Florida Statewide Quality Assurance Program

Annual Report
Contract Year 6
July 2006 – June 2007

provided by
Delmarva Foundation

September 2007
Presented to the Agency for Health Care Administration
and the Agency for Persons with Disabilities
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List of Acronyms

ADT—Adult Day Training
AHCA—Agency for Health Care Administration
APD—Agency for Persons with Disabilities
CORE—Collaborative Outcomes Review and Enhancement
CQL—Council on Quality and Leadership
CRE—CORE Results Elements
DD—Developmental Disabilities
FOCUS plan—Formula Offering Cooperative Unified Success
FSL—Family and Supported Living
FSQAP—Florida Statewide Quality Assurance Program
FU—Follow-up
HCBS—Home and Community Based Services
IHSS—In Home Support Services
MSR—Minimum Service Requirements
NRSS—Non-Residential Support Services
PCR—Person Centered Review
POM—Personal Outcome Measures
PPR—Provider Performance Review
QA—Quality Assurance
QI—Quality Improvement
QIC—Quality Improvement Consultant
SLC—Supported Living Coaching
SMHC—Special Medical Home Care
TA—Technical Assistance
WiSCC—Waiver Support Coordination Consultation
WRE—WiSCC Results Elements
WSC—Waiver Support Coordinator
Executive Summary

Since September of 2001, Delmarva Foundation, in cooperation with the Agency for Persons with Disabilities (APD) and the Agency for Health Care Administration (AHCA), has provided quality assurance, quality improvement and technical assistance to several thousand providers of services under the Developmental Disabilities Home and Community Based Services Waiver (DD) through the Florida Statewide Quality Assurance Program (FSQAP). In July 2006, individuals receiving services through the Family and Supported Living Waiver (FSL) were added to the QA program. As part of the FSQAP, Delmarva consultants have also conducted thousands of Person Centered Reviews (PCR) with individuals to determine their quality of life. The PCR includes a Personal Outcome Measures (POM) interview as developed by The Council on Quality and Leadership (CQL), a partner of Delmarva’s in this endeavor, interviews with relevant family members/guardians and the Waiver Support Coordinator, and reviews of the individual’s records. This report includes information, data analysis, results, discussion and recommendations from activities from July 2006 – June 2007—the sixth year of the FSQAP contract.

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

Delmarva’s QICs use three different types of reviews:

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

- Desk Reviews are conducted on all other providers who do not receive a CORE or WiSCC and render a service that is subject to a QA review (does not include Adult Dental, Consumable Medical Supplies, Adaptive Equipment or Environmental Modifications). These are not onsite reviews but do include phone interviews with individuals.

Desk Reviews

QICs have completed 624 Desk Reviews during the 12 month period ending June 30, 2007. This is considerably less than in previous years due to a contract amendment, shifting resources away from the Desk Review process into the onsite CORE processes. Results for Desk Reviews indicate (Figure ES1):

- Some differences between agency and solo providers across the years;
- Fairly consistent annual scores through Year Five, ranging between approximately 75 percent and 77 percent since the second year of the contract;
- The Statewide score in Year Six dropped from 77 percent in Years Four and Five to just over 73 percent.
- On average, solo providers have scored somewhat higher than agency providers.

Figure ES1: Desk Review Scores by Provider Type and Year

<table>
<thead>
<tr>
<th>Review Year</th>
<th>Average Review Score</th>
<th>Agency</th>
<th>Solo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1 (1001)</td>
<td>79.5%</td>
<td>71.2%</td>
<td></td>
</tr>
<tr>
<td>Year 2 (1207)</td>
<td>74.5%</td>
<td>78.3%</td>
<td></td>
</tr>
<tr>
<td>Year 3 (1090)</td>
<td>70.3%</td>
<td>75.8%</td>
<td></td>
</tr>
<tr>
<td>Year 4 (1247)</td>
<td>72.8%</td>
<td>78.7%</td>
<td></td>
</tr>
<tr>
<td>Year 5 (1051)</td>
<td>77.4%</td>
<td>77.4%</td>
<td></td>
</tr>
<tr>
<td>Year 6 (624)</td>
<td>69.7%</td>
<td>74.2%</td>
<td></td>
</tr>
<tr>
<td>State (6220)</td>
<td>73.8%</td>
<td>76.2%</td>
<td></td>
</tr>
</tbody>
</table>
Desk Review results for Year Six also indicate the following:

- Approximately 29 percent of the providers received at least one Background Screening alert, indicating documentation was not present verifying background screening for one or more employees. This is an increase from 23 percent in Year Five and similar to Year Two and Three levels;
- Approximately 57 percent of the background screening citations in Year Six were rectified by the time of the Documentation Follow-up Review;
- Close to 50 percent of providers who received a Desk Review in Year Six had at least one recoupment citation.

Collaborative Outcomes Review and Enhancement (CORE)
On the CORE process, providers are evaluated as Achieving, Implementing, Emerging or Not Emerging on elements that are results oriented. The original CORE process had 18 Core Results Elements (CRE)—ensuring the provider has effective systems in place to provide the necessary supports to individuals on the various measures including health and safety and assuring positive results are attained by individuals served. Providers are also scored as Met or Not Met on process elements, the Minimum Service Requirement (MSR) elements that indicate if training, background screening and other service documentation requirements are fulfilled. There were seven MSR elements in the original CORE process. On March 12, 2007, a revised CORE was implemented with eight CREs and four MSRs. Some results from the revised process are presented in this report.

Quality Improvement Consultants (QICs) completed 886 CORE consults between July 2006 – June 2007—523 original CORE and 363 revised version. On average, solo providers each year have been more likely to score as Achieving than agency providers, and less likely to be evaluated as Emerging. Scores vary quite a bit across APD Areas. However, the number of CORE conducted in each Area during Year Six using the two different CORE versions, before and after March 12, 2007, is somewhat small. So comparisons to Year Six across years or APD Areas should be made with caution.
The overall CRE evaluation on the original tool indicates the following (Figure ES2):

- Providers improved somewhat from the first to second year after implementation of the process;
- A small downturn is evident through March 12, 2007, in Year Six.
- Close to 60 percent of providers were evaluated as Implementing or Achieving in Year Four, and 65 percent in Year Five. However, this had dropped to 56 percent in Year Six (6A).
- Providers in Year 6A were more likely to be evaluated as Emerging and less likely to be evaluated as Implementing, compared to the previous two years.

![Figure ES2: CORE Results Elements Scores by Year](image-url)
The information in Figure ES3 informs us that:

- Independent CORE Results Elements most likely to be scored as Achieving are the elements indicating organizational systems ensure individuals are safe (Element 9), they are treated with dignity and respect (Element 2) and that privacy for individuals is ensured (Element 3).
- The organizational area most likely to be scored as Not Emerging indicates if individuals routinely review and update their Implementation Plans.
Results on the CORE Minimum Service Requirements are presented in Figure ES4. On average they indicate the following:

- The statewide annual score dropped from 75 percent in Year Four (July 2004 – June 2005) to 64 percent in Year Six, up through March 12, 2007;
- Providers show their best performance on the element indicating they are authorized to render the service;
- Providers are least likely to have requirements met for Projected Service Outcomes or maintaining documentation.

![Figure ES4: CORE Minimum Service Requirements by Year](image)

In addition, CORE results in this report indicate:

- On average, solo providers appear to have performed better on the MSRs over time than agency providers;
- A majority of the alert citations were for noncompliance with background screening requirements;
- Close to 44 percent of providers who had a CORE consult received at least one recoupment citation.
Waiver Support Coordination Consultation (WiSCC)

QICs completed 511 WiSCC evaluations that included a review of 707 Waiver Support Coordinators (WSC) and Personal Outcome Measures (POM) interviews with 1,413 individuals. Figure ES5 shows the percent of Results Elements scored at each evaluation level for WSCs for the first three years of WiSCC activity: Achieving, Implementing, Emerging and Not Emerging.

- The percent of elements scored as Achieving has increased from 16.4 percent to close to 25 percent;
- Over 63 percent of the WiSCC Results Elements (WREs) were scored as Achieving or Implementing in Year Six, up from 54 percent in Year Four. This improvement is true for support coordinators working alone (solo) or with an agency;
- Both solo and agency providers have increased the percent of elements scored as Achieving and Implementing since Year Four, while at the same time reducing the percent scored as Emerging.

**Figure ES5: WSC Results Elements by Percent at Each Level**
*July 2004 - June 2007*

<table>
<thead>
<tr>
<th>Year</th>
<th>Achieving</th>
<th>Implementing</th>
<th>Emerging</th>
<th>Not Emerging</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 4 (671)</td>
<td>16.4%</td>
<td>37.5%</td>
<td>43.6%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Year 5 (685)</td>
<td>21.6%</td>
<td>42.6%</td>
<td>33.9%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Year 6 (707)</td>
<td>24.7%</td>
<td>38.5%</td>
<td>34.1%</td>
<td>2.8%</td>
</tr>
</tbody>
</table>
Results for each WiSCC Results Element (WRE) are shown in the following graph (Figure ES6). In general, WSCs appear to have improved consistently in developing systems that generate positive results for individuals they support. Results indicate:

- A majority of WSCs were evaluated as Achieving or Implementing on each element;
- WSCs are most likely to have systems in place that allow them to know the people they serve, 48 percent scored this as Achieving;
- Approximately 14.6 percent of WSCs have scored Achieving in the area of Health and Safety, and over 40 percent scored this as Implementing. This indicates that a majority of WSCs have organizational systems in place to ensure the health and safety of each individual, but not all are allowing individuals to direct their own health care planning.
- A high percent of WSCs scored Emerging or Not Emerging on Element 6, measuring the extent to which they facilitate positive results for individuals (47.3%).
- 45.4 percent scored as Emerging and Not Emerging on Element 5 which measure the extent to which the provider has systems in place to facilitate the use of the three Es—Education, Exposure and Experience.

![Figure ES6: WiSCC Results Elements by Evaluation Level July 2006 - June 2007](image-url)
Compliance information for the five Minimum Service Requirements (MSR) is presented in figure ES7:

- The total percent of Minimum Service Requirements scored as Met during Year Six has decreased compared to Year Four and Year Five, from 91/92 percent to 88 percent;
- While support coordinators have improved in the area of required training they have shown worse performance on elements measuring their authorization to render the service and on maintaining documentation.

### Figure ES7: WSC MSR Elements Percent Met by Year
**July 2004 - June 2007**

<table>
<thead>
<tr>
<th></th>
<th>Background Screening</th>
<th>Training</th>
<th>Authorized to Render</th>
<th>Bills as Authorized</th>
<th>Maintains Documentations</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 4 (671)</strong></td>
<td>94.9%</td>
<td>77.9%</td>
<td>96.7%</td>
<td>96.7%</td>
<td>88.7%</td>
<td>91.0%</td>
</tr>
<tr>
<td><strong>Year 5 (685)</strong></td>
<td>95.6%</td>
<td>84.4%</td>
<td>96.1%</td>
<td>98.7%</td>
<td>85.7%</td>
<td>92.1%</td>
</tr>
<tr>
<td><strong>Year 6 (707)</strong></td>
<td>94.1%</td>
<td>86.4%</td>
<td>87.4%</td>
<td>99.7%</td>
<td>73.8%</td>
<td>88.3%</td>
</tr>
</tbody>
</table>
Personal Outcome Measures

During the first few years of the FSQAP contract, results from the individual Personal Outcome Measures (POM) interviews reflected a downward trend in the percent of outcomes and supports present in the lives of people served through the DD Waiver (Figure ES8). In Year Five this trend appeared to shift upwards, with an increased percent of both outcomes and supports present. During Year Six, results from the POM interviews indicate a possible downward shift. The decrease is not apparent across all POM items as the following seven remained the same or showed some improvement since Year Five, including a small increase in the item measuring if an individual is free from abuse, neglect and exploitation:

- Chooses where and with whom to live
- Satisfied with services
- Lives in integrated environments
- Realizes personal goals
- Is safe
- Has the best possible health
- Is free from abuse and neglect

![Figure ES8: Personal Outcome Measures](image-url)

**Percent Present by Year, July 2002 - June 2007**

<table>
<thead>
<tr>
<th>Year</th>
<th>Pct Outcomes</th>
<th>Pct Supports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>49.6%</td>
<td>53.6%</td>
</tr>
<tr>
<td>Year 3</td>
<td>44.9%</td>
<td>48.9%</td>
</tr>
<tr>
<td>Year 4</td>
<td>45.1%</td>
<td>48.2%</td>
</tr>
<tr>
<td>Year 5</td>
<td>48.6%</td>
<td>53.0%</td>
</tr>
<tr>
<td>Year 6</td>
<td>46.1%</td>
<td>50.5%</td>
</tr>
</tbody>
</table>
The criterion of 13 or More Outcomes Present is a measure used by the legislature to track the progress of individuals receiving services through the waiver programs. Data indicate the overall pattern for this measure over the years is similar to the overall Outcomes Present shown in Figure ES8. The percent of individuals with 13 or More Outcomes Present by Service is provided in Figure ES9. It is important to note that individuals can receive more than one of these services and there are no controls for other factors that impact outcomes, such as the total number of supports, age, residential type and other services received.

![Figure ES9: 13 or More Outcomes Present by Service](image)

In general, results demonstrate the following:

- Individuals receiving Supported Employment and Supported Living Coaching are more likely to have 13 or More Outcomes present in their lives. This pattern has persisted for the past several years, and the percent with 13 or More Present receiving these services has improved.
- Individuals receiving Residential Habilitation are least likely to have 13 or More Outcomes Present.
- Individuals receiving ADT and NRSS are also less likely to have 13 or More Outcomes Present.
The last seven POM items are the Foundational Outcomes and are considered most important as they measure safeguards, rights and the health and wellness of individuals. The percent of individuals who have all of the Foundational Outcomes Present is a measure reported to the legislature annually.

- The percent of individuals with all seven Foundational Outcomes Met has decreased since Year Five, from 10.8 percent to 7.6 percent.

In this report we explore in more detail the results presented above, including an analysis of POM results across various demographic characteristics. We provide discussion and recommendations to the State based on the information contained in the report and a review of contract activity over the past year.
Introduction

This is the annual report for Year Six of the Florida Statewide Quality Assurance Program (FSQAP) contract, July 2006 – June 2007. Information in this report includes fourth quarter activity as well as a review of the project across the year. The report is divided into three sections. The first section, Data Analysis and Results, provides analysis and interpretation of the data collected from July 2006 through June 2007, including annual trends when possible. Data are presented to provide AHCA and APD with information they may utilize to enhance the services provided through the Developmental Disabilities (DD) and Family and Supported Living (FSL) waivers. This section includes:

- Volume of Activity: Desk Reviews and CORE Consultations;
- Desk Reviews;
- CORE Results;
- WiSCC Results;
- Personal Outcome Measures Volume and Results;
- Medical Peer Review Findings.

The second section, Discussion of Data Analysis Findings and Recommendations, provides interpretation of results and recommendations based on a review of the data and activities for the year.

The third section, Summary of Quarterly and Annual Project Compliance Activities, presents information relevant to compliance with contract issues during the fourth quarter of the contract year, with some annual summaries. In this section we detail the activities and accomplishments of the Delmarva Staff and their partners, including:

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

Volume of Activity-Desk Reviews and CORE Consultations

Providers who do not render one of the eight services subject to an onsite review as listed below and provide at least one other service through the DD or FSL waiver that is subject to a review, and meet the following criteria are subject to a Desk Review:¹

- Any provider who had an Alert or a Recoupment on the previous review.
- Any provider last reviewed prior to two years ago.
- Any provider who had discontinued the provision of all services which require an onsite consultation.
- All new providers.

