Appendix 1:
Person Centered Review Aggregate Information
## Table 1
Personal Outcome Measures: Presence of Outcomes and Supports by Area and Item

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</tr>
<tr>
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<td>688</td>
</tr>
<tr>
<td></td>
<td>O</td>
<td>423</td>
</tr>
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<td></td>
<td>S</td>
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<tr>
<td></td>
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<td>633</td>
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<tr>
<td></td>
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<td>Has friends</td>
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<td>S</td>
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<td>S</td>
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<td>Is safe</td>
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<tr>
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### Table 4
Person-centered Reviews
13 or More Outcomes/Supports by District

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<th>Number Reviews</th>
<th>Percent of Total Reviews</th>
<th>Number Reviews</th>
<th>Percent of Total Reviews</th>
<th>Total Reviews</th>
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<td>63.5%</td>
<td>148</td>
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<td>187</td>
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<td>78</td>
<td>39.0%</td>
<td>200</td>
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<td>105</td>
<td>60.3%</td>
<td>76</td>
<td>43.7%</td>
<td>174</td>
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<td>73.0%</td>
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<td>50.0%</td>
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### Table 5
Person-centered Reviews
Outcomes By District and Age Group - 13 Or More Outcomes Met

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<th>3 to 17 years</th>
<th>18 to 21 years</th>
<th>22 to 25 years</th>
<th>26 to 44 years</th>
<th>45 to 64 years</th>
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<td>13 or more outcomes met</td>
<td>13 or more outcomes met</td>
<td>13 or more outcomes met</td>
<td>13 or more outcomes met</td>
<td>13 or more outcomes met</td>
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Person-centered Review 13 or More Outcomes Met by District and Home Type

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<th>ALF</th>
<th>FOSTER HOME</th>
<th>LARGE GROUP HOME</th>
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<td>13</td>
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### Table 7

**Person-centered Reviews**  
**Foundational Outcomes Met**

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<td>23</td>
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<th>Home Type</th>
<th>Number Reviews</th>
<th>Percent of Total Reviews</th>
<th>Total Reviews Completed</th>
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<td>Family Home</td>
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<td>Independent/Supported Living</td>
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<td>Small Group Home</td>
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<td>ALF</td>
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<td>Foster Home</td>
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<tr>
<td>Other/Unknown</td>
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<th>Foundational POM</th>
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<td>19 - Is connected to natural support networks</td>
<td>2,109</td>
<td>72.28%</td>
</tr>
<tr>
<td>20 - Is safe</td>
<td>2,040</td>
<td>69.91%</td>
</tr>
<tr>
<td>21 - Exercises rights</td>
<td>1,128</td>
<td>38.66%</td>
</tr>
<tr>
<td>22 - Is treated fairly</td>
<td>1,806</td>
<td>61.89%</td>
</tr>
<tr>
<td>23 - Has the best possible health</td>
<td>1,626</td>
<td>55.72%</td>
</tr>
<tr>
<td>24 - Is free from abuse and neglect</td>
<td>2,502</td>
<td>85.74%</td>
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<tr>
<td>25 - Experiences continuity and security</td>
<td>1,541</td>
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### Table 8  Person-centered Review Recommendations

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<th>Pct of Total Recommendations</th>
<th>Nbr Reviews with Recommendation</th>
<th>Pct of Reviews with This Recommendation</th>
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<td>Other:</td>
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<td>Behavioral review is indicated</td>
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<td>Dental care is indicated</td>
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<td>Environmental assessment is indicated</td>
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<td>Evaluation of adaptive equipment is indicated</td>
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<td>Female preventive healthcare is indicated</td>
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<td>Locate a PCP</td>
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<td>Oral motor evaluation is indicated</td>
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Appendix 2

Provider Performance Review Aggregate Data
### Table 9
Statewide Results by District for All Provider Performance Reviews
January – March 2003 Original Review Tools and Protocols

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<th>Number of Reviews</th>
<th>Average Review Score</th>
<th>Number Reviews with Alerts</th>
<th>Total Number of Alerts</th>
<th>Reviews with Recoupment Citations</th>
<th>Total Number of Recoupment Citations</th>
<th>Number of Reviews Requiring Submission of a Quality Improvement Plan (QIP)</th>
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<td>2</td>
<td>2</td>
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<td>10</td>
<td>12</td>
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<td>7</td>
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<td>4</td>
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<td>5</td>
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<td>Total</td>
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<td>Average Provider Review Score</td>
<td>Number Provider Reviews with Alerts</td>
<td>Total Number of Alerts</td>
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<td>-----------------------------</td>
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Table 10
Statewide Results by District for All Provider Performance Reviews
January – March 2003 Revised Review Tools and Protocols
### Table 11
Summary of Provider Performance Review On-Site Review Results
January – March 2003 Original Tools and Protocols

<table>
<thead>
<tr>
<th>District</th>
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<th>Average Review Score</th>
<th>Number Reviews with Alerts</th>
<th>Number of Reviews with Recoupment</th>
<th>Total Number of Alerts with Recoupment Citations</th>
<th>Number of Reviews Requiring Submission of a Quality Improvement Plan (QIP)</th>
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<td>8</td>
<td>3</td>
<td>83%</td>
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<td>5</td>
<td>7</td>
</tr>
<tr>
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<td>5</td>
<td>90% 96%</td>
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<td>11</td>
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</tr>
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<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>23</td>
<td>30</td>
<td>88% 92%</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>135</td>
<td>38</td>
<td>18</td>
<td>20</td>
<td>67</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>93</td>
<td>38</td>
<td>18</td>
<td>20</td>
<td>67</td>
<td>14</td>
</tr>
<tr>
<td>Average</td>
<td>38</td>
<td>10</td>
<td>3</td>
<td>4</td>
<td>67</td>
<td>14</td>
</tr>
<tr>
<td>Statewide Score</td>
<td>89% 90%</td>
<td>38</td>
<td>18</td>
<td>20</td>
<td>67</td>
<td>14</td>
</tr>
</tbody>
</table>

Average Statewide Score: 89%, 90%
## Table 12
**Summary of Provider Performance Review On-Site Review Results**
*January – March 2003 Revised Tools and Protocols*

<table>
<thead>
<tr>
<th>District</th>
<th>Number of Reviews</th>
<th>Average Provider Review Score</th>
<th>Number Provider Reviews with Alerts</th>
<th>Total Number of Alerts</th>
<th>Provider Reviews with Recoupment Citations</th>
<th>Total Number of Recoupment Citations</th>
<th>Number of Provider Reviews Requiring Submission of a Quality Improvement Plan (QIP)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agency</td>
<td>Solo</td>
<td>Total</td>
<td>Agency</td>
<td>Solo</td>
<td>Agency</td>
<td>Solo</td>
</tr>
<tr>
<td>1</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>95%</td>
<td>85%</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>8</td>
<td>12</td>
<td>20</td>
<td>83%</td>
<td>85%</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>90%</td>
<td>97%</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>96%</td>
<td>96%</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>92%</td>
<td>91%</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>90%</td>
<td>71%</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>90%</td>
<td>92%</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td>90%</td>
<td>92%</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>9</td>
<td>3</td>
<td>12</td>
<td>93%</td>
<td>88%</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>3</td>
<td>5</td>
<td>8</td>
<td>90%</td>
<td>89%</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>8</td>
<td>3</td>
<td>11</td>
<td>84%</td>
<td>92%</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>89%</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>13</td>
<td>4</td>
<td>17</td>
<td>83%</td>
<td>81%</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

