiver Support Coordinators and providers were in attendance. They presented information on the new Support Plan process as well as providing general Delmarva updates.

In a continuing effort to bring new ideas of quality management to the Florida program, Bob Foley attended the NASDDDS Conference in Crystal City, Virginia, November 9 and 10.

Internal Quality Assurance Initiatives

Delmarva has established a system of Internal Quality Assurances to ensure results from reviews and consults are consistent and data gathered during these activities are valid and useful to APD and other stakeholders. This system of assurances includes but is not limited to:

- Comprehensive training as a new hire and annually thereafter;
- Bi-weekly conference calls with all QICs and managers;
- Reliability assurances on the individual POM interviews, CORE individual interviews, CORE and WiSCC scoring on the Results Elements and Minimum Service Requirements elements;
- Gold Standard Management review of all CORE, WiSCC and Desk Review reports;

²⁵ These presentations were included in the first quarterly report this year. However, the conference was actually during this quarter.

- Availability and use of the Nurse Reviewer, Linda Tupper, during all CORE and WiSCC activities for consultation on any health or behavioral related issues or problems;
- Weekly managers meetings;
- And, an annual manager’s retreat.

These and other Internal Quality Assurance activities are described in more detail in Appendix 1, Attachment 1.

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 Areas 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, web page information/help 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, and conducts Desk Reviews on a regular basis.

During the first two quarters of Year Six, the six month period ending December 2006, a team including the Customer Service Specialist, Managers, and other support staff handled over 750 contacts. The following table lists the contacts for Years Four, Five and the first half of Year Six.

Table 22: Customer Service Contacts
July 2004 – December 2006

Area	Number			Percent		
	Year 4	Year 5	Year 6 Jul - Dec	Year 4	Year 5	Year 6 Jul - Dec
Desk Reviews	1,460	1,379	509	74.7%	77.3%	67.3%
CORE	292	132	49	14.9%	7.4%	6.5%
WiSCC	48	23	3	2.5%	1.3%	0.4%
Interpreting Services	76	35	0	3.9%	2.0%	0.0%
Complaints	0	35	8	0.0%	2.0%	1.1%
On Line Assistance	0	68	29	0.0%	3.8%	3.8%
Miscellaneous	78	111	158	4.0%	6.2%	20.9%
Total	1,954	1,783	756	100.0%	100.0%	100.0%

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, material the provider needs to send to Delmarva for the review or the Documentation Follow-up review, training, Level 2 Background screening, recoupments, and explanations of provider performance scores. A total of 509 contacts have been logged in this area thus far this year.

CORE and WiSCC

There have been 49 calls related to the CORE procedure and only three related to WiSCC during the first two quarters of Year Six. Many of the CORE related calls were requests for clarification of the different evaluations levels. Providers were assisted with questions regarding the Quality Enhancement Plan, Follow-Up procedures, or other general information. The WiSCC calls were support coordinators needing to solicit information/clarification about sections of the WiSCC report they had received.

Complaints

The customer service representative has also fielded several complaints over the course of the first six months of this contract year (29):²⁶

- The sister, and legal guardian, of a 70 year old individual residing in a group home disagreed with the recommendations of a WiSCC report.
- A provider who had complaints about a Consultant (QIC) and wanted to have a different one was referred to one of our Regional Managers for resolution.
- A person complained about the performance of Medicaid Waiver providers in general and wanted to know who monitors them and what Delmarva's role was in this area.
- An individual recipient of services complained about an Agency who changed her supported living provider against her will.
- A Pharmacist complained about the requirement to follow up with the prescribing physician as part of a medication review monitoring check list and threatened to stop providing the service if he had to comply with this requirement.

Interpreting Services

There have been no requests for this service during the first two quarters of Year Six of the contract.

Miscellaneous

The proportion of Miscellaneous Contacts thus far this year is much greater than in previous years. This is because there were close to 40 calls concerning scheduling of POM interviews for the CORE QIC POM training session.