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

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

The following table shows the number of annual provider reviews and CORE consultations completed each year during the first six years of the contract. Delmarva has conducted 11,285 annual reviews with providers of services on the Medicaid DD or FSL Waiver. As indicated in Table 1, the Onsite Provider Performance Reviews during the first three years were replaced with CORE in the fourth year. The 18 CORE conducted during Year Three were part of the pilot study and results from these are excluded from all data analyses. In addition, 5,593 Desk Reviews were completed for providers of all DD/FSL Waiver Services that do not require a CORE, with the exception of Adult Dental Services, Consumable Medical Supplies, Durable Medical Equipment and Supplies, Personal Emergency Response System, and Environmental Modifications.

¹ Providers of Support Coordination are included in the WiSCC results section. See Desk Review procedures for a list of services (http://www.dfmc-florida.org/provider_pdr_procedures.htm).
Table 1: Annual Provider Performance Reviews and CORE Consults

July 2001 - June 2007

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Year 6</th>
<th>Total</th>
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<tbody>
<tr>
<td>Onsite</td>
<td>882</td>
<td>846</td>
<td>940</td>
<td>24</td>
<td>NA</td>
<td>NA</td>
<td>2,692</td>
</tr>
<tr>
<td>CORE</td>
<td>0</td>
<td>0</td>
<td>18</td>
<td>639</td>
<td>850</td>
<td>866</td>
<td>2,373</td>
</tr>
<tr>
<td>Desk</td>
<td>1,001</td>
<td>1,207</td>
<td>1,090</td>
<td>1,247</td>
<td>1,051</td>
<td>624</td>
<td>6,220</td>
</tr>
<tr>
<td>Total</td>
<td>1,883</td>
<td>2,053</td>
<td>2,048</td>
<td>1,910</td>
<td>1,901</td>
<td>1,490</td>
<td>11,285</td>
</tr>
</tbody>
</table>

Delmarva also provides a number of different Follow-up activities to enhance the providers’ capacity to assist individuals they serve and to meet documentation requirements. Three potential Provider Performance Review (PPR)/CORE activities subsequent to an annual review include: Follow-up with Technical Assistance, Reconsiderations, and Documentation Follow-up. Regular Follow-up reviews were discontinued in Year Six. The few that were conducted resulted from reviews completed before the amended contract eliminating these types of reviews was finalized.

In the CORE process, providers receive a Follow-up with Technical Assistance if the overall finding from the onsite is Not Emerging or Emerging, if the finding is Implementing and the provider requests that Technical Assistance be attached to the Follow-up, or if the finding is Achieving and the provider requests a Follow-up with Technical Assistance through the APD Area office. Additionally, any CORE in which an Alert is identified generates a Follow-up with Technical Assistance.

Follow-up with TA reviews may include the following:

- Assistance in the development of the QEP, as needed.
- Assistance with the development of organizational practices key to facilitating the achievement of outcomes for the individuals served.
- Review of each of the elements not scored as Achieving to determine how the provider plans to address or is addressing the area.
- If deemed necessary, the consultant 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.

<table>
<thead>
<tr>
<th>Follow-up Type</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Year 6</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up</td>
<td>64</td>
<td>221</td>
<td>180</td>
<td>144</td>
<td>163</td>
<td>13</td>
<td>785</td>
</tr>
<tr>
<td>Documentation Follow-up</td>
<td>0</td>
<td>277</td>
<td>823</td>
<td>664</td>
<td>663</td>
<td>453</td>
<td>2,880</td>
</tr>
<tr>
<td>Follow-up w/ TA</td>
<td>0</td>
<td>140</td>
<td>136</td>
<td>284</td>
<td>359</td>
<td>326</td>
<td>1,245</td>
</tr>
<tr>
<td>Reconsideration</td>
<td>92</td>
<td>91</td>
<td>131</td>
<td>89</td>
<td>79</td>
<td>26</td>
<td>508</td>
</tr>
<tr>
<td>Total</td>
<td>156</td>
<td>729</td>
<td>1,270</td>
<td>1,181</td>
<td>1,264</td>
<td>818</td>
<td>5,418</td>
</tr>
</tbody>
</table>

A total of 5,418 follow-up reviews of some type have been completed over the six 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. Of the 26 Reconsiderations completed in Year Six, nine were for a CORE consult and 17 for a Desk Review. Of the 453 Documentation Follow-up reviews, only 18 were subsequent to a CORE consult.

**Desk Reviews**

**Volumes and Scores by APD Area**

The number and percent of desk reviews in each APD Area are presented below. The total number of desk reviews decreased since Year Four. As part of the contract amendment implemented this year, a reduced number of Desk Reviews was targeted for completion, allowing more time and budget allocation for onsite CORE and Follow-up with Technical Assistance reviews. Therefore, in eight of the Areas there were 30 or fewer reviews completed in Year Six and care should be taken when interpreting results.
Table 3: Number of Desk Reviews by Year and APD Area

<table>
<thead>
<tr>
<th>APD Area</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Year 6</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>16</td>
<td>28</td>
<td>31</td>
<td>25</td>
<td>24</td>
<td>25</td>
<td>149</td>
</tr>
<tr>
<td>2</td>
<td>117</td>
<td>132</td>
<td>112</td>
<td>146</td>
<td>117</td>
<td>64</td>
<td>688</td>
</tr>
<tr>
<td>3</td>
<td>62</td>
<td>70</td>
<td>62</td>
<td>73</td>
<td>51</td>
<td>29</td>
<td>347</td>
</tr>
<tr>
<td>4</td>
<td>63</td>
<td>90</td>
<td>90</td>
<td>116</td>
<td>97</td>
<td>62</td>
<td>518</td>
</tr>
<tr>
<td>7</td>
<td>82</td>
<td>110</td>
<td>104</td>
<td>129</td>
<td>99</td>
<td>57</td>
<td>581</td>
</tr>
<tr>
<td>8</td>
<td>23</td>
<td>24</td>
<td>36</td>
<td>26</td>
<td>30</td>
<td>13</td>
<td>152</td>
</tr>
<tr>
<td>9</td>
<td>29</td>
<td>55</td>
<td>52</td>
<td>43</td>
<td>36</td>
<td>25</td>
<td>240</td>
</tr>
<tr>
<td>10</td>
<td>31</td>
<td>37</td>
<td>56</td>
<td>58</td>
<td>63</td>
<td>28</td>
<td>273</td>
</tr>
<tr>
<td>11</td>
<td>86</td>
<td>98</td>
<td>104</td>
<td>147</td>
<td>116</td>
<td>57</td>
<td>608</td>
</tr>
<tr>
<td>12</td>
<td>51</td>
<td>56</td>
<td>59</td>
<td>71</td>
<td>76</td>
<td>55</td>
<td>368</td>
</tr>
<tr>
<td>13</td>
<td>57</td>
<td>72</td>
<td>54</td>
<td>58</td>
<td>61</td>
<td>30</td>
<td>332</td>
</tr>
<tr>
<td>14</td>
<td>27</td>
<td>27</td>
<td>31</td>
<td>24</td>
<td>20</td>
<td>21</td>
<td>150</td>
</tr>
<tr>
<td>15</td>
<td>48</td>
<td>49</td>
<td>50</td>
<td>50</td>
<td>46</td>
<td>29</td>
<td>272</td>
</tr>
<tr>
<td>23</td>
<td>309</td>
<td>359</td>
<td>249</td>
<td>281</td>
<td>215</td>
<td>129</td>
<td>1,542</td>
</tr>
<tr>
<td>Total</td>
<td>1,001</td>
<td>1,207</td>
<td>1,090</td>
<td>1,247</td>
<td>1,051</td>
<td>624</td>
<td>6,220</td>
</tr>
</tbody>
</table>

Figure 1: Desk Review Scores by APD Area

Year 4, Year 5 and Year 6
Of greater interest is the trend in Desk Review scores across the years. Because numbers in the APD Areas are often small, particularly in Year Six as noted above, comparison of scores across years and Areas should be done with caution. As shown in Figure 1, the average score for the state has dropped somewhat since Year Four, from just over 77 percent to approximately 73 percent. The greatest declines since that time were seen in Areas 3, 9 and 14.

Desk Review Scores by Provider Type

Over the years, some differences between agency and solo providers have been noted. These are reflected below in Figure 2. Comparisons between the two types of providers indicate:

- A majority of Desk Reviews are completed on solo providers—on average, approximately 77 percent.
- Scores for both types of providers have fluctuated somewhat over the years. Compared to Year Five, the average score is down somewhat for both types, but more so for agency providers with a drop of 7.7 percentage points from 77.4 percent to 69.7 percent.
- With the exception of Year Five, the gap between the scores for each provider type has persisted since Year Two, with solo providers scoring slightly higher.

![Figure 2: Desk Review Scores by Provider Type and Year](image-url)
Background Screening Compliance

Documentation for compliance with background screening requirements is the only item for which providers subject to a Desk Review can receive an alert. If Delmarva consultants find missing documentation for these critical screenings, the provider is given 10 days to produce the documentation. The following table shows the number and percent of providers who received a desk review and had the necessary documentation for background screening and re-screening compliance. The analysis indicates:

- Over the six year period, background screening was completed for over 74 percent of providers who received a Desk Review.

- During this same time period, close to 94 percent of providers had documentation for the required 5-year Level II Background re-screening.

- The percent of compliance for background screening has increased consistently up through Year Five, from close to 67 percent to 82 percent, but dropped somewhat in the current year to just over 78 percent.

- Compliance for re-screening has been considerably higher, but has also dropped somewhat in the current year.

### Table 4: Number and Percent of Providers W/ Background Screening/Re-screening Documentation on Desk Reviews

<table>
<thead>
<tr>
<th>Year</th>
<th>Reviews</th>
<th>Screening</th>
<th>Percent</th>
<th>Re-screening</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>998</td>
<td>666</td>
<td>66.7%</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1,207</td>
<td>872</td>
<td>72.2%</td>
<td>1,147</td>
<td>95.0%</td>
</tr>
<tr>
<td>3</td>
<td>1,090</td>
<td>795</td>
<td>72.9%</td>
<td>1,035</td>
<td>95.0%</td>
</tr>
<tr>
<td>4</td>
<td>1,247</td>
<td>940</td>
<td>75.4%</td>
<td>1,177</td>
<td>94.4%</td>
</tr>
<tr>
<td>5</td>
<td>1,051</td>
<td>862</td>
<td>82.0%</td>
<td>979</td>
<td>93.1%</td>
</tr>
<tr>
<td>6</td>
<td>624</td>
<td>489</td>
<td>78.4%</td>
<td>548</td>
<td>87.8%</td>
</tr>
<tr>
<td>Total</td>
<td>6,217</td>
<td>4,624</td>
<td>74.4%</td>
<td>4,886</td>
<td>93.6%</td>
</tr>
</tbody>
</table>

The following chart (Figure 3) shows results for background screening/re-screening compliance, by provider type and year. For providers who render services that are monitored with the desk review process, agency providers are far more likely to be lacking in background screening documentation than solo providers. However, it is reasonable to see results that indicate agency providers are more
likely to be missing background screening documentation, as they have more than one provider rendering services. Agency providers have improved considerably since Year Two, from 34 percent to 53 percent in Year Six. Solo providers also demonstrated a steady increase since the first year of the contract. However, results indicate that both types of providers dropped somewhat in background screening compliance during Year Six.

<table>
<thead>
<tr>
<th>Contract Year</th>
<th>Year 1 (1001)</th>
<th>Year 2 (1207)</th>
<th>Year 3 (1090)</th>
<th>Year 4 (1247)</th>
<th>Year 5 (1051)</th>
<th>Year 6 (624)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>57.1%</td>
<td>34.2%</td>
<td>37.1%</td>
<td>45.0%</td>
<td>57.6%</td>
<td>53.0%</td>
</tr>
<tr>
<td>Solo</td>
<td>69.1%</td>
<td>79.1%</td>
<td>81.7%</td>
<td>82.9%</td>
<td>84.2%</td>
<td>76.7%</td>
</tr>
<tr>
<td>State</td>
<td>66.8%</td>
<td>70.6%</td>
<td>70.7%</td>
<td>73.4%</td>
<td>77.2%</td>
<td>71.0%</td>
</tr>
</tbody>
</table>

Recoupment

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

- In Year Six, nearly half of the providers who had a Desk Review were cited with a recoupment.
- The average annual percent of providers with a citation is greater in Year Six than in any of the previous three years for both agency and solo providers.

---

2 Recoupment citations were not recorded in Year One.
While a slightly higher percent of solo providers received a recoupment citation in Year Six, they average fewer recoupments per provider than agency providers.

<table>
<thead>
<tr>
<th>Table 5: Summary of Recoupment by Provider Type and Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desk Reviews: July 2003 - June 2007</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Agency Providers</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Year 3</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Providers Subject to Recoupment</td>
</tr>
<tr>
<td>Total Number of Citations</td>
</tr>
<tr>
<td>Percent of Providers w/ Citation</td>
</tr>
<tr>
<td>Average Citation per Provider</td>
</tr>
</tbody>
</table>

Documentation Follow-up

Of the 624 Desk Reviews completed during Year Six, a total of 4,594 performance elements were scored as Not Met during the annual review. At the time of the Documentation Follow-up Review, close to half (49.4%) had not been addressed, approximately 3.6 per review. As indicated in Table 6, this percent is somewhat higher than in Years Four and Five, with 47.9 percent and 44.5 percent respectively. However, the total number of elements per review not “fixed” at follow-up has remained fairly consistent over the past several years.

<table>
<thead>
<tr>
<th>Table 6: Elements Scored as Not Met During Desk Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and Percent Scored as Not Met at Follow-up</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Contract Year</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
</tbody>
</table>
The table below shows a summary analysis of Documentation Follow-up Reviews for the past four years of the contract. Findings indicate the following:

- Of the 405 Desk Reviews requiring a Documentation Follow-up in Year Six, 89 (22.0%) received an evaluation of Met on 100 percent of elements that were previously scored as Not Met. This reflects a decrease from the previous year.
- Over 40 percent of reviews in Year Five requiring a Documentation Follow-up received an evaluation of Met on 75 percent or more of elements that were previously Not Met. This has dropped to just over 34 percent in Year Six.

### Table 7: Documentation Follow-up Reviews

<table>
<thead>
<tr>
<th>Percent Changed to MET from Initial Review</th>
<th>Contract Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>&gt;=75%, &lt;100%</td>
<td></td>
</tr>
<tr>
<td>&gt;=50%, &lt;75%</td>
<td></td>
</tr>
<tr>
<td>&gt;=25%, &lt;50%</td>
<td></td>
</tr>
<tr>
<td>&lt;25%</td>
<td></td>
</tr>
<tr>
<td>Number Reviews</td>
<td>277</td>
</tr>
</tbody>
</table>

**CORE Consultations**

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

Each provider is evaluated on 25 elements. The first 18 are the CORE Results Elements (CRE), with a focus on the following areas: rights, choices, community, health and safety, a person-centered approach and communication. Each CRE is evaluated as Achieving, Implementing, Emerging or Not Emerging. The provider’s CORE Results evaluation level is based upon a compilation of CRE.

---

3 See the procedures and tools on the Delmarva website for a detailed description of the elements and evaluation levels within each element ([http://www.dfmc-florida.org/provider/resources/core_wiszec_tools.htm](http://www.dfmc-florida.org/provider/resources/core_wiszec_tools.htm)).
results (Elements 1-18). Providers are also evaluated on seven process-based elements referred to as the Minimum Service Requirement Elements (MSR). These are scored as Met or Not Met, with a focus on qualification requirements such as background screening and training requirements. Results from the first year were used to establish benchmarks, and comparisons are made to these benchmarks when possible.

During year six the CORE tool and procedures were modified, reducing the number of elements from 25 to 12, including eight CREs and four MSRs. Revised procedures were implemented March 13, 2007. As part of the revisions, some changes were implemented into the overall CRE scoring. Therefore, we include data for the entire year when possible and when appropriate to the type of trend or analysis being used, and note when data from March 13 through June 30 are excluded or reported separately due to differences in the tool and procedures. In this report, CORE results using the original tool are referred to with Year 6A and revised results with Year 6B.