**Total Reviews** | **142** | **41** | **183** |
**Total Providers** | **61** | **41** | **102** |

**Average Statewide Score** | **88%** | **88%** |
Table 13
Statewide Summary of Provider performance review results by Service Category
January – March 2003 -Original Review Tools and Protocols

<table>
<thead>
<tr>
<th>Component Reviewed</th>
<th>Number of Reviews</th>
<th>Average Review Score</th>
<th>Number of Reviews with Alerts</th>
<th>Total Number of Alerts</th>
<th>Reviews with Recoupment Citations</th>
<th>Total Number of Recoupment Citations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agency</td>
<td>Solo</td>
<td>Total</td>
<td>Agency</td>
<td>Solo</td>
<td>Total</td>
</tr>
<tr>
<td>Core Assurances</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Day Training</td>
<td>13</td>
<td>13</td>
<td>26</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
</tr>
<tr>
<td>Non-Residential Support Services</td>
<td>27</td>
<td>16</td>
<td>43</td>
<td>87%</td>
<td>88%</td>
<td>87%</td>
</tr>
<tr>
<td>Residential Habilitation</td>
<td>87</td>
<td>8</td>
<td>95</td>
<td>88%</td>
<td>86%</td>
<td>88%</td>
</tr>
<tr>
<td>Support Coordination</td>
<td>7</td>
<td>29</td>
<td>36</td>
<td>90%</td>
<td>92%</td>
<td>91%</td>
</tr>
<tr>
<td>Supported Employment Services</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td>93%</td>
<td>84%</td>
<td>91%</td>
</tr>
<tr>
<td>Supported Living Coaching</td>
<td>28</td>
<td>15</td>
<td>43</td>
<td>90%</td>
<td>91%</td>
<td>90%</td>
</tr>
</tbody>
</table>
Table 14
Statewide Summary of Provider Performance Review results by Service Category
January – March 2003 -Revised Review Tools and Protocols

<table>
<thead>
<tr>
<th>Component Reviewed</th>
<th>Number of Provider Reviews</th>
<th>Average Provider Review Score</th>
<th>Number of Provider Reviews with Alerts</th>
<th>Total Number of Alerts</th>
<th>Total Number of Recoupment Citations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agency</td>
<td>Solo</td>
<td>Total</td>
<td>Agency</td>
<td>Solo</td>
</tr>
<tr>
<td>Core Assurances</td>
<td>60</td>
<td>41</td>
<td>101</td>
<td>89%</td>
<td>88%</td>
</tr>
<tr>
<td>Adult Day Training</td>
<td>10</td>
<td>10</td>
<td>20</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>Non-Residential Support Services</td>
<td>18</td>
<td>14</td>
<td>32</td>
<td>86%</td>
<td>87%</td>
</tr>
<tr>
<td>Residential Habilitation</td>
<td>30</td>
<td>7</td>
<td>37</td>
<td>87%</td>
<td>81%</td>
</tr>
<tr>
<td>Support Coordination</td>
<td>3</td>
<td>17</td>
<td>20</td>
<td>94%</td>
<td>90%</td>
</tr>
<tr>
<td>Supported Employment Services</td>
<td>7</td>
<td>7</td>
<td>14</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>Supported Living Coaching</td>
<td>30</td>
<td>6</td>
<td>36</td>
<td>90%</td>
<td>87%</td>
</tr>
</tbody>
</table>

