Florida Statewide Quality Assurance Program

Annual Report
Contract Year 4
July 2004 – June 2005

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Executive Summary

The efforts of Delmarva Foundation and its partners in the Florida Statewide Quality Assurance Program (FSQAP) focused on new and ongoing initiatives over Year Four of the contract. The year began with the implementation of two new review processes and ended with a four year contract renewal with AHCA. Delmarva managers, AHCA and APD worked collaboratively to produce a smooth transition into the new review processes that had been developed in Year Three, The Waiver Support Coordination Consultation (WiSCC) and Collaborative Outcomes Review Evaluation (CORE). In the face of expected delays due to the start up of new procedures, the state was struck by one tropical storm and four hurricanes, seriously impacting the volume of activity for several months. However, in spite of these challenges, Quality Improvement Consultants completed a complement of reviews/consultations within the contracted range for all with the exception of a few follow up reviews. Delmarva increased the number of training/education sessions offered and technical assistance was provided to providers as needed/requested.

In addition to the implementation of the new processes, another major achievement this year was the development of a new Public Reporting website. A workgroup consisting of representatives of relevant agencies, families and individuals worked together to determine the purpose, intended audience, format, and content of the website. Information on provider demographics and some provider performance measures are currently available on the web page. While many ideas were too “grand” for the time and budget constraints faced this year, the workgroup will continue to meet to help determine the future direction of the website (www.flldresource.com).

Delmarva continues to reach out across the state with training sessions and various types of presentations and contacts with the community. Overall, approximately 1,438 people within the state of Florida attended some type of face to face presentation/training session with Delmarva this past year. The sessions were conducted in each area of the state. Delmarva also made presentations and conducted training at four statewide conferences, including FASC, ARC Florida, Florida ARF, and Family Café. Delmarva staff teamed with APD on two presentations at the national Home and Community Based Services Conference in May 2005. Finally, close to 2,000 calls were made to the Delmarva customer service representative in the Tampa office.

Six web-based training modules were developed this year to enhance Delmarva’s ability to reach as many individuals, families and providers as possible. These are available on the Delmarva web site and are:

- Desk Review Process
- Recognizing and Reporting Abuse
- An Introduction to Implementation Planning
- Results Focused Reviews/Overview of CORE and WiSCC
• Why Do I Want a Medication Review?
• Empowerment: Locating, Hiring and Replacing Your Provider

The Support Plan developed for individuals on the Waiver has evolved into two separate purposes that seem to be in conflict with one another. Therefore, a Support Plan Stakeholder Group was established to analyze the effectiveness of the current Support Plan (SP) tool as it relates to the two primary functions: depicting that which accurately reflects the life situation and needs/wishes of individuals receiving services under the HCBS DD Waiver program (Person Driven Planning), and justifying financial requests via medical necessity to assist individuals to adequately address these needs/wishes (Prior Service Authorization). The group will continue to meet in Year Five to help develop a new Support Plan process.

Quality Improvement Consultants completed close to 650 CORE consults and over 430 WiSCCs. As part of the WiSCC process 662 Waiver Support Coordinators and close to 1,400 individuals were interviewed. The new processes evaluate the providers as Achieving, Implementing, Emerging or Not Emerging on elements that are outcome oriented—ensuring the provider has systems in place and that those systems reach all the individuals they serve to help them achieve desired outcomes. The average evaluations on each process were Emerging to Implementing. Each process also scores the providers on certain “process” elements such as determining if they have the proper training and background screening. Most providers have done relatively well on these, as they are similar to the processes on which they were reviewed for the previous three years.

Personal Outcome Measure Interviews were completed on approximately 1,400 individuals in the program during Year Four, an accumulation of over 8,000 interviews since the inception of the project in September 2001. With the new consultative approaches, all providers are encouraged to develop and implement systems that generate results for the people they serve. These new processes also provide information vital to targeting root causes for declining attainment of outcomes and supports, and forming the basis of corrective measures. While it is too early to draw any direct correlations, the outcomes in the lives of individuals being served appear to have stopped decreasing, a trend we had witnessed over the first three years of this project.

Over 41 percent of the individuals evaluated during the current year had 13 or more outcomes Met, and over 46 percent had 13 or more supports Present. This reflects a slight increase since the previous year, after three years of decline. A comparison of the percentage of outcomes Met and supports Present by individual POM item for the first three years of the contract indicates a significant downward trend in the percentages Met or Present, but a leveling off in Year Four. Only one, performs different social roles, showed any substantial decrease. The top five POM items for which the Outcome is most frequently Met and the Support is Present remained fairly consistent from Year One to Year Four as did the five POM items most frequently Not Met or Present. In addition, the percent of individuals with all the foundational outcomes met has increased to 8.5 percent from 6.6 percent in Year Three.
In addition to the WiSCC, CORE and POM interviews, QICs conducted 1,247 Desk Reviews during Year Four. The average statewide score for Desk Reviews was 77 percent. This is an increase from the average score in Year One of 72 percent but no change since Year Two. For the agency providers, the average score has decreased from over 79 percent to approximately 73 percent from Year One to Year Four. The opposite trend has occurred for solo providers where the average score has improved from 71 percent to close to 79 percent over the same time period.

Quality improvement initiatives continue to be a focus for the project. Over three years, the FSQAP has compiled data from over 20,000 individual review activities to support and identify directions for quality improvement initiatives and improved strategies and approaches for supports and services. A work group was established in Year Three that culminated in a report format for quarterly distribution of data reports, based on specific area needs. These reports were updated in Year Four to reflect results from the new review processes, and continue to provide each Area Case Management Team information on individuals identified with high risk drug profiles who require medication monitoring.

Five Quality Improvement Studies were also completed during the fourth contract year:

1. Public Reporting Website Development: Current Initiatives and Developments
2. Personal Outcome Measures: Reason Supports are Not Present
3. Consumer-Directed Care Plus (CDC+) Outcomes and Supports Analysis
   Comparison of DD HCBS and CDC+:
4. CORE Element Level Comparison to Provider Performance Reviews
5. Outcome Results Analysis: Best Predictors of Percent of Outcomes Met

As result of the data analysis presented in this report, Delmarva presents the following recommendations:

1. A workgroup representing all relevant parties should examine the Desk Review process and suggest modifications where appropriate. The Quality Improvement Study examining the Desk Review results at the element level that was completed in Year Three should be used to guide the process of determining elements that need greater focus. Incorporating the outcome-based focus and elements of CORE, as/if possible, may help to enhance the process. Also, a deeper analysis may help determine which elements are most frequently cited for recoupment and if that has changed over the years.

2. It was noted that a possible reason that agency providers do not always perform as well as solo providers is the challenge they may have meeting the requirements for multiple employees and services, and managing turnover. It is recommended that this challenge be explored. Perhaps the Area Quality Leaders (AQL) could help design a system that could enhance agency performance, particularly in areas that reflect adherence to required procedures such as training and background screening, as measured with the Minimum Service Requirement (MSR) elements.
3. It is not clear why WSCs perform better on background screening than other providers, whether solo or agency. Further exploration into this phenomenon could be helpful. Practices routinely performed by WSCs may help providers of other services who are reviewed onsite.

4. Results reflect a consistency between the two tools (CORE and WiSCC), as the systems reviewed overlap, affecting all the individuals being served. As more data become available, continued review of the connection between the two processes is recommended.

5. Follow-up review results are encouraging and support the continued development of a strong on-site follow-up and technical assistance program. Efforts should continue to identify areas most helpful to providers for the follow-up process. Providers who continue to receive a Not Met on elements should be monitored the following year and referred to the district if needed.

6. A study should be completed that examines the effect of any new processes on outcomes and supports. In this study, a longitudinal review of the impact of “external” factors is essential. For example, a new Service Authorization process is beginning in Year Five and it is not known how this may impact results on the POM outcomes and supports. A review of factors such as this over the past few years should help determine how individuals’ lives are impacted by changes in provider rates, service authorization requirements, or other relevant administrative or legislative actions.

7. Delmarva and APD should closely monitor the outcomes for people living in large group homes and explore the extent to which the decline in outcomes since Year Three may be a result of recent policy/program changes or other factors within our power to address/impact.

8. Complete a Quality Improvement Study that focuses on the longitudinal data. This study should be completed in Year Five of the contract and include Time Series Analysis as well as comparisons to the POM data collected from different individuals each year (the annual POM sample).

9. Complete a Quality Improvement Study on the barriers to service as identified through the WiSCC process. This study should have both a quantitative and qualitative component. While analysis of the data collected by the Quality Improvement Consultants (QIC) is important, focus group discussions organized across the state would help further identify barriers at the local level. These groups should include the AQLs or other relevant APD representatives.

10. Delmarva should work with APD and the AQLs to examine the reports currently provided to each area. Changes should be made based upon the usefulness and clarity of the information.

As the FSQAP moves into its fifth year, revisions and enhancements to the new quality improvement processes and protocols are anticipated. Delmarva will continue to work closely with AHCA and APD to help establish the best process in order to achieve a DD system where individuals’ needs and desires are the focus. Five or six more Quality Improvement studies will be completed to help identify needs and target areas of concern.
Introduction

This is the annual report for Year Four of the Florida Statewide Quality Assurance Program (FSQAP) contract, July 2004 – June 2005. Information in this report includes fourth quarter activity reports as well as a review of the project across the year. The report is divided into three sections. The first section, **Summary of Quarterly and Annual Project Compliance Activities**, presents information relevant to compliance with contract issues during the fourth quarter of the contract year. In this section we detail the activities and accomplishments of the Delmarva Staff and their partners, including:

- Contract Renewal;
- Implementation of New Consultation Processes;
- Liaison and Education Activities;
- Internal Quality Assurance Initiatives;
- External Communication Modalities;
- Summary of Customer Service Activity;
- Quality Improvement Initiatives.

The second section, **Data Analysis and Results**, provides analysis and interpretation of the data collected from July 2004 through June 2005, including some annual trends since July 2001 when possible. Data are presented to provide AHCA and APD with information they may utilize to enhance the services provided to the DD population. This section includes:

- Desk Reviews
- CORE Evaluations
- Projected Service Outcomes
- WiSCC Evaluations
- Personal Outcome Measures (POM) Interview Sample Description
- Personal Outcome Measures Volume and Results
- Medical Peer Review Findings

The third section, **Discussion of Findings and Recommendations**, provides a brief summary of the contract activities, interpretation of results and recommendations based on a review of the data and activities for the year.
Section One: Summary of Quarterly and Annual Project Compliance Activities

The final year of the first contract period included a variety of changes and challenges. The year started with the implementation of two new review/consultation processes, the Collaborative Outcomes Review Evaluation (CORE) and Waiver Support Coordination Consultation (WiSCC). Issues related to the “start-up” of any new procedure causes some delays in production. As the same time, Florida was struck by four hurricanes and one tropical storm, causing massive damage throughout the state and further delays in the ability of the Quality Improvement Coordinators (QIC) to contact and interview providers or consumers. However, Delmarva staff achieved a volume of reviews/consultations within the required range for each review process by year’s end, with the exception of a few follow up reviews.

In addition to the new processes and weather challenges, Delmarva managed a variety of other accomplishments during the past year. Several managers from Delmarva worked with an eclectic group to develop and implement a new Public Reporting website where consumers and their families can search for providers across the state. The site provides a variety of provider demographic information as well as some basic performance evaluation measures. Delmarva staff collaborated with APD on two different presentations for the National Home and Community Based Services conference. A Stakeholder group was brought together to begin development of a new Support Plan process that will better serve the needs of consumers and providers alike. The District Quarterly Reports were revised to reflect the new CORE and WiSCC results and five Quality Improvement Studies were submitted to AHCA and APD. These and other project activities during Year Four are summarized in the following sections.

Contract Renewal

During the fourth contract year, AHCA contracted with Florida State University’s Center for Health Equity to conduct an independent review of Delmarva Foundation (FSQAP) to assess the quality of work and overall opinion of services provided by Delmarva as part of their contract requirements.¹ Surveys were emailed to a variety of IQC members, as well as Delmarva, AHCA and APD employees. It was recommended in the final report that Delmarva continue the FSQAP contract with AHCA for an additional four years. The initial four-year contract was amended in June 2005 to renew the contract for another four years, following the same format and scope of work.

Implementation of New Consultation Processes for Onsite Reviews

¹ June 30, 2004. The Center for Health Equity, Florida State University. Anita Zervigon-Hakes, PhD, Project Director, Donna Barber, RN, MPH, Medical Director.
Analysis of data from the first two years of the project reflected a disparity between the monitoring process results for providers and the outcomes present in the lives of individuals served by the program. While providers seemed to consistently improve their performance, individuals were showing a steady decline on measures identifying the quality of outcomes in their life. The Provider Performance Review (PPR) process originally used to monitor providers focused on the processes, procedures and licensure requirements needed to be eligible to provide DD Waiver services. As providers were monitored on this tool, they increased their ability to document training and other procedural requirements. However, this improvement did not appear to translate to a better life for the individuals they served as the Personal Outcome Measures used to determine the quality of life for individuals slowly declined.

New review processes were developed that are outcome and person-centered oriented, with a shift from a “review” to a “consultative” approach: Waiver Support Coordination Consultation (WiSCC) and the Collaborative Outcome Review and Enhancement (CORE). The Quality Improvement Consultants were trained on the new processes and began implementing them in August 2004. The development and implementation of these tools is detailed in other reports and studies submitted to AHCA.2

The Waiver Support Coordination Consultation (WiSCC) was developed to blend the PPR and PCR activities, thus generating a more efficient and outcome oriented approach to review the work performed by Waiver Support Coordinators. As the procedures were developed through a stakeholder work group, a consultative approach to the review process emerged. The Personal Outcome Measures (POM) interview and the Medical Peer Review components of the former Person-centered Review were complemented with the addition of the new WiSCC review tool containing 11 elements. Six elements focus on outcomes or the degree to which Waiver Support Coordinators are addressing needs and supports that produce results that are important to the individual. Five elements, identified as key process elements or Minimum Service Requirements (MSRs), measure compliance with basic waiver requirements that are process oriented.

As part of the WiSCC, a Focused Plan is developed with the Waiver Support Coordinator and a follow up consultation is scheduled to review progress. The purpose of the Focus Plan is for WSCs to identify areas they would like to improve as related to their supports and services. It is also developed to keep the WSC’s momentum going as related to assisting individuals achieve the results that matter most to them.

While no additional funding was appropriated to specifically target changes to other Onsite review processes (Adult Day Training, Non-Residential Support Services, Residential Habilitation, Supported Employment and Supported Living), the project implementation team felt this was important to address, giving all Onsite service reviews an outcomes-based focus. Therefore, in addition to the development of the Waiver Support Coordination Consultation review process, in cooperation with APD and AHCA as well as others in the stakeholder group, the project team undertook the development of a new review process for the other waiver services reviewed on site. This new review

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2 See the first three quarterly reports submitted to AHCA for Year Four of the contract.
process, the Collaborative Outcome Review and Enhancement (CORE), shifted evaluation of the providers from a largely compliance-based process to one that is results oriented, based on the needs and goals of the individuals being served. One review tool is used to review all services subject to an Onsite review. The tool contains 25 elements. The first 18 elements relate directly to outcome-oriented areas, while the additional seven are the Minimum Service Requirements (MSR) are used to examine critical waiver process elements similar to the WiSCC. The outcome elements relate to one of the following affiliations: Rights, Choice, Community, Health and Safety, Person Centered Approach and Communication. Based upon the provider’s overall determination at the time of the closing, the consultant will identify any necessary follow up activity.