Results by APD Area

Table 8 shows the distribution, across APD Areas, of the Year Five and Year Six CORE consults. A total of 886 were completed in Year Six, 36 more than in Year Five and within the expected range of CORE to be completed (between 725 and 1,029). Of these, 363 were conducted using the revised CORE procedures.

<table>
<thead>
<tr>
<th>Area</th>
<th>Year 5</th>
<th>Year 6A</th>
<th>Year 6B</th>
<th>Pct Year 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>33</td>
<td>20</td>
<td>13</td>
<td>3.7%</td>
</tr>
<tr>
<td>2</td>
<td>90</td>
<td>52</td>
<td>36</td>
<td>9.9%</td>
</tr>
<tr>
<td>3</td>
<td>74</td>
<td>39</td>
<td>11</td>
<td>5.6%</td>
</tr>
<tr>
<td>4</td>
<td>65</td>
<td>32</td>
<td>26</td>
<td>6.5%</td>
</tr>
<tr>
<td>7</td>
<td>62</td>
<td>32</td>
<td>22</td>
<td>6.1%</td>
</tr>
<tr>
<td>8</td>
<td>27</td>
<td>22</td>
<td>9</td>
<td>3.5%</td>
</tr>
<tr>
<td>9</td>
<td>22</td>
<td>11</td>
<td>7</td>
<td>2.0%</td>
</tr>
<tr>
<td>10</td>
<td>63</td>
<td>41</td>
<td>39</td>
<td>9.0%</td>
</tr>
<tr>
<td>11</td>
<td>110</td>
<td>62</td>
<td>64</td>
<td>14.2%</td>
</tr>
<tr>
<td>12</td>
<td>55</td>
<td>0</td>
<td>16</td>
<td>1.8%</td>
</tr>
<tr>
<td>13</td>
<td>55</td>
<td>36</td>
<td>16</td>
<td>5.9%</td>
</tr>
<tr>
<td>14</td>
<td>27</td>
<td>21</td>
<td>11</td>
<td>3.6%</td>
</tr>
<tr>
<td>15</td>
<td>49</td>
<td>28</td>
<td>18</td>
<td>5.2%</td>
</tr>
<tr>
<td>23</td>
<td>118</td>
<td>127</td>
<td>75</td>
<td>22.8%</td>
</tr>
<tr>
<td>Total</td>
<td>850</td>
<td>523</td>
<td>363</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

*See Section Three, Tool Revisions for a more detailed discussion of the CORE revisions.*
The following two charts display the average score for the CORE Results Elements and the percent of Minimum Service Requirement elements met by APD Area. The average CRE score is calculated within each area with a simple mean, based upon a scale of zero to three:

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

Figure 4a above depicts the average CORE CRE score by APD Area for Years Four, Five and Year 6A, up through March 12, 2007. Highlights from the chart include the following:

5 See Appendix 2, Exhibit 1 for CORE results by outcome level and area.
• Overall, the average CRE score statewide in Year 6A is lower than the baseline year and lower than Year Five, is between Emerging and Implementing, and is somewhat closer to Implementing.

• APD Area 7 showed slight improvement since Year Five.

• APD Areas 8 and 13 showed over a half point decrease since Year Five and Areas 3 and 9 over a quarter point decrease.

• Providers in Areas 1, 7, 11, 14 and 23 have performed better in Year Five and Six than in the baseline Year (Four).

Figure 4b gives the distribution of CORE CRE scores across APD Areas for the revised CORE process. Providers in Area 1 show the highest performance for this last part of the year. Patterns across the other Areas are similar as seen in Figure 4a. Results from the revised procedure indicate an average score in Year 6B that is somewhat less than in Year 6A, 1.49 and 1.71 respectively. This is to be expected because of revisions to the scoring method for the overall determination of Achieving, Implementing, Emerging and Not Emerging for the provider. While determinations on each element are similar, the revised scoring method generates a greater number of providers as Implementing and fewer as Achieving.  

Figure 4b: Average CORE Results Element Score by APD Area
March 13, 2007 - June 30, 2007
Year 6B, N=363

<table>
<thead>
<tr>
<th>APD Area</th>
<th>CORE Results Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2.23</td>
</tr>
<tr>
<td>2</td>
<td>1.58</td>
</tr>
<tr>
<td>3</td>
<td>1.09</td>
</tr>
<tr>
<td>4</td>
<td>1.58</td>
</tr>
<tr>
<td>7</td>
<td>1.73</td>
</tr>
<tr>
<td>8</td>
<td>1.33</td>
</tr>
<tr>
<td>9</td>
<td>1.57</td>
</tr>
<tr>
<td>10</td>
<td>1.36</td>
</tr>
<tr>
<td>11</td>
<td>1.28</td>
</tr>
<tr>
<td>12</td>
<td>1.56</td>
</tr>
<tr>
<td>13</td>
<td>1.5</td>
</tr>
<tr>
<td>14</td>
<td>1.55</td>
</tr>
<tr>
<td>15</td>
<td>1.28</td>
</tr>
<tr>
<td>23</td>
<td>1.55</td>
</tr>
<tr>
<td>State</td>
<td>1.49</td>
</tr>
</tbody>
</table>

6 See the CORE revisions in Section Three.
In the following chart (Figure 5a), the distribution of the percent of Minimum Service Requirement (MSR) elements is shown across APD Areas for Years Four, Five and Year Six through March 12, 2007 (6A). Highlights from the information given in the chart include the following:

- The overall percent of MSR elements met has decreased considerably in some APD Areas, and by over 10 percentage points statewide since implementation of the CORE process in Year Four.

- It is important to note that Areas 1, 8, 9, 14, and 15 reflect the results from fewer than 30 providers.

- APD Area 15, with 28 providers having received a consult in Year 6A, continues to show a rather dramatic drop in the percent of MSR elements that are Met, with the lowest score of only 29.2 percent.

- APD Areas 1, 7, 11, and 14 demonstrate the highest rates of compliance, six or more points over the statewide average.
Results in Table 5b reflect compliance with the MSR elements since implementation of the revised CORE process on March 13, 2007. There are only four elements, compared to seven in the original tool, and therefore comparisons between the two time periods are not appropriate. For example, if a provider missed one of the training elements in the original CORE the overall score would be six out of seven, or 85.7 percent. However, if a provider misses one of the training requirements in the revised tool the score becomes three out of four, or 75 percent. In addition, many Area results reflect a very small number of providers.

\[\text{Figure 5b: CORE Minimum Service Requirements by APD Area} \]

\[\text{Year 6b N=363}\]

<table>
<thead>
<tr>
<th>APD Area</th>
<th>Percent Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>88.5%</td>
</tr>
<tr>
<td>2</td>
<td>61.8%</td>
</tr>
<tr>
<td>3</td>
<td>43.2%</td>
</tr>
<tr>
<td>4</td>
<td>51.0%</td>
</tr>
<tr>
<td>7</td>
<td>73.9%</td>
</tr>
<tr>
<td>8</td>
<td>47.2%</td>
</tr>
<tr>
<td>9</td>
<td>57.1%</td>
</tr>
<tr>
<td>10</td>
<td>53.2%</td>
</tr>
<tr>
<td>11</td>
<td>69.9%</td>
</tr>
<tr>
<td>12</td>
<td>56.3%</td>
</tr>
<tr>
<td>13</td>
<td>43.8%</td>
</tr>
<tr>
<td>14</td>
<td>54.5%</td>
</tr>
<tr>
<td>15</td>
<td>54.0%</td>
</tr>
<tr>
<td>23</td>
<td>58.1%</td>
</tr>
</tbody>
</table>

CORE Results Elements (CRE)

CRE by Provider Type

During the twelve months ending June 30, 2007, 686 agency and 200 solo providers received a CORE. The graphic depiction below (Figure 6) shows the distribution of CORE consults by provider type and statewide for both time periods in Year Six, the original CORE (6A) and revised CORE (6B) processes. The revised scoring methodology has been applied retroactively to all providers.

\[\text{See Appendix 2, Exhibit 2 for results by element.}\]
CORE results to provide more appropriate comparisons between the two CORE versions.\(^8\) When viewing results, it is important to note that differences between the original and revised scoring may generate from differences in scoring the new CRE elements, slight differences when applying the methodology to the original tool’s results (18 elements rather than 8), or the “natural” cycle of providers reviewed at different times during the year. Therefore, comparisons must be made with caution and a greater number of consults from the revised CORE will be analyzed in the 2\(^{nd}\) Quarter Report for Year Seven. Results from Figure 6 indicate:

- Both agency and solo providers were most likely to score as Implementing in the first time period (6A). Agencies using the revised CORE process (6B) were more likely to score as Emerging.
- A much larger proportion of solo providers scored as Emerging in Year 6B than in year 6A.
- Solo providers were much more likely to score Achieving than were agency providers in Year 6A, but equally likely when using the revised method (6B).
- Agency providers were somewhat more likely to score Emerging than solo providers.

### Figure 6: CORE CRE by Provider Type

**Year 6A (July 2006 - March 12, 2007) and Year 6B (March 13 - June 30, 2007)**

<table>
<thead>
<tr>
<th></th>
<th>Year 6A</th>
<th>Year 6B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieving</td>
<td>4.3%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Implementing</td>
<td>47.7%</td>
<td>44.6%</td>
</tr>
<tr>
<td>Emerging</td>
<td>45.1%</td>
<td>43.5%</td>
</tr>
<tr>
<td>Not Emerging</td>
<td>2.9%</td>
<td>5.4%</td>
</tr>
</tbody>
</table>

\(^8\) See Section Three, Tool Revisions for a description of the scoring methodology. The only difference in the retroactive calculations is in the total numeric score used to determine the different levels and cut-off points, based on 18 rather than 8 elements.
CORE Results Elements by Element

As indicated above, each CRE is evaluated as Achieving, Implementing, Emerging or Not Emerging. Exhibit 2 in Appendix 2 shows the results by element for Years Four, Five and Six of the contract, and results are graphically depicted below for the July 2006 – March 12, 2007 time period. A summary of findings from the original CORE tool indicates:

- On average, the percent of outcome elements scored as Achieving or Not Emerging each year has remained fairly constant.

- Having systems in place to help treat all individuals with dignity and respect (Element 2) and to help all individuals feel safe (Element 9) were elements most likely to be evaluated as Achieving, each approximately 38 percent.

- On five elements proportionately fewer providers in Year Six, compared to the baseline year (Year 4), scored Achieving—the highest performance level, fewer by five percentage points or more. Providers appeared less likely to score Achieving in: helping individuals participate in the design of the implementation plan; organizing resources, strategies and interventions to facilitate outcomes for individuals; achieving desired outcomes for individuals; disseminating information to all families and other providers; or to have all individuals satisfied with their services.

- On ten CREs, 50 percent or more of the providers scored as Implementing or Achieving.

- Eight of the CREs showed improvement over the Year Four levels—a greater percent scoring at the Achieving level: treating individuals with dignity and respect, ensuring privacy, ensuring services are provided in integrated settings, affording choice to individuals, ensuring individuals are healthy and are directing their own health care planning, ensuring individuals are safe, using a personal outcome approach, and ensuring individuals participate in the review and update of the implementation plan.

- Element 14, indicating individuals routinely participate in review of the implementation plan and direct changes desired to assure outcomes/goals are met, remains the area most likely to be scored as Not Emerging, 21 percent of the providers in Year Six.

- Elements 10 and 12, measuring the degree to which providers help individuals develop social roles and allow them to participate in the design of the implementation plan, are also more likely than other elements to be scored as Not Emerging, both at approximately 11 percent.

---

9 See Appendix 1 Attachment 2 for a brief description of the elements and see the procedures and tools on the Delmarva website for a detailed description of the elements and evaluation levels within each element (http://www.dfmc-florida.org/provider/resources/core_wisce_tools.htm).
Key for Elements:

1: Individuals are educated on and fully exercises rights.
2: Individuals are treated with dignity and respect.
3: Personal privacy is observed.
4: Individuals actively participate in their life’s decisions.
5: Services are provided in integrated settings.
6: Individuals are afforded choice of services and supports.
7: Individuals are free from abuse, neglect and exploitation.
8: Individuals are healthy.
9: Individuals are safe.
10: Desired social roles are being developed.
11: A personal outcomes approach is used.
12: Individual directs design of Implementation Plan.
13: Provider facilitates individuals’ outcome achievements.
14: Individual routinely reviews the Implementation Plan.
15: Individuals are achieving desired outcomes and goals.
16: Provider advocates for individuals beyond scope of service.
17: Provider coordinates dissemination of information.
18: Individuals are satisfied with services.

Exhibit 2 in Appendix 2 also shows results by element for the revised CORE process. Results are graphically depicted in Figure 6b:

- On average, 47.3 percent of elements on the revised tool were evaluated as Achieving or Implementing, and 45.5 percent as Emerging.
- Providers were most likely to score as Achieving on Elements 3 and 7, indicating they have systems in place to ensure collaboration and to ensure all individuals are free from abuse, neglect and exploitation and receive education/information on reporting abuse, neglect or exploitation.
- Achieving Results element is most likely to be evaluated as Not Emerging and least likely to be evaluated as Achieving.
CORE Results Elements by Service

The following series of charts (Figures 7-12) shows CORE trends by the type of services provided: ADT, NRSS, Residential Habilitation, Supported Living Coaching, Supported Employment, and In-Home Support Services. It is important to note that each provider may render several different services and that CORE consult results are based upon the lowest score for any service that is provided. Therefore, comparing across services at the aggregate level is not appropriate as a low score may be due to a different service that was rendered by the providers. However, comparing the same service over the years includes many of the same providers each year and is therefore a more acceptable analysis. For comparative purposes, each figure that follows gives the Year Four, Five and Six results. A summary of findings includes the following:  

- Within every service, the proportion of providers at Emerging in Year 6B has increased to or is above the Year Four level.
- With the exception of ADT, a slightly greater proportion of providers received an evaluation of Not Emerging compared to Year Four. However, these numbers are still very small—one to eight providers.
- Providers of Supported Living Coaching and Supported Employment have a greater percent evaluated as Achieving in Year 6B than in any previous time period.