FSQAP Quarterly Report
January – March 2003
<table>
<thead>
<tr>
<th>Service Component</th>
<th>Element</th>
<th>Element Text</th>
<th>Number of Reviews</th>
<th>Number of Reviews with Met Element</th>
<th>Percent Reviews Element Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Training (ADT)</td>
<td>50</td>
<td>The provider has established a systematic method to collect projected service outcome data. (Was ADT 42)</td>
<td>15</td>
<td>8</td>
<td>53.3%</td>
</tr>
<tr>
<td></td>
<td>51</td>
<td>The provider reviews data periodically and corrective measures are put in place if the data indicates that the goal is not being achieved. (Was ADT 43)</td>
<td>15</td>
<td>8</td>
<td>53.3%</td>
</tr>
<tr>
<td></td>
<td>52</td>
<td>Individuals receiving services demonstrate an increase in abilities, self-sufficiency, and changes in their lives consistent with their support plan. (NEW 2003)</td>
<td>15</td>
<td>12</td>
<td>80.0%</td>
</tr>
<tr>
<td></td>
<td>53</td>
<td>Individuals served who have a stated support plan goal to be employed in the community, access supported employment or other competitive employment opportunities. (NEW 2003)</td>
<td>9</td>
<td>7</td>
<td>77.8%</td>
</tr>
<tr>
<td></td>
<td>54</td>
<td>Individuals served are satisfied with the services based on the results of the annual satisfaction survey or are satisfied that their concerns raised during the survey have been addressed. (NEW 2003)</td>
<td>14</td>
<td>11</td>
<td>78.6%</td>
</tr>
<tr>
<td></td>
<td>55</td>
<td>Individuals achieve or make progress toward the support plan goal(s) assigned to the provider. (NEW 2003)</td>
<td>15</td>
<td>11</td>
<td>73.3%</td>
</tr>
<tr>
<td></td>
<td>56</td>
<td>Individuals who use the supports and services of the provider are allowed maximum freedom of choice, including being informed about rights and service options (i.e., more inclusive programs, supported employment, etc.). (NEW 2003)</td>
<td>15</td>
<td>9</td>
<td>60.0%</td>
</tr>
<tr>
<td>Non-Residential Support Services</td>
<td>48</td>
<td>The provider has established a systematic method of data collection for projected service outcome data. (Was NRSS 47)</td>
<td>34</td>
<td>14</td>
<td>41.2%</td>
</tr>
<tr>
<td></td>
<td>49</td>
<td>There is evidence that the data are reviewed periodically and that corrective measures are put in place if the data indicates that the goal is not being achieved. (Was NRSS 48)</td>
<td>33</td>
<td>9</td>
<td>27.3%</td>
</tr>
<tr>
<td></td>
<td>50</td>
<td>Individuals achieve goals on their support plan during the year. (New 2003)</td>
<td>31</td>
<td>24</td>
<td>77.4%</td>
</tr>
<tr>
<td></td>
<td>51</td>
<td>Individuals receiving NRSS from the provider are satisfied with the services based on the results of the annual satisfaction survey or are satisfied that their concerns raised during the survey have been addressed. (New 2003)</td>
<td>33</td>
<td>30</td>
<td>90.9%</td>
</tr>
<tr>
<td></td>
<td>52</td>
<td>Individuals who use the supports and services of the provider demonstrate an increase in abilities, self-sufficiency, and changes in their lives, consistent with their personal goal(s). (New 2003)</td>
<td>33</td>
<td>26</td>
<td>78.8%</td>
</tr>
<tr>
<td></td>
<td>53</td>
<td>Individuals who use the services of the provider achieve an increased level of community inclusion or community involvement. (New 2003)</td>
<td>33</td>
<td>29</td>
<td>87.9%</td>
</tr>
<tr>
<td></td>
<td>54</td>
<td>Individuals receiving this service from the provider have these services provided in an integrated community setting. (New 2003)</td>
<td>33</td>
<td>32</td>
<td>97.0%</td>
</tr>
<tr>
<td>Residential Habilitation</td>
<td>47</td>
<td>Provider has established a systematic method to collect outcome data. (Was RH 44)</td>
<td>102</td>
<td>50</td>
<td>49.0%</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----</td>
<td>-------------------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td>48</td>
<td>The provider reviews data periodically and corrective measures are put in place if the data indicates that the goal is not being achieved. (Was RH 45)</td>
<td>102</td>
<td>59</td>
<td>57.8%</td>
</tr>
<tr>
<td></td>
<td>49</td>
<td>Individuals receiving residential habilitation services achieve or make progress toward the support plan goal(s) assigned to the provider. (NEW 2003)</td>
<td>102</td>
<td>81</td>
<td>79.4%</td>
</tr>
<tr>
<td></td>
<td>50</td>
<td>Individuals served are satisfied with their residential habilitation services based on the results of the annual satisfaction survey, or are satisfied that their concerns raised during the survey have been addressed. (NEW 2003)</td>
<td>100</td>
<td>78</td>
<td>78.0%</td>
</tr>
<tr>
<td></td>
<td>51</td>
<td>Individuals who use the supports and services of the provider remain healthy and free from injury, abuse or neglect. (NEW 2003)</td>
<td>102</td>
<td>93</td>
<td>91.2%</td>
</tr>
<tr>
<td></td>
<td>52</td>
<td>Individuals using supports &amp; services of the provider demonstrate increase in abilities, self-sufficiency, &amp; changes in their lives, consistent with personal goal(s). (NEW 2003)</td>
<td>102</td>
<td>86</td>
<td>84.3%</td>
</tr>
<tr>
<td></td>
<td>53</td>
<td>Individuals who use the supports and services of the provider are allowed maximum freedom of choice, including being informed about rights, service options, and making all possible decisions with regard to the conduct of their lives. (NEW 2003)</td>
<td>101</td>
<td>82</td>
<td>81.2%</td>
</tr>
<tr>
<td>Support Coordination</td>
<td>90</td>
<td>The provider has established a systematic method of data collection to measure success on projected service outcomes. (Was SC 83)</td>
<td>20</td>
<td>10</td>
<td>50.0%</td>
</tr>
<tr>
<td></td>
<td>91</td>
<td>There is evidence that projected service outcome data are reviewed periodically and that corrective measures are put in place if the data indicates the service outcomes are not being achieved. (Was SC 84)</td>
<td>19</td>
<td>8</td>
<td>42.1%</td>
</tr>
<tr>
<td></td>
<td>92</td>
<td>Individuals receiving support coordination have maximum freedom of choice in all areas of their lives, including setting personal goals, being fully informed about service options and making all possible decisions with regard to the conduct</td>
<td>19</td>
<td>14</td>
<td>73.7%</td>
</tr>
<tr>
<td></td>
<td>93</td>
<td>Individuals receiving services demonstrate an increase in abilities, self-sufficiency and changes in their lives consistent with their personal goals. (New 2003)</td>
<td>19</td>
<td>13</td>
<td>68.4%</td>
</tr>
<tr>
<td></td>
<td>94</td>
<td>Individuals are satisfied with their support coordination services based on the results of the annual satisfaction survey, or are satisfied that their concerns raised during the survey have been addressed. (New 2003)</td>
<td>17</td>
<td>15</td>
<td>88.2%</td>
</tr>
<tr>
<td>Supported Employment Services</td>
<td>44</td>
<td>Provider has established systematic method of data collection for outcome data. (Was SE 39)</td>
<td>8</td>
<td>4</td>
<td>50.0%</td>
</tr>
<tr>
<td></td>
<td>45</td>
<td>The provider reviews data periodically and corrective measures are put in place if the data indicates that the goal is not being achieved. (Was SE 40)</td>
<td>8</td>
<td>3</td>
<td>37.5%</td>
</tr>
<tr>
<td></td>
<td>46</td>
<td>Individuals in the individual model do not need paid job coaching in excess of an average of 20% of the beneficiaries average work hours. (New 2003)(For example, if a person works 30 hours per week then job coaching would not exceed 6 hours per week)</td>
<td>8</td>
<td>6</td>
<td>75.0%</td>
</tr>
<tr>
<td></td>
<td>47</td>
<td>Individuals receiving supported employment achieve the goal(s) identified on their support plan for which the provider is responsible. (New 2003)</td>
<td>8</td>
<td>4</td>
<td>50.0%</td>
</tr>
<tr>
<td></td>
<td>48</td>
<td>The provider achieves a satisfactory or better rating on the annual individual satisfaction survey. (New 2003)</td>
<td>7</td>
<td>5</td>
<td>71.4%</td>
</tr>
<tr>
<td>Supported Living Coaching Services</td>
<td>58</td>
<td>The provider has established a systematic method of data collection for outcome data. (Was SLC 54)</td>
<td>37</td>
<td>21</td>
<td>56.8%</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>----</td>
<td>----</td>
<td>-------</td>
</tr>
<tr>
<td>59</td>
<td></td>
<td>There is evidence that the data is reviewed periodically and that corrective measures are put in place if the data indicators that the goal is not being achieved. (Was SLC 55)</td>
<td>37</td>
<td>18</td>
<td>48.6%</td>
</tr>
<tr>
<td>60</td>
<td></td>
<td>Individuals in supported living are the lessee or owner of the home in which they reside. (NEW 2003)</td>
<td>37</td>
<td>31</td>
<td>83.8%</td>
</tr>
<tr>
<td>61</td>
<td></td>
<td>The provider achieves a satisfactory or better rating, based upon the results of annual individual satisfaction surveys. (NEW 2003)</td>
<td>36</td>
<td>34</td>
<td>94.4%</td>
</tr>
<tr>
<td>62</td>
<td></td>
<td>Individuals in supported living live in homes occupied by no more than two other beneficiaries with developmental disabilities and in areas in which persons with disabilities account for no more than 10% of the houses or 10% of the units in an apartment</td>
<td>36</td>
<td>31</td>
<td>86.1%</td>
</tr>
<tr>
<td>63</td>
<td></td>
<td>Individuals who use the supports and services of the provider demonstrate an increase in abilities, self-sufficiency, and changes in their lives consistent with their Support Plan goal(s). (NEW 2003)</td>
<td>37</td>
<td>27</td>
<td>73.0%</td>
</tr>
<tr>
<td>64</td>
<td></td>
<td>Individuals who use the services of the provider achieve an increased level of community inclusion or community involvement. (NEW 2003)</td>
<td>37</td>
<td>28</td>
<td>75.7%</td>
</tr>
<tr>
<td>65</td>
<td></td>
<td>Individuals who use the services of the provider maximize freedom of choice in all areas of their lives as evidenced by setting personal goals, being fully informed about service options and making all possible decisions with regard to the conduct of</td>
<td>37</td>
<td>28</td>
<td>75.7%</td>
</tr>
</tbody>
</table>
**Table 16: State Elements of Performance Most Often Not Met**  
**January – March 2003**  
**Core Assurances**