Both the WiSCC and CORE processes were designed with a consultative approach in order to create an environment conducive to learning. Providers are encouraged within this process to develop systems that generate results for the people they serve. Some revisions and “fine-tuning” have occurred over this first year, and other modifications will be adopted as appropriate and approved by AHCA and APD.

**Liaison and Education Activities**

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

- Presentation/Training Sessions
- Stakeholder Workgroups
- On Line Training Modules

**Presentation/Training Sessions**

Overall, approximately 1,438 people within the state of Florida attended some type of face to face presentation/training session with Delmarva. The sessions were conducted in each Area of the state. Delmarva also made presentations and conducted training at four statewide conferences, including FASC, ARC Florida, Florida ARF, and Family Café. Several training sessions were conducted at the beginning of the year to provide information to providers, district personnel, individuals and other interested parties relating to the two new consultative processes, CORE and WiSCC. Other types of training sessions included information on the Implementation Plan process, My Personal Compass, Psychotropic Medications, Desk Review Process, and Medical Information Gathering.

The following bar graph demonstrates the number of people trained each month. Months with the highest number of training sessions were conducted in August 2004 and June 2005.
Website Resources and On-Line Training Modules
Delmarva expanded its current public web site (www.dfmc-florida.org) to include additional links that may be of interest and importance to anyone visiting the site. New information related to CORE and WiSCC was added, including the tools, policy and procedures, and provider survey. Continuing features include copies of the Provider Performance Review (PPR) tools, training announcements, IQC information, My Personal Compass and approved reports.

The Upcoming Training Information on the website includes a link for users to access the on-line training modules. In the last year, the project staff worked with an experienced instructional designer to develop six web-based training modules that were all available through the Resource Center by June 30, 2004. All of the modules were reviewed by several content experts and coordinated with APD. Each course includes a test for the user to complete. The new On-Line training modules include the following:

1. A module for providers of HCBS waiver services who are required to complete a Desk Review. This was identified as a need due to the low PPR scores these providers were receiving as a result of their Desk Review. A one hour training session informs providers about the documentation requirements, timelines, and review.
2. Recognizing and Reporting Abuse is a one hour course informing individuals and family members about abuse, including how to recognize it and what to do if

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3 The sixth is in the final stages of approval and expected to be available by September 30, 2005.
someone suspects a person is the victim of abuse. After completing this course, participants should be able to describe different types of abuse, how to recognize possible abuse, and how to report abuse.

3. An *Introduction to Implementation Planning* was developed due to evidence that providers continue to have challenges in this area. This two hour course provides information on the use of a person centered approach, implementation plan process and development.

4. *Results Focused Reviews/Overview of CORE and WiSCC* was developed to inform individuals, providers and other stakeholders about the why and how of the exciting new changes in Delmarva’s review processes. The one hour course provides information that is helpful to providers who have not yet experienced a CORE or WiSCC consultation, with some guidance on the expectations of the processes.

5. *Why Do I Want a Medication Review* targets individuals and their families. The one hour session is designed to familiarize individuals, families and professionals with the Medication Review Service available to individuals with developmental disabilities who are served by the Medicaid Home and Community Based Waiver Program.

6. *Empowerment: Locating, Hiring and Replacing Your Provider* is the training module that has not yet been posted on the website due to the extensive feedback from stakeholders and suggested revisions. It is in the final stages of approval and is expected to be posted in September 2005. Designed to provide strategies and approaches centered on assisting people in developing an independent, self-directed life, the focus is on supports and services required to obtain desired goals and specific needs. Tools are provided that can be used to assist individuals in defining their goals and needs and using this information to determine the supports and services required to meet them. It includes information related to natural supports and an individual’s circle of support. Information is also provided on how to hire and replace paid supports. This training is estimated to take approximately two hours.

All of the On Line Training Modules identify target audiences; however, it does not limit anyone from taking any of the training sessions. Anyone can utilize these training modules.

**Stakeholder Workgroups**

The facilitation and support of two stakeholder groups was also a component of the expanded education and training activities during Year Four. The purpose of the Support Plan Stakeholder Group in Year 4 was to analyze the effectiveness of the current Support Plan (SP) tool as it relates to two primary functions: depicting that which accurately reflects the life situation and needs/desires of individuals receiving services under the HCBS Medicaid Waiver program (Person Driven Planning), and justifying financial requests via medical necessity to assist individuals to adequately address these needs/desires (Prior Service Authorization). A second Support Plan Stakeholder Group in Year Five will then make specific recommendations to APD directed towards improving the functionality of the Support Plan Tool and Support Planning processes, as
well as assisting APD in establishing a corresponding training curriculum for those charged with developing and utilizing Support Plans.

The primary conclusion from the Year Four workgroup was that the Support Plan cannot be both a reflection of that which is important to individuals and at the same time used as a primary source of information to justify Prior Service Authorization requirements. Several recommendations were made for the Year Five Support Plan Stakeholder Group to address:

1) Define the information that is needed to make Prior Service Authorization decisions, and capture this information in a Justification Checklist or Assessment Tool that is independent of the Support Plan.
2) Once this function is removed from the Support Plan, re-evaluate the components of the Support Plan and explore the other ideas put forth by the group.
3) Where there is overlap in information between the Justification Checklist and Support Plan, look for electronic efficiencies such that information does not need to be entered twice.
4) Explore the option of reducing the need to resubmit the same justifying information each year such that paperwork and workload can be reduced.
5) Evaluate APS’s Care Connection tool and blend the content with recommendations from this group.
7) Create a training curriculum for the entire Support Planning process, including topics such as: information gathering, conducting an effective person driven Support Plan meeting, utilizing the new Support Plan tool, and developing a truly fluid person driven planning tool.

Over the course of the first three years of Delmarva Foundation’s work in the Florida Statewide Quality Assurance Program, a key observation was made. Though many stakeholders within local communities were committed to assisting individuals with developmental disabilities to receive services, there was no clear and effective system for the different groups to work together as a team to generate desired results. Therefore, the District 14 Stakeholder Group was developed to address that specific issue, by bringing people together and facilitating the communication that would eventually lead to collaboration and cooperation. This group was additionally designed to get people up to speed on Delmarva’s activities and findings such that they could be knowledgeable regarding the status of service delivery within their community. With data and findings staring stakeholders in the face, the lingering question became, “Where do we go from here?” This District 14 Stakeholder Group was able to define the challenges and barriers that confront them, and to take an active role in identifying and implementing relevant solutions. The hope is that this group can be a source of information and support to the new Steering Committee in District 14 and keep the momentum going. Delmarva will gradually remove itself from the group, though it is recommended that other participants continue in their efforts as long as they maintain their passion and continue to be a positive force in District 14.
Internal Quality Assurance Initiatives

CORE/WiSCC Training
Consultants and other Delmarva managers attended a five day training session in August of 2004 to learn the CORE and WiSCC procedures. The training consisted of the review of the new processes and procedures as well as instruction on how to utilize a consultative approach in the implementation of the new processes and organizing principles developed by the Council on Quality and Leadership (CQL). Performance improvement and quality improvement models were shared with the consultants. The Joint Commission Resources (JCR) consultants also received training related to the Personal Outcome Measures and interviewing skills developed by CQL.

Education/Training
Delmarva Foundation’s efforts to ensure a high standard of performance included numerous internal training and quality assurance activities.4 A method of training utilized the consultant conference calls that were conducted either on a weekly or bi-weekly basis. WiSCC conference calls were conducted approximately weekly up through April 2005 and biweekly thereafter. CORE conference calls were biweekly on a fairly consistent basis. During these conference calls, consultants are provided with additional information related to the processes and, if necessary, clarification on different components. Formal scenarios are periodically discussed with the consultants after they have had a chance to review them and determine findings. These discussions focus on the key decision making criteria for each element and are designed to improve the reliability of the consultants using each tool. Another key component of the conference calls is sharing of experiences by the consultants, such as best practices they have observed so these can potentially be shared with other providers. These bi-weekly conference calls ensured that consultants received consistent information regarding procedures, interpretations, and system updates. Managers reinforce and supplement this information through telephone and face-to-face contact with the QICs. Policy clarification and interpretation supplements the information provided during the conference calls, when appropriate.

Three formal education sessions were conducted via conference call with the consultants. The first formal training session was conducted by Steve Dunaway of APD for both the CORE and WiSCC consultants and focused on the Data Sets. The second and third formal training sessions were conducted with the CORE and the WiSCC QICs and focused on each procedure’s processes and goals. These sessions were used to fine tune the CORE focus and help develop more consistency among the consultants.

Reliability Assurances

4 While activities for the year are summarized here, a more complete description is included in Appendix 3, the Internal Quality Assurance Program document.
Reliability for WiSCC QICs was maintained through The Council on Quality and Leadership (CQL). This occurred formally through the annual reliability process and through on site monitoring of five percent of the reviews throughout the year. Annual reliability was conducted in the use of the POM for adults and for Children/Youth. All PCR reviewers maintained their reliability throughout Year Four. Two of the consultants (Christie Gentry and Susan DeBeaugrine) were certified in Child/Youth reliability and two of the Regional Managers (Marion Olivier-Ruelas and Claudia Kassack) became certified to interview Adults. During Year Four, mid year evaluations were conducted with each of the WiSCC consultants in December 2004. The WiSCC Observation Feedback form, designed to include a review of the skills needed to conduct the WiSCC consultation, was developed for this purpose, covering relevant areas related to the consultative process.

In the past year, reliability activities for the CORE process mainly consisted of the Regional Managers’ observation of the consultant conducting a consultation. The Regional Manager accompanied a consultant to an onsite visit, attending all onsite activities. The Quality Assurance Coordinator (QAC), Anna Quintyne also observed the monitoring activities for some of the consultants. Scenarios, as discussed above, were used to help establish reliability on an element by element basis.

Reliability activities were also conducted for the Provider Performance Review process for Desk Reviews. Anna Quintyne chose random samples of five desk reviews for each consultant. The results demonstrated that the overall score for Desired Documentation/Contents of the report was 99% with eleven Reviewers receiving 100% on eight of the elements. Under the Elements of Performance category, the overall score was 93% with eleven Reviewers receiving 100% on four of the elements. The overall score for the Narrative Summary category was 98% with eleven Reviewers receiving 100% on two of the elements. The consultants were provided with feedback on their performance after the review and received information on the review process and interpretation of the elements of performance.

Manager Review
Delmarva Foundation managers continued to review and approve 100% of all WiSCC, CORE and PPR Desk Review reports prior to their distribution. Direct feedback was provided to individual QICs as questions or concerns were identified, and more general concerns were addressed on the bi-weekly conference calls. Another internal system related to this area was the Medical Peer Review system. Linda Tupper, the Nurse Reviewer, has the opportunity to correct any errors or issues identified with the content or data included in the report.

Weekly Manager Meetings
Delmarva managers meet weekly to discuss any new or on going issues related to the FSQAP. IT staff participate in each call, enhancing communications between managers and staff in Easton who provide vital technical and database management support.
Staff Changes
To continue to meet the ongoing contract requirements as well as implement the Year Four initiatives, several personnel changes occurred over the past year. Several new WiSCC Quality Improvement Consultants (QIC) and CORE consultants were hired as full time employees:

- Donale Cochran and Cheryl King were hired to help conduct consults in Area 7;
- Berta Santos was hired for Area 11;
- Christy Gentry, contract staff, was hired as a WiSCC QIC;
- Carole von Rossum (contract staff) continued to conduct WiSCCs throughout the year;
- JCR Inc. hired Mario Arreaga as a CORE consultant for Area 11 to replace Lydia Catalan;
- Delmarva hired Eskaria Cowart to replace Nilda Barreto in Area 2;
- Claudia Kassack, regional manager, left her position at Delmarva and is expected to be replaced internally in the early part of Year Five.

With the implementation of the CORE and WiSCC processes, and due to their similar approaches and components, a QIC was hired to conduct both processes in Area 8. Krista McCracken was hired part-time by both JCR, Inc. and Delmarva. Susan deBeaugrine, in Area 2, remained employed on a PRN basis with Delmarva.

Marcia Hill also left the project as the Vice President of Florida Operations in Year Four, but will remain available to contract with the project when needed. Bob Foley was then promoted to Director of Florida Programs. Another Regional Manager position will be developed rather than filling the Director of Florida Operations position Bob Foley previously held.

Area (District) Quarterly Reports
In Year Three of the contract, Delmarva worked with state and area level APD representatives and Medstat to produce data reports for each area. The intent was to provide information APD area staff could utilize to monitor their providers and target areas needing improvement. In Year Four these reports were modified to reflect the new review processes. They continue to be distributed on a quarterly basis.

External Communication Modalities
In this last year, Delmarva Foundation continued to ensure that Florida stakeholders had the ability to stay current with FSQAP activities, procedures, and findings. Through a variety of efforts, including the utilization of meetings, training sessions, letters, report distribution, web-based technology, and general customer service availability, Delmarva Foundation has established a variety of mechanisms for information distribution.\(^5\)

Interagency Quality Council

\(^5\) See Appendix 1, Attachment 6 for a list of activities.
Three quarterly meetings with the Interagency Quality Council (IQC) were held in a variety of locations throughout Florida in Year Four, and Delmarva Foundation was an active participant and presenter at each of these meetings. During two of the IQC meetings, consultants for both the CORE and WiSCC participated in panel discussions to share their experiences in implementing the new processes. They reported on some preliminary findings, barriers and best practices. While sharing of quarterly data provided a cornerstone for these meetings, the IQC also served as a key forum for sharing and developing future FSQAP initiatives. For example, during the March 2005 meeting, a provider suggested that an On-Line Training module be developed which addresses professional standards to use by direct care staff and this training module will be developed in Year Five.

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

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

Other Presentations/Meetings
Delmarva and APD joined to deliver two different presentations at the national annual meeting—Home and Community Based Waiver Conference (Orlando, Florida). Bob Foley, Sue Kelly and representatives of APD presented on Florida’s Quality Improvement Initiative, system change from process to an outcome based focus, discussing the new consultative and outcome oriented processes. Marion Olivier-Ruelas, Carol McDuff and APD representatives presented on the development of quality improvement verses quality assurance processes including a discussion of key components of the CORE and WiSCC processes.

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

**Summary of Customer Service Activity**

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

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

During Year Four, a team including the Customer Service Specialist, Managers, and other support staff handled 1,954 contacts during the twelve month period ending June 30, 2005. This is down from 2,590 in Year Three and 2,009 in Year Two. The following table lists the contacts for Year Four by quarter.