IHSS and Special Medical Home Care (SMHC) were added to the list of services monitored through a CORE consult in Year Five of the contract. Only one provider renders SMHC and was evaluated as Emerging in Year Five and Implementing in Year Six.
Figure 7: CRE Results for Adult Day Training Providers
July 2004 - June 2007

<table>
<thead>
<tr>
<th>Year</th>
<th>Achieving</th>
<th>Implementing</th>
<th>Emerging</th>
<th>Not Emerging</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 4 (N=90)</td>
<td>4.4%</td>
<td>53.3%</td>
<td>40.0%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Year 5 (N=143)</td>
<td>4.2%</td>
<td>69.2%</td>
<td>26.6%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Year 6A (N=70)</td>
<td>5.7%</td>
<td>61.4%</td>
<td>31.4%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Year 6B (N=38)</td>
<td>5.3%</td>
<td>50.0%</td>
<td>44.7%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Figure 8: CRE Results for NRSS Providers
July 2004 - June 2007

<table>
<thead>
<tr>
<th>Year</th>
<th>Achieving</th>
<th>Implementing</th>
<th>Emerging</th>
<th>Not Emerging</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 4 (N=249)</td>
<td>2.4%</td>
<td>61.0%</td>
<td>36.5%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Year 5 (N=337)</td>
<td>7.1%</td>
<td>56.7%</td>
<td>35.0%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Year 6A (N=236)</td>
<td>5.9%</td>
<td>46.6%</td>
<td>44.5%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Year 6B (N=159)</td>
<td>4.4%</td>
<td>35.8%</td>
<td>56.0%</td>
<td>3.8%</td>
</tr>
</tbody>
</table>
**Figure 9: CRE Results for Residential Habilitation Providers**
*July 2004 - June 2007*

![Bar chart showing CRE results for Residential Habilitation Providers from Year 4 to Year 6B.](chart1.jpg)

- **Achieving:**
  - Year 4: 3.0%
  - Year 5: 4.2%
  - Year 6A: 2.8%
  - Year 6B: 2.0%
- **Implementing:**
  - Year 4: 47.6%
  - Year 5: 56.7%
  - Year 6A: 43.5%
  - Year 6B: 45.3%
- **Emerging:**
  - Year 4: 48.2%
  - Year 5: 38.1%
  - Year 6A: 50.4%
  - Year 6B: 48.6%
- **Not Emerging:**
  - Year 4: 1.2%
  - Year 5: 1.0%
  - Year 6A: 3.3%
  - Year 6B: 4.1%

**Figure 10: CRE Results for Supported Living Coaching Providers**
*July 2004 - June 2007*

![Bar chart showing CRE results for Supported Living Coaching Providers from Year 4 to Year 6B.](chart2.jpg)

- **Achieving:**
  - Year 4: 10.9%
  - Year 5: 12.3%
  - Year 6A: 9.9%
  - Year 6B: 14.9%
- **Implementing:**
  - Year 4: 62.7%
  - Year 5: 64.2%
  - Year 6A: 57.0%
  - Year 6B: 43.9%
- **Emerging:**
  - Year 4: 26.4%
  - Year 5: 22.4%
  - Year 6A: 30.8%
  - Year 6B: 37.7%
- **Not Emerging:**
  - Year 4: 0.0%
  - Year 5: 1.1%
  - Year 6A: 2.3%
  - Year 6B: 3.5%
Figure 11: CRE Results for Supported Employment Providers
July 2004 - June 2007

<table>
<thead>
<tr>
<th>Year</th>
<th>Achieving</th>
<th>Implementing</th>
<th>Emerging</th>
<th>Not Emerging</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>1.3%</td>
<td>59.2%</td>
<td>39.5%</td>
<td>0.0%</td>
</tr>
<tr>
<td>5</td>
<td>7.3%</td>
<td>65.0%</td>
<td>27.6%</td>
<td>0.0%</td>
</tr>
<tr>
<td>6A</td>
<td>6.3%</td>
<td>60.8%</td>
<td>31.6%</td>
<td>1.3%</td>
</tr>
<tr>
<td>6B</td>
<td>8.7%</td>
<td>43.5%</td>
<td>43.7%</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

Year 4 (N=76)  
Year 5 (N=123)  
Year 6A (N=79)  
Year 6B (N=46)

Figure 12: CRE Results for In-Home Support Services Providers
July 2004 - June 2007

<table>
<thead>
<tr>
<th>Year</th>
<th>Achieving</th>
<th>Implementing</th>
<th>Emerging</th>
<th>Not Emerging</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>7.4%</td>
<td>60.3%</td>
<td>30.6%</td>
<td>1.7%</td>
</tr>
<tr>
<td>6A</td>
<td>5.2%</td>
<td>52.3%</td>
<td>40.0%</td>
<td>2.6%</td>
</tr>
<tr>
<td>6B</td>
<td>5.1%</td>
<td>33.3%</td>
<td>55.8%</td>
<td>5.8%</td>
</tr>
</tbody>
</table>

Year 5 (N=229)  
Year 6A (N=155)  
Year 6B (N=138)
Minimum Service Requirements

The last seven of the 25 elements in the CORE are the Minimum Service Requirement (MSR) elements, and the last four in the revised tool. Providers must supply documentation of the required background screening, required training, proof of meeting service limitations, and proper billing procedures. MSR elements are evaluated as Met or Not Met. The following chart (Figure 13) shows the percent of consults distributed across the percent of MSR elements that were scored as Met, by provider type.

Recall that for the Year 6B time period, there were only four MSR elements, compared to seven in the other time periods. However, this represents the same number of compliance issues. For example, in the original CORE tool, Element 23 identifies if the provider is authorized to provide the service, and Element 24 identifies if the service is provided and billed as authorized. If one of these is missing the MSR would be 6/7 or 85.7 Percent. These are combined into Element 11 in the revised tool. Therefore, if one is missing the MSR score would be 3/4 or 75 percent.

- The data from Year Four through Year 6A indicate an increase in the percent of both agency and solo providers who have half or fewer of the MSRs met.

11 See Appendix 2 Attachment 2 for a brief summary of the elements and see the procedures and tools on the Delmarva website for a detailed description of the elements and evaluation levels within each element (http://www.dlmc-florida.org/provider/resources/core_wisce_tools.htm).
Both types of providers are also less likely to have all seven of the MSRs scored as Met in Year 6A, compared to the baseline in Year Four.

Using the revised tool in Year 6B, a majority of providers score Met on up to half of the four MSR elements.

During the Year 6B time period, agencies were somewhat more likely than solo providers to score all four (100%) of the MSR elements as Met.

In Figure 14 the number and percent of MSR elements scored as Met are given at the element level for the original CORE tool; Years Four, Five and 6A. Highlights from the results include the following:

- In general, agency providers are more likely to have requirements fulfilled for Projected Service Outcomes than are solo providers.
Solo providers are more likely to have documentation for Background Screening than are agency providers. This is greatest in Year 6A, with over a 20 point difference between the two types of providers.

On average, providers score lowest every year on requirements for Projected Service Outcomes and in maintaining documentation for billing. This is most evident in Year 6A with only 43 percent of agency providers and 39 percent of Solo providers scoring each of these as Met.

The most current data (Year 6A) indicate solo providers outperform agencies on four of the seven MSR elements: background screening, training (specific to the individual as well as abuse and neglect), and billing as authorized.

Agency providers have performed worse in Year 6A on every MSR element compared to either Year Four or Year Five.

In Year 6A solo providers improved somewhat on four MSR elements compared to Year Five: projected service outcomes, background screening and authorization issues.

Figure 15 shows the percent met for the CORE MSR elements for Year 6B, using the revised CORE tool. On average, solo providers appear to do somewhat better on background screening documentation and training requirements, similar to results using the original tool. A more complete analysis of the elements using the revised CORE tool will be possible in the Year Seven 2nd Quarter Report.
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; health; or safety warrant immediate corrective action. Failure to meet the requirements for background screening is also cited as an Alert item. Elements are cited as a Recoupment if the provider is not in compliance with the monitoring and billing documentation and authorization and services limits requirements for the services rendered.

The number and percent of each item scored as an alert are depicted in Figure 16 for Years 4, 5 and 6A. As documented, a majority of CORE alerts relate to background screening. The remaining alerts are in the areas of dignity and respect; privacy; abuse, neglect and exploitation; health; and safety. The proportion of alerts due to an issue with health has increased each year and the proportion due to background screening has decreased somewhat since Year Four. Figure 17 shows alerts for providers who received a CORE between March 13, 2007, and June 30, 2007, using the revised tool.

![Figure 16: CORE Alerts](July 2005 - March 12, 2007)

<table>
<thead>
<tr>
<th>Type of Alert</th>
<th>Year 4 (228)</th>
<th>Year 5 (304)</th>
<th>Year 6A (264)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dignity/respect</td>
<td>7.9%</td>
<td>5.9%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Privacy</td>
<td>4.4%</td>
<td>8.9%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Abuse/neglect</td>
<td>3.9%</td>
<td>4.3%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Health</td>
<td>2.6%</td>
<td>4.9%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Safety</td>
<td>9.6%</td>
<td>7.2%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Background</td>
<td>71.5%</td>
<td>68.8%</td>
<td>65.2%</td>
</tr>
</tbody>
</table>

12 Alert items are Elements 2, 3, 7, 8 and 9. For the MSR elements, the “level 2 background screening” element (20) is an alert item. In the revised tool, Elements 2, 3, 4 and 9 are alert items.

13 See Appendix 2, Exhibits 3 and 4 for information on alerts and recoupments by APD Area.
Table 8 displays recoupment information by APD Area for Year Six. Of the 886 providers reviewed in Year Six, 386 (43.6%) received a recoupment citation, with a total of 571 citations. The percent of providers who were cited with a recoupment ranged from 13 percent in Area 7 to over 74 percent in Area 8. Areas 3, 8 and 15 all indicate that 70 percent or more of the providers reviewed with a CORE during Year Six had at least one recoupment citation.
Follow Up with Technical Assistance Reviews

During Year Six of the contract, a total of 339 providers who received a CORE consult also received a Follow Up review. The only “scores” that are subject to change during the Follow Up are the MSR elements. A follow-up can be completed for providers who scored all the MSR elements as Met, but needed a follow-up for an outcome element. Of the 339 Follow Up reviews, 250 providers had at least one MSR element scored as Not Met. These 250 providers had 801 MSR elements scored as Not Met during the annual CORE consult. Results in Table 8 show the percent of these elements that were scored as Met during the Follow-Up review.

<table>
<thead>
<tr>
<th>Percent Met at FU</th>
<th># of Providers</th>
<th>% of Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year 6A</td>
<td>Year 6B</td>
</tr>
<tr>
<td>&lt; 25%</td>
<td>39</td>
<td>16</td>
</tr>
<tr>
<td>25% - &lt; 50%</td>
<td>33</td>
<td>13</td>
</tr>
<tr>
<td>50% to &lt; 75%</td>
<td>40</td>
<td>14</td>
</tr>
<tr>
<td>75% to &lt; 100%</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>100%</td>
<td>56</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>188</td>
<td>62</td>
</tr>
</tbody>
</table>

- Of the 250 Follow Up reviews that were completed, 55 providers (22%) received a Met on fewer than 25 percent of the elements that had been scored as Not Met during the annual CORE consult and 28 percent (70) had reconciled 100 percent of elements previously scored as Not Met.
- Of the 62 providers who had an annual consult with the revised CORE process (6B), close to 26 percent had not reconciled any of the MSR elements that had been scored as Not Met.
- In Year 6A, 19 percent had not met compliance on any of the MSR elements. This was similar to Year 5, at 18 percent.

14 13 of these were Follow-up reviews and the remainder was Follow-up with Technical Assistance. Delmarva no longer offers a regular Follow-up review and these are combined for the analysis.
Reconsiderations

In Year Five, 26 Reconsiderations were processed, 9 for a CORE and 17 for a Desk Review. Of these, 11 were approved. It is important to note 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 for Years Four through Six, the number approved or denied, and the percent approved.

<table>
<thead>
<tr>
<th>Year</th>
<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>Year Four</td>
<td>Desk</td>
<td>1,247</td>
<td>47</td>
<td>23</td>
<td>5.6%</td>
<td>67.1%</td>
</tr>
<tr>
<td></td>
<td>CORE</td>
<td>646</td>
<td>8</td>
<td>10</td>
<td>2.8%</td>
<td>44.4%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>1,893</td>
<td>55</td>
<td>33</td>
<td>4.6%</td>
<td>62.5%</td>
</tr>
<tr>
<td>Year Five</td>
<td>Desk</td>
<td>1,051</td>
<td>45</td>
<td>12</td>
<td>5.4%</td>
<td>78.9%</td>
</tr>
<tr>
<td></td>
<td>CORE</td>
<td>850</td>
<td>4</td>
<td>19</td>
<td>2.7%</td>
<td>17.4%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>1,901</td>
<td>49</td>
<td>31</td>
<td>4.2%</td>
<td>61.3%</td>
</tr>
<tr>
<td>Year Six</td>
<td>Desk</td>
<td>624</td>
<td>10</td>
<td>7</td>
<td>2.7%</td>
<td>58.8%</td>
</tr>
<tr>
<td></td>
<td>CORE</td>
<td>886</td>
<td>1</td>
<td>8</td>
<td>1.0%</td>
<td>11.1%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>1,510</td>
<td>11</td>
<td>15</td>
<td>1.7%</td>
<td>42.3%</td>
</tr>
</tbody>
</table>

WiSCC Evaluations

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

WiSCC Distribution by APD Area

A total of 511 WiSCCs were completed and approved during Year Six of the Contract, July 2006 – June 2007. This is somewhat more than the target for the year of 461. As part of these consults, 707
Waiver Support Coordinators (WSC) were reviewed and 1,413 individuals were interviewed. (Consultants expected to interview approximately 1,416 individuals before June 30, 2007). The WiSCC consults and WSCs were distributed across the APD Areas as shown in the following table.

Table 12: WiSCC and WSCs by APD Area

<table>
<thead>
<tr>
<th>Area</th>
<th>WiSCCs</th>
<th>WSCs</th>
<th>Percent WSCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>17</td>
<td>31</td>
<td>4.4%</td>
</tr>
<tr>
<td>2</td>
<td>42</td>
<td>56</td>
<td>7.9%</td>
</tr>
<tr>
<td>3</td>
<td>23</td>
<td>35</td>
<td>4.9%</td>
</tr>
<tr>
<td>4</td>
<td>66</td>
<td>76</td>
<td>10.7%</td>
</tr>
<tr>
<td>7</td>
<td>88</td>
<td>100</td>
<td>14.1%</td>
</tr>
<tr>
<td>8</td>
<td>19</td>
<td>27</td>
<td>3.8%</td>
</tr>
<tr>
<td>9</td>
<td>11</td>
<td>11</td>
<td>1.6%</td>
</tr>
<tr>
<td>10</td>
<td>32</td>
<td>47</td>
<td>6.6%</td>
</tr>
<tr>
<td>11</td>
<td>65</td>
<td>77</td>
<td>11.1%</td>
</tr>
<tr>
<td>12</td>
<td>18</td>
<td>31</td>
<td>4.4%</td>
</tr>
<tr>
<td>13</td>
<td>19</td>
<td>39</td>
<td>5.5%</td>
</tr>
<tr>
<td>14</td>
<td>18</td>
<td>29</td>
<td>4.1%</td>
</tr>
<tr>
<td>15</td>
<td>12</td>
<td>12</td>
<td>1.7%</td>
</tr>
<tr>
<td>23</td>
<td>81</td>
<td>136</td>
<td>19.2%</td>
</tr>
<tr>
<td>Total</td>
<td>511</td>
<td>707</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Each Waiver Support Coordinator (WSC) is evaluated on six WSC Results Elements (WRE) and five Minimum Service Requirements (MSR). With the WREs 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 WSC helping individuals direct their own health care? 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.\(^{15}\)

For purposes of analysis, a WRE score is calculated for each Support Coordinator using the same values for each evaluation level as described earlier for CORE.\(^{16}\)

---

\(^{15}\) See Appendix 1 Attachment 3 for a brief summary of each element and see the procedures and tools on the Delmarva website for a detailed description of the elements and evaluation criteria within each element ([http://www.dfmc-florida.org/provider/resources/core_wiscc_tools.htm](http://www.dfmc-florida.org/provider/resources/core_wiscc_tools.htm)).

\(^{16}\) 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.
• Achieving = 3
• Implementing = 2
• Emerging = 1
• Not Emerging = 0

A WRE average score, between zero and three, is calculated for each WSC, based upon the element level evaluations. Therefore, if WSCs score Achieving on all six WREs, the WRE score is a three. These are then summed and divided by the number of elements scored in each APD Area for an average WSC score per Area. Results for the first three years of WiSCC data are presented in Figure 18.

• The statewide average over the three years has remained between Emerging and Implementing, somewhat closer to Implementing. However, this has increased somewhat consistently to 1.85.
• The average score in 10 of the Areas has improved since Year Four.
• Areas 9, 10 and 11 showed the greatest improvement since Year 4, with increases of .58, .52, and .53 respectively. On a three point scale, movement of over half a point in either direction seems substantial.
• Areas 7, 8, 12, and 13 were the only Areas demonstrating a decrease in the WRE score, below both the Year Four and Year Five levels.