<table>
<thead>
<tr>
<th>Question ID</th>
<th>Description</th>
<th>Count Not Met</th>
<th>Percent Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Original Core Assurances</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>297</td>
<td>The assessment examines the organization's compliance with requirements found in the Medicaid Waiver Agreement and Assurances, and applicable rules and regulations.</td>
<td>60</td>
<td>37.0%</td>
</tr>
<tr>
<td>298</td>
<td>A Quality Improvement Plan (QIP) is developed to address areas needing improvement.</td>
<td>58</td>
<td>35.8%</td>
</tr>
<tr>
<td>247</td>
<td>The provider has a policy to educate the individual and/or family/guardian about how to report abuse, neglect or exploitation.</td>
<td>44</td>
<td>27.2%</td>
</tr>
<tr>
<td>244</td>
<td>Consents for release of information are specific, time limited, signed and dated by the person or authorized representative.</td>
<td>44</td>
<td>27.2%</td>
</tr>
<tr>
<td>261</td>
<td>The provider actively coordinates the dissemination of information to the individual/family/guardian and other providers in order to promote a cohesive planning and support process.</td>
<td>43</td>
<td>26.5%</td>
</tr>
<tr>
<td><strong>Revised Core Assurances</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1920</td>
<td>The assessment examines the provider's compliance with requirements found in the Medicaid Waiver Agreement and Assurances, and applicable rules and regulations. (Was CA 72)</td>
<td>59</td>
<td>48.0%</td>
</tr>
<tr>
<td>1922</td>
<td>A Quality Improvement Plan (QIP) is developed and implemented to address areas needing improvement. (Was CA 73)</td>
<td>54</td>
<td>43.9%</td>
</tr>
<tr>
<td>1923</td>
<td>Satisfaction survey results needing improvement are incorporated into the provider Quality Improvement Plan.</td>
<td>54</td>
<td>43.9%</td>
</tr>
<tr>
<td>1921</td>
<td>The provider's self-assessment is effective in determining the need for improvement. (NEW 2003)</td>
<td>51</td>
<td>41.5%</td>
</tr>
<tr>
<td>1901</td>
<td>Grievance procedures are annually reviewed and signed by the individual, family and/or guardian, and the provider keeps a copy on file. (Was CA 50)</td>
<td>44</td>
<td>35.8%</td>
</tr>
</tbody>
</table>
Table 17: State Elements of Performance Most Often Not Met  
January – March 2003  
Adult Day Training

<table>
<thead>
<tr>
<th>Question ID</th>
<th>Description</th>
<th>Count Not Met</th>
<th>Percent Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Original Adult Day Training</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>828</td>
<td>The IP is reviewed periodically to determine whether progress is being made and is updated to reflect new interests, goals, needs, or strategies to promote meaningful progress.</td>
<td>6</td>
<td>46.2%</td>
</tr>
<tr>
<td>850</td>
<td>The provider and each of its employees receive training on use of personal outcomes to establish a person-centered approach to service delivery. [CA 2.1]</td>
<td>5</td>
<td>38.5%</td>
</tr>
<tr>
<td>863</td>
<td>Performance data on the selected service outcomes</td>
<td>4</td>
<td>30.8%</td>
</tr>
<tr>
<td>866</td>
<td>The provider has established a systematic method of data collection for outcome data that is consistent with requirements found in their Agreement with the District.</td>
<td>4</td>
<td>30.8%</td>
</tr>
<tr>
<td>827</td>
<td>The IP identifies strategies and methods to assist the individual in meeting goal(s) as well as the data collection system to be used to assess success and achievement.</td>
<td>3</td>
<td>23.1%</td>
</tr>
<tr>
<td><strong>Revised Adult Day Training</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1527</td>
<td>The IP is reviewed periodically to determine whether progress is being made and is updated to reflect new interests, goals, needs, or strategies to promote meaningful progress. (Was ADT 4)</td>
<td>13</td>
<td>86.7%</td>
</tr>
<tr>
<td>1528</td>
<td>The provider is tracking and acting on an individual's progress or lack of progress.</td>
<td>13</td>
<td>86.7%</td>
</tr>
<tr>
<td>1537</td>
<td>At least annually, providers conduct an orientation informing individuals of supported employment and other competitive employment opportunities in the community. (NEW 2003)</td>
<td>8</td>
<td>53.3%</td>
</tr>
<tr>
<td>1569</td>
<td>Provider has at a minimum performance data on the Projected Service Outcomes. (Was ADT 39)</td>
<td>7</td>
<td>46.7%</td>
</tr>
<tr>
<td>1572</td>
<td>The provider has established a systematic method to collect projected service outcome data. (Was ADT 42)</td>
<td>7</td>
<td>46.7%</td>
</tr>
<tr>
<td>1573</td>
<td>The provider reviews data periodically and corrective measures are put in place if the data indicates that the goal is not being achieved. (Was ADT 43)</td>
<td>7</td>
<td>46.7%</td>
</tr>
</tbody>
</table>
### Table 18: State Elements of Performance Most Often Not Met
January – March 2003
Non-Residential Support Services

<table>
<thead>
<tr>
<th>Question ID</th>
<th>Description</th>
<th>Count Not Met</th>
<th>Percent Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Non-Residential Support Service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>61</td>
<td>There is evidence that the data are reviewed periodically and that corrective measures are put in place if the data indicates that the goal is not being achieved.</td>
<td>26</td>
<td>60.5%</td>
</tr>
<tr>
<td>17</td>
<td>The IP is reviewed periodically to determine whether progress is being made and is updated to reflect new interests, goals, needs, or strategies to promote meaningful progress.</td>
<td>25</td>
<td>58.1%</td>
</tr>
<tr>
<td>50</td>
<td>Monthly summary of individual's progress and activities toward achieving support plan goal(s) for the period being reviewed</td>
<td>17</td>
<td>39.5%</td>
</tr>
<tr>
<td>53</td>
<td>Performance data on the district selected Service Outcomes</td>
<td>17</td>
<td>39.5%</td>
</tr>
<tr>
<td>16</td>
<td>The IP identifies strategies and methods to assist the individual in meeting goal(s), as well as the data collection system to be used to assess success and achievement.</td>
<td>16</td>
<td>37.2%</td>
</tr>
</tbody>
</table>

| Revised Non-Residential Support Service                                                                 |
| 1641        | The IP is reviewed periodically to determine whether progress is being made and is updated to reflect new interests, goals, needs, or strategies to promote meaningful progress. (Was NRSS 4) | 24            | 70.6%           |
| 1685        | There is evidence that the data are reviewed periodically and that corrective measures are put in place if the data indicates that the goal is not being achieved. (Was NRSS 48) | 24            | 70.6%           |
| 1642        | Progress, or the lack there of, is noted in the daily progress notes, monthly summary and annual report. (New 2003) | 21            | 61.8%           |
| 1684        | The provider has established a systematic method of data collection for projected service outcome data. (Was NRSS 47) | 20            | 58.8%           |
| 1676        | Provider has at a minimum a monthly summary, including the training location, for the days services were provided of individual's progress and activities toward achieving support plan goal(s) for the period being reviewed. (Was NRSS 37) | 16            | 47.1%           |
## Table 19: State Elements of Performance Most Often Not Met
### January – March 2003
#### Residential Habilitation