<table>
<thead>
<tr>
<th>Customer Service Contacts</th>
<th>July 2004 - June 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Area</strong></td>
<td>Jul - Sep</td>
</tr>
<tr>
<td>Desk Reviews</td>
<td>236</td>
</tr>
<tr>
<td>PPR / CORE</td>
<td>59</td>
</tr>
<tr>
<td>WiSCC</td>
<td>9</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>31</td>
</tr>
<tr>
<td>Interpreting Services</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>336</td>
</tr>
</tbody>
</table>
Desk Reviews
The majority of the telephone calls and other forms of communication from the provider community continue to relate to desk reviews. Most common issues that generate questions are related to timeframes, training, level 2 background screening, recoupments, and explanations of provider performance scores. A total of 1,460 contacts were logged in this area. This area as always generated a large number of calls to customer service, 1,286 in Year Two and 1,926 in Year Three and 1,460 in Year Four. This translates to 1.06, 1.77 and 1.17 calls per review respectively. Because of the high volume of activity, the on-line training module was created to better disseminate information about the review process. We expect the number of customer service contacts to continue to decrease over this next contract Year.

CORE and WiSCC
There were 292 calls related to the CORE procedure and only 48 related to WiSCC during the year. Most of the CORE related calls were requests for clarification of the different levels and interpretation of the results. Other questions pertained to the Quality Enhancement Plans (QEP) and the follow ups. Because Delmarva has provided extensive training on the process and the QICs have increased experience explaining pre-site and follow-up procedures, we expect confusion in these areas to decrease. According to Said Sanchez, most providers who have called seem to be adjusting well and making progress with the CORE procedures. For the WiSCC process, questions are generally related to the process itself, the difference between process and outcomes oriented elements, and the meaning of a number assigned to the WSC level in the computer application.

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

Miscellaneous
Miscellaneous contacts during the year can be broken down into the following: general information, updates, information specific to various websites, contacts related to missing reports and complaints.

- General Information has been requested and provided about Medicaid Waiver services, training, and advocacy.
 Updates to provider contact information has been entered into our Delmarva database at the provider’s request and reported to the Easton Office to prevent reoccurrence of missing reports, returned reports or other correspondence errors.

 Assistance with Delmarva and AHCA websites has been provided. Names of other websites have also been provided to callers upon request.

 Complaints of various kinds have been received. Usually it is suggested that these complaints be presented in writing to the appropriate person or Agency.

 Customer service has also assisted with many other questions or issues related to the above such as the timeframes to respond, how to deal with second or third notices, information about the different trainings, address updates, requests for extensions, interpretation of the scores and complaints. To better assist callers in those areas the Customer Service Unit makes frequent use of available resources such as consultation with Managers and/or colleagues, the DD “Handbook”, Delmarva CORE and WiSCC literature, the Florida Statutes and others.

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

 Quality Improvement Initiatives

 A major activity this year was the development of a public reporting website. A work group consisting of representatives from AHCA, APD, IQC, families and other relevant organizations collaborated with Delmarva on the design and implementation of the new site. The group determined the primary audience as individuals with developmental disabilities and their families, and the primary purpose was to disseminate information that would enhance their ability to select a provider that best suits their needs. The site provides demographic information on current providers and performance measures for providers reflecting compliance with background screening and training requirements. The work group has plans to continue to meet to help determine the future of the web site: expansion possibilities, funding, maintenance, etc. The prototype for the site was completed by June 30, 2005, with a “go-live” date scheduled on August 15, 2005.

 Five quality improvement studies were completed this past year.

 - Public Reporting Website Development: Current Initiatives and Developments: In this study we document the development of the Public Reporting website and present recommendations to help the work group, AHCA and APD move forward with expansion in the future.

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• Personal Outcome Measures: Reason Supports are Not Present: In this study we examine the reasons individuals are lacking the supports they need to achieve desired outcomes. The reasons are provided by the QICs conducting Personal Outcome Measure interviews.

• Consumer-Directed Care Plus (CDC+) Outcomes and Supports Analysis: Comparison of DD HCBS and CDC+: This study topic was requested by the state to examine the outcomes and supports CDC+ consumers achieve in comparison to individuals on the DD HCBS Waiver. Do people who have more control over directing their own plan of care have better outcomes?

• CORE Element Level Comparison to Provider Performance Reviews: In this study we provide some initial analysis that examines the outcome measures from the CORE results with the process based measures from the old PPR procedure from Year Three. The research question of interest was to determine if having documentation in place on process and procedural requirements, such as training and background screening, produces a system that generates better results for individuals being served.

• Outcome Results Analysis: Best Predictors of Percent of Outcomes Met: A study design was produced, in part, to “reassess” the driver indicators identified several years ago as the best predictors for having 13 or more outcomes met: chooses work and chooses services. In this study we also assess the impact each POM item has on the other items to help determine which may be the best predictors of an overall better quality of life.
Section Two: Data Analysis and Results

Volume of Activity-Provider Performance Reviews and Consultations

There were several categories of providers subject to a Provider Performance Desk Review or a CORE in Year Four of the contract.7

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

The following table shows the number of annual provider reviews/consultations completed each year during the first four years of the contract. Delmarva has conducted 7,894 annual reviews with providers of services on the Medicaid DD HCBS Waiver. As indicated in the table, 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. Providers of Support Coordination, Supported Living Coaching, Supported Employment, Adult Day Training, Residential Habilitation or Non Residential Support Services were subject to an Onsite review and all of these except Support Coordinators received a CORE. In addition, 4,545 Provider Performance Reviews completed during the four years were Desk Reviews of providers of all other DD Waiver Services, with the exception of Adult Dental Services, Consumable Medical Supplies, Adaptive Equipment and Environmental Modifications.

| Number of Provider Reviews/Consultations |
|-------------|----------------------|----------------------|-----------------------|----------------------|-------|
| Onsite      | 882                  | 846                  | 940                   | 24                   | 2,692 |
| CORE        | 0                    | 0                    | 18                    | 639                  | 657   |
| Desk        | 1,001                | 1,207                | 1,090                 | 1,247                | 4,545 |
| Grand Total | 1,883                | 2,053                | 2,048                 | 1,910                | 7,894 |

In addition to the annual consults, Delmarva provides a number of different Follow-up activities to enhance the provider’s capacity to assist individuals they serve and to meet documentation requirements. Four potential post-consult/review activities include: Follow-up, Follow-up with Technical Assistance, Documentation reviews, and Reconsiderations.

7 Providers of Support Coordination are included in the WiSCC results section.
In the PPR process utilized in Years 1-3, Follow-ups were generated if a provider scored less than 90% on their onsite review or if they did not submit a Quality Improvement Plan (QIP). In the CORE process, providers receive a Follow-up if the overall finding from their onsite activity is Implementing and they do not choose to receive a Follow-up with Technical Assistance.

Current Follow Up activities may include the following:
- Review of the provider’s Quality Enhancement Plan (QEP).
- Review of each element not scored as “achieving” to determine what improvements the provider has made, or what plans the provider has identified to improve organizational practices.
- If deemed necessary, the reviewer may interview individuals, staff, and others.

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

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

Documentation Reviews are primarily conducted for providers who have received a desk review, to ensure they have corrected elements that were scored as not met or for which correct documentation was not submitted at the time of the original review. Occasionally providers receiving an onsite consult are required to submit information for a documentation review if they scored Achieving but had minimum service requirements scored as not-met. Providers have 30 days to submit materials for Documentation reviews.

Reconsiderations are conducted when a provider contests the results of the CORE annual onsite consultation or annual desk review. Reconsiderations can only be requested on the minimum service requirement elements in the CORE process (elements 19-25).
A total of 3,319 follow-up reviews have been completed over the four 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. On the other hand, while the number of Desk reviews completed increased between Year Three and Year Four (1,090 to 1,247), the number of Documentation Follow-up reviews has decreased. Perhaps increased efforts to train providers on the Desk Review process have helped clarify the procedure and reduce the degree of missing documentation from each provider.

**Desk Reviews**

The number and percent of desk reviews (annual) in each area is presented below. The number of desk reviews has remained fairly steady across the areas each year. However, the number of reviews in some areas each year is relatively low, particularly in Areas 1, 8 and 14.
Of greater interest is the trend in Desk Review scores across the years. In the following table, the average score is presented for each area and each year of the contract, as well as a four-year average.

<table>
<thead>
<tr>
<th>Area</th>
<th>Year One 2001 - 2002</th>
<th>Year Two 2002 - 2003</th>
<th>Year Three 2003 - 2004</th>
<th>Year Four 2004 - 2005</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>75.8%</td>
<td>73.4%</td>
<td>85.1%</td>
<td>85.6%</td>
<td>80.5%</td>
</tr>
<tr>
<td>2</td>
<td>76.6%</td>
<td>84.1%</td>
<td>82.4%</td>
<td>82.4%</td>
<td>81.5%</td>
</tr>
<tr>
<td>3</td>
<td>77.4%</td>
<td>85.4%</td>
<td>77.5%</td>
<td>80.5%</td>
<td>80.4%</td>
</tr>
<tr>
<td>4</td>
<td>68.7%</td>
<td>76.2%</td>
<td>74.3%</td>
<td>78.7%</td>
<td>75.2%</td>
</tr>
<tr>
<td>7</td>
<td>68.0%</td>
<td>70.8%</td>
<td>73.2%</td>
<td>75.4%</td>
<td>72.3%</td>
</tr>
<tr>
<td>8</td>
<td>75.5%</td>
<td>66.1%</td>
<td>69.8%</td>
<td>76.7%</td>
<td>71.8%</td>
</tr>
<tr>
<td>9</td>
<td>67.9%</td>
<td>67.4%</td>
<td>77.6%</td>
<td>69.5%</td>
<td>71.0%</td>
</tr>
<tr>
<td>10</td>
<td>73.9%</td>
<td>72.3%</td>
<td>64.8%</td>
<td>73.3%</td>
<td>70.6%</td>
</tr>
<tr>
<td>11</td>
<td>77.1%</td>
<td>79.3%</td>
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<td>75.8%</td>
<td>74.7%</td>
</tr>
<tr>
<td>12</td>
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<td>74.0%</td>
<td>76.3%</td>
<td>74.0%</td>
<td>73.3%</td>
</tr>
<tr>
<td>13</td>
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<td>77.3%</td>
<td>78.9%</td>
</tr>
<tr>
<td>14</td>
<td>72.9%</td>
<td>75.6%</td>
<td>69.0%</td>
<td>74.1%</td>
<td>72.7%</td>
</tr>
<tr>
<td>15</td>
<td>64.9%</td>
<td>65.4%</td>
<td>58.0%</td>
<td>60.9%</td>
<td>62.3%</td>
</tr>
<tr>
<td>23</td>
<td>72.0%</td>
<td>80.4%</td>
<td>77.7%</td>
<td>79.9%</td>
<td>77.5%</td>
</tr>
<tr>
<td>Total</td>
<td>72.8%</td>
<td>77.5%</td>
<td>74.5%</td>
<td>77.2%</td>
<td>75.7%</td>
</tr>
</tbody>
</table>

The following highlights are evident for Desk Review evaluation scores across the four years of the contract (July 2001 – June 2005):

- The average score has increased since the first year from 72.8 percent to 77.2 percent;
- Area 15 has consistently posted the lowest average score for the year;
- Areas 13 and 15 are the only areas in which the Desk Review scores decreased from the first to the fourth year;
- Area 1 had the highest score in Year Four;
- Areas 1, 2 and 3 had the highest four-year average scores in the state.
Over the years, some differences between agency and solo providers have been noted. These are reflected below.

### Desk Review Scores by Provider Type and Year

<table>
<thead>
<tr>
<th>Year</th>
<th>Agency</th>
<th>Solo</th>
<th>Average Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Reviews</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agency</td>
<td>Solo</td>
<td>Agency</td>
</tr>
<tr>
<td>1</td>
<td>191</td>
<td>810</td>
<td>79.5%</td>
</tr>
<tr>
<td>2</td>
<td>228</td>
<td>979</td>
<td>74.5%</td>
</tr>
<tr>
<td>3</td>
<td>267</td>
<td>823</td>
<td>70.3%</td>
</tr>
<tr>
<td>4</td>
<td>313</td>
<td>934</td>
<td>72.8%</td>
</tr>
<tr>
<td>Total</td>
<td>999</td>
<td>3,546</td>
<td>73.8%</td>
</tr>
</tbody>
</table>

Comparisons between the two types of providers indicate:

- Just over 78 percent of all Desk Reviews were conducted on Solo providers, 3,546Solo compared to 999 Agency;
- Scores for Agency providers have decreased since the first year, from 79.5 percent to 72.8 percent;
- At the same time, scores for Solo providers have increased from 71.2 percent to 78.7 percent.\(^8\)

Documentation for compliance with background screening requirements is the only item for which providers who only provide services that are 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.

### Number and Percent of Desk Reviews W/ Background Screening and/or Background Re-screening Documentation

<table>
<thead>
<tr>
<th>Screening</th>
<th>Re-screening</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
</tr>
<tr>
<td></td>
<td>Met</td>
</tr>
<tr>
<td>Year</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1,151</td>
</tr>
<tr>
<td>2</td>
<td>1,417</td>
</tr>
<tr>
<td>3</td>
<td>1,349</td>
</tr>
<tr>
<td>4</td>
<td>1,604</td>
</tr>
<tr>
<td>Total</td>
<td>5,521</td>
</tr>
</tbody>
</table>

\(^8\) This trend was noted and discussed in the Quality Improvement study completed during the third year of the contract, Provider Performance Review, Desk Review Procedures, submitted by Delmarva to AHCA, June 30, 2004.
The information in the table above reflects the number and percent of reviews with the proper documentation of background screening. The analysis indicates:

- Over the four year period, background screening was completed in 71.3 percent of reviews;
- For 88.2 percent of reviews, the required 5-year level 2 background re-screening was documented.
- The percent of compliance for background screening has increased, and at the same time the percent of compliance for the 5-year re-screening has declined somewhat. As we move further into the fifth year of the contract, more providers will be eligible for the 5-year re-screening requirement.

The following table shows the distribution of background screening compliance, distributed across Agency and Solo Providers for each year.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number Reviews</th>
<th>Screen</th>
<th>Re-screen</th>
<th>Number Reviews</th>
<th>Screen</th>
<th>Re-screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>191</td>
<td>60.5%</td>
<td></td>
<td>810</td>
<td>70.4%</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>228</td>
<td>38.2%</td>
<td>86.4%</td>
<td>979</td>
<td>81.8%</td>
<td>90.1%</td>
</tr>
<tr>
<td>3</td>
<td>267</td>
<td>41.8%</td>
<td>83.8%</td>
<td>823</td>
<td>86.2%</td>
<td>91.2%</td>
</tr>
<tr>
<td>4</td>
<td>313</td>
<td>51.9%</td>
<td>82.8%</td>
<td>934</td>
<td>86.0%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Total</td>
<td>999</td>
<td>47.8%</td>
<td>84.3%</td>
<td>3,546</td>
<td>81.3%</td>
<td>90.1%</td>
</tr>
</tbody>
</table>

- Solo providers were more likely to have documentation of background screening and 5-year re-screening than Agency providers.
- Agency providers show a high degree of variation for background screening compliance from Year One to Year Four, with an overall decrease of close to nine percentage points. They show a decrease for 5-year re-screening as well, but not as great. Agencies were much more likely to be compliant on the 5-year re-screening than on the original background screening check.
- Solo providers showed an increase in compliance for background screening, 70.4 percent in Year One to 86.0 percent in Year Four. They remained fairly consistent on 5-year re-screening

Elements of Performance for Desk Reviews subject to Recoupment are service specific requirements related to reimbursement documentation. Results for Desk Reviews (below) indicate that:
On average over the three-year period, Solo providers were slightly more likely to have a recoupment citation than were Agency providers.\(^9\)

The difference between the two types of providers has decreased from four percentage points (11.8 v 15.8) in Year Two to just over one point in Year Four (15.4% v 16.6%).