²⁶ Complaints were logged and discussed in the Year Four annual report as well, but were incorporated into the Miscellaneous category.

Quality Improvement Initiatives

Area Data 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 reviews are updated quarterly. Delmarva has worked with the Area Quality Leaders (AQL) to implement some modifications to these tables.

Quarterly/Annual Reports

As noted previously, Delmarva has worked closely with APD this quarter to update the format of the quarterly and annual reports distributed to APD and AHCA. The new formats, including a newly formatted Executive Summary, were designed to improve the quality of the presentation and to allow for a simpler more concise report suitable for a wider audience.

Quality Improvement Studies

The Barriers Analysis QI study has been approved by AHCA and is now posted on Delmarva's FSQAP website. Four other QI studies completed during Year Five are currently awaiting approval. Two Psychotherapeutic Drug Use studies have also been submitted and are in the review process with APD and AHCA.

One QI study topic has been approved for Year Six, investigating abuse, neglect and exploitation issues. Preliminary results were presented at the December IQC meeting. A second topic, examining POM outcomes across services, has been presented at two status meetings but has not yet been approved.

Section Three: Discussion of Findings and Recommendations

Through December 31, 2006, the Florida Statewide Quality Assurance Program (FSQAP) has conducted over 10,000 Personal Outcome Measure interviews with individuals who were receiving services and supports through the Developmental Disabilities Home and Community Based Services (DD HCBS) Waiver. Over 10,000 annual Provider Performance Reviews/CORE have been completed along with 5,015 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 and one half years consultants conducted over 1,000 WiSCCs that included close to 1,600 interviews with 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 and to the Interagency Quality Council (IQC). 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. A workgroup has been formed and a quality improvement study is being completed to examine issues of Abuse and Neglect based upon a presentation and feedback provided during the Spring IQC meeting.

The data available for the first two quarters of Year Six represent only a portion of the providers who will be reviewed this year. Also, the number of individuals who have participated in a POM interview is only a small portion of the total sample. Therefore, we present here limited discussion and recommendations from the findings and will include more thorough analyses, discussion and recommendations in the annual report.

Desk Reviews

The average score for Desk Reviews, a procedure that has changed very little over the five plus years of the contract, has increased somewhat since Year One but has remained fairly consistent since Year Two, with a current score of around 75 percent. Solo providers continue to score somewhat higher than agency providers, perhaps a result of less paper work and/or required documentation. While the average score has maintained a constant level, the percent of elements that are “fixed” at the time of the Documentation Follow-up Review has dropped.

Recommendation 1: It is recommended that Delmarva continue to track this possible trend of a decreased number of elements scored as Met during the Documentation Review—that had previously been scored as Not Met during the annual review. Interventions may be necessary in order to ensure providers who render services that are desk reviewed are completing requirements necessary to provide the service.

CORE Results Elements

Results for the CREs indicate that on average, providers are less likely to be evaluated as Implementing and more likely to be evaluated as Emerging, compared to the previous two years. However, this result is derived from the agency providers as solo providers have improved since Year Five and continue to score better than agencies and a much greater proportion of providers are agencies. Because providers who scored Achieving in Year Five are exempt from a consult this year, it is possible that results so far in Year Six may be reflecting the fact that better performing providers are not included in the analyses.

At the CORE element level, on average during the first two quarters of this year, providers have improved somewhat in helping individuals develop social roles that are important to them. This is important because building various social roles has been found to be an important indicator of improved outcomes for individuals. However, providers were most likely to lack organizational systems that ensure individuals are routinely included in the development and review of their implementation plans. This area was most likely to be scored as Not Emerging. Implementation Planning has historically been an area where providers have struggled to effectively utilize Support Plan information and input from the individual receiving services to generate a sound plan of action. Previous research has indicated that training in this area might help improve outcomes for individuals.²⁷

Recommendation 2: If training on Implementation Plans is regularly offered throughout the state, APD should develop a program that ensures all providers attend at least one session. They should also review the training curriculum and update as needed. If this type of training is not offered a sufficient number of times and in various locations, APD should develop an Implementation Plan training seminar or work with Delmarva to offer one or two sessions in the state.