<table>
<thead>
<tr>
<th>Question ID</th>
<th>Description</th>
<th>Count Not Met</th>
<th>Percent Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Original Residential Habilitation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>218</td>
<td>There is evidence that the data are reviewed periodically and that corrective measures are put in place if the data indicates that the goal is not being achieved.</td>
<td>58</td>
<td>61.1%</td>
</tr>
<tr>
<td>177</td>
<td>The IP is reviewed periodically to determine whether progress is made and is updated to reflect new interest, goals, needs, or strategies to promote meaningful progress.</td>
<td>46</td>
<td>48.4%</td>
</tr>
<tr>
<td>215</td>
<td>Performance data on the district selected Service Outcomes</td>
<td>37</td>
<td>38.9%</td>
</tr>
<tr>
<td>217</td>
<td>The provider has established a systematic method of data collection for outcome data that is consistent with requirements found in their Agreement with the District.</td>
<td>36</td>
<td>37.9%</td>
</tr>
<tr>
<td>201</td>
<td>The provider and each of its employees receive training on use of personal outcomes to establish a person-centered approach to service delivery. [CA.2.1]</td>
<td>35</td>
<td>36.8%</td>
</tr>
<tr>
<td></td>
<td><strong>Revised Residential Habilitation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1705</td>
<td>The IP is reviewed periodically to determine whether progress is made and is updated to reflect new interest, goals, needs, or strategies to promote meaningful progress. (Was RH 4)</td>
<td>61</td>
<td>59.8%</td>
</tr>
<tr>
<td>1706</td>
<td>The provider is tracking and acting on an individual's progress or lack of progress. (New 2003)</td>
<td>61</td>
<td>59.8%</td>
</tr>
<tr>
<td>1747</td>
<td>The provider has established a systematic method to collect outcome data. (Was RH 44)</td>
<td>52</td>
<td>51.0%</td>
</tr>
<tr>
<td>1744</td>
<td>Provider has at a minimum performance data on the Projected Service Outcomes. (Was RH 42)</td>
<td>47</td>
<td>46.1%</td>
</tr>
<tr>
<td>1748</td>
<td>The provider reviews data periodically and corrective measures are put in place if the data indicates that the goal is not being achieved. (Was RH 45)</td>
<td>43</td>
<td>42.2%</td>
</tr>
</tbody>
</table>
**Table 20: State Elements of Performance Most Often Not Met**  
**January – March 2003**  
**Support Coordination**

<table>
<thead>
<tr>
<th>Question ID</th>
<th>Description</th>
<th>Count Not Met</th>
<th>Percent Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Original Support Coordination</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>763</td>
<td>Provider assures a medication review by a Licensed Consultant Pharmacist is conducted at least annually</td>
<td>15</td>
<td>41.7%</td>
</tr>
<tr>
<td>803</td>
<td>Contacts with individuals are scheduled based on the individual's choice and are at a time and in a location convenient to the individual receiving services. [C.4]</td>
<td>15</td>
<td>41.7%</td>
</tr>
<tr>
<td>802</td>
<td>Contacts with individuals in community settings are planned in advance of the visit. [C.4]</td>
<td>14</td>
<td>38.9%</td>
</tr>
<tr>
<td>810</td>
<td>Central records contain copies of annual or professional reports and individual implementation plans submitted by other providers as required and appropriate to each service. [D.2.b]</td>
<td>14</td>
<td>38.9%</td>
</tr>
<tr>
<td>946</td>
<td>Provider assures a comprehensive psychiatric (for psychiatric medication) review is completed annually by a licensed psychiatrist/neurologist or an A.R.N.P., who acts pursuant to a protocol with the psychiatrist/neurologist.</td>
<td>14</td>
<td>38.9%</td>
</tr>
<tr>
<td><strong>Revised Support Coordination</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1044</td>
<td>There is evidence that projected service outcome data are reviewed periodically and that corrective measures are put in place if the data indicates the service outcomes are not being achieved. (Was SC 84)</td>
<td>11</td>
<td>55.0%</td>
</tr>
<tr>
<td>1043</td>
<td>The provider has established a systematic method of data collection to measure success on projected service outcomes. (Was SC 83)</td>
<td>10</td>
<td>50.0%</td>
</tr>
<tr>
<td>1037</td>
<td>Central records or provider records contain performance data on the Projected Service Outcomes.(Was SC 79)</td>
<td>8</td>
<td>40.0%</td>
</tr>
<tr>
<td>1041</td>
<td>Progress notes indicate a review of the individual's health, safety and well-being and an updated housing survey. (New 2003)</td>
<td>6</td>
<td>30.0%</td>
</tr>
<tr>
<td>1046</td>
<td>Individuals receiving services demonstrate an increase in abilities, self-sufficiency and changes in their lives consistent with their personal goals. (New 2003)</td>
<td>6</td>
<td>30.0%</td>
</tr>
</tbody>
</table>
## Table 21: State Elements of Performance Most Often Not Met  
**January – March 2003**  
**Supported Employment Services**

<table>
<thead>
<tr>
<th>Question ID</th>
<th>Description</th>
<th>Count Not Met</th>
<th>Percent Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Original Supported Employment Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>945</td>
<td>An individualized implementation plan (IP) or employment plan is developed under the direction of the consumer, which identifies training programs, and activities to accomplish desired goals and identified needs.</td>
<td>3</td>
<td>50.0%</td>
</tr>
<tr>
<td>951</td>
<td>The IP identifies strategies and methods to assist the individual in meeting goal(s), as well as the data collection system to be used to assess success and achievement.</td>
<td>3</td>
<td>50.0%</td>
</tr>
<tr>
<td>398</td>
<td>Independent vendors and employees of agencies who render services have a bachelor's degree from an accredited college or university with a major in nursing, education, or social, behavioral or rehabilitative science (In lieu of a bachelor's degree, a</td>
<td>2</td>
<td>33.3%</td>
</tr>
<tr>
<td>952</td>
<td>The IP is reviewed periodically to determine whether progress is being made and is updated to reflect new interests, goals, needs, or strategies to promote meaningful progress.</td>
<td>2</td>
<td>33.3%</td>
</tr>
<tr>
<td>394</td>
<td>Services include providing consultation to employers to enhance supports natural to the workplace</td>
<td>1</td>
<td>16.7%</td>
</tr>
<tr>
<td><strong>Revised Supported Employment Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1600</td>
<td>The IP is reviewed periodically to determine whether progress is being made and is updated to reflect new interests, goals, needs, or strategies to promote meaningful progress. (Was SE 11)</td>
<td>6</td>
<td>75.0%</td>
</tr>
<tr>
<td>1601</td>
<td>The provider is tracking and acting on an individual's progress or lack of progress. (New 2003)</td>
<td>5</td>
<td>62.5%</td>
</tr>
<tr>
<td>1633</td>
<td>The provider reviews data periodically and corrective measures are put in place if the data indicates that the goal is not being achieved. (Was SE 40)</td>
<td>5</td>
<td>62.5%</td>
</tr>
<tr>
<td>1624</td>
<td>The provider has at a minimum, a monthly summary of an individual's progress and activities toward achieving support plan goal(s) for the period being reviewed. (Was SE 33)</td>
<td>4</td>
<td>50.0%</td>
</tr>
<tr>
<td>1632</td>
<td>The provider has established a systematic method of data collection for outcome data. (Was SE 39)</td>
<td>4</td>
<td>50.0%</td>
</tr>
<tr>
<td>1635</td>
<td>Individuals receiving supported employment achieve the goal(s) identified on their support plan for which the provider is responsible. (New 2003)</td>
<td>4</td>
<td>50.0%</td>
</tr>
</tbody>
</table>
### Table 22: State Elements of Performance Most Often Not Met
January – March 2003
Supported Living Coaching