![Figure 18: Average WSC Results Element Score by APD Area July 2004 - June 2007](attachment:average_wsc_results.png)
The five MSRs are process elements and are similar to those discussed in the CORE section of this report. These are scored as Met or Not Met. The average percent of MSRs scored as Met in each APD Area for the first two years of CORE utilization is shown in Figure 19.

- The state average for Year 6 (July 2006 – June 2007) is 88.3 percent, down several points from the previous two years.
- The scores in Year Six ranged from a low of 72.6 percent in Area 8 to a high of 98.7 percent in Area 11.
- Area 11 has demonstrated consistent improvement since the implementation of the WiSCC process, with close to an 11 point increase in Year Six compared to the baseline year (Year 4).
- Areas 9 and 13 also show improvement since Year 4.
- Areas 7, 8, and 23 have shown a consistent drop in the percent of the MSR elements that were scored as Met, with Area 8 demonstrating a 15.6 point decrease since Year 4. Areas 2, 3, 4, 7, 8, 12, 14, 15 and 23 all show current rates lower than in Year Four.

Figure 19: Average WSC MSR Score (Percent Met) by APD Area
July 2004 - June 2007
WSC Results Elements (WRE)

Each of the 707 WSCs received an evaluation of Achieving, Implementing, Emerging or Not Emerging on the six WREs. The distribution of the number and percent for each element is displayed in the next figure. Year Four, Five and Six statewide averages are presented for comparative purposes.

Information from the data in Figure 20 indicates the following:

- On average, support coordinators have scored more elements as Achieving each year since implementation of the WiSCC process in Year Four, an increase from 16.4 percent to 24.7 percent. This average increase is evident within each WRE when comparing Year Four to Year Six, ranging from 2.6 points on Element 2 (Health and Safety) to 12 points on Element
4 (WSC evaluates the effectiveness of all supports) and 12.3 points on Element 1 (Systems are in place that allow the WSC to learn all about individuals served).

- Over 63 percent of the WREs were scored as Implementing or Achieving in Year Six, an increase from 54 percent in Year Four. Across each element, this percent ranges from 52.6 percent on Element 6 (Facilitating Results) to 86.9 percent on Element 1 (Knows Person).
- Providers remain most likely to score Achieving on Element 1 (48.1%), indicating they often have an effective method for learning about the people they serve. This is up from just over 35 percent in Year Four, the greatest gain among all the results elements at the Achieving level;
- Providers were least likely to score Achieving on Element 2 (14.6%) indicating that although most WSC have systems in place that guarantee the health and safety of the individuals they serve (55% at Implementing or Achieving), many are not yet allowing individuals to direct their own health care planning.

**Results Elements by Provider Type**

A comparison across provider types reveals small differences between support coordinators working for an agency or operating as a solo provider. During Year Six, there were 333 support coordinators working with an agency and 372 working as solo providers. Results of the evaluations on the WiSCC elements for WSCs are presented for agency and solo providers in the following three charts: Figure 21 shows the results in Year Six by provider type; Figure 22 shows results for agency providers for three years; Figure 23 shows results for solo providers for three years. Percents represent the percent of elements scored at the various levels, i.e., Achieving, Implementing, Emerging or Not Emerging.
Figure 21: WISCC Element Level Results by Provider Type
Year 6 (July 2006 - June 2007)

Figure 21 above pictures the difference between agency and solo providers for the 12 month period ending June 2007. They appear to be performing at about the same level, with agency providers slightly more likely to have elements scored as Achieving and solo providers somewhat more likely to have elements scored as Implementing. Approximately 64 percent of the results elements for solo providers were evaluated as Implementing or Achieving, compared to approximately 62 percent for agencies.

Figure 22: WISCC Agency Provider Element Level Results
Years 4, 5 and 6
WRE results for the first three years of WiSCC activity for the two different provider types are shown separately in Figures 22 (Agency) and 23 (Solo). On average, both types of providers have shown an increase in the percent of elements scored as Achieving. Both have increased the percent of elements scored as Achieving and Implementing since Year Four, while at the same time reducing the percent scored as Emerging.

![Figure 23: WiSCC Solo Provider Element Level Results Years 4, 5 and 6](image)

<table>
<thead>
<tr>
<th>Year</th>
<th>Achieving</th>
<th>Implementing</th>
<th>Emerging</th>
<th>Not Emerging</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 4 (310)</td>
<td>15.9%</td>
<td>36.7%</td>
<td>44.6%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Year 5 (347)</td>
<td>20.5%</td>
<td>43.2%</td>
<td>34.7%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Year 6 (372)</td>
<td>23.3%</td>
<td>40.6%</td>
<td>33.4%</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

**Minimum Service Requirements**

As noted previously, the Minimum Service Requirement (MSR) elements; providers must supply documentation of the required background screening, required training, and proper billing procedures. MSR elements are evaluated as Met or Not Met. The following graph portrays the percent of Waiver Support Coordinators distributed across the number of MSR elements that were scored as Met for the three year period ending June 30, 2007. The numbers zero through five represent the number of MSR elements and the percent is the percent of providers for each number Met.
Only one WSC in the three year period was shown as having none of the MSR elements scored as Met—one solo provider in Year Four (0.3%).

A majority of support coordinators scored all five MSR elements as Met in both years. However, this has dropped from 70 percent in Year Four to approximately 59 percent in Year Six.

In the following figure, the number and percent of MSR elements scored as met is given at the element level by year. Highlights from Figure 25 include:

- The average Percent Met on the MSR elements for support coordinators has dropped from around 91 percent in the first two years to 88 percent in Year Six.
- WSCs have shown steady improvement in maintaining documentation to verify the proper training has been completed.
- The greatest decreases are seen in the provider’s ability to document authorization to render the service and in maintaining documentation required for billing.
- On average across each year approximately 95 percent of WSCs were able to provide Level II Background screening documentation and in Year Six close to 100 percent were in compliance with billing authorization criteria.
Follow-up With Technical Assistance

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

FOCUS Plan

As part of the WiSCC, the Delmarva Consultant helps the WSC agency or solo provider develop a FOCUS plan. This includes expectations for the WSC that will enhance performance and increase outcomes for individuals. For each WiSCC, one or more expectations are developed. The following graph shows the number of expectations per WiSCC for the first three years since implementation of the process. Because the expectations are determined to be Met or Not Met during the Follow Up
Review, results are included only if the Follow Up has been completed. A majority of the WSC entities have one or two expectations in the FOCUS Plan each year (Figure 26).

![Figure 26: Number of FOCUS Plan Expectations by Year](image)

The following graph (Figure 27) shows the percent of expectation that were completed at the time of the Follow Up review. On average across the years, about 48 percent of providers had not met any of the expectations delineated in the FOCUS Plan (0.0%), but close to 42 percent of the providers had addressed all of them (100%).

![Figure 27: Percent FOCUS Plan Expectations Met at Follow-up by Year](image)
Reconsiderations

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

Personal Outcome Measure Sample Description

The Florida Developmental Disabilities Program has been in the forefront of efforts to provide a community-based person centered/outcomes approach to delivery of services to persons with developmental disabilities. They have adopted the use of the Personal Outcomes Measures (POMs) developed and published by The Council on Quality and Leadership (CQL) to report Performance Indicators to the State of Florida.17

The Person Centered Review (PPR) is a component of the WiSCC process, conducted as a part of the FSQAP consultation functions. The focus of the review is on measures that emphasize values-based supports and services, individualized planning, and personal outcomes. In addition to the POM, components of the PCR include follow-up interviews, a central record review with the WSC, and a Medical Peer Review.

POM Interviews were completed on 1,413 randomly selected recipients of Developmental Disabilities (DD) or Family and Supported Living (FSL) Waiver services in Year Six 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 has completed a POM interview at any time during the previous 12 months, that person is excluded from the sample.

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

17 Go to http://www.thecouncil.org for information on the history of the Council, their mission statement and the development of the POM tool.
agency are selected to participate in the WiSCC, four with each consultation. Individuals who had previously completed a POM were excluded from the sample.\textsuperscript{18}

**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. CQL conducts annual reliability testing on all Delmarva Quality Improvement Consultants (QIC). QICs who have established reliability in the use of the interview tool conduct POM interviews. As described above, a random sample of two individuals was selected for each Waiver Support Coordinator participating in a WiSCC.

The table below provides data indicating the outcomes and supports for individuals decreased over the first three years, increased through Year Five and dropped somewhat in Year Six. The average number of outcomes present per individual each year has remained fairly consistent, around 11 or 12 for the past five years. The average number of supports has remained at approximately 12 or 13 over the same time period.

<table>
<thead>
<tr>
<th>Table 13: Personal Outcome Measures</th>
<th>Average and Percent Outcomes and Supports Present</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year One</td>
</tr>
<tr>
<td>Number of Person Centered Reviews</td>
<td>1,907</td>
</tr>
<tr>
<td>Average Number of Outcomes Met per Consumer</td>
<td>13.2</td>
</tr>
<tr>
<td>Average Percent of Outcomes Met</td>
<td>52.8%</td>
</tr>
<tr>
<td>Average Number of Supports Present per Consumer</td>
<td>14.9</td>
</tr>
<tr>
<td>Average Percent of Supports Present</td>
<td>59.5%</td>
</tr>
</tbody>
</table>

\textsuperscript{18} During the previous years the demographics of the sample have matched the population fairly well, as demonstrated in previous annual reports. Because all the population data (both the DD and FSL population) were unavailable at the time of this report, comparisons were not possible. These may be added if the data are available when revisions to the report are completed.
POM Results by Individual Item

The POM interview is a 25-item assessment tool that determines if for the individual a personal Outcome and/or Supports are Present for each item, regardless of the service received. Quality improvement studies have statistically linked the increased presence of supports with increased outcomes for individuals. Figures 28 and 29 on the following pages provide the percentage of Outcomes and Supports Present by POM item for the sample of individuals who received a Person Centered Review in Years Four, Five or Six of the contract.

Data indicate:

- *Is free from abuse and neglect* shows the highest percent Present for both outcomes and supports each year, has increased somewhat each year, and was close to 88 percent present in Year Six. Close to 68 percent of the individuals who had this scored as Not Present were identified as still impacted from some past abuse event (Appendix 2, Exhibit 5). Therefore, approximately 70 people were identified with a current and/or unreported incident of abuse, neglect or exploitation at the time of the POM interview—five percent of the sample.

- Although the average percent of Outcomes Present in Year Six has dropped somewhat since Year Five, seven POM items remained about the same or slightly improved over this time period:

  - Chooses where and with whom to live
  - Satisfied with services
  - Lives in integrated environments
  - Realizes personal goals
  - Is safe
  - Has the best possible health
  - Is free from abuse and neglect

- *Performs different social roles* remains the lowest among all the POM items on both outcomes and supports, and both outcomes and supports have decreased somewhat since Year Five.

- Only two POM items show fewer than 30 percent of individuals with Outcomes Present: *Perform different social roles* and *Chooses services*.

- Four POM items show only 30 percent or fewer individuals with Outcomes Present:

  - Performs social roles
  - Has friends
  - Uses their environment

---

Chooses services

- Ten POM items have close to 50 percent or higher on the percent of Outcomes Present and 12 on the percent of Supports Present.
- *Chooses personal goals* and *Interacts with the community* demonstrated the largest declines since Year Five, 7.7 and 7.2 points respectively.
- The pattern for Supports Present is similar to the pattern for Outcomes Present across all the POM items.

The top five POM items for which the outcome is most frequently Present have remained consistent from Year One through Year Six.\(^{20}\)

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

The item measuring abuse and neglect has consistently shown the highest percent present across the years of the FSQAP contract. While an average of 85 percent of individuals may have this met, in presenting this to the Interagency Quality Council the members noted that 15 percent do not have this met—which is not in line with APD’s zero tolerance policy. Therefore, a workgroup was formed and a Quality Improvement Study was completed to further explore this area. As a result, APD was able to focus some efforts in specific APD areas where the outcome was least likely to be present. It is encouraging to note that this was among the better performing outcome indicators in Year Six, slightly improving, even though outcomes on average have declined somewhat.

\(^{20}\) See Appendix 2, Exhibit 5 for a list of the reasons outcome/supports are not present.
Figure 29: Percent POM Supports Present
July 2004 - June 2007

- 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 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
POM Results by APD Area

The following two charts display the average percent of POM Outcomes Present (Figure 30) and Supports Present (Figure 31), by APD Area for Years Four, Five and Six of the contract. Highlights from these include the following:

- In five APD Areas the percent of Outcomes Present was the same or greater in Year Six than in Year Five: Areas 2, 3, 4, 9 and 15.
- Areas 2, 4, 9, 11, 15 and 23 showed improvement on Supports Present.
- Area 9 demonstrated the greatest gains since Year Five in both Outcomes (11.5 percentage points) and Supports (25.7 points). However, this represents only 22 interviews.
- Area 10 shows the greatest decrease in the percent of Outcome Present since Year Five (11.3 points).
- The greatest reduction in the percent of Supports Present was seen in Area 1, with a drop of over 10 points since Year Five. Areas 7 and 13 showed about a nine point drop during the same time period.
Figure 30: Percent POM Outcomes Present by APD Area
July 2004 - June 2007

- Year 4 (1357)
- Year 5 (1363)
- Year 6 (1413)
Figure 31: Percent POM Supports Present by APD Area
July 2004 - June 2007

APD Area vs Percent Met

Year 4 (1357)
Year 5 (1363)
Year 6 (1413)
Driver Indicators

Through a series of analyses, the POMs with the highest ability to predict the number of Outcomes present in an individual’s life 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. These were defined as “driver indicators” and if Present, increase the likelihood that at least 13 or more Outcomes will be present.

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

<table>
<thead>
<tr>
<th>Personal Outcome</th>
<th>Year 4 (1357)</th>
<th>Year 5 (1363)</th>
<th>Year 6 (1413)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Driver Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chooses work</td>
<td>28.8%</td>
<td>35.7%</td>
<td>32.6%</td>
</tr>
<tr>
<td>Chooses services</td>
<td>25.3%</td>
<td>29.8%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Feel respected</td>
<td>48.9%</td>
<td>54.2%</td>
<td>49.0%</td>
</tr>
<tr>
<td>Exercise rights</td>
<td>34.9%</td>
<td>37.8%</td>
<td>34.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Driver Supports</th>
<th>Percent Supports Present</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chooses daily routine</td>
<td>52.1%</td>
<td>55.1%</td>
<td>50.2%</td>
</tr>
<tr>
<td>Is connected to natural support networks</td>
<td>73.7%</td>
<td>82.2%</td>
<td>77.8%</td>
</tr>
<tr>
<td>Chooses where/with whom to live</td>
<td>41.1%</td>
<td>47.8%</td>
<td>46.5%</td>
</tr>
<tr>
<td>Decides when to share personal information</td>
<td>60.0%</td>
<td>62.2%</td>
<td>57.7%</td>
</tr>
<tr>
<td>Has intimate relationships</td>
<td>43.5%</td>
<td>45.3%</td>
<td>41.5%</td>
</tr>
</tbody>
</table>

---

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

With the exception of Chooses services, each of the POM items has decreased since Year Five. The Diver Outcomes are all at or above the Year Four levels but only two of the Driver Supports, Chooses where and with whom to live and Is connected to natural support networks have remained above the Year Four percents.

Reasons Supports and Outcomes were Not Met

For several years, the QICs have collected information on the reasons outcomes and supports are not met for each individual. These are collected in the form of “drop down” menus. Two quality improvement studies have been completed examining these reasons for both outcomes and supports.23

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

While individuals most often have outcomes and supports present on Free from abuse and neglect, 218 individuals served in the program were not achieving this important outcome when interviewed in Year Six, and 174 had no supports in place to address issues of abuse and neglect. A majority of individuals were “out” on this outcome due to distress over past abuse (67.7%). This is similar to results from previous years. Among supports, counseling and training for protection are often not being addressed and Reporting Training is missing.24

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 Present has been established for reporting purposes and has been tracked since Year One of the project.