Citations have increased somewhat more for Agency providers since Year Two than for Solo Providers.

### Desk Review Recoupment Citations by Year and Provider Type

<table>
<thead>
<tr>
<th></th>
<th>Agency</th>
<th></th>
<th>Solo</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Met</td>
<td>Not Met</td>
<td>Percent w/</td>
<td>Met</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Recoupment</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td></td>
<td></td>
<td>Citation</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1,238</td>
<td>165</td>
<td>11.8%</td>
<td>3,667</td>
</tr>
<tr>
<td>3</td>
<td>1,726</td>
<td>391</td>
<td>18.5%</td>
<td>3,343</td>
</tr>
<tr>
<td>4</td>
<td>1,969</td>
<td>359</td>
<td>15.4%</td>
<td>3,735</td>
</tr>
<tr>
<td>Total</td>
<td>4,933</td>
<td>915</td>
<td>15.6%</td>
<td>10,745</td>
</tr>
</tbody>
</table>

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

- Of the 663 Desk Reviews requiring a Documentation Follow-up, 150 (23.0%) received an evaluation of Met on 100 percent of elements that were previously Not Met. This is relatively higher than for Years Two and Three (22.0% and 19.8% respectively).
- Close to 40 Percent of reviews in Year Four requiring a Documentation Follow-up received an evaluation of Met on 75 percent or more on elements that were previously Not Met. This is also relatively greater than for Years Two and Three (36.1% and 34.6% respectively).
- The percent of reviews that had no change in the number of elements scored as Met has increased somewhat since the second year, from 7.2 percent to 9.3 percent. However, this is not a statistically significant relationship, with a better than 27 percent probability this difference could be due to chance or sampling fluctuations.

---

\(^9\) Recoupment citations were not recorded in Year One.
**Documentation Follow-up Reviews**

Percent Change from Initial Review

<table>
<thead>
<tr>
<th>Change</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% Met</td>
<td>22.0%</td>
<td>19.8%</td>
<td>23.0%</td>
</tr>
<tr>
<td>&gt;75% Met</td>
<td>36.1%</td>
<td>34.6%</td>
<td>39.8%</td>
</tr>
<tr>
<td>0% Met</td>
<td>7.2%</td>
<td>10.0%</td>
<td>9.3%</td>
</tr>
</tbody>
</table>

Core Consultations

Because the CORE procedure was implemented in Year Four, no annual trend analyses are possible. However, the following section summarizes results from this initial year and recommendations from these results are included in the final section of the report. Providers of Adult Day Training, Non-Residential Support Services, Residential Habilitation, Supported Employment and Supported Living Coaching are subject to a CORE consultation. Providers who were monitored in Year Three with the onsite Provider Performance Review and achieved a 90% or higher with no alerts, were exempt from a CORE in Year Four.

A total of 639 CORE have been completed and approved during the fourth year of the FSQAP contract. This falls somewhat short of the designated range of CORE expected to be completed, between 725 and 1,029. Each provider is evaluated on 25 elements. The first 18 are outcome-based with a focus on the following areas: rights, choices, community, health and safety, a person-centered approach and communication. Each Outcome Element is evaluated as Achieving, Implementing, Emerging or Not Emerging.\(^{10}\) The provider’s overall CORE evaluation level is based upon a compilation of Outcome Element results. 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. Because this is the first full year of data available for this new process, the results will be used to establish benchmarks.

The following table shows the distribution across areas of the consumer population and the 639 CORE reviews completed during the twelve month period ending June 30, 2005.\(^{11}\) The average evaluation score and average percent of MSR elements scored as Met are also presented.

---

\(^{10}\) See Appendix 1, Attachment 2, for a description of the levels of evaluation and Attachment 3 for a description of each CORE element.

\(^{11}\) Population data were taken from APD’s ABC database.
## CORE Consultations by Area

### Number, Percent and Average Score

**July 2004 - June 2005**

<table>
<thead>
<tr>
<th>Area</th>
<th>Number Consumers</th>
<th>Number CORE</th>
<th>Percent CORE</th>
<th>Average Outcome Score</th>
<th>MSR Percent Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1,263</td>
<td>20</td>
<td>3.1%</td>
<td>1.50</td>
<td>75.7%</td>
</tr>
<tr>
<td>2</td>
<td>1,884</td>
<td>47</td>
<td>7.4%</td>
<td>2.36</td>
<td>90.3%</td>
</tr>
<tr>
<td>3</td>
<td>1,095</td>
<td>48</td>
<td>7.5%</td>
<td>1.85</td>
<td>74.7%</td>
</tr>
<tr>
<td>4</td>
<td>1,897</td>
<td>59</td>
<td>9.2%</td>
<td>2.24</td>
<td>74.5%</td>
</tr>
<tr>
<td>7</td>
<td>2,360</td>
<td>38</td>
<td>5.9%</td>
<td>1.76</td>
<td>76.3%</td>
</tr>
<tr>
<td>8</td>
<td>799</td>
<td>19</td>
<td>3.0%</td>
<td>1.95</td>
<td>77.4%</td>
</tr>
<tr>
<td>9</td>
<td>1,361</td>
<td>17</td>
<td>2.7%</td>
<td>2.06</td>
<td>81.4%</td>
</tr>
<tr>
<td>10</td>
<td>2,060</td>
<td>25</td>
<td>3.9%</td>
<td>1.40</td>
<td>65.1%</td>
</tr>
<tr>
<td>11</td>
<td>3,356</td>
<td>61</td>
<td>9.5%</td>
<td>1.25</td>
<td>75.4%</td>
</tr>
<tr>
<td>12</td>
<td>822</td>
<td>38</td>
<td>5.9%</td>
<td>1.74</td>
<td>70.3%</td>
</tr>
<tr>
<td>13</td>
<td>1,228</td>
<td>56</td>
<td>8.8%</td>
<td>1.70</td>
<td>70.9%</td>
</tr>
<tr>
<td>14</td>
<td>824</td>
<td>31</td>
<td>4.9%</td>
<td>1.26</td>
<td>82.9%</td>
</tr>
<tr>
<td>15</td>
<td>770</td>
<td>59</td>
<td>9.2%</td>
<td>1.75</td>
<td>72.3%</td>
</tr>
<tr>
<td>23</td>
<td>4,267</td>
<td>121</td>
<td>18.9%</td>
<td>1.64</td>
<td>72.4%</td>
</tr>
<tr>
<td>Total</td>
<td>23,986</td>
<td>639</td>
<td>100.0%</td>
<td>1.74</td>
<td>75.1%</td>
</tr>
</tbody>
</table>

Area 23 has more consumers than any other area, followed by Area 11, and Area 15 has the fewest number of consumers, with only 770. The number of CORE completed in each area varies from a low of 17 in Area 9 to a high of 121 in Area 23. The average outcome score is calculated within each area with a simple mean, based upon a scale of zero to three:\(^{12}\)

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

Areas 11 and 14 appear to have the lowest average CORE scores with 1.25 and 1.26 respectively.\(^ {13}\) Areas 2, 4, and 9 have an average CORE score greater than two. The 47 CORE completed in Area 2 have the highest average score of 2.36. There does not appear to be a very strong correlation between the average Outcome score and MSR.

---

\(^{12}\) See Appendix 2, Tab 1 for CORE results by outcome level and area.

\(^{13}\) It is important to note here that we are calculating an “average” from what is essentially qualitative (ordinal) data. While often used for analytic purposes, the “distance between” each value is not a standard unit, such as with age.
results. The MSR Percent Met for Areas 2, 4, and 9 (the top Outcome scores), varies from 75 percent to over 90 percent.14

Outcome Elements
During the twelve months ending June 30, 2005, 511 agency and 128 solo providers received a CORE. As indicated in the table below, the majority of providers scored Emerging or Implementing, a total of 78.9 percent. Only 3.1 percent (20 providers) were evaluated as “Not Emerging”. Results from the “CORE Consultations” table that follows also indicate that:

- Solo providers are much more likely to score Achieving than are agency providers;
- Agency providers are much more likely to score Emerging than solo providers. One solo providers scored Not Emerging.
- Only 20 providers (3.1%) were evaluated as Not Emerging, but 19 of these were agencies.

<table>
<thead>
<tr>
<th>CORE Consultations: Evaluation Level by Provider Type</th>
<th>July 2004 - June 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agency</td>
</tr>
<tr>
<td>Achieving</td>
<td>70</td>
</tr>
<tr>
<td>Implementing</td>
<td>208</td>
</tr>
<tr>
<td>Emerging</td>
<td>214</td>
</tr>
<tr>
<td>Not Emerging</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>511</td>
</tr>
</tbody>
</table>

14 The Quality Improvement Study, CORE Element Level Comparison to Provider Performance Reviews, explores in some detail any possible relationship between Outcome and Process oriented elements.
As indicated above, each of the 18 Outcome Elements is evaluated. The following table shows the elements from 639 CORE consults, with the percent of providers at each level of evaluation for each element.\(^{15}\)

<table>
<thead>
<tr>
<th>Element</th>
<th>Achieving</th>
<th>Implementing</th>
<th>Emerging</th>
<th>Not Emerging</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>13.8%</td>
<td>25.5%</td>
<td>57.3%</td>
<td>3.4%</td>
<td>100.0%</td>
</tr>
<tr>
<td>2</td>
<td>37.6%</td>
<td>30.0%</td>
<td>30.4%</td>
<td>2.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>3</td>
<td>31.6%</td>
<td>31.8%</td>
<td>34.7%</td>
<td>1.9%</td>
<td>100.0%</td>
</tr>
<tr>
<td>4</td>
<td>19.7%</td>
<td>26.9%</td>
<td>51.3%</td>
<td>2.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>5</td>
<td>18.5%</td>
<td>29.7%</td>
<td>49.3%</td>
<td>2.5%</td>
<td>100.0%</td>
</tr>
<tr>
<td>6</td>
<td>15.2%</td>
<td>29.9%</td>
<td>52.6%</td>
<td>2.3%</td>
<td>100.0%</td>
</tr>
<tr>
<td>7</td>
<td>23.8%</td>
<td>28.2%</td>
<td>46.2%</td>
<td>1.9%</td>
<td>100.0%</td>
</tr>
<tr>
<td>8</td>
<td>25.4%</td>
<td>37.2%</td>
<td>35.7%</td>
<td>1.7%</td>
<td>100.0%</td>
</tr>
<tr>
<td>9</td>
<td>32.1%</td>
<td>34.9%</td>
<td>31.6%</td>
<td>1.4%</td>
<td>100.0%</td>
</tr>
<tr>
<td>10</td>
<td>11.6%</td>
<td>22.7%</td>
<td>56.5%</td>
<td>9.2%</td>
<td>100.0%</td>
</tr>
<tr>
<td>11</td>
<td>13.3%</td>
<td>29.1%</td>
<td>52.9%</td>
<td>4.7%</td>
<td>100.0%</td>
</tr>
<tr>
<td>12</td>
<td>18.0%</td>
<td>25.0%</td>
<td>47.6%</td>
<td>9.4%</td>
<td>100.0%</td>
</tr>
<tr>
<td>13</td>
<td>21.4%</td>
<td>21.1%</td>
<td>52.3%</td>
<td>5.2%</td>
<td>100.0%</td>
</tr>
<tr>
<td>14</td>
<td>14.2%</td>
<td>18.6%</td>
<td>44.1%</td>
<td>23.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>15</td>
<td>23.8%</td>
<td>25.7%</td>
<td>46.5%</td>
<td>4.1%</td>
<td>100.0%</td>
</tr>
<tr>
<td>16</td>
<td>27.7%</td>
<td>32.7%</td>
<td>36.8%</td>
<td>2.8%</td>
<td>100.0%</td>
</tr>
<tr>
<td>17</td>
<td>32.2%</td>
<td>29.4%</td>
<td>35.7%</td>
<td>2.7%</td>
<td>100.0%</td>
</tr>
<tr>
<td>18</td>
<td>38.5%</td>
<td>37.6%</td>
<td>21.9%</td>
<td>2.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>23.2%</td>
<td>28.7%</td>
<td>43.5%</td>
<td>4.6%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

- On average, the Outcome Elements are most likely to be scored as Emerging.
- Close to 52 percent of all Outcome Elements scored Achieving or Implementing.
- Elements 18 and 2 are more often evaluated as Achieving than any other elements, 38.5 percent and 37.6 percent respectively. These indicate that individuals are satisfied with their services and they are treated with dignity and respect.
- Element 10 is least likely to be evaluated as Achieving, indicating individuals are not adequately developing desired social roles that they value. Only 11.6 percent of providers (74) scored Achieving on this element.
- 23 percent of providers (147) who received a CORE were evaluated as Not Emerging on Element 14, indicating individuals do not routinely participate in review of the implementation plan or direct changes desired to assure outcomes/goals are met.

\(^{15}\) See Appendix 1, Attachment 3 for a description of each outcome element.
Close to 10 percent of providers received a Not Emerging on Elements 10 and 12, 59 and 60 providers respectively. Element 10 pertains to developing social roles and Element 12 reflects the degree to which individuals direct the design of the implementation plan.

Minimum Service Requirements
The last seven of the 25 elements in the CORE are the Minimum Service Requirement (MSR) elements. They are process related and are similar to elements scored during the first three years of the contract. Providers must supply documentation of the required background screening, required training, and proper billing procedures. MSR elements are evaluated as Met or Not Met. The following table shows the number and percent of consults, distributed across the number of MSR elements that were scored as Met. For example, only three of the 639 providers who completed a CORE had none of the seven MRS elements scored as Met. These were all agency providers.

- Over 52 percent of the providers scored Met on six or more MSR elements.
- Close to 16 percent of providers scored Met on three or fewer MSR elements.
- Over 35 percent of solo providers scored Met on all seven of the MSR elements compared to 27 percent of agency providers. However, this does not represent a statistically significant difference between the two groups, based on a five percent error level.
- 88 (17.2%) agency providers scored Met on three or fewer MSR elements compared to only 12 (9.4%) solo providers. This does appear to be a statistically significant difference, with only a one percent probability the results shown here are due to chance or sampling fluctuation.