<table>
<thead>
<tr>
<th>Question ID</th>
<th>Description</th>
<th>Count Not Met</th>
<th>Percent Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Original Supported Living Coaching</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>519</td>
<td>The IP is reviewed periodically to determine whether progress is being made and is updated to reflect new interest, goals, needs, or strategies to promote meaningful progress.</td>
<td>22</td>
<td>51.2%</td>
</tr>
<tr>
<td>571</td>
<td>There is evidence that the data are reviewed periodically and that corrective measures are put in place if the data indicators that the goal is not being achieved.</td>
<td>21</td>
<td>48.8%</td>
</tr>
<tr>
<td>567</td>
<td>Performance data on district selected service outcomes</td>
<td>17</td>
<td>39.5%</td>
</tr>
<tr>
<td>570</td>
<td>The provider has established a systematic method of data collection for outcome data that is consistent with requirements found in their Agreement with the District.</td>
<td>17</td>
<td>39.5%</td>
</tr>
<tr>
<td>518</td>
<td>The IP identifies strategies and methods to assist the individual in meeting goal(s) as well as the data collection system to be used to assess success and achievement.</td>
<td>16</td>
<td>37.2%</td>
</tr>
<tr>
<td><strong>Revised Supported Living Coaching</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1818</td>
<td>The provider forwards a copy of the annual satisfaction survey to the waiver support coordinator. (Was SLC 45)</td>
<td>24</td>
<td>64.9%</td>
</tr>
<tr>
<td>1828</td>
<td>There is evidence that the data is reviewed periodically and that corrective measures are put in place if the data indicators that the goal is not being achieved. (Was SLC 55)</td>
<td>19</td>
<td>51.4%</td>
</tr>
<tr>
<td>1827</td>
<td>The provider has established a systematic method of data collection for outcome data. (Was SLC 54)</td>
<td>16</td>
<td>43.2%</td>
</tr>
<tr>
<td>1774</td>
<td>The IP is reviewed periodically to determine whether progress is being made and is updated to reflect new interest, goals, needs, or strategies to promote meaningful progress. (Was SLC 4)</td>
<td>14</td>
<td>37.8%</td>
</tr>
<tr>
<td>1775</td>
<td>The provider is tracking and acting on an individual's progress or lack of progress.</td>
<td>14</td>
<td>37.8%</td>
</tr>
</tbody>
</table>
Table 23
Second Year Provider Performance Reviews by District and Average Percentage Change in Score

<table>
<thead>
<tr>
<th>District</th>
<th>Total Nbr Providers Reviewed</th>
<th>Nbr Providers w/Repeat Reviews</th>
<th>Percent Providers w/Repeat Reviews</th>
<th>Average Pct Change in Score*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>112</td>
<td>20</td>
<td>17.9%</td>
<td>12%</td>
</tr>
<tr>
<td>2</td>
<td>382</td>
<td>46</td>
<td>12.0%</td>
<td>24%</td>
</tr>
<tr>
<td>3</td>
<td>214</td>
<td>14</td>
<td>6.5%</td>
<td>15%</td>
</tr>
<tr>
<td>4</td>
<td>262</td>
<td>13</td>
<td>5.0%</td>
<td>12%</td>
</tr>
<tr>
<td>7</td>
<td>290</td>
<td>23</td>
<td>7.9%</td>
<td>12%</td>
</tr>
<tr>
<td>8</td>
<td>81</td>
<td>1</td>
<td>1.2%</td>
<td>2%</td>
</tr>
<tr>
<td>9</td>
<td>142</td>
<td>8</td>
<td>5.6%</td>
<td>1%</td>
</tr>
<tr>
<td>10</td>
<td>171</td>
<td>9</td>
<td>5.3%</td>
<td>3%</td>
</tr>
<tr>
<td>11</td>
<td>357</td>
<td>49</td>
<td>13.7%</td>
<td>23%</td>
</tr>
<tr>
<td>12</td>
<td>171</td>
<td>24</td>
<td>14.0%</td>
<td>38%</td>
</tr>
<tr>
<td>13</td>
<td>240</td>
<td>28</td>
<td>11.7%</td>
<td>19%</td>
</tr>
<tr>
<td>14</td>
<td>145</td>
<td>16</td>
<td>11.0%</td>
<td>4%</td>
</tr>
<tr>
<td>15</td>
<td>155</td>
<td>5</td>
<td>3.2%</td>
<td>4%</td>
</tr>
<tr>
<td>23</td>
<td>831</td>
<td>90</td>
<td>10.8%</td>
<td>7%</td>
</tr>
<tr>
<td>97</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>98</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>3,555</td>
<td>346</td>
<td>9.7%</td>
<td>16%</td>
</tr>
</tbody>
</table>

*Based on 216 repeat reviews done using original process
Appendix 3
# Attachment 1