CORE MSR Elements

One of the most troubling findings from the CORE data is the drop in performance on the MSR elements. On average, the percent of MSR elements met so far this year represents a 10 point drop since Year Four, and is particularly apparent on the elements measuring projected service outcomes, background screening, training and documentation for billing. It is not clear why this may be occurring. The new processes focus on outcomes and it is possible providers are not as concerned about documentation and have “let it slide” a little. However, this possible trend is not as apparent among Support Coordinators. It is also possible there are new providers, particularly with the influx of individuals on the FSL Waiver, and they have not yet put systems in place to ensure requirements are fulfilled.

²⁷ CORE Element Level Comparison to Provider Performance Reviews. June 2005. Prepared by Delmarva Foundation and presented to the Agency for Health Care Administration and the Agency for Persons with Disabilities. http://www.dfmc-florida.org/quality_improvement_studies/2004-2005/core/FSQAP_CORE_element_to_PPR_comparison_study.pdf

Recommendation 3: It is critical for Delmarva and APD to monitor results of the CORE MSR elements closely. If providers continue to show a decreased performance in these areas, Delmarva should work with APD to develop and implement a process to specifically address the MSR process elements.

CORE Follow-up Reviews

Similar to the Documentation Review results for Desk Reviews, fewer providers are showing MSR elements as “fixed” at the time of the Follow-up. Scoring Met on 75 percent or more on the elements that had previously been scored as Not Met is one method used to measure performance. This has dropped by 20 points since Year Four.

Recommendation 4: It is recommended that Delmarva continue to track this trend in the reduced number of elements scored as Met during the Follow-up Review—that had previously been scored as Not Met during the annual review. Interventions may be necessary in order to ensure providers are completing requirements necessary to provide the service. This may be done in conjunction with a process or training used to address the MSR elements in general.

WiSCC Results Elements

Results for WREs indicate that on average agency and solo support coordinators have been performing at about the same level each year, showing a slight improvement since Year Four. Performance varies across each individual element. Only 8.5 percent of solo WSC and 14 percent of WSCs working for an agency were evaluated as Achieving in the area of health and safety. Therefore, most WSCs do not have systems in place that consistently ensure the health and safety of all their consumers. In addition, CORE alerts in this area appear to have increased somewhat since Year Five.

Recommendation 5: Because health and safety are basic needs for all individuals, Delmarva and APD should further explore why WSCs are least likely to score this element as Achieving and most likely to score it as Not Emerging. Mandatory training should be offered, if indicated.

WiSCC MSR Elements

WSCs have maintained a fairly consistent percent of MSR elements scored as Met since implementation of the WiSCC process. Each year a greater percent have shown documentation of having attended required training sessions and the WSCs are close to 100 percent on the element that measures if they are billing as authorized. However, they are much less likely to maintain the proper billing documentation and somewhat less likely, thus far in Year Six, to have documentation of background screening.

Background screening results from the CORE also indicated a drop during the first two quarters of the current year. Delmarva and APD have worked together to develop a new procedure intended to improve performance of providers in this area. The procedure was implemented in April 2006 and should help providers obtain proper background screening when this is scored as Not Met during the annual consult. Positive results should be reflected at the time of the Follow-up review. Preliminary analysis has not

shown an improvement among providers who had a CORE or Desk Review, before and after implementation of the new process.

Recommendation 6: As more data are gathered, we recommend further analysis for background screening at Follow-up. If no improvement is noted, a workgroup may be needed to develop and implement a modified program to ensure providers are obtaining the required screenings. APD should consider implementing provider sanctions and/or termination of eligibility to providers if screenings are not documented.