### Minimum Service Requirements: Total Number Met by Provider Type

**CORE Consultations: July 2004 – June 2005**

<table>
<thead>
<tr>
<th>Number</th>
<th>Number of Providers</th>
<th>Percent of Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agency</td>
<td>Solo</td>
</tr>
<tr>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>27</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>46</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>73</td>
<td>14</td>
</tr>
<tr>
<td>5</td>
<td>101</td>
<td>18</td>
</tr>
<tr>
<td>6</td>
<td>112</td>
<td>39</td>
</tr>
<tr>
<td>7</td>
<td>137</td>
<td>45</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>511</strong></td>
<td><strong>128</strong></td>
</tr>
</tbody>
</table>

---

16 See Appendix 1, Attachment 3 for a description of each MSR element.
17 Probability is .0734, indicating a greater than 7% chance the difference is due to chance or sampling fluctuations.
In the following table, the number and percent Met of MSR elements is given at the element level. Of the 639 CORE consults completed during the twelve month period ending June 30, 2005, slightly over 75 percent were scored as Met. Findings that identify Solo scores as being higher than Agency scores in some areas may reflect the challenge Agencies have in meeting requirements for multiple employees and managing turnover. Highlights include:

- On average, solo providers appear to be scoring better on these elements than are agency providers, 80.7 percent to 73.6 percent respectively. This is a statistically significant relationship, with a probability that it is due to chance of almost zero.
- Solo providers demonstrated over 90 percent Met on Element 20 and 23, indicating they usually have the required background screening documentation and are properly authorized to provide the service.
- Solo providers appear to be doing much better with documenting background screening (20) than are agency providers. This is a statistically significant relationship, with a probability that it is due to chance of almost zero.
- Agency providers were most likely to score Met on Element 23, reflecting proper authorization to provide the service(s).
- Agency and solo providers alike scored lowest on the same elements: Element 25, indicating they maintain the required documentation and Element 19 indicating the provider meets service specific projected service outcomes.

### Minimum Service Requirements: Percent Met by Element and Provider Type

**CORE Consultations: July 2004 - June 2005**

<table>
<thead>
<tr>
<th>Element</th>
<th>Number Met</th>
<th>Percent Met</th>
<th>Total Met</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agency</td>
<td>Solo</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>322</td>
<td>80</td>
<td>402</td>
</tr>
<tr>
<td>20</td>
<td>360</td>
<td>116</td>
<td>476</td>
</tr>
<tr>
<td>21</td>
<td>347</td>
<td>97</td>
<td>444</td>
</tr>
<tr>
<td>22</td>
<td>402</td>
<td>111</td>
<td>513</td>
</tr>
<tr>
<td>23</td>
<td>461</td>
<td>121</td>
<td>582</td>
</tr>
<tr>
<td>24</td>
<td>430</td>
<td>108</td>
<td>538</td>
</tr>
<tr>
<td>25</td>
<td>310</td>
<td>90</td>
<td>400</td>
</tr>
</tbody>
</table>

**Total Consults**

<table>
<thead>
<tr>
<th>Number Met</th>
<th>Percent Met</th>
<th>Total Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>511</td>
<td>73.6%</td>
<td>639</td>
</tr>
</tbody>
</table>

### CORE Alerts and Recoupments

Several elements in the CORE evaluation are Recoupment or Alert items. Elements are cited as an alert if it is determined by the consultant that areas of dignity and respect; privacy; abuse, neglect and exploitation; heath; or safety warrant immediate corrective action. 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.

---

18 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.
action. Failure to meet the requirements for background screening is also cited as an Alert item. Elements are cited as a Recoupment if the provider is not in compliance with the monitoring and billing documentation requirement for the services rendered.

The number and percent of each item scored as an alert are listed in the following table. As documented, a majority of CORE alerts relate to background screening. Over 78 percent indicate background screening had not been obtained as required. The remaining 65 alerts are in the areas of dignity and respect; privacy; abuse, neglect and exploitation; health; and safety. The 299 alerts listed in the table involved 195 different providers. Of these providers:

- 229 had one alert;
- 21 had two alerts;
- 3 had three alerts;
- 2 had four alerts;
- 1 had five alerts;
- 1 had six alerts.

<table>
<thead>
<tr>
<th>Alert Item</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dignity and respect</td>
<td>18</td>
<td>6.0%</td>
</tr>
<tr>
<td>Privacy</td>
<td>10</td>
<td>3.3%</td>
</tr>
<tr>
<td>Abuse, neglect and exploitation</td>
<td>9</td>
<td>3.0%</td>
</tr>
<tr>
<td>Health</td>
<td>6</td>
<td>2.0%</td>
</tr>
<tr>
<td>Safety</td>
<td>22</td>
<td>7.4%</td>
</tr>
<tr>
<td>Background</td>
<td>234</td>
<td>78.3%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>299</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

In addition, of the 639 CORE completed in the twelve-month period ending June 2005, 199 providers received a total of 274 recoupment citations. The following table presents the percent of CORE consults, by provider type, that had an alert or a recoupment, by area. Comparisons across areas for providers are meaningful. However, comparisons between the two different types of providers are not appropriate for two reasons: 1) there are usually more opportunities for agencies to be cited for alerts and recoupments, and 2) as shown in Exhibit 3 (Appendix 2), the number of solo CORE consults in each area is often quite small.

---

19 See Appendix 2, Exhibits 2 and 3 for information on alerts and recoupments by area.
CORE Alerts and Recoupments by Area
Year 4 - July 2004 - June 2005

<table>
<thead>
<tr>
<th>Area</th>
<th>Agency</th>
<th>Solo</th>
<th>Total</th>
<th>Agency</th>
<th>Solo</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>15.8%</td>
<td>100.0%</td>
<td>20.0%</td>
<td>21.1%</td>
<td>0.0%</td>
<td>25.0%</td>
</tr>
<tr>
<td>2</td>
<td>16.7%</td>
<td>13.8%</td>
<td>14.9%</td>
<td>11.1%</td>
<td>6.9%</td>
<td>4.3%</td>
</tr>
<tr>
<td>3</td>
<td>33.3%</td>
<td>33.3%</td>
<td>33.3%</td>
<td>50.0%</td>
<td>33.3%</td>
<td>58.3%</td>
</tr>
<tr>
<td>4</td>
<td>41.9%</td>
<td>6.3%</td>
<td>32.2%</td>
<td>58.1%</td>
<td>43.8%</td>
<td>47.5%</td>
</tr>
<tr>
<td>7</td>
<td>27.3%</td>
<td>20.0%</td>
<td>26.3%</td>
<td>24.2%</td>
<td>0.0%</td>
<td>36.8%</td>
</tr>
<tr>
<td>8</td>
<td>33.3%</td>
<td>25.0%</td>
<td>31.6%</td>
<td>13.3%</td>
<td>25.0%</td>
<td>21.1%</td>
</tr>
<tr>
<td>9</td>
<td>14.3%</td>
<td>0.0%</td>
<td>11.8%</td>
<td>28.6%</td>
<td>0.0%</td>
<td>41.2%</td>
</tr>
<tr>
<td>10</td>
<td>16.7%</td>
<td>100.0%</td>
<td>20.0%</td>
<td>29.2%</td>
<td>0.0%</td>
<td>52.0%</td>
</tr>
<tr>
<td>11</td>
<td>34.5%</td>
<td>16.7%</td>
<td>32.8%</td>
<td>23.6%</td>
<td>33.3%</td>
<td>36.1%</td>
</tr>
<tr>
<td>12</td>
<td>34.5%</td>
<td>22.2%</td>
<td>31.6%</td>
<td>34.5%</td>
<td>55.6%</td>
<td>44.7%</td>
</tr>
<tr>
<td>13</td>
<td>43.2%</td>
<td>16.7%</td>
<td>37.5%</td>
<td>54.5%</td>
<td>33.3%</td>
<td>58.9%</td>
</tr>
<tr>
<td>14</td>
<td>50.0%</td>
<td>0.0%</td>
<td>45.2%</td>
<td>25.0%</td>
<td>33.3%</td>
<td>25.8%</td>
</tr>
<tr>
<td>15</td>
<td>32.5%</td>
<td>15.8%</td>
<td>27.1%</td>
<td>12.5%</td>
<td>31.6%</td>
<td>10.2%</td>
</tr>
<tr>
<td>23</td>
<td>40.2%</td>
<td>0.0%</td>
<td>35.5%</td>
<td>32.7%</td>
<td>14.3%</td>
<td>38.8%</td>
</tr>
<tr>
<td>Florida</td>
<td>34.4%</td>
<td>14.8%</td>
<td>30.5%</td>
<td>32.7%</td>
<td>25.0%</td>
<td>36.6%</td>
</tr>
</tbody>
</table>

On average, 30.5 percent of CORE consults completed had at least one alert and 36.6 percent had at least one recoupment citation. Agencies had a similar proportion of consults with alerts and recoupments, while solo providers were somewhat more likely to have recoupment citations than alerts. Among agencies, providers in Area 14 were more likely to have received an alert citation and providers in Area 4 were more likely to have received a recoupment citation than in the other areas.

Follow Up Reviews and Follow Up with Technical Assistance Reviews
During Year Four of the contract, a total of 55 providers received a Follow Up review and 208 received a Follow Up with Technical Assistance review subsequent to a CORE consult. The only “scores” that are subject to change in either of the follow up procedures are the seven MSR elements.

- Of the 55 Follow Up reviews that were completed, only 25 providers received a Not Met on one or more of the MSR elements. Of these, 22 scored Met on 100 percent of the elements that had previously been scored as Not Met.
- Of the 208 Follow Up reviews with Technical Assistance, 144 providers received a Not Met on one or more of the MSR elements. Of these, 75 (52.1%) providers scored Met on 100% of the elements that had previously been scored as Not Met. An additional eight providers scored Met on 75 or 80 percent of the elements previously scored as Not Met.
• Just over 10 percent (15 providers) had no change in the MSR elements following the review with Technical Assistance.

Reconsiderations

For Year Four, 77 reconsiderations were processed. Of these, 47 were approved. It is important to note that the number of reconsiderations accepted is based upon multiple sites and reconsiderations are considered approved if even one element is accepted. The table below displays the number of reconsiderations completed for Desk Reviews and CORE consults and the number and percent approved or denied. Just over four percent of the total number of providers who received a Desk or CORE requested a reconsideration review. Most of these were for Desk Reviews. No CORE reconsiderations were accepted while over 68 percent of Desk was accepted.

Reconsiderations: Desk and CORE
July 2004 - June 2005

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Number Reviews</th>
<th>Accepted</th>
<th>Denied</th>
<th>Percent Recon</th>
<th>Percent Accepted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desk</td>
<td>639</td>
<td>47</td>
<td>22</td>
<td>10.8%</td>
<td>68.1%</td>
</tr>
<tr>
<td>CORE</td>
<td>1,247</td>
<td>0</td>
<td>8</td>
<td>0.6%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>1,886</td>
<td>47</td>
<td>30</td>
<td>4.1%</td>
<td>61.0%</td>
</tr>
</tbody>
</table>

Projected Service Outcomes

Projected Service Outcomes are program outcomes identified in the Developmental Services Waiver Services Medicaid Coverage and Limitations handbook that the provider must meet for each individual who receives one of these services. The Standard related to Projected Service Outcomes has changed with implementation of the CORE and WiSCC processes. In the PPR process utilized previously, there were specific Elements of Performance that measured the Projected Service Outcomes for each service that was reviewed onsite: The Projected Service Outcomes Standard. The elements within this Standard related to having a systematic method for collecting outcome data as well as a process to periodically review outcome data and take appropriate corrective measures if the data indicate the program goal is not being achieved. Elements of Performance for each service also measure common areas including satisfaction, choice, and the effective use of supports to assist individuals in making progress toward desires and goals important to them. If the providers did not have systems in place to demonstrate they were systematically collecting data and reviewing the data reflective of the projected service outcomes for each individual receiving the service, these Elements of Performance were scored as Not Met.
In the CORE process, consultants continue to monitor Projected Service Outcomes with Element 19, the first MSR element: The provider meets service specific projected services outcome(s) as identified for each service that is reviewed onsite with a CORE consultation (ADT, NRSS, Residential Habilitation, Supported Employment, and Supported Living Coaching). As indicated above, both agency and solo providers perform relatively poorly on Element 19, with 63.4 percent and 62.5 percent Met respectively. This indicates providers are often not meeting the standards of performance on the Projected Service Outcomes.

**WiSCC Evaluations**

All providers of Support Coordination receive a Waiver Support Coordination Consultation (WiSCC). The WiSCC combines a consultation with the waiver support coordinator and Personal Outcome Measure interviews with at least two individuals the support coordinator serves. A total of 431 WiSCCs were completed and approved during Year Four of the Contract, July 2004 – June 2005. This is somewhat more than the target for the year of 406. As part of these consults, 662 Waiver Support Coordinators (WSC) were reviewed and 1,355 individuals were interviewed.\(^{20}\) (Consultants expected to interview approximately 1,572 individuals before June 30, 2005.)

Each Waiver Support Coordinator (WSC) is evaluated on six Outcome Elements and five Minimum Service Requirements. With the Outcome Elements, consultants determine if organizational systems are in place that help individuals being served achieve outcomes that are important to them. For example, is the WSC learning about the people served and aware of their health, safety and well-being? Is the individual helping with the development of a support plan? The WSCs are evaluated on these six elements similar to the way CORE providers are evaluated, as Achieving, Implementing, Emerging and Not Emerging.\(^{21}\) 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. Because this is the first full year of data available for this new process, the results will be used to establish benchmarks.

The WiSCC consults and number of WSCs were distributed across the areas as shown in the following table. An average score for the Support Coordinators is also given for each area as well as the percent of MSR elements met. The average WSC score is calculated using the same values for each evaluation level as described earlier for CORE.\(^{22}\)

- Achieving = 3
- Implementing = 2

---

\(^{20}\) Additional individual Personal Outcome Measures (POM) interviews were completed but are not part of the random sample for the POM and are not included in the data analysis.

\(^{21}\) See Appendix 1, Attachment 3 and 4 for a description of the evaluation levels and a list of the WiSCC Elements.

\(^{22}\) As with the CORE scores, it is important to note here that we are calculating an “average” from what is essentially qualitative (ordinal) data. While often used for analytic purposes, the “distance between” each value is not a standard unit, such as with age.
A score, between zero and three, is calculated for each WSC, based upon the element level evaluations. Therefore, if WSCs score Achieving on all six Outcome Elements, their score is a three. These are then summed and divided by the number of WSC interviewed in each area for an average WSC score per area. The statewide average for the initial year of the WiSCC process is 1.68, between Emerging and Implementing, somewhat closer to Implementing. The average scores range from a low of 1.32 in Area 13 to a high of 2.16 in Area 1.