## Training, Education, and Liaison

### Contacts and meetings

**Year Two – January - March 2003**

<table>
<thead>
<tr>
<th>Project Management</th>
<th>Description of Activity</th>
<th>Participants and Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>January 19, 2003</strong></td>
<td>Project Overview provided to State Advocacy Center Board of Directors</td>
<td>Marcia Hill and SAC Board members and representatives (20 persons)</td>
</tr>
<tr>
<td><strong>February 5 – 6, 2003</strong></td>
<td>Interagency Quality Council</td>
<td>Delmarva staff and partners presented at IQC Quarterly meeting</td>
</tr>
<tr>
<td><strong>March 2003</strong></td>
<td>Update Presentation for DD Program Office</td>
<td>Marcia Hill and DD Staff (@ 15)</td>
</tr>
<tr>
<td><strong>April 2003</strong></td>
<td>Update and Overview for Leadership Meeting</td>
<td>Marcia Hill, Bob Maryanski; Richard Hollis and @ 40 participants</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>District/local contacts</th>
<th>Description of Activity</th>
<th>Participants and Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>District 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28-Jan-03</td>
<td>Quarterly Meeting with District Staff</td>
<td>Richard Hollis and district staff</td>
</tr>
<tr>
<td><strong>District 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-Mar-03</td>
<td>District 2 provider training</td>
<td>Delmarva staff participated in District 2 training for providers</td>
</tr>
<tr>
<td><strong>District 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23-Jan-03</td>
<td>Quarterly Meeting with District Staff</td>
<td>Richard Hollis and district staff</td>
</tr>
<tr>
<td><strong>District 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-Feb-03</td>
<td>District Training staff meeting</td>
<td>Staff met with District Training staff regarding district-sponsored training and its relation to the monitoring tool.</td>
</tr>
<tr>
<td><strong>District 4</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31-Jan-03</td>
<td>Quarterly Meeting with District Staff</td>
<td>Richard Hollis and district staff</td>
</tr>
<tr>
<td>District 7</td>
<td>Quarterly Meeting</td>
<td>Marsha Napier and Carol McDuff met with three district staff. Reviewed and discussed changes in the PPR tool. Discussed possible agenda items for the Delmarva Training.</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>17-Mar-03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>District 8</td>
<td>Quarterly Meeting</td>
<td>Lydia Catalon, Michele Phelps, and Carol McDuff met with four staff. Reviewed and discussed changes in the PPR tool. Discussed possible agenda items for the Delmarva Training.</td>
</tr>
<tr>
<td>14-Mar-03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>District 9</td>
<td>Quarterly Meeting</td>
<td>Noeline Coore, Carol Taylor, Lydia Catalon, and Carol McDuff met with six district staff. Reviewed and discussed changes in the PPR tool. Discussed possible agenda items for the Delmarva Training.</td>
</tr>
<tr>
<td>31-Mar-03</td>
<td></td>
<td></td>
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<tr>
<td>District 10</td>
<td>Quarterly Meeting</td>
<td>Avril Wilson, Carol Taylor, Lydia Catalon, Anna Quintyne, and Carol McDuff met with district staff. Discussed both PPR and PCR processes. Provided clarification on PCR processes. Four district staff participated.</td>
</tr>
<tr>
<td>7-Jan-03</td>
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<tr>
<td>District 11</td>
<td>Quarterly Meeting</td>
<td>Jose Navarro, Lydia Catalon, Beth Townsend, and Carol McDuff met with six district staff. Reviewed and discussed changes in the PPR tool. Discussed possible agenda items for the Delmarva Training.</td>
</tr>
<tr>
<td>13-Mar-03</td>
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<tr>
<td>District 12</td>
<td>30-Jan-03</td>
<td><strong>Quarterly Meeting with District Staff</strong></td>
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<tr>
<td>District 13</td>
<td>10-Jan-03</td>
<td>Staff spoke to 35 members of FFRA (Family &amp; Friends of Retarded Adults) regarding the Personal Outcomes Measures and the Person Centered Review process</td>
</tr>
<tr>
<td>District 13</td>
<td>12-Mar-03</td>
<td>Inservice for ADEPT Support Coordination</td>
</tr>
<tr>
<td>District 13</td>
<td>25-Mar-03</td>
<td>DDPO Quality Assurance Team</td>
</tr>
<tr>
<td>District 14</td>
<td>21-Feb-03</td>
<td><strong>Quarterly Meeting</strong></td>
</tr>
<tr>
<td>District 14</td>
<td>17-Mar-03</td>
<td>District Discussion</td>
</tr>
<tr>
<td>District 15</td>
<td>12-Mar-03</td>
<td><strong>Quarterly Meeting</strong></td>
</tr>
<tr>
<td>District 15</td>
<td>12-Mar-03</td>
<td>Meeting with Dist. 15 Waiver Support Coordinator</td>
</tr>
<tr>
<td>District 23</td>
<td>Date</td>
<td>Event Type</td>
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<tr>
<td></td>
<td>22-Jan-03</td>
<td>District Discussion</td>
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<tr>
<td></td>
<td>28-Jan-03</td>
<td>District Discussion</td>
</tr>
<tr>
<td></td>
<td>18-Feb-03</td>
<td>Quarterly Meeting</td>
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<tr>
<td></td>
<td>13-Mar-03</td>
<td>District Discussion</td>
</tr>
<tr>
<td></td>
<td>20-Mar-03</td>
<td>WSC Training</td>
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<tr>
<td></td>
<td>21-Mar-03</td>
<td>District Discussion</td>
</tr>
</tbody>
</table>
The Organizational Review Board (ORB) met following the Interagency Quality Council meeting in February 2003 to review the status of project implementation activities, the level of review volume, and timelines for project deliverables, as well as to discuss internal quality assurance activities for the 3rd quarter. Representatives from Medstat, the Joint Commission on the Accreditation of Healthcare Organizations and The Council as well as Delmarva’s Senior Vice President and Chief Operating Officer, Tim Jones met with the Florida Management Team which included the Vice President for Florida Programs, the Director for Florida Operations, the Regional Managers, and Nurse Reviewer.

At the November ORB meeting, the Management team had been asked to develop recommendations for IQAP revisions to clarify and modify internal quality assurance components and processes to better reflect project operations. Staff identified a number of performance indicators related to review production, volume, and performance to be added to the on going internal quality improvement process. These indicators will be identified in the on going development and implementation of automated review status logs and tested through the remainder of Year 2. A systemic review and revision to the IQAP process will be completed during the 1st quarter of Year 3 and will include those indicators found to most effective and comprehensive in measuring performance.

The group discussed current internal quality assurance monitoring activities and identified specific areas of focus for the upcoming quarter.

The following provides a report of internal quality assurance activities that occurred during the January-March 2003 period.

**New Staff Orientation and training**

Two new person centered review full time staff and seven contract staff were hired during this quarter. The corporate office provided general orientation for full time staff. Project staff provided appropriate orientation for contract staff as well as program specific training related to the person-centered review process for all staff.

Comprehensive training in the use of the POM’s for Adults was provided to all new review staff by The Council staff. In addition to small group instruction, training included one-on-one modeling and coaching in the use of the POM tool with a final reliability assessment administered to determine competence to use the POM Interview. Additional coaching sessions were provided when deemed necessary. One of the full time review staff chose to terminate employment after the initial training. One additional contract staff person did not pass reliability. After consultation with Council staff, Delmarva chose not continue the contractual relationship with this individual. A total of seven additional reviewers reliable to complete the POM interview were added to the complement of PCR Review staff.
Additionally, the hiring process for a part time Medical Director was completed. In addition to a reintroduction to Delmarva policies and procedures (employee worked for Delmarva in a consulting capacity for other projects), a orientation to the Florida Statewide Quality Assurance Program was provided by project staff as well as training specific to the Medical Peer Review and internal quality assurance process.

**Person-centered Reviews**

**POM Monitoring and Annual Reliability**
The Council provides on site monitoring of 5% of all POM’s conducted annually. Council staff accompanies Reviewers on interviews and observes the administration of the POM’s. Monitoring is designed to ensure that reliability in conducting the POM interviews is maintained and as well as to provide on going technical assistance as needed. In addition to the interview coaching and reliability activities for new staff, The Council monitored 26 interviews with existing staff. Additional coaching was provided for three additional interviews conducted during this period and one additional reliability was completed for a reviewer.

Training and coaching in the use of the Personal Outcome Measures for Children and Youth was provided to three staff (2 reviewers and 1 Regional Manager) who had been trained and found reliable in the assessment process for adults in November 2002. Subsequently, reliability reviews were successfully completed for these three staff in the Children and Youth Assessment process.

**Annual Gold Standard Reviews**
100% of the person–centered review reports continued to be reviewed by the Regional Managers though the 3rd quarter and has replaced the use of scenarios until a sampling of reviews is implemented. Regional Manager review and approval of all reports will continue for the remainder of the contract year to ensure accuracy and consistency in the identification and development of recommendations. The process of report review and approval includes individual follow up and consultation with the reviewer as well as periodic checks with selected waiver support coordinators to verify information and recommendations.

**Consumer and Family Feedback**
The AHCA Beneficiary Feedback Survey has been implemented by AHCA and information is provided to project staff related to the responses. No formal education and training sessions were conducted during the third quarter.