POM Results

The most disturbing results in this report are the apparent decline in outcomes and supports present in the lives of people served through the Waiver programs. With a few exceptions, this decrease is evident across all age groups, living arrangements and POM items. It is important to remember that only part of the sample is represented in these results. However this type of possible trend should be addressed. It is not clear why this may be occurring but there are several possible explanations:

- There has been a tremendous influx of individuals on the Family and Supported Living Waiver (FSL). This waiver does not offer the same array of services as the DD Waiver. Therefore, because supports are directly tied to outcomes, it is reasonable to assume individuals will not have the same level of outcomes in their lives.
- With the FSL waiver there has also been a wave of new support coordinators. Analysis indicates that for over 38 percent of the WSCs reviewed thus far in Year Six, this was their first WiSCC. Delmarva's QICs have indicated they may not all have received the POM training necessary to help individuals achieve outcomes.
- When APS first started operations during Year Five they were approving multiple services, possibly because their systems were not in place to adequately review all the documentation necessary to make service authorization determinations. However, as they have developed their system, QICs indicate they are now declining services at a higher rate.
- During the initial stages of this fiscal year, WSC workload was impacted due to the need to modify cost plans reflecting changes in the provider rate structure. It has been noted historically that the cumulative impact of these types of special projects can have a negative impact on the frequency and quality of WSC interactions with the people needing support.
- Confusion and procedures concerning Medicaid, the Medicaid Waivers and billing appear to be increasing. Consultants in the field have talked with WSCs about a "big push" recently to get written denials from Medicaid before APS will approve waiver funding. Therefore, if Medicaid does not deny the service it is not approved through the Waiver. At least one provider has mentioned being told to pursue Medicaid funding for Tracking Systems and other items, such as gloves. However, Medicaid often does not cover the item, or does cover it but the reimbursement rate is so low no provider will accept it. It appears there have also been some questions concerning Medicaid billing codes. For example, a WSC was attempting to acquire a bath lift for an individual. APS informed the person to go through Medicaid but the WSC,

through information obtained from the Medical Supplies provider, insisted Medicaid does not pay for this item. When APS did provide the Medicaid billing code under which the WSC should bill, the code was for a raised toilet seat.

The explanation that individuals on the FSL Waiver have fewer outcomes met, on average, is a testable hypothesis. Delmarva has been including FSL participants in all consults and interviews since July 1, 2006. With the implementation of the new WiSCC application, a data field identifies FSL participants. However, because this application was implemented in mid December, only seven individuals fall into this category as of the end of the second quarter in Year Six. It is also possible to identify them via procedure codes in the Claims Data.

Recommendation 7: For the Annual Report, analyze data to determine if individuals on the FSL Waiver have fewer outcomes met in their lives. Include Claims data procedure codes to help ensure identification of all FSL participants.

POM training for WSCs is an important component to enhancing communication skills with individuals, thereby improving outcomes. Anecdotal evidence suggests QICs are concerned that WSCs are not receiving this training as necessary. At the same time, however, the MSR element measuring WSC training requirements has improved, up by 10 points since Year Four. The influx of new WSCs could be impacting this phenomenon.

Recommendation 8: Delmarva should analyze data to compare results for new WSCs with those who have more than one WiSCC consult to determine if the perceived problem with POM training is a real issue for new providers. APD should ensure all new WSCs are in fact receiving this vital component of their training regimen.

Issues surrounding the relationship among Medicaid, the Medicaid Waiver, Waiver providers and APS are complex. If problems are surfacing due to a change in or a breakdown of the interconnections among them, this could definitely impact the supports and outcomes for people on the Waiver programs.

Recommendation 9: APD and AHCA should work together to investigate issues noted in this report: a requirement from APS for a documented denial from Medicaid before approving the Waiver service; problems with billing; and confusion as to what Medicaid will or will not cover. A workgroup should be formed that will investigate how substantial these problems may be, explore other problems that may exist, determine how the identified problems are impacting individuals and providers, and recommend strategies to address the identified concerns.