### WiSCC and WSCs by Area

<table>
<thead>
<tr>
<th>Area</th>
<th>WiSCCs</th>
<th>WSCs</th>
<th>Percent WSCs</th>
<th>Average WSC Score</th>
<th>Percent MSR Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>14</td>
<td>33</td>
<td>5.0%</td>
<td>2.16</td>
<td>96.4%</td>
</tr>
<tr>
<td>2</td>
<td>42</td>
<td>54</td>
<td>8.2%</td>
<td>1.82</td>
<td>95.6%</td>
</tr>
<tr>
<td>3</td>
<td>18</td>
<td>30</td>
<td>4.5%</td>
<td>1.50</td>
<td>92.7%</td>
</tr>
<tr>
<td>4</td>
<td>51</td>
<td>56</td>
<td>8.5%</td>
<td>1.63</td>
<td>87.5%</td>
</tr>
<tr>
<td>7</td>
<td>53</td>
<td>64</td>
<td>9.7%</td>
<td>1.67</td>
<td>95.3%</td>
</tr>
<tr>
<td>8</td>
<td>16</td>
<td>22</td>
<td>3.3%</td>
<td>1.96</td>
<td>88.2%</td>
</tr>
<tr>
<td>9</td>
<td>18</td>
<td>33</td>
<td>5.0%</td>
<td>1.48</td>
<td>94.5%</td>
</tr>
<tr>
<td>10</td>
<td>32</td>
<td>50</td>
<td>7.6%</td>
<td>1.37</td>
<td>91.2%</td>
</tr>
<tr>
<td>11</td>
<td>61</td>
<td>110</td>
<td>16.6%</td>
<td>1.74</td>
<td>88.0%</td>
</tr>
<tr>
<td>12</td>
<td>15</td>
<td>27</td>
<td>4.1%</td>
<td>1.67</td>
<td>85.2%</td>
</tr>
<tr>
<td>13</td>
<td>10</td>
<td>25</td>
<td>3.8%</td>
<td>1.32</td>
<td>83.2%</td>
</tr>
<tr>
<td>14</td>
<td>13</td>
<td>20</td>
<td>3.0%</td>
<td>1.87</td>
<td>89.0%</td>
</tr>
<tr>
<td>15</td>
<td>20</td>
<td>25</td>
<td>3.8%</td>
<td>1.53</td>
<td>87.2%</td>
</tr>
<tr>
<td>23</td>
<td>68</td>
<td>113</td>
<td>17.1%</td>
<td>1.70</td>
<td>93.8%</td>
</tr>
<tr>
<td>Total</td>
<td>431</td>
<td>662</td>
<td>100.0%</td>
<td>1.68</td>
<td>91.2%</td>
</tr>
</tbody>
</table>

On average, 91.2 percent of the MSR Elements were met during this same time period. This ranged from a low of 83.2 percent in Area 13 to a high of 96.4 percent in Area 1. Because the distribution of each score is not “normal”, standard correlation analyses is not recommended. A simple chi sq test for significance does indicate a weak but significant correlation exists between the two scores. WSCs who scored high on the Outcome Elements also tended to score high on the process elements.

**Outcome Elements**

Each of the 662 WSCs received an evaluation of Achieving, Implementing, Emerging or Not Emerging on the six Outcome elements. The distribution of the number and percent
for each element is displayed in the next table. On average, elements were most likely to be evaluated as Emerging, but 54 percent were evaluated as Achieving or Implementing and only 2.4 percent as Not Emerging.

<table>
<thead>
<tr>
<th>Outcome Elements</th>
<th>Achieving</th>
<th>Implementing</th>
<th>Emerging</th>
<th>Not Emerging</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Pct</td>
<td>Number</td>
<td>Pct</td>
</tr>
<tr>
<td>1</td>
<td>237</td>
<td>35.8%</td>
<td>269</td>
<td>40.6%</td>
</tr>
<tr>
<td>2</td>
<td>76</td>
<td>11.5%</td>
<td>184</td>
<td>27.8%</td>
</tr>
<tr>
<td>3</td>
<td>86</td>
<td>13.0%</td>
<td>285</td>
<td>43.1%</td>
</tr>
<tr>
<td>4</td>
<td>114</td>
<td>17.2%</td>
<td>285</td>
<td>43.1%</td>
</tr>
<tr>
<td>5</td>
<td>66</td>
<td>10.0%</td>
<td>238</td>
<td>36.0%</td>
</tr>
<tr>
<td>6</td>
<td>72</td>
<td>10.9%</td>
<td>231</td>
<td>34.9%</td>
</tr>
<tr>
<td>Total</td>
<td>651</td>
<td>16.4%</td>
<td>1,492</td>
<td>37.6%</td>
</tr>
</tbody>
</table>

Information from the data indicates the following:

- Providers were most likely to score Achieving on Element 1 (35.8%), indicating they often have an effective method for learning about the people they serve;
- Providers were least likely to score Achieving on Element 5 (10.0%), an indication they are not facilitating education, experience and exposure for individuals; and Element 6 (10.9%) indicating they have not facilitated positive results reflective of the preferences that matter most to the individual.
- Elements 2, 5, and 6 were more likely than the other elements to be scored as Not Emerging, indicating that some WSCs exhibit a lack of awareness for the health, safety and well-being of individuals; have not increased opportunities for choice and self-determination; and have not facilitated positive results reflective of the preferences that matter most to the individual.

A comparison across provider types reveals little difference between support coordinators working for an agency or operating as a solo provider. The following table displays the percent of elements at each level of evaluation by the type of provider. There were 353 support coordinators working with an agency and 309 working as solo providers. The evaluations for the elements for WSCs were similar for the two groups, with no more than a two percentage point difference between them at any level.

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

24 See Appendix 2, Exhibit 3 for evaluations by provider type.
WSC Outcomes by Provider Type
Percent of Elements by Evaluation Level
July 2004 - June 2005

<table>
<thead>
<tr>
<th>Outcome Level</th>
<th>Agency</th>
<th>Solo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieving</td>
<td>16.9%</td>
<td>15.7%</td>
</tr>
<tr>
<td>Implementing</td>
<td>38.3%</td>
<td>36.7%</td>
</tr>
<tr>
<td>Emerging</td>
<td>42.7%</td>
<td>44.6%</td>
</tr>
<tr>
<td>Not Emerging</td>
<td>2.0%</td>
<td>2.9%</td>
</tr>
</tbody>
</table>

Consults        353 309

Minimum Service Requirements
As noted previously, the Minimum Service Requirement (MSR) elements are process related and are similar to elements scored during the first three years of the contract. Providers must supply documentation of the required background screening, required training, and proper billing procedures. MSR elements are evaluated as Met or Not Met. The following table shows the number and percent of Waiver Support Coordinators, distributed across the number of MSR elements that were scored as Met. Of the 662 WSCs who participated in a WiSCC from July 2004 – June 2005, only one is shown as having none of the MSR elements scored as Met.

Minimum Service Requirements: Total Number Met by Provider Type
WiSCC Evaluations: July 2004 - June 2005

<table>
<thead>
<tr>
<th>Number</th>
<th>Number of Providers</th>
<th>Percent of Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agency</td>
<td>Solo</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>3</td>
<td>19</td>
<td>24</td>
</tr>
<tr>
<td>4</td>
<td>78</td>
<td>73</td>
</tr>
<tr>
<td>5</td>
<td>252</td>
<td>200</td>
</tr>
<tr>
<td>Total</td>
<td>353</td>
<td>309</td>
</tr>
</tbody>
</table>

- On average, just over 68 percent scored Met on all five MSR elements.
- Agency WSC providers were somewhat more likely to score Met on all five elements than were solo WSC providers.

25 See Appendix 1, Attachment 5 for a description of each MSR element.
6.5 percent of agency WSCs scored Met on three or fewer compared to 11.7 percent of solo WSCs.

In total, close to nine percent (59 WSCs) scored Met on three or fewer MSR elements.

In the following table, the number and percent Met of MSR elements is given at the element level. Of the 662 WSCs interviewed during the twelve month period ending June 30, 2005, 91.2 percent of MSR elements were scored as Met.

### Minimum Service Requirements: Percent Met by Element and Provider Type

**WiSCC Evaluations: July 2004 - June 2005**

<table>
<thead>
<tr>
<th>Element</th>
<th>Number Met</th>
<th>Percent Met</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agency</td>
<td>Solo</td>
</tr>
<tr>
<td>7</td>
<td>340</td>
<td>289</td>
</tr>
<tr>
<td>8</td>
<td>275</td>
<td>245</td>
</tr>
<tr>
<td>9</td>
<td>350</td>
<td>290</td>
</tr>
<tr>
<td>10</td>
<td>347</td>
<td>294</td>
</tr>
<tr>
<td>11</td>
<td>322</td>
<td>266</td>
</tr>
<tr>
<td>Consulti</td>
<td>353</td>
<td>309</td>
</tr>
</tbody>
</table>

Highlights from the above table include:

- With the exception of Element 8, WSCs with an agency appear to be scoring slightly better on these elements than are solo WSCs.
- Greater than a five percentage point gap exists between the two on Elements 9 and 11. Agencies are more likely to maintain documentation required for billing and are more likely to have documentation of that which is authorized by an approved cost plan and service authorization (or purchasing plan for individuals on CDC Plus). In fact, close to 100 percent of the 353 agency WSCs who were part of a WiSCC scored Met on Element 9.
- Both solo and agency WSCs were least likely to score Met on Element 8, indicating they are not always attending the required training.
- Solo providers are less likely to have the required background screening than are agency providers (Element 7). Providers are given 10 days to submit information on background screening if they are scored as Not Met on element seven.

**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.

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26 See Appendix 1, Attachment 5 for a description of the WiSCC MSR elements.
Assistance. This takes place between 10 and 90 days for solo WSCs and small WSC agencies. Follow-up with Technical Assistance for large WSC agencies may occur between 10 and 180 days following the WiSCC. These follow-up activities determine the effectiveness of the FOCUS plan initiatives, as well as provide an opportunity to review any follow-up to individual recommendations. Technical Assistance is directed toward maintaining the momentum of the WSC entity, and ensuring that WSC efforts are still on target to assist individuals toward achieving results that reflect communicated choices and preferences that matter most to them.

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

**Personal Outcome Measure Interview Sample Description**

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

POM Interviews were completed on 1,355 randomly selected consumers of DD HCBS Waiver services in Year Four of the contract. The sample is a random cluster design, stratified by provider type. For all solo WSCs, two individuals they served at the time of their consultations were randomly selected for the POM interview. Each individual was assigned a number, and computer generated random numbers were used to identify individuals selected for the sample. If the individual had completed a POM interview at any time during the first three years of the contract, that person was excluded from the sample.

For agencies with more than four WSCs, two different consultations were completed, with the second one at least six months after the first. A two step sampling process was followed. First four WSCs were randomly selected for the first consultation, using the same process as described above and then two individuals were randomly selected from each WSC. For the second consultation, the process was completed again, eliminating

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27 Go to [http://www.thecouncil.org](http://www.thecouncil.org) for information on the history of the Council, their mission statement and the development of the POM tool.

28 Random numbers are automatically generated for QICs with WiSCC application. Prior to development of the application, random numbers were generated with the sampling process in Excel.
the WSCs already selected. A maximum of eight WSCs from any agency were selected to participate in the WiSCC, four with each consultation. Individuals who had previously completed a POM were excluded from the sample.

Individuals selected for the sample had the option to decline to participate in the POM interview. An over sample was used to replace these individuals. During Year Four, 201 individuals declined to participate or were otherwise replaced. The following table provides a breakdown of these replacements by reason over the first four years of the contract.

<table>
<thead>
<tr>
<th>Reason Individuals Originally Selected for POM were Not Interviewed</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deceased</td>
<td>19</td>
<td>79</td>
<td>47</td>
<td>0</td>
</tr>
<tr>
<td>Declined Participation</td>
<td>265</td>
<td>498</td>
<td>605</td>
<td>63</td>
</tr>
<tr>
<td>Not Medicaid Waiver Eligible</td>
<td>34</td>
<td>74</td>
<td>63</td>
<td>0</td>
</tr>
<tr>
<td>QAR Unable to Make Contact</td>
<td>270</td>
<td>331</td>
<td>415</td>
<td>11</td>
</tr>
<tr>
<td>Review Later</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>73</td>
</tr>
<tr>
<td>Previously Reviewed</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>52</td>
</tr>
<tr>
<td>Relocated Out of State</td>
<td>26</td>
<td>51</td>
<td>21</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>614</td>
<td>1033</td>
<td>1151</td>
<td>201</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason Replaced</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deceased</td>
<td>3.1%</td>
<td>7.6%</td>
<td>4.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Declined Participation</td>
<td>43.2%</td>
<td>48.2%</td>
<td>52.6%</td>
<td>31.3%</td>
</tr>
<tr>
<td>Not Medicaid Waiver Eligible</td>
<td>5.5%</td>
<td>7.2%</td>
<td>5.5%</td>
<td>0.0%</td>
</tr>
<tr>
<td>QAR Unable to Make Contact</td>
<td>44.0%</td>
<td>32.0%</td>
<td>36.1%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Review Later</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>36.3%</td>
</tr>
<tr>
<td>Previously Reviewed</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>25.9%</td>
</tr>
<tr>
<td>Relocated Out of State</td>
<td>4.2%</td>
<td>4.9%</td>
<td>1.8%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Clearly there has been a marked difference in the number of declines during this past year when compared to the previous three years. Only 201 individuals (approximately 12 percent) are recorded as having not participated in the POM interview when asked. There are several possible explanations for this positive shift in the number of declines.

- The POM interview is now a critical part of the WiSCC process. Therefore, it is in the best interest of the WSC to help ensure the QIC can make contact with the selected individuals.
- The QIC obtains a current list of individuals served by the WSC shortly before the sample is drawn. Therefore, it is much less likely the list will contain individuals who have moved, are no longer eligible, or are deceased.
During the first several months of start-up while paper tools were still in use, some data elements such as this may not have been input.

In addition to the random sample, 276 individuals were also randomly selected as part of a Longitudinal Study and agreed to receive a POM interview every year for four years. Individuals participating in the Longitudinal Study were interviewed using the same review protocols. There were 187 individuals in the longitudinal sample after Year Three interviews were completed. Many of these individuals have completed a POM in Year Four. However, the interviews on the entire sample are not yet completed and the data are not yet processed. The data will be available for an in-depth study during Year Five of the contract.

Demographic Distribution of the Sample
The following table provides information on the eligible population and sample of individuals who received a POM interview in the twelve month period ending June 30, 2005. While the proportion of individuals in the sample varies somewhat from the population, the variances are generally quite small, no greater than 1.3 percentage points. Therefore, the sample appears to be a good representation of the population across the areas in the state.