**Provider Performance Reviews**

**Q & A document and protocol update**
During this reporting period, revisions to the PPR tool and laptop application were implemented. These revisions were based on changes made to the service requirements included DD Medicaid Waiver Services handbook. While most of these changes were included in the training provided during the November 2002 training session, the biweekly conference calls were expanded to include additional discussion of the new requirements, implementation issues and questions related to interpretation. Staff from the Developmental
Disabilities program participated in the calls, when appropriate, to provide specialized training. Minutes of these meetings were provided to all review staff and include Q&A’s.

**Scoring and documentation analysis**
For the 3rd quarter, Regional Managers reviewed and approved 100% of the Provider Performance Reviews. On going feedback was provided as necessary. On going review by the Regional Managers provided a mechanism to ensure that the tool revisions were being appropriately interpreted and scored as well as being correctly recorded in the new laptop application.

**Rater reliability testing**
Formal rater reliability for on site reviews was completed during this quarter for all (9) Provider Performance Review staff. The primary focus of this second rater-reliability evaluation was to determine if the QAR’s were implementing the review process as designed and to offer a comparative study of the last year monitoring results as well as define future training needs. Areas being evaluated included:
- Pre-review activity
- Active listening skills
- Interviewing skills
- Observation skills
- Communication skills
- Implementation of the review agenda
- Level of interaction between the Reviewer and provider/staff
- Sample selection process for consumer records
- Documentation and record review approach
- Opening and exit conference content and approach
- Ability to review all applicable elements of performance in the allotted time
- Use of protocols
- Interpretation of elements of performance
- Observation of joint commissions corporate values
- Appropriate designation selection and rationale based on investigation results

This year the pre-review activity was added as an evaluation element. Reviewers were expected to contact the district offices for information on incidents and grievances, as well as any issues or concerns. Reviewers are also required to review information from person-centered reviews to incorporate in their findings.

The Quality Assurance Coordinator (QAC) accompanied each QAR to an onsite provider performance review. The QAC attended all interview activities, reviewed documentation, followed facility tours, and listened to discussions with consumers and others who contributed data to the review. The QAC was not an active participant in the review. The QAC reviewed all PCR/PPR reports on the Delmarva website for each provider that was being reviewed. The QAR offered information on grievances, incidents or any issues/concerns presented by the district. The QAR also discussed PCR results or outstanding issues from the provider’s last review.
Each Provider Performance Review QAR was rated on each evaluation element using a four tier scale: EE = Exceeds Expectations, ME = Meets Expectations, NI = Needs improvement, NA = Not Applicable. The NA designation was used when the QAC was not present for the entire duration of the review or could not fully evaluate performance.

Quality Assurance Reviewers generally met or exceeded expectations. All Reviewers demonstrated a high degree of professionalism and were courteous throughout the review. The majority of the Reviewers met expectations for completing district contacts and reviewing the PCR reports for the provider. The information was used in discussions with the provider either directly or indirectly to capture results of PCR recommendations. One Reviewer exceeded expectations by contacting the Person centered reviewer and support coordinator to discuss findings and recommendations of the PCR report.

More than half of the Reviewers exceeded expectations on communication skills, observation of JCAHO/JCR corporate values during review, and appropriate designation selection and rationale based on investigation results. Reviewers were pleasant, friendly, punctual and professional, and respected the provider’s opinion throughout the review. They were open/receptive to the provider’s request for reconsideration. Reviewers used good judgment and rationale to score the elements of performance.

During the previous reviewer rater-reliability evaluation, the area noted that needed significant reinforcement related to engaging the providers in the review of documentation. During this review of QARs, it was observed that Reviewers continue to read through documents and search for information needed to score the element. While familiarity with the provider’s documents from the previous years review allowed the Reviewer to identify areas of compliance more rapidly, the Reviewers would frequently request information from the provider if they were unable to easily locate the needed information. This practice is appropriate, as the revised scoring criteria requires Reviewers to evaluate the actual implementation of policies and procedures.

Areas of concern noted this year include the opening/exit conferences and the sample selection process for consumers. Reviewers are not consistently starting their reviews with an opening conference and discussing the review agenda. During the exit conferences, the areas requiring improvement are discussed with the provider but the exact element by number is not always given to the provider. QAR’s are not consistently giving the provider an opportunity to select a sample record for review.

**Recommendations**

- Regional managers will review each QAR’s performance, provide copies of their evaluations and provide training as needed.
- Two Reviewers will receive another reliability monitoring and training.
- PPR conference call trainings will address the following areas:
  - Opening/Exit conferences
  - Sample selection process for consumers
  - Interactive documentation review
  - Best practices.
  - Follow up requirements.
## Provider Performance Review
### QAR Rater Reliability Monitoring Results
#### Second Quarter, 2003

<table>
<thead>
<tr>
<th>Evaluation Element</th>
<th>QAR Performance Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EE</td>
</tr>
<tr>
<td>1. Pre-review activity</td>
<td>1</td>
</tr>
<tr>
<td>2. Active Listening skills</td>
<td>3</td>
</tr>
<tr>
<td>3. Interviewing skills</td>
<td>3</td>
</tr>
<tr>
<td>4. Observation skills</td>
<td>2</td>
</tr>
<tr>
<td>5. Communication skills</td>
<td>6</td>
</tr>
<tr>
<td>6. Implementation of the review agenda (covered all)</td>
<td>1</td>
</tr>
<tr>
<td>7. Level of interaction between reviewer and provider/staff</td>
<td></td>
</tr>
<tr>
<td>8. Sample selection process for consumer records</td>
<td></td>
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<tr>
<td>9. Document and record review approach (provider engagement in activity)</td>
<td>1</td>
</tr>
<tr>
<td>10. Opening conference content and approach</td>
<td>2</td>
</tr>
<tr>
<td>11. Exit conference content and approach</td>
<td></td>
</tr>
<tr>
<td>12. Ability to review all applicable elements of performance in the allotted time</td>
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<tr>
<td>13. Use of protocols</td>
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<tr>
<td>14. Interpretation of elements of performance (over/under interpretation)</td>
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</tr>
<tr>
<td>15. Observation of Joint Commission corporate values (quality, respect, integrity,</td>
<td>5</td>
</tr>
<tr>
<td>courtesy, teamwork, recognition, improvement, empowerment, responsiveness) during</td>
<td></td>
</tr>
<tr>
<td>review</td>
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<tr>
<td>16. Appropriate designation selection (Met, Not Met, Not Applicable) and rationale</td>
<td>8</td>
</tr>
</tbody>
</table>

*Observer not present for the entire duration of the review and could not fully evaluate performance.*
Reliability of Desk Reviews
Reliability of desk reviews will be completed during the 4th quarter.

Medical Peer Review
The Medical Director completed 10 quality assurance reviews of completed medical peer reviews. No issues or recommendations were noted.

Reconsiderations
Nine reconsideration requests were processed during this quarter. One Regional Manager has assumed responsibility for this activity. During this quarter, reviews of selected reconsideration requests were conducted by the Director of Florida Operations. No discrepancies or issues were noted.

Evaluation of Provider/consumer education
No formal education programs were provided during the 2nd quarter.

Timeliness and Submission of Deliverables
Delmarva and its program partners are continuing to develop internal management systems to ensure that required timelines for conducting reviews are being met and that review data is being gathered in a format that can be analyzed in an aggregate form. Delmarva management will work with its auditors and the subcontractor Garcia and Ortiz, to complete provider compliance audit during the 1st quarter of Year 3.