24 See Appendix 2, Exhibit 5 for a list of the top three reasons outcomes and supports are not present for all 25 POM items.
Results for this indicator are presented below for the last five years of the contract. Over this time period, July 2002 – June 2007, on average 44.1 percent of individuals had 13 or more Outcomes Present and 50.1 percent had 13 or more Supports Present. In both areas, this decreased from Year Two to Year Three, and slowly increased through Year Five. In Year Six, the percent of 13 or more Supports Present has remained at about the same level as in Year Five but the percent of 13 or more Outcomes present has dropped from 46.4 percent in Year Five to 43.1 percent in Year Six.

### Figure 32: 13 or More Outcomes or Supports Present

#### Year 2 - Year 6

<table>
<thead>
<tr>
<th>Year</th>
<th>Outcomes</th>
<th>Supports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 (2496)</td>
<td>49.3%</td>
<td>56.3%</td>
</tr>
<tr>
<td>Year 3 (2456)</td>
<td>39.8%</td>
<td>46.0%</td>
</tr>
<tr>
<td>Year 4 (1357)</td>
<td>41.3%</td>
<td>46.4%</td>
</tr>
<tr>
<td>Year 5 (1361)</td>
<td>46.4%</td>
<td>50.5%</td>
</tr>
<tr>
<td>Year 6 (1413)</td>
<td>43.1%</td>
<td>49.8%</td>
</tr>
</tbody>
</table>

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

Exhibit 6 (Appendix 2) shows the distribution of individuals who had 13 or more outcomes or supports present across APD Areas, age groups and type of living arrangement for Year Six.²⁵ 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:

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²⁵ Some numbers and percents in the Appendices vary slightly from tables and graphs in the body of the report due to downloading the database at an earlier date. Missing values on key demographic variables also creates some differences across tables and graphs.
• Residents in Independent or Supported Living continue to have the largest proportion of individuals with 13 or more of both outcomes and supports met, with 64.6 percent and 70.3 percent respectively. This is consistent with findings over the previous five years.
• The percent of residents in large group homes that met the criterion of 13 or more outcomes met decreased from 22 percent in Year Five to 17.2 percent in Year Six.
• The data suggest fairly large variations across Areas on the percent of 13 or more outcomes met, from a high of 94.1 percent in Area 11 to a low of 22.1 percent in Area 13. Several areas have a small number of participants in the sample, which lends itself to large fluctuations in point estimates. This also produces variation from one year to the next.
• 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 Six is somewhat higher than for Year Five, at approximately close to 65 percent compared to 61 percent.

13 or More Met Results by Service
Figure 33 displays the distribution of the percent of individuals who had 13 or more outcomes met by services for Years Four, Five and Six. Services included are subject to an Onsite CORE consult. When reviewing these results it is important to note that individuals may have received more than one of these services and may have received any number of other services as well. In addition, claims data were used to identify services received by the individuals and not all POM results were successfully linked to the claims data.

Figure 33 provides graphic evidence that:

• Individuals receiving Supported Employment (SE) or Supported Living Coaching (SLC) were more likely to have 13 or more outcomes met than individuals receiving the other services displayed, and this was true both in all three years and has increased somewhat each year.
• Among the “day services”, ADT, NRSS and SE, people receiving Supported Employment are much more likely to achieve 13 or more outcomes.
• Individuals receiving ADT, NRSS or Residential Habilitation were less likely to have 13 or more outcomes present in Year Six than in Year Five.

26 In Home Support Services and Special Medical Home Care were reviewed Onsite beginning in Year Five. Only one person interviewed received SMHC.
27 See the quality improvement study Outcome Results Analysis: Impact of Waiver Services on POM Outcomes Present for a detailed analysis of outcomes across services, controlling for other factors that influence the relationships. (http://www.dfmc-florida.org/quality_improvement_studies/2006-2007/index.htm)
Figure 33: 13 or More Outcomes Present by Service
July 2004 - June 2007

<table>
<thead>
<tr>
<th>Service</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Year 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Training</td>
<td>27.7%</td>
<td>36.8%</td>
<td>32.8%</td>
</tr>
<tr>
<td>Non-Residential Supports</td>
<td>32.2%</td>
<td>46.2%</td>
<td>36.8%</td>
</tr>
<tr>
<td>Residential Habilitation</td>
<td>20.2%</td>
<td>27.8%</td>
<td>22.6%</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>59.5%</td>
<td>68.6%</td>
<td>69.8%</td>
</tr>
<tr>
<td>Supported Living Coaching</td>
<td>49.7%</td>
<td>61.9%</td>
<td>63.7%</td>
</tr>
<tr>
<td>In Home Support Services</td>
<td></td>
<td></td>
<td>54.4%</td>
</tr>
</tbody>
</table>

Foundational Outcomes

The last seven Personal Outcome Measures include the items measuring Safeguards, Rights, and Health and Wellness. These are the Foundational Outcomes and are considered to be basic outcomes that most people with developmental disabilities should expect to have present most of the time. The percent of reviews for which all seven Foundational Outcomes are Present has been selected as a Performance Indicator that is reported to the Governor and Florida Legislature.

Table 15: Foundational Outcomes
Percent Met by Year

<table>
<thead>
<tr>
<th>Foundational Performance Outcome Measures</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Year 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 - Is connected to natural support networks</td>
<td>70.5%</td>
<td>64.6%</td>
<td>65.1%</td>
<td>68.5%</td>
<td>67.2%</td>
</tr>
<tr>
<td>20 - Is safe</td>
<td>67.7%</td>
<td>67.3%</td>
<td>61.9%</td>
<td>68.5%</td>
<td>69.1%</td>
</tr>
<tr>
<td>21 - Exercises rights</td>
<td>36.6%</td>
<td>33.9%</td>
<td>34.9%</td>
<td>37.8%</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>
<td>61.6%</td>
<td>56.9%</td>
</tr>
<tr>
<td>23 - Has the best possible health</td>
<td>50.2%</td>
<td>39.5%</td>
<td>40.8%</td>
<td>46.2%</td>
<td>46.9%</td>
</tr>
<tr>
<td>24 - Is free from abuse and neglect</td>
<td>84.6%</td>
<td>83.0%</td>
<td>83.0%</td>
<td>84.2%</td>
<td>84.6%</td>
</tr>
<tr>
<td>25 - Experiences continuity and security</td>
<td>49.2%</td>
<td>37.2%</td>
<td>38.5%</td>
<td>41.7%</td>
<td>35.4%</td>
</tr>
</tbody>
</table>
The seven Foundational Outcomes are listed in the Table 15 for Years Four – Six. While several of the Foundational Elements have remained fairly stable since Year Five, three have shown a decline: *Exercises rights*, *Is treated fairly* and *Experiences continuity and security* have each decreased by three points or more.

The following two charts show the distribution of POMs across the number of Foundational Outcomes scored as Present—individuals who have zero to seven of the foundational outcomes present. The overall rate that All Foundational Outcomes were met during the twelve month period ending June 30, 2007, (Figure 34) was 7.6 percent (108 individuals). This shows a decrease from 10.8 percent in Year Five and from 8.3 percent in Year Four.

![Figure 34: Percent with Foundational Outcomes Met By Number of Outcomes July 2004 - June 2007](image)

<table>
<thead>
<tr>
<th>Number Foundational Outcomes Met</th>
<th>Year 4 (1357)</th>
<th>Year 5 (1363)</th>
<th>Year 6 (1413)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>8.3%</td>
<td>10.8%</td>
<td>7.6%</td>
</tr>
<tr>
<td>6</td>
<td>10.8%</td>
<td>15.0%</td>
<td>15.6%</td>
</tr>
<tr>
<td>5</td>
<td>16.9%</td>
<td>19.3%</td>
<td>17.6%</td>
</tr>
<tr>
<td>4</td>
<td>16.8%</td>
<td>16.6%</td>
<td>16.6%</td>
</tr>
<tr>
<td>3</td>
<td>18.3%</td>
<td>16.2%</td>
<td>19.3%</td>
</tr>
<tr>
<td>2</td>
<td>15.9%</td>
<td>12.0%</td>
<td>14.2%</td>
</tr>
<tr>
<td>1</td>
<td>7.9%</td>
<td>7.8%</td>
<td>6.5%</td>
</tr>
<tr>
<td>0</td>
<td>3.1%</td>
<td>2.4%</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

Figure 35 displays the Percent of POMs (individuals) with a cumulative number of the Foundational Outcomes met, 7, 6 or more, 5 or more, and 4 or more. Over 23 percent of individuals interviewed in Year Six had six or seven of these important POMs present in their lives. The pattern remains the same over the years.
Foundational Outcome Results by Home Type, Area, and Age Group

Results in Exhibit 9 (Appendix 2) display the number and percent of individuals for whom a Person Centered Review was completed who met all seven Foundational Outcomes, displayed for each home type, APD Area and age group, for Years Four - Six.\(^{28}\) In addition, Figures 36 and 37 present a graphic display of the results by home type and APD Areas. The number of POM interviews completed in several areas and within some home types and age groups is relatively small, which can produce unstable point estimates.

- The youngest age group was most likely to have all of the foundational outcomes met each year, with the exception of elderly people over age 65 in Year Six. However, the result for the elderly people represents only 22 interviews and three people with all the foundational outcomes present.
- Each year, the percent with all of the foundational outcomes met is highest for people living in a family home (with the exception of the “other/unk” category in Years Four and Five).\(^{29}\) However, the proportion Present in family homes is down considerably from 15 percent to 9.8 percent.

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\(^{28}\) See Appendix 2, Exhibit 8 for summary information on Foundational Outcomes by district, age group and home type for Years 1, 2, and 3.

\(^{29}\) This category consists of 14 people in Residential Treatment Facilities and five Unknown in Year Four and 10 in Residential Treatment and two Unknown in Year Five.
• There is quite a bit of variation across APD Areas as well as within some areas over time. However, this is expected because the number of POM interviews in most areas is generally small, eight Areas with 70 or fewer. Area 11 displays the greatest percent of individuals with all the foundational outcomes present, but also shows a great decrease since Year Five.

Figure 36: Percent with All Foundational Outcomes Present by Home Type
July 2004 - June 2007

Figure 37: Percent with All Foundational Outcomes Met by APD Area
July 2004 - June 2007
Medical Peer Review Findings

The Nurse Reviewer is responsible for overseeing the recommendations that are automatically generated by the QIC through the utilization of the Health Behavioral Questionnaire - Appendix 1, Attachment 5. As part of the approval process for the report, the Nurse Reviewer evaluates the appropriateness of recommendations, and compares the findings to information contained in the claims data. If discrepancies exist in any of the findings, the Nurse Reviewer may initiate a Focused Review or request Medical Records. Any significant findings are reported to the WSC and possibly to the local Medical Case Manager, if appropriate.

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

<table>
<thead>
<tr>
<th>Disposition</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requesting Medical Records</td>
<td>5</td>
<td>0.4%</td>
</tr>
<tr>
<td>Waiting for expert review</td>
<td>4</td>
<td>0.3%</td>
</tr>
<tr>
<td>Waiting for RN review</td>
<td>10</td>
<td>0.7%</td>
</tr>
<tr>
<td>Done - no additional concerns</td>
<td>1,372</td>
<td>96.8%</td>
</tr>
<tr>
<td>Done - additional concerns to WSC</td>
<td>25</td>
<td>1.8%</td>
</tr>
<tr>
<td>Done - no concern/no claims</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Done - concern yes/no claims</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Done - ancillary claims only</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Done - additional concerns to MCM</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>Total</td>
<td>1,417</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The distribution of Medical Dispositions is presented in Table 16. The overwhelming majority show no additional concerns were noted (96.8%), consistent with previous years. The change in procedures with the implementation of WiSCC has allowed input from the Nurse Reviewer during the WiSCC process. For this reason, most concerns are addressed on site rather than sent to the WSC or Medical Case Manager.

Additional information about the recommendations and a summary of the frequency and types of specific health or behavioral health recommendations is provided in Exhibit 11, Appendix 2.
Section Two: Discussion of Data Analysis Findings and Recommendations

Through June 30, 2007, the Florida Statewide Quality Assurance Program (FSQAP) has conducted over 11,000 Personal Outcome Measure interviews with individuals who were receiving services and supports through the Developmental Disabilities Home and Community-Based Services Waiver. Over 11,000 annual Provider Performance Reviews/CORE have been completed along with 4,900 follow up reviews/consultations. This number does not include the number of follow-up visits QICs conducted subsequent to a WiSCC. Over the past two years consultants conducted approximately 1,400 WiSCC that included an interview with 2,066 Waiver Support Coordinators.

Review/Consult results from these activities have been reported on a regular basis through quarterly reports and presentations at state and local meetings. As project staff have shared the data and worked with the State and APD Areas to improve the quality assurance process and provide training and technical assistance, emerging trends and patterns have been noted and are being used to direct improvements in supports and services. Results from the quality improvement studies have also been reported and used to help implement quality improvement initiatives or a shift in focus. For example, the POM item measuring abuse, neglect and exploitation was identified as an area of concern. APD is currently undergoing efforts to improve results on this POM item in targeted APD Areas.

Desk Reviews

The average score for Desk Reviews, a procedure that has changed very little over the five years of the contract, has increased somewhat since Year One and remained fairly consistent through Year Five. The current average of 73 percent is down from approximately 77 percent shown in both Year Four and Five. The percent of Desk Reviewed providers who had documentation for their Level 2 Background screening had improved every year from 67 percent in Year One to 82 percent in Year Five. However, this has dropped to 78 percent in Year Six. The percent of providers compliant with the 5-year Re-screening has also dropped since Year Five. The percent of providers who received a Desk Review and had a Recoupment citation has increased from 36 percent in Year Four to over 48 percent in Year Six.

From this evidence, it appears the process used for providers of services who are monitored with a Desk Review is not helping to improve performance evaluations for these providers. Therefore, the process does not appear to be one of Quality Improvement. In the annual reports for Year Four and Year Five, it was recommended that a work group representing all relevant parties examine the Desk Review process and suggest modifications where appropriate.
Recommendation 1: It is again recommended that a work group examine the Desk Review process and modify as appropriate. The Desk Review quality improvement study should be used to guide initial discussions. As part of this effort, data should be analyzed comparing outcomes and supports for individuals who receive services only from providers who are Desk Reviewed with individuals who receive services from providers who receive a CORE consult.

**CORE Results Element**

The average CORE Results Element (CRE) scores have dropped in Year Six to slightly below the Year Four level. On average, solo providers have performed better than agencies. Prior to implementing the revised CORE process, 74 percent of solo providers were evaluated as Achieving or Implementing compared to 52 percent of agencies. This difference is also evident when reviewing results from the revised CORE tool, but to a lesser degree: 51 percent for solo providers and 45 percent for agencies. This pattern has persisted since the Year Four results were analyzed, although the difference between the two types of providers was not as great in Year Five.

Recommendation 2: Area APD offices should explore this trend among their Area providers. What is it about agency providers that tends to impact performance? Is additional oversight needed? Analysis of agency providers, examining the association between the number of consumers and CORE performance levels may be helpful in determining if the size of the agencies impacts their ability to organize their systems so they are able to render optimal services to individuals. Analysis could also explore the impact of rendering a different number of services or various types of services within the same agency. Are some combinations better than others?

At the element level, CORE results inform us that over 50 percent of providers were evaluated as Implementing or Achieving on 10 of the 18 CREs and on eight different elements a greater percent of providers scored as Achieving compared to Year Four, the year CORE was implemented. On the other hand, providers were most likely to score Not Emerging on the two elements pertaining to an individuals Implementation Plan (IP): the individual directs the design of the IP, identifying needed skills and strategies to accomplish personal desired goals; and the individual participates in the routine review of the IP and directs changes desired to assure outcomes/goals are met. Previous research has pointed to problems that may be present in terms of IP planning and development.31

**Recommendation 3:** Implementation Plan training should be offered in each Area that identifies the importance of individual participation in the design and review of the IP. If this training is already

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31 Barriers Analysis, submitted by Delmarva Foundation to AHCA and APD, June 30, 2006.
offered, Delmarva and APD should review its content and revise as appropriate, and APD should require and ensure that all providers attend within the next 12 month period.