<table>
<thead>
<tr>
<th>Area</th>
<th>Eligible Individuals</th>
<th>Individuals in Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1,263</td>
<td>66</td>
</tr>
<tr>
<td>2</td>
<td>1,884</td>
<td>113</td>
</tr>
<tr>
<td>3</td>
<td>1,095</td>
<td>60</td>
</tr>
<tr>
<td>4</td>
<td>1,897</td>
<td>117</td>
</tr>
<tr>
<td>7</td>
<td>2,360</td>
<td>137</td>
</tr>
<tr>
<td>8</td>
<td>799</td>
<td>50</td>
</tr>
<tr>
<td>9</td>
<td>1,361</td>
<td>66</td>
</tr>
<tr>
<td>10</td>
<td>2,060</td>
<td>101</td>
</tr>
<tr>
<td>11</td>
<td>3,356</td>
<td>210</td>
</tr>
<tr>
<td>12</td>
<td>822</td>
<td>56</td>
</tr>
<tr>
<td>13</td>
<td>1,228</td>
<td>52</td>
</tr>
<tr>
<td>14</td>
<td>824</td>
<td>43</td>
</tr>
<tr>
<td>15</td>
<td>770</td>
<td>49</td>
</tr>
<tr>
<td>23</td>
<td>4,267</td>
<td>235</td>
</tr>
</tbody>
</table>

Total 23,986 100.0% 1,355 100.0%

Gender information for the population and sample in Year Four indicates that 53.7 percent of the consumers reviewed were male, and 46.3 percent were female. This distribution is somewhat different from demographic information for the entire DS-HCBS Waiver population. There is a slightly higher percentage of males in the population, but the difference is less than five percentage points and therefore consistent with some degree of sampling fluctuation.
POM Interviews by Gender
Year 4 - July 2004 - June 2005

| Gender | Population | | | Sample | | |
|---|---|---|---|---|---|
| | Number | Percent | | Number | Percent |
| Female | 10,278 | 42.8% | | 628 | 46.3% |
| Male | 13,708 | 57.2% | | 727 | 53.7% |
| Total | 23,986 | 100.0% | | 1,355 | 100.0% |

The population and sample distributions by age group are shown below in Table 4. The proportion of children age three to 17 in the sample has typically been somewhat lower than the proportion in the population. The eligible population was approximately 22 percent children while the samples were closer to 13 percent. This age group is shown to represent a slightly smaller segment of the DD HCBS population in Year Four, and the difference between the population and sample is relatively small, 17.5 percent and 14.3 percent respectively. The sample appears to represent the population fairly well in terms of age distribution.²⁹

POM Interviews by Age Group
Year 4 - July 2004 - June 2005

| Age Group | Population | | | Sample | | |
|---|---|---|---|---|---|
| | Number | Percent | | Number | Percent |
| 3 - 17 | 4,123 | 17.5% | | 180 | 14.3% |
| 18 - 21 | 1,836 | 7.8% | | 84 | 6.7% |
| 22 - 25 | 2,148 | 9.1% | | 123 | 9.8% |
| 26 - 44 | 9,841 | 41.8% | | 561 | 44.7% |
| 45 - 54 | 3,289 | 14.0% | | 195 | 15.5% |
| 55 - 64 | 1,770 | 7.5% | | 88 | 7.0% |
| 65+ | 518 | 2.2% | | 24 | 1.9% |
| Total | 23,525 | 100.0% | | 1,255 | 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 eligible population and the fourth year sample at the time of the interview. Over half of

²⁹ The population total is somewhat smaller in this table, likely due to missing birth dates in the ABC data. The sample also has 100 individuals with missing birth dates. We intend to update any age-related tables in the revised version of this report, when time is available to retrieve the missing data.
the population and sample resided in family homes. There was a somewhat smaller percent of family home residents in the sample and a somewhat larger percent 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.

### POM Interviews by Living Arrangement

**Year 4 - July 2004 - June 2005**

<table>
<thead>
<tr>
<th>Type of Living Arrangement</th>
<th>Population</th>
<th></th>
<th></th>
<th>Sample</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family home</td>
<td>14,245</td>
<td>59.4%</td>
<td>707</td>
<td>52.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent/supported living</td>
<td>3,165</td>
<td>13.2%</td>
<td>264</td>
<td>19.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small group home (6 or less)</td>
<td>4,255</td>
<td>17.7%</td>
<td>241</td>
<td>17.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assisted Living Facility</td>
<td>0</td>
<td>0.0%</td>
<td>30</td>
<td>2.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foster home</td>
<td>428</td>
<td>1.8%</td>
<td>19</td>
<td>1.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large group home (&gt; 6)</td>
<td>1,590</td>
<td>6.6%</td>
<td>66</td>
<td>4.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>303</td>
<td>1.3%</td>
<td>28</td>
<td>2.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23,986</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>1,355</strong></td>
<td><strong>100.0%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Personal Outcome Measures Volume and Results

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

#### Personal Outcome Measures: Year 1 – Year 4

*Average and Percent Outcomes Met and Supports Present*

<table>
<thead>
<tr>
<th></th>
<th>Year One</th>
<th>Year Two</th>
<th>Year Three</th>
<th>Year Four</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Person Centered Reviews</td>
<td>1,907</td>
<td>2,539</td>
<td>2,456</td>
<td>1,355</td>
</tr>
<tr>
<td>Average Number of Outcomes Met / Consumer</td>
<td>13.2</td>
<td>12.4</td>
<td>11.2</td>
<td>11.3</td>
</tr>
<tr>
<td>Average Percent of Outcomes Met</td>
<td>52.8%</td>
<td>49.6%</td>
<td>44.9%</td>
<td>45.1%</td>
</tr>
<tr>
<td>Average Number of Supports Present / Consumer</td>
<td>14.9</td>
<td>13.4</td>
<td>12.2</td>
<td>12.1</td>
</tr>
<tr>
<td>Average Percent of Supports Present</td>
<td>59.5%</td>
<td>53.6%</td>
<td>48.9%</td>
<td>48.2%</td>
</tr>
</tbody>
</table>

The table above provides data indicating the Outcomes and Supports for individuals decreased over the first three years but appear to have leveled off during the fourth year. The implementation of the two new review processes is expected to help increase
outcomes and supports for individuals. As we enter the fifth year, and second year utilizing the outcome/person-centered processes, we hope to see the outcomes and supports increase. If this trend is not realized, efforts will be made to revise the processes in order to continue to enhance the person-centered nature of the program.

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. Theoretically, if more supports are present, outcomes for the consumer should also be better. In other words, if the supports are correlated with outcomes, the percent Present on the two measures for each item should be similar. Figure 1 on the following page provides the percentage of Outcomes Present and Supports Present by POM item for the sample of individuals who received a POM interview in Year Four of the contract. At the aggregate level, it appears there is a continuing correlation between the provision of supports and achievement of personal outcomes. However, it is important to note here that this is an aggregate representation and should not be over-interpreted. For example, on the item Participates in the life of the community we know that 35.9 percent of individuals scored this outcome as Present and 43.5 percent scored this as Supports Present, but we do not know if these are the same people.

Data indicate:
- Is free from abuse and neglect shows the highest percent Present for both outcomes and supports, at 82.9 percent and 84.1 percent respectively.
- Performs different social roles remains the lowest on both of all the POM items, although this has improved somewhat since Year Three.
- Four POM items show fewer than 30 percent of individuals with Outcomes Present: Chooses where they work, Perform different social roles, Has friends and Chooses services.
- Two POM items show fewer than 30 percent of individuals with Supports Present: Performs social roles and Has friends.
- Ten POM items have close to 50 percent or higher on both Outcomes Present and Supports Present.
Percent Outcomes/Supports Met
July 2004 - June 2005

- Chooses personal goals
- Chooses where and with whom they live
- Chooses where they work
- Has intimate relationships
- Satisfied with services
- Satisfied with personal life situations
- Chooses daily routine
- Has Privacy
- Decides when to share personal info
- Uses their environment
- Lives in integrated environments
- Participates in the life of the community
- Interacts with members of the community
- Performs different social roles
- Has friends
- Is respected
- Chooses services
- Realizes personal goals
- Is connected to natural support networks
- Is safe
- Exercises rights
- Is treated fairly
- Has the best possible health
- Is free from abuse and neglect
- Experiences continuity and security

Outcomes Present
Supports Present
An analysis of POM results by item over the first three years of the contract is presented in the following table. While most POM items showed a decrease in the percent of outcomes and supports present from Year Two to Year Three, in Year Four many of the items remained fairly consistent with small increases or decreases. Performs different social roles, Has friends, and Is treated fairly are items that continued to shift downward in Year Four.

### Personal Outcome Measures by Item: Years 2, 3 and 4

<table>
<thead>
<tr>
<th>Personal Outcome Measure</th>
<th>Year 2 N=1,907</th>
<th>Year 3 N=2,540</th>
<th>Year 4 N=2,457</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcomes Present</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supports Present</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chooses personal goals</td>
<td>44%</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Chooses where and with whom they work</td>
<td>50%</td>
<td>36%</td>
<td>38%</td>
</tr>
<tr>
<td>Chooses where they work</td>
<td>30%</td>
<td>23%</td>
<td>29%</td>
</tr>
<tr>
<td>Has intimate relationships</td>
<td>59%</td>
<td>45%</td>
<td>46%</td>
</tr>
<tr>
<td>Satisfied with services</td>
<td>54%</td>
<td>48%</td>
<td>54%</td>
</tr>
<tr>
<td>Satisfied with personal life situations</td>
<td>74%</td>
<td>73%</td>
<td>71%</td>
</tr>
<tr>
<td>Chooses daily routine</td>
<td>55%</td>
<td>47%</td>
<td>50%</td>
</tr>
<tr>
<td>Has Privacy</td>
<td>71%</td>
<td>64%</td>
<td>65%</td>
</tr>
<tr>
<td>Decides when to share personal info</td>
<td>48%</td>
<td>46%</td>
<td>49%</td>
</tr>
<tr>
<td>Uses their environment</td>
<td>54%</td>
<td>34%</td>
<td>35%</td>
</tr>
<tr>
<td>Lives in integrated environments</td>
<td>33%</td>
<td>27%</td>
<td>32%</td>
</tr>
<tr>
<td>Participates in the life of community</td>
<td>46%</td>
<td>38%</td>
<td>36%</td>
</tr>
<tr>
<td>Interacts with members of the community</td>
<td>52%</td>
<td>44%</td>
<td>41%</td>
</tr>
<tr>
<td>Performs different social roles</td>
<td>27%</td>
<td>22%</td>
<td>15%</td>
</tr>
<tr>
<td>Has friends</td>
<td>39%</td>
<td>29%</td>
<td>26%</td>
</tr>
<tr>
<td>Is respected</td>
<td>55%</td>
<td>48%</td>
<td>49%</td>
</tr>
<tr>
<td>Chooses services</td>
<td>31%</td>
<td>23%</td>
<td>25%</td>
</tr>
<tr>
<td>Realizes personal goals</td>
<td>46%</td>
<td>48%</td>
<td>51%</td>
</tr>
<tr>
<td>Is connected to natural support networks</td>
<td>74%</td>
<td>65%</td>
<td>65%</td>
</tr>
<tr>
<td>Is safe</td>
<td>73%</td>
<td>67%</td>
<td>62%</td>
</tr>
<tr>
<td>Exercises rights</td>
<td>40%</td>
<td>34%</td>
<td>35%</td>
</tr>
<tr>
<td>Is treated fairly</td>
<td>65%</td>
<td>60%</td>
<td>53%</td>
</tr>
<tr>
<td>Has the best possible health</td>
<td>59%</td>
<td>39%</td>
<td>41%</td>
</tr>
<tr>
<td>Is free from abuse and neglect</td>
<td>87%</td>
<td>83%</td>
<td>83%</td>
</tr>
<tr>
<td>Experiences continuity and security</td>
<td>55%</td>
<td>37%</td>
<td>39%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>50%</td>
<td>45%</td>
<td>45%</td>
</tr>
</tbody>
</table>

While it is too early to determine the impact of the new processes initiated this year, as mentioned above, the results reflect a shift from the downward trend established over the first three years of POM interviews. The current year’s results presented in this report have not been weighted for the cluster sample design. However, the nature of a complex design such as used in Year Four affects standard errors and statistical manipulations.

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30 Because Year One was a “start-up” year with all consultants gaining experience with the POM interview process, we do not include it here. Results were generally higher in Year One than in any other year.
The statewide results, displayed for descriptive purposes such as in the table above, should not be greatly impacted as the sample is a good demographic representation of the population (see demographic section).

The top five POM items for which the outcome is most frequently Present and the support is most frequently Present have remained consistent from Year One through Year Four.\(^{31}\)

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

The lowest levels of both supports provided and outcomes achieved have remained consistent since Year Three.

- Performs different social roles
- Chooses services
- Has friends
- Chooses work
- Lives in an integrated environment

The following table presents an analysis on a case by case basis of the 25 POM items. Information provided gives the number and percent of times POM items had both outcomes and supports Not Present and the number and percent of times the items had both outcomes and supports Present. In other words, in Year Four (July 2004 – June 2005), 1,355 individuals were interviewed on a total of 33,875 POM questions. On 16,150 questions (items), neither outcomes nor supports were Present and on 13,883 items both were Present.

Data from the following table indicate:

- There had been a steady decline in the percent where both are Present, from 49.6 percent in Year One to 40.9 percent in Year Three. This remained the same in Year Four.
- At the same time, there had been a steady increase in the percent where both are Not Present, and this has also remained the same in Year Four.\(^{32}\)

\(^{31}\) See Appendix 2, Exhibit 5 for a list of the top three reasons outcome/supports are not present (forthcoming).

\(^{32}\) These changes are statistically significant at p<.000. However, with such a large number of cases in the analysis, even very small differences may show statistical significance.
• The percent of POM items with a different result, one Present and one Not Present, has continued to decline.
• Each year a high percentage of cases (Close to 89% in Year Four) show a direct correlation between outcomes and supports—both Present or both Not Present.

### Outcomes and Supports Both Present or Not Present

<table>
<thead>
<tr>
<th>Contract Year</th>
<th>Number With Both</th>
<th>Percent With Both</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Present</td>
<td>Present</td>
</tr>
<tr>
<td>Jul 01 - Jun 02</td>
<td>17,775</td>
<td>23,663</td>
</tr>
<tr>
<td>Jul 02 - Jun 03</td>
<td>26,536</td>
<td>28,594</td>
</tr>
<tr>
<td>Jul 03 - Jun 04</td>
<td>28,925</td>
<td>25,117</td>
</tr>
<tr>
<td>Jul 04 - Jun 05</td>
<td>16,150</td>
<td>13,883</td>
</tr>
</tbody>
</table>

### Outcome and Supports Differ

<table>
<thead>
<tr>
<th>Contract Year</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul 01 - Jun 02</td>
<td>6,237</td>
<td>13.1%</td>
</tr>
<tr>
<td>Jul 02 - Jun 03</td>
<td>8,370</td>
<td>13.2%</td>
</tr>
<tr>
<td>Jul 03 - Jun 04</td>
<td>7,358</td>
<td>12.0%</td>
</tr>
<tr>
<td>Jul 04 - Jun 05</td>
<td>3,842</td>
<td>11.3%</td>
</tr>
</tbody>
</table>

**Driver Indicators**

Two Personal Outcome Measures have been identified as “driver” indicators. A driver indicator has been defined as a Personal Outcome Measure that if Present, increases the likelihood that at least 13 or more Outcomes will be Present and Supports will be present. Through a series of analyses, the POMs with the highest predictive value were identified; two were selected by the IQC - Chooses services and Chooses where they work as indicators to be targeted and tracked for Quality Improvement initiatives. While there has been improvement this year, these POM items are still among those most frequently Not Present on outcomes and supports. The reasons these are most often not Present are similar and related to limited or no options or opportunities available; that choices for the individuals are made by others, including family members; barriers are not addressed; and the organization is not increasing education about choices or working to learn the preferences of the individuals they serve.

• Chooses work: 28.6 percent Outcomes Present, 36.7 percent Supports Present.
• Chooses services: 25.2 percent Outcomes Present, 32.0 percent Supports Present.

**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. Over the four year period, on average 46.3 percent of individuals had 13 or more outcomes Met and 53.4 percent had 13 or more supports Present. In both areas, this has shown a decrease over the first three years but that trend has stabilized in Year Four. As demonstrated previously, the downward trend on these criteria since Year One has abated somewhat in Year Four.

| Contract Year | Outcomes | Supports | Total
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>Jul 01 – Jun 02</td>
<td>1,040</td>
<td>54.5%</td>
<td>1,219</td>
</tr>
<tr>
<td>Jul 02 – Jun 03</td>
<td>1,230</td>
<td>49.3%</td>
<td>1,406</td>
</tr>
<tr>
<td>Jul 03 – Jun 04</td>
<td>977</td>
<td>39.8%</td>
<td>1,130</td>
</tr>
<tr>
<td>Jul 04 – Jun 05</td>
<td>557</td>
<td>41.4%</td>
<td>630</td>
</tr>
<tr>
<td>Total</td>
<td>3,804</td>
<td>46.3%</td>
<td>4,385</td>
</tr>
</tbody>
</table>

Results by Home Type, Area, and Age Group

Exhibit 6 (Appendix 2) shows the distribution of individuals who had 13 or more outcomes Met or supports Present across areas, age groups and type of living arrangement for Year Four. 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 are most likely to have both outcomes and supports met, with 56.4 percent and 58.7 percent respectively. This is consistent with findings over the previous three years, although the percent with 13 or more outcomes met has decreased every year from 71.2 percent in Year One.
- The percent of residents in large group homes that met the criterion of 13 or more outcomes met has decreased from 29.6 percent in Year Three to 19.7 percent in Year Four.
- The data suggest fairly large variations across areas on the percent of 13 or more outcomes met. Several areas have a small number of participants in the sample, which lends itself to large fluctuations in point estimates. Some areas do, however, show large differences since Year Three: Area 1 decreased from 71.5
percent to 57.6 percent, Area 8 increased from 25.2 percent to 46.0 percent and Area 12 increased from 27.4 percent to 46.4 percent.\textsuperscript{33}

- Children age 17 and under continue to be most likely to have this criterion met for both outcomes and supports. The percent met for Year Four is the same as for Year Three, at approximately 60 percent.
- People age 22 to 25 have the highest level of 13 or more Outcomes met (43.9\%) or 13 or more Supports present (48.8\%) among all the adult age groups.

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 would expect to have met most of the time. The percent of reviews for which all seven Foundational Outcomes are Met has been selected as a Performance Indicator that is reported to the Governor and Florida Legislature.\textsuperscript{34}

The seven outcomes are listed in the following table. The percent met on \textit{Is safe} and \textit{Is treated fairly} dropped somewhat since Year Two: from 67 percent to 62 percent and from 61 percent to 53 percent respectively. The remaining foundational outcome items remained fairly consistent since Year Three. The outcome most often met for each of the year indicates individuals are \textit{free from abuse and neglect}, and that individuals \textit{Exercise rights} has remained the worst performer each year.

<table>
<thead>
<tr>
<th>Foundational Performance Outcome Measures</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 - Is connected to natural support networks</td>
<td>70.5%</td>
<td>64.6%</td>
<td>64.9%</td>
</tr>
<tr>
<td>20 - Is safe</td>
<td>67.7%</td>
<td>67.3%</td>
<td>61.9%</td>
</tr>
<tr>
<td>21 - Exercises rights</td>
<td>36.6%</td>
<td>33.9%</td>
<td>34.8%</td>
</tr>
<tr>
<td>22 - Is treated fairly</td>
<td>60.5%</td>
<td>60.1%</td>
<td>53.1%</td>
</tr>
<tr>
<td>23 - Has the best possible health</td>
<td>50.2%</td>
<td>39.5%</td>
<td>40.7%</td>
</tr>
<tr>
<td>24 - Is free from abuse and neglect</td>
<td>84.6%</td>
<td>83.0%</td>
<td>82.9%</td>
</tr>
<tr>
<td>25 - Experiences continuity and security</td>
<td>49.2%</td>
<td>37.2%</td>
<td>38.5%</td>
</tr>
</tbody>
</table>

The following table shows the number of individuals who have zero to seven of the foundational outcomes met. The overall rate that All Foundational Outcomes were met during the twelve month period ending June 30, 2005, was 8.5 percent (115 individuals). This shows an increase over the past two years, up from 6.6 percent in Year Three. Nineteen percent of individuals had at least six of these important outcomes met.

\textsuperscript{33} See Appendix 2 Exhibit 7 for 13 or more outcomes/support met by area (district) and year.
\textsuperscript{34} See Appendix 2, Exhibit 8 for summary information on Foundational Outcomes by district, age group and home type for Years 1, 2, and 3.
Results by Home Type, Area, and Age Group
Results in Exhibit 9 (Appendix 2) display the percent of individuals for whom a Person-centered Review was completed who Met all seven Foundational Outcomes, displayed for each home type, area and age group. Again, the number of POM interviews completed in several areas and within some home types and age groups is relatively small, which can produce unstable point estimates.

- The percent with all of the foundational outcomes met is highest for people living in a family home (11%), with the exception of the “other/unk” category (12 out of 28). This proportion Met in family homes is greater than for the previous two years.
- There is quite a bit of variation across areas as well as within some areas over time. However, because the numbers in most areas are generally small, this is expected. In Year Four, Areas 4, 10, and 11 have a percent met on all foundational outcomes above the statewide average of 8.5 percent.
- At the same time, none of the individuals interviewed in Areas 13, 14, or 15 had all of these outcomes met.
- The youngest age group and individuals age 45 to 54 were most likely to have all of the foundational outcomes met.

Medical Peer Review Findings

New Medical Review procedures were implemented when QIC began doing WiSCC. For the review, the Nurse Reviewer is responsible for overseeing the recommendations

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35 This category consists of 14 people in Residential Treatment Facilities and 14 Unknown.
that are generated by the QIC who utilizes 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. 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 QIC’s. 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.\(^{36}\) The overwhelming majority show no additional concerns were noted. This is quite different from previous years. One explanation is that the change in procedures allows input from the Nurse Reviewer during the WiSCC process so that concerns are addressed on site rather than sent to the WSC or Medical Case Manager.

<table>
<thead>
<tr>
<th>Disposition</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requesting Medical Records</td>
<td>9</td>
<td>0.7%</td>
</tr>
<tr>
<td>Done - no additional concerns</td>
<td>1,243</td>
<td>95.6%</td>
</tr>
<tr>
<td>Done - additional concerns to WSC</td>
<td>27</td>
<td>2.1%</td>
</tr>
<tr>
<td>Done - no concern/no claims</td>
<td>8</td>
<td>0.6%</td>
</tr>
<tr>
<td>Done - concern yes/no claims</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>Done - ancillary claims only</td>
<td>2</td>
<td>0.2%</td>
</tr>
<tr>
<td>Done - additional concerns to MCM</td>
<td>10</td>
<td>0.8%</td>
</tr>
<tr>
<td><strong>Total with Disposition</strong></td>
<td>1,300</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

\(^{36}\) Additional information about the recommendations and a summary of the frequency and types of specific health or behavioral health recommendations is provided in Exhibit 10, Appendix 2.
Section Three: Discussion of Findings and Recommendations

Through June 30, 2005, the Florida Statewide Quality Assurance Program (FSQAP) has conducted over 8,300 Personal Outcome Measure interviews with individuals who were receiving services and supports through the Developmental Disabilities Home and Community Based Services (DD HCBS) Waiver. Close to 8,000 annual Provider Performance Reviews/CORE have been completed along with over 3,300 follow up reviews/consultations. This number does not include the number of follow-up visits QICs had subsequent to a WiSCC. Review results from these have been reported on a regular basis through quarterly reports and presentations at state and local meetings. As project staff have shared the data and worked with the State and districts to improve the quality assurance process and provide training and technical assistance, emerging trends and patterns have been noted and are being used to direct improvements in supports and services.

The average score for Desk Reviews, a procedure that has changed very little over the four year contract, has increased somewhat since Year One but has remained fairly consistent since Year Two, with a four-year average of 75.7 percent. The percent of Desk Reviewed providers who had documentation for their Level 2 Background 5-Year Re-screening has decreased, perhaps because many providers are now due for this procedure for the first time. The percent of providers with their Level 2 Background Screening has steadily improved each year, but remains relatively low at just over 74 percent. Finally, the percent of Recoupment Citations has remained fairly constant.

Recommendation: A workgroup representing all relevant parties should examine the Desk Review process and suggest modifications where appropriate. The Quality Improvement Study examining the Desk Review results at the element level that was completed in Year Three should be used to guide the process of determining elements that need greater focus. Incorporating the outcome-based focus and elements of CORE, as/if possible, may help to enhance the process. Also, a deeper analysis may help determine which elements are most frequently cited for recoupment and if that has changed over the years.

Because this is the first year implementing the CORE and WiSCC processes, the data analyzed in this report provide a baseline from which to move forward into the fifth year of the contract. In both processes providers were most likely to attain Emerging or Implementing. On the Outcome Elements, there was very little difference in the evaluation levels between Support Coordinators (WiSCC) who worked for an agency or in a solo capacity. However, solo providers who received a CORE appeared to have performed better than agency providers who received a CORE (Outcome Elements). CORE results also indicate that solo providers had relatively more MSR elements Met than agency providers, particularly in background screening and maintaining the required documentation.

Recommendation: It was noted earlier that a possible reason that agency providers do not always perform as well as solo providers is the challenge they may have meeting the
requirements for multiple employees and services, and managing turnover. It is
recommended that this challenge be explored. Perhaps the Area Quality Leaders could
help design a system that could enhance agency performance, particularly in areas that
reflect adherence to required procedures such as training and background screening, as
measured with the MSR elements.

On average, Waiver Support Coordinators, either with an agency or solo, are performing
well in terms of background screening requirements (Element 7). Performance in this
area is not as good among providers who had a CORE consult, particularly agency
providers (Element 20).

Recommendation: It is not clear why WSCs perform better on this measure than other
providers, whether solo or agency. Further exploration into this phenomenon could be
helpful. Practices routinely performed by WSCs may help providers of other services
who are reviewed onsite.

There appears to be some similarity in the Outcome Element results across the CORE and
WiSCC. Both measure the extent to which organizations have systems in place to
provide outcomes that are most important to the individuals they serve. In both
procedures, individuals are interviewed to determine if they are achieving their desired
outcomes and goals. CORE results indicate that individuals are often not adequately
developing desired social roles that they value and that providers do not routinely have
individuals participate in the review of their implementation plan or direct changes
desired to assure outcome/goals are met. At the same time, WiSCC results indicate
WSCs are often not facilitating education, experience and exposure for individuals
(hindering the development of desired social roles) and do not often facilitate positive
results reflective of the preferences that matter most to the individual (not allowing
individuals to help direct their lives to ensure goals are met). In addition, WSCs most
often have an effective method for learning about the people they serve while results
from CORE on the Outcome Elements indicate their best performance is that people are
satisfied with their services and they are treated with dignity and respect. We show
people dignity and respect by taking the time to learn who they really are, and knowing
the people you serve well will certainly enhance satisfaction levels.

Recommendation: These results reflect a consistency between the two tools, as the
systems reviewed overlap, affecting all the individuals being served. As more data
become available, continued review of the connection between the two processes is
recommended.

Follow-up data available in an automated format reflect that providers who have a CORE
benefit greatly from the Follow-up visit. Only MSR scores are changed subsequent to a
Follow-up review, and of the 25 providers who received one and had at least one MSR
scored as Not Met, 22 scored Met on 100 percent of the elements. Providers who receive
a Follow-up with Technical Assistance often have more “issues” to address. Over half of
these 144 providers scored Met on 100 percent of elements that were previously scored as Not Met.37

Recommendation: These findings are encouraging and support the continued development of a strong on site follow up and technical assistance program. Efforts should continue to identify areas most helpful to providers for the follow-up process. Providers who continue to receive a Not Met on elements should be monitored the following year and referred to the district if needed.

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

However, results for Year Four suggest this trend may have subsided. The percent of individuals with all of the foundational outcomes met has increased somewhat and the percent of individuals scoring Met has either remained constant or increased somewhat on all but a few of the 25 POM items. While it is not clear why the downward trend in outcomes and supports has slowed, it is encouraging to witness such a change after implementation of review processes designed specifically to impact outcomes in people’s lives.

Recommendation: A study should be completed that examines the effect of the new processes on outcomes and supports. In this study, a longitudinal review of the impact of “external” factors is essential. For example, a new Service Authorization process is beginning in Year Five and it is not known how this may impact results on the POM outcomes and supports. A review of factors such as this over the past few years should help determine how individuals’ lives are impacted by changes in provider rates, service authorization requirements, or other relevant administrative or legislative actions.

The data from Year Four indicate a rather substantial decrease in the criterion measuring 13 or more outcomes for residents in large group homes, from 29.6 percent in Year Three to 19.7 percent in Year Four. While this could possibly be a reflection of the sample that was used this year, the decrease is sufficient enough to warrant continued monitoring.

Recommendation: Delmarva and APD should closely monitor the outcomes for people living in large group homes and explore the extent to which this decline may be a result of recent policy/program changes or other factors within our power to address/impact.

37 Follow-up reviews are provided for WSCs as well, however the change in scores is not available in the database system.
The number of individuals who “declined” to be interviewed this year was significantly lower than for previous years. This could be, in part, the result of using the paper tools for several months during the implementation of the WiSCC process, whereby all the information for individuals who declined to participate may not have been input into the system. However, the WiSCC process requires a POM as part of the evaluation. Therefore, support coordinators are more likely to contact individuals and schedule their interviews. Also, a current list of individuals is obtained from the WSC from which to select the sample for the POM interviews.

Recommendation: In order to preserve the integrity of the random sample of individuals for analysis purposes, it is important that a high percent of individuals selected for the interview actually participate. In previous years the decline rate has been relatively high (approximately 40 percent). We suggest this current trend be followed closely throughout Year Five in order to determine if the new process has in fact positively impacted the number of declines from individuals.

Delmarva has continued to collect data on a panel of individuals who agreed to have a POM interview every year for four years. The data were not yet ready for analysis at the time this report was completed.

Recommendation: Complete a Quality Improvement Study that focuses on the longitudinal data. This study should be completed in Year Five of the contract and include Time Series Analysis as well as comparisons to the POM data collected from different individuals each year (the annual POM sample).

An important component of the new review processes is to identify barriers to service delivery that impact consumers. This information is not yet available for analysis. However, the importance of identifying barriers and any subsequent solutions to removing those barriers can not be overstated.

Recommendation: Complete a Quality Improvement Study on the barriers to service as identified through the WiSCC process. This study should have both a quantitative and qualitative component. While analysis of the data collected by the QICs is important, focus group discussions organized across the state would help further identify barriers at the local level. These groups should include the AQLs or other relevant APD representatives.

Finally, Area (District) Quarterly Reports have been distributed to the areas for approximately two years, using some of the same data presented in this report. The information contained in the area reports reflects area and statewide results on provider performance, and also provider performance information specific to each Area to enable improvement in the quality of service provided to individuals. Areas also receive information on individuals who are potentially at risk of dangerous drug interactions and/or dangerous reactions to specific drugs if not properly monitored. At this point it is not known how the data are used and if modifications to the information would be helpful.
Recommendation: Delmarva should work with APD and the AQLs to examine the reports currently provided to each area. Changes should be made based upon the usefulness and clarity of the information.