Elements 11 through 14 are directly related to the implementation plan process. These include using a person directed/outcome approach, involving the individual in the initial development and continued review and modification of the IP and developing strategies to support the individual’s desired outcomes. These in turn may impact Element 15 (Achieving Results) and Element 18 (Satisfaction with Services). Unfortunately, Elements 11 through 14 are among those least likely to be scored as Achieving or Implementing. Projected Service Outcomes (MSR Element) measure the extent to which providers are ensuring individuals are making progress or achieving their desired goals. This is one of the two elements most often scored as Not Met.

Recommendation 4: Train providers on developing better systems and practices to evaluate individual progress on outcomes. The training should include techniques providers can use to develop internal quality management systems, including tracking and evaluating Projected Service Outcomes. These are then used to examine and enhance their quality of supports and services.

WiSCC Results Elements

WRE results for providers of Support Coordination (WiSCC, first six elements) indicate Agency and Solo providers were evaluated at similar levels, with Agency WSCs slightly more likely to have elements scored as Achieving and Implementing. Both types of providers improved over Year Four and Year Five. Every WRE has shown a steady increase at the Achieving level since Year Four and the percent of elements scored as Achieving or Implementing has increased from 54 percent to 63 percent. Therefore we have no specific recommendations concerning the WiSCC process.

However, at the same time as WSCs have improved, performance of providers who receive a CORE has dropped, as indicated above. One of the major differences between the CORE and WiSCC procedures is the use of the FOCUS plan (Formula Offering Cooperative and Unified Success) in the WiSCC. The FOCUS plan is developed cooperatively with the WSCs during the closing conference, providing several concrete areas in which the WSCs can improve their systems in order to help individuals achieve outcomes. In addition, APD has often requested more specific and clear recommendations from the CORE process so providers can focus on ways to improve.

Recommendation 5: Delmarva and APD should work together to design and implement a procedure for the CORE process similar to the WiSCC FOCUS plan.
Minimum Service Requirements

In both the CORE and WiSCC processes, data indicate a decrease in compliance with handbook requirements as measured by the Minimum Service Requirements: Background screening, training, and in particular maintaining billing documentation and Projected Service Outcomes.

Recommendation 6: APD should train all providers on documentation requirements as defined in the Developmental Disabilities Waiver Services Coverage and Limitation Handbook.

Personal Outcome Measures

Data from the Personal Outcome Measures are regularly presented to IQC, the APD central office, local APD offices, and the legislature. Results reported over Year Six indicate the percent of All Foundational Outcomes present has dropped from 10.8 percent in Year Five to 7.8 percent in Year Six (Figure 34). The two Foundational Outcomes with the greatest decline since Year Five were People are treated fairly and People experience continuity and security. In addition, a small decline in the overall percent of Outcomes and Supports Present, down on average by approximately two percentage points, has been identified. These declines could reflect, in part, the influx of individuals who are on the Family and Supported Living Waiver which offers fewer services. In addition a number of new FSL WSCs started this past year and are new to the program and outcomes-based process.

Recommendation 7: A quality improvement study should be conducted to examine outcomes for individuals who are on the DD v the FSL waiver and include the length of time the WSC has rendered support coordination services. This study would also control for other relevant factors as determined by Delmarva, AHCA and APD.

Several reasons are provided when the outcomes and/or supports are not present, as shown in the table in Appendix 2, Exhibit 5. When the individuals do not feel they are being treated fairly it is most often because due process has not been provided or the individual has not received training on due process and does not fully understand it’s implications. For example, the outcome will not be present if an individual is unaware of the right to exercise due process. When supports are not provided for this POM item it is most often because fair treatment issues are not solicited from the person or the procedures for addressing the person’s concerns are not effective.

When the outcome People experience continuity and security is not present reasons most often cited indicate changes that impact an individual’s life are not determined or defined by the person. When supports are not present it is most often due to the person not having control over life’s decisions, for example parents and providers of services determining staff changes without the person’s input
or knowledge. Another significant reason the support is not present may be that an organization does not know the person’s needs and/or desires.

**Recommendation 8:** APD should work with the DD Council, the Advocacy Center, Family Care Council, and other relevant and interested organizations to help educate individuals and families on due process.

**Recommendation 9:** A training session should be developed by Delmarva and APD, and presented to all stakeholders, that clearly delineates the expectation that all individuals be included in all of their life’s decisions. Emphasis should be placed on Education, Exposure and Experience to support individuals in making informed choices.

Results in this report indicate some improvements are evident in WSC performance but Delmarva and APD should closely monitor outcomes to determine if the slight drop is a reflection of sampling fluctuation or a trend, particularly with the many changes in services and the additional proposed changes to services and the APD service delivery system being implemented beginning in July 2007. APD should also closely monitor CORE results. If the second quarter report in Year Seven reflects a continued drop in POMs or CORE provider performance, increased oversight and further investigation into reasons behind the declines should be considered.
Section Three: Summary of Quarterly and Annual Project Compliance Activities

During the course of the sixth contract year, Delmarva was able to draw down all of the dollars in the contract. In addition to consultations, reviews and quarterly/annual reports, Delmarva managed a variety of other accomplishments during the past year, including improvements to the Public Reporting website, revisions to the CORE tool and procedures, modifications to the WiSCC tool and procedures and completion of three Quality Improvement Studies submitted to AHCA and APD. These and other project activities during Year Six are discussed and summarized in the following section of this report.

Contract Monitoring

Several significant contract activities became effective in Year 6 of the Delmarva FSQAP contract. Amendment 6 of the contract was signed in November of 2006, enabling Delmarva the opportunity to incorporate the Family and Supported Living Waiver into the CORE and WiSCC activities. As a result of this, modifications were made to the CORE and WiSCC tools, and the corresponding computer applications. The amendment also allocated dollars to enable Delmarva to obtain additional training for all of the Quality Improvement Consultants (QICs) in the area of Organizational Practices. This training was provided by The Council on Quality and Leadership (CQL), and was broadly designed to assist QICs to evaluate and impact big picture practices within the organizations at which they consult. CORE QICs were also provided with POM training by CQL, and were required to obtain reliability in making decisions based upon the interview process.

Amendment 6 was also utilized to redistribute some of the dollars allocated to the Delmarva contract. To meet AHCA’s/APD’s goal of increasing the number of CORE onsite consults conducted in the contract year, targets for other services were reduced. Studies were decreased from 5 to 3, training from 25 to 14, Desk Reviews from 1200 to 600, and Documentation Reviews from 750 to 385. Within the context of these newly defined AHCA targets, Delmarva was able to effectively manage the contract and conduct activities within established production ranges.

Medical Peer Review

Pamela Wainwright worked with Delmarva staff to modify the monitoring tools for the Medical Peer Review to improve the process and to better reflect CORE and WiSCC activities. These new processes were used for Medical Peer Review monitoring during Year Six. However, with the
temporary absence of Pamela Wainwright, no Medical Peer Review monitoring has occurred during
the last two quarters of Year Six.

Training and Education Activities

Year Six Fourth Quarter Formal Activities

During the last quarter of the year (April – June 2007), eight formal training and educational sessions
were conducted. Topics were decided upon by Delmarva staff in collaboration with local APD staff,
Delmarva managers and a review of quarterly data.

In April, Areas 14 and 15 received sessions entitled Health and Behavioral Risk Indicators. Although
the sessions were tailored for the specific audience in each Area, the central theme of each included a
very detailed discussion of the three risk indicators—Health, Behavioral and Functional. This was
accompanied by examples of each type of risk and the possible consequences to individual’s health
and safety. Examples were provided by the presenter as well as from the audience. Since support
 coordinators and providers of other services attended the same sessions, much of the sessions
focused on how they could work together to identify risks and address them effectively.

In Area 4 support coordinators and APD staff were provided with a session on Rights and People
First Language. The session began by educating people of individual rights and proceeded to actually
assisting people to exercise their rights. Many examples were given and members of the audience
presented and brainstormed barriers to exercising rights. Handouts were used to illustrate the
various points. Support coordinators were also assisted to understand and implement their role in
ensuring that other providers rendering services to individuals promote and ensure individuals’ rights
are not violated and they have ample opportunities to exercise their rights according to their
preferences.

The Area 4 training then addressed the concept of people first language. While many examples of
inappropriate language were given, the focus remained on using positive language and examples of
these were given throughout. “Word Watch” is a tool created to increase awareness of the use of
inappropriate language. It was successfully utilized during the session by posting offensive and
inappropriate language on a flip chart for all to see, with suggestions for alternate words and phrases.
Feedback revealed that most of the material covered was understood and relevant to enhancing the
self image of people receiving services.

In Area 11 an educational session was provided covering documentation, per Medicaid Waiver
requirements, for a variety of services. Attendees included support coordinators as well as providers
of other services. This proved to be a great opportunity to ensure that providers of various services not only understood the documentation requirements for their services but how critical it is to use documentation as a method of communication, as a tool to evaluate progress and effectiveness of supports, and as a way to maintain historical information. The session was delivered in 4 parts:

1. Providers were taken through specific documentation requirements as dictated by the service provided and included discussion on service logs, monthly summaries, implementation plans, annual reports, service authorizations, satisfaction surveys, progress notes, self assessments, projected service outcomes, and behavior service plans.

2. This was followed by a detailed explanation of required training such as Core Assurances, Zero Tolerance, Choice and Rights, Health and Safety, Personal Outcome Process, Direct Care Competency, Service Specific Required Documentation, CPR, HIV/Aids, Infection Control and the Needs and Characteristics of Individuals. Discussion on training was followed by information on policies and procedures which included topics such as health and safety, the personal outcome process, rights, abuse and neglect, marketing practices, medication administration and grievance procedures.

3. The third component of the training session focused on the use of documentation as a method of communicating information on progress toward outcomes, positives, barriers, referral systems, follow up methods, advocacy, empowerment, and coordination of information. This section also examined the role of documentation as an historical tool that can capture people’s experiences, past experiences, likes, dislikes, past abuse, and current events. The use of documentation as an evaluation tool to assist in data comparison, next steps, and tracking systems was covered with participation from attendees being encouraged throughout.

4. The fourth portion of the session involved participants breaking out into small workgroups, each facilitated by a Delmarva staff person. Each group was given examples of documentation from a service and then asked to brainstorm ideas for rewriting the service log/progress note or summary to reflect the essence of the entire training session: service specific requirements along with information related to communication, history and evaluation. A spokesperson from each group then presented the rewritten documentation to the entire audience.

At the Quality Symposium in Ft Lauderdale (Area 9), a power point presentation explaining the driving factors and benefits to all stakeholders of a quality improvement system versus a quality assurance system was followed by a breakout session consisting of several groups. Each group was facilitated by a Delmarva staff person who encouraged attendees to consider all sources of support, beginning with natural and community resources. Overall, many creative and unique responses were brought forth by the different stakeholders.
At the annual Family Café conference in Orlando, in addition to a combine Delmarva/AHCA presentation two separate sessions were conducted. Both sessions targeted individuals receiving services, family members and providers. Approximately 10,000 people attended Family Café and many received information disseminated at an informational booth in addition to the formal sessions provided.

1. One session focused on the use of psychotherapeutic drugs in children, adolescents and adults with disabilities. It included detailed information on medications, side effects and results of various drug therapies. The session provided individuals with developmental disabilities, families and caregivers with a basic understanding of navigating through the maze of psychotherapeutic medications that are commonly prescribed. Diagnoses, both psychiatric and behavioral, were explored as well as the most commonly used psychotherapeutic medications. Attendees were assisted to identify specific questions to ask a health care provider and to identify when one needs to see a health care provider.

2. A second session included a thorough discussion of a step by step process to promote individual inclusion in matters of personal health. The topics included how to interview prospective medical professionals, what to look for in a provider’s office to ensure appropriate accommodation could be provided for special needs, what to expect from a physical exam, what paperwork to bring to an appointment and specific preventive health measures of which to be aware. Handouts for the presentation were provided as well as information/tools regarding preventive health, female health and health care specific to several diagnoses (Downs Syndrome, Spina Bifida, Cerebral Palsy).

Website Resources and On-Line Training Modules

During Years Four and Five of the contract, project staff worked with an experienced instructional designer to develop web-based training modules that are all available through the Resource Center. All of the On-Line Training Modules identify target audiences. However, they do not limit anyone from taking any of the training sessions. Anyone can utilize these training modules.

Annual Education/Training Summary

Over the course of the year, a total of 19 formal training sessions were conducted. In addition to these contractual obligations, Delmarva staff has continued to provide education and information at statewide forums and other venues. A total of 1,026 people attended one of the formal training sessions in Year Six. The following graph (Figure 38) demonstrates the number of people trained each month in one of the formal sessions provided by Delmarva. Six sessions focused on Health and Behavioral Risk Indicators conducted by the Nurse Reviewer, Linda Tupper. Five sessions
focused on Person Directed Planning in Quality Management. Other sessions included educational information on Functional Documentation, How to Prepare for a Desk Review, My Personal Health, Psychotherapeutic Medications, Rights and Person First Language, Transition from Quality Assurance to Quality Improvement, Social Capital, and Community Life. Training Sessions were also conducted at National and Statewide Conferences. Delmarva staff presented at the annual Family Café conference, annual Florida ARC conference, and Quality Symposia. In April and June 2007 over 200 people attended one of the training sessions.

**Figure 38: Number of Attendees at Training Sessions**

_July 2006 - June 2007_

![Bar chart showing number of attendees per month from July 2006 to June 2007.]

**Tool Revisions**

**CORE**

Revisions to the CORE were completed and implemented March 13, 2007. The number of CORE Results Elements (CRE) was reduced from 18 to eight, combining elements from each “domain” in the original tool and reducing the amount of duplication in the results. The number of Minimum Service Requirements (MSR) was reduced from seven to four. While the providers are “scored” on fewer elements the revised tool examines the same number of areas, but provides a less repetitive format for the consult. More detailed directions are provided to the consultants and a more
thorough description of each evaluation level and how to achieve each level is outlined for providers. The new elements measure the following areas:\footnote{Please see the new processes and procedures available on the Delmarva Website for a detailed description of each element and the evaluation levels within each element: \url{http://www.dfmce-florida.org/provider_resources.htm}.}

- Person Directed Planning
- Health and Safety
- Free from Abuse, Neglect and Exploitation
- Rights
- Choice
- Community Life
- Collaboration
- Achieving Results
- Level II Background Screening
- Provider/Staff Training
- Service Authorization/Billing as Authorized
- Maintains Billing Documentation.

As well as a reduced number of elements, a revised scoring methodology was implemented to better reflect the overall CRE level for each provider. It was noted that when using the original method to determine an overall Results Score for the provider, a provider could have scored 10 CRE as Implementing and eight as Achieving, and yet attain an overall score of Achieving for the review. The new methodology, approved by both AHCA and APD, will score this provider as Implementing. Several other stipulations were added as indicated in the chart and description of the method that follows.

For each element level evaluation a numerical value of 0, 1, 2 or 3 will be applied.

<table>
<thead>
<tr>
<th>Designation</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Emerging</td>
<td>0</td>
</tr>
<tr>
<td>Emerging</td>
<td>1</td>
</tr>
<tr>
<td>Implementing</td>
<td>2</td>
</tr>
<tr>
<td>Achieving</td>
<td>3</td>
</tr>
</tbody>
</table>

The numbers assigned to the results elements will be summed, a range from 0 to 18. The provider’s consultation results will be based upon ranges as designated in the following table.
RESULT OF FINDINGS | DETERMINATION
---|---
Achieving | No score of “Not Emerging” (on 1-8 elements)
No Alerts
All Minimum Service Requirement Elements scored as “Met” (9-12)
Score either “Achieving” or “Implementing” on Element 8
Overall score of 21 or greater
If numeric score is 20, Element 8 score is achieving.
Implementing | Overall score of 13 – 19
If numeric score is 12, Element 8 score is at least “Implementing”
Emerging | Overall score of 5 – 11
If numeric score is 4, Element 8 score is at least "Emerging"
Not Emerging | Overall score of 0 to 3

As indicated in the table, if the provider’s numeric score for the CREs falls at 20, 12 or 4, the determination of Element 8, “Achieving Results”, will define the provider’s overall CRE score. These numeric values indicate scores at the cut-off point between two levels, and it was therefore decided that if the provider was successful in helping individuals achieve results that are important to them, the provider was performing at the higher level.

WiSCC
Revisions to the WiSCC tool and procedures were completed and approved in Year Six. Basic procedures and processes in reviewing and making determinations for the elements have remained the same. However, the revised procedures provide more clarity and direction for consultants and providers alike. Two changes to the process were included and implemented July 1, 2007: review of a third record to help determine the status of the support coordinator on Elements 9 and 11—billing and recoupment issues; a scoring methodology to provide an overall WiSCC Results Element (WRE) evaluation level for each WSC.

Because QICs only review the records of the individuals who participate in a POM interview, there had been some concern WSCs had the opportunity to “fix” those particular records, thereby masking inefficiencies that may exist throughout their systems. Therefore, APD, AHCA and Delmarva researched and developed a procedure for QICs to randomly pull a third record, telling the WSC the
morning of the consult which third record to bring. Delmarva will analyze results from this process and report them as soon as possible.

A second addition to the WiSCC process was to begin to identify an overall performance level for the WSC. The scoring methodology is similar to the CORE method described above. These procedures will be applied to determine both the Agency and Treating Provider overall descriptive designations. WiSCC Results Elements 1 through 6 are each given an element level designation of Achieving, Implementing, Emerging, or Not Emerging. These element level designations have been given numeric ratings of 3, 2, 1, and 0 respectively.

<table>
<thead>
<tr>
<th>Designation</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieving</td>
<td>3</td>
</tr>
<tr>
<td>Implementing</td>
<td>2</td>
</tr>
<tr>
<td>Emerging</td>
<td>1</td>
</tr>
<tr>
<td>Not Emerging</td>
<td>0</td>
</tr>
</tbody>
</table>

Adding together the numeric rating designated to each of these six elements generates an overall numeric score between 0 and 18 per WSC. Providers with more than one Waiver Support Coordinator (WSC or Treating Provider) receive an average numeric rating based upon the sum of all the element level ratings, divided by the number of WSCs involved in the WiSCC. The following table identifies the system for converting overall numeric ratings to overall descriptive designations.

<table>
<thead>
<tr>
<th>Numeric Rating</th>
<th>Descriptive Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 - 18</td>
<td>Achieving</td>
</tr>
<tr>
<td>And</td>
<td></td>
</tr>
<tr>
<td>All involved WSC’s ratings meet the following additional criteria:</td>
<td></td>
</tr>
<tr>
<td>With no “Not Emerging” elements;</td>
<td></td>
</tr>
<tr>
<td>*With no alerts;</td>
<td></td>
</tr>
<tr>
<td>With Element 6 at Achieving or Implementing</td>
<td></td>
</tr>
<tr>
<td>With elements 7-11 Met</td>
<td></td>
</tr>
<tr>
<td>9 - 14</td>
<td>Implementing</td>
</tr>
<tr>
<td>(See Note Below)</td>
<td></td>
</tr>
<tr>
<td>3 - 8</td>
<td>Emerging</td>
</tr>
<tr>
<td>0 - 2</td>
<td>Not Emerging</td>
</tr>
</tbody>
</table>
As indicated in the table, if the overall numeric rating is 15-18, but an individual element is identified as “Not Emerging”, or there is an alert (i.e., Element 2 Alert is turned on or Element 7 is scored as “Not Met”), or Element 6 is scored as Emerging or Not Emerging, or any one of Element 7 to 11 are scored as “not met” the overall descriptive designation becomes “Implementing” rather than “Achieving”.

Numeric ratings of 15, 9, and 3, are cut off points between levels. As with the CORE method, Element 6 (Achieving Results for the individuals served) is used to determine which designation the WSC will receive, determined as follows:

- If the overall numeric rating is a 15 and Element 6 is Achieving then the overall designation is Achieving.
- If the overall numeric rating is 15 and Element 6 is an Implementing, Emerging or Not Emerging then the overall designation is Implementing.
- If the overall numeric rating is 9 and Element 6 is Achieving or Implementing then the overall designation is Implementing.
- If the overall numeric rating is 9 and Element 6 is Emerging or Not Emerging then the overall designation is Emerging.
- If the overall numeric rating is a 3 and Element 6 is Achieving, Implementing, or Emerging then the overall designation is Emerging.
- If the overall numeric rating is a 3 and Element 6 is Not Emerging the designation is Not Emerging.

**Liaison/External Communication Modalities**

In this last year, Delmarva Foundation continued to ensure that Florida stakeholders had the ability to stay current with FSQAP activities, procedures, and findings. Through a variety of efforts, including the utilization of meetings, training sessions, letters, report distribution, web-based technology, and general customer service availability, Delmarva Foundation has established a variety of mechanisms for information distribution.33

**Interagency Quality Council**

Four quarterly meetings with the Interagency Quality Council (IQC) were held in a variety of locations throughout Florida in Year Six, and Delmarva Foundation was an active participant and

33 See Appendix 1, Attachment 4 for a list of activities.
presenter at each of these meetings. Data are routinely presented to update IQC on provider performance across the state and current Personal Outcome Measure trends among individuals receiving services through the waivers. In addition, during the June meeting a summary of the Year 6 Psychotherapeutic Drug Use study was presented.

The IQC meetings also serve as a key forum for sharing and developing future FSQAP initiatives. Several work groups were formed in which Delmarva participated:

- Sue Kelly and Marshall Patterson worked with AHCA and APD to determine the benefits and problems associated with distributing the data sets to providers during a CORE review.
- Bob Foley, Carol McDuff and Marion Olivier-Ruelas participated in a work group to address concerns raised by Area staff on a variety of issues and to help develop quality improvement initiatives in relevant areas.
- Sue Kelly worked with IQC and AHCA on a work group to provide an in-depth analysis of abuse and neglect as identified in the POM interviews and other Delmarva activities.
- Charmaine Pillay and Beth Townsend worked with an IQC work group on issues surrounding training needs.

**Project Status Meetings**

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

**Area Quarterly Meetings**

Regional Managers met quarterly with each APD Area to discuss results from the consultative processes and Desk Reviews, FSQAP impacts to the system, Area and/or Regional initiatives to utilize Delmarva Foundation’s data, training and education opportunities, and any other topic that might impact service quality. In addition to the Regional Manager, a consultant from both the CORE and WiSCC often attend these meetings to discuss specific review findings and trends identified within the community. APD participants included the liaison with Delmarva Foundation, staff involved in the QI process, and on occasion, the APD Area Administrator or other
representatives. In an on going effort to maximize the effectiveness of these meetings, Delmarva managers are developing different methods of contacting Area offices with data and other information prior to the formal meeting. In this way, data discussions can be more focused and helpful to the Areas.

Area Quality Leader Steering Committee Meetings

With the implementation of the Real Choice Systems Grant awarded to APD, Area Quality Leaders (AQL) were assigned to each APD area. In part, their task is to use the Delmarva data to identify concerns or issues specific to their Area that would benefit from quality improvement efforts. Each AQL has developed a Steering Committee that meets monthly. The Committee is comprised of providers, family members, individuals and Area APD representatives—a mini Interagency Quality Council. Delmarva managers and/or consultants have attended and assisted with approximately many Steering Committee meetings during Year Six of this contract that have been reported previously, and two during the last quarter of the year (Areas 14 and 23).

In addition to the steering committee meetings, Sue Kelly has met with AQLs twice during the year to discuss the Area specific data tables. In Orlando, she conducted a training session on the data for the new AQLs. During an AQL conference call in May 2007, she discussed changes to the data tables and the new data that will be available from the revised CORE process.

National/International Conference Representation

Charmaine Pillay and Beth Townsend presented at the National Home and Community-Based Services conference in Minneapolis. The presentation was on the transition from Quality Assurance to Quality Improvement program. Charmaine Pillay also presented in collaboration with Steve Dunaway (APD) on data driving changes in the Support Planning process.

Bob attended the NASDDDS Conference in Crystal City, Virginia in an effort to learn about the quality management efforts being utilized in other states.
Internal Quality Assurance Initiatives

Annual Consultant Training
Consultants and Delmarva managers attended a five day training retreat in August of 2006. Highlights from the week include the following:

- Sue Kelly provided a summary of the quality improvement studies that had been completed throughout the year and opened discussion to gather ideas for studies in Year Six.
- Rose McAllister presented a session on communicating with individuals with unique or challenging communication styles.
- A session on “Open Spaces” allowed QICs to present problem areas within the review processes and develop ideas to address them.
- Anne Buechner presented a day-long training—The Place that Quality Built on organizational systems and practices.
- The Delmarva Human Resources Office provided corporate training on Business Recovery, Harassment and Security.

Manager’s Annual Retreat
Delmarva has many methods to monitor internal quality including bi-weekly calls with all consultants, quality assurance checks on production and billing processes, and bi-weekly manager’s meetings. These are explained in detail in Appendix 1, Attachment 4. However, while the bi-weekly manager’s meetings are essential and productive, they do not allow time for in-depth work on strategic planning or other issues that may arise. The Delmarva managers held a two day retreat in October 2006 to discuss improvements to the current processes and to strategically map out plans that may benefit the FSQAP program over the next several years. Any strategic plan identified as a potential direction for the current program is brought to the status meetings for discussion.

Summary of Customer Service Activity

The Customer Service unit serves as a primary liaison between Delmarva, 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

34 While some activities for the year are summarized here, a more complete description is included in Appendix 1, Attachment 1, the Internal Quality Assurance Program document.
processes, including observing a CORE and WiSCC, in order to better field questions and concerns about these processes. He also participates on the CORE and WiSCC bi-weekly conference calls and completes Desk Reviews.

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 Six, a team including the Customer Service Specialist, Managers, and other support staff handled at least 1,711 contacts during the twelve month period ending June 30, 2007. This continues a downward trend since the second year of the contract, from 1,954 in Year Four, 2,590 in Year Three and 2,009 in Year Two. The following table lists the contacts for Years Four, Five and Six.

<table>
<thead>
<tr>
<th>Area</th>
<th>Number Year 4</th>
<th>Number Year 5</th>
<th>Number Year 6</th>
<th>Percent Year 4</th>
<th>Percent Year 5</th>
<th>Percent Year 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desk Reviews</td>
<td>1,460</td>
<td>1,379</td>
<td>1,224</td>
<td>74.7%</td>
<td>77.3%</td>
<td>71.5%</td>
</tr>
<tr>
<td>CORE</td>
<td>292</td>
<td>132</td>
<td>138</td>
<td>14.9%</td>
<td>7.4%</td>
<td>8.1%</td>
</tr>
<tr>
<td>WiSCC</td>
<td>48</td>
<td>23</td>
<td>7</td>
<td>2.5%</td>
<td>1.3%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Interpreting Services</td>
<td>76</td>
<td>35</td>
<td>21</td>
<td>3.9%</td>
<td>2.0%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Complaints</td>
<td>0</td>
<td>35</td>
<td>19</td>
<td>0.0%</td>
<td>2.0%</td>
<td>1.1%</td>
</tr>
<tr>
<td>On Line Assistance</td>
<td>0</td>
<td>68</td>
<td>69</td>
<td>0.0%</td>
<td>3.8%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>78</td>
<td>111</td>
<td>233</td>
<td>4.0%</td>
<td>6.2%</td>
<td>13.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,954</strong></td>
<td><strong>1,783</strong></td>
<td><strong>1,711</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>100.0%</strong></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. Frequently requests are made for assistance with explaining documents the provider needs to submit for a desk review or how to address deficiencies noted in the reports after the reviews have been completed. Other common issues that generate questions are related to timeframes, training, Level 2 Background screening, recoupments, and explanations of provider performance scores. A total of 1,224 contacts were logged in this area.
CORE and WiSCC

There were 138 calls related to the CORE procedure and only 7 related to WiSCC during the year. Many of these calls were providers seeking clarification of a request for a second Quality Improvement Plan. These had been sent in error. Easton was notified and the problem was rectified. Calls are often to request clarification of the different evaluation levels or clarification of the numeric level provided with the WiSCC results, explanation of the minimum service requirement scores, what they need to do next in terms of the follow-up, and interpretation of the results.

Interpreting Services

In addition to the typical customer service supports, the Customer Service Specialist was also involved in arranging interpreter services on a number of occasions. Bilingual assistance (English-Spanish) is available to providers, consumers, their families and to QICs as requested. This service is arranged for individuals whose primary language is Spanish and also for individuals who communicate through American Sign Language. Services are generally established to facilitate the effective completion of the Personal Outcome Measures interview or to communicate with family members. Requests for this service have dropped from 76 in Year Four to 21 in Year Six. The Customer Service Representative assisted with two sessions this past quarter.

Complaints

The customer service representative fielded six complaints during the 4th quarter of Year Six, a total of 19 for the year. Complaints during the quarter included a relative of an individual who disagreed with the results of a POM interview and another who was not satisfied with the services provided to her brother. A provider complained about the employer who refused to pay an earned salary and another provider was upset with the results of a Desk Review.

One tool extensively utilized in the overall customer service process is 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. Several call are received each year from people seeking help with either the Delmarva, APD or Public Reporting websites.

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

Area Quarterly Reports

Statewide data, as well as information specific to each APD Area, continues to be distributed monthly to each area. Some provider information is updated monthly while APD Area data from the WiSCC and CORE consults are updated quarterly. Delmarva has worked with the Area Quality Leaders (AQL) to implement some modifications to these tables. As a result, a number of graphic displays have been added for each Area.

Public Reporting Workgroup

Several initiatives were completed on the Public Reporting Website during Year six:

- Much of the website was updated with more user friendly language.
- Marshall Patterson worked to enhance and simplify the provider search engine.
- A method was developed, using data from APD, to remove providers from the site when they become ineligible to render services. Prior to this, providers remained on the “active list” until they no longer showed up in the claims data.
- The original Public Reporting Workgroup met to discuss some issues that had developed concerning various aspects of the website, particularly with the provider search mechanism and listing providers who were eligible but had not yet rendered any services. The group also discussed the addition of elements to be posted to the site including overall desk review scores for each service and performance evaluation levels from the CORE and WiSCC.

Quality Improvement Studies

All of the studies and reports completed during Year Five were posted to the Delmarva website. Three quality improvement studies and one psychotherapeutic drug study were completed during the sixth year of the contract. These will be posted on the Delmarva website when approved (http://www.dfmc-florida.org/quality_improvement_studies/2006-2007/index.htm).

Personal Outcome Measure: “Person is Free from Abuse, Neglect and Exploitation”

Demographic Patterns and Predictors. This study emanated from concern expressed by members of IQC relating to the percent of individuals who consistently scored this POM item as Not Present—about 15 percent. Findings indicated that a majority of individuals with this scored as Not Present were not suffering from current abuse, neglect or exploitation but rather had lingering effects from past abuse incidents.

Outcome Results Analysis: Impact of Waiver Services on POM Outcomes Present. Every year APD presents information to the legislature comparing the percent of POM outcomes present for
individuals who receive different services—showing consistently that individuals receiving Supported Employment were always more likely to have outcomes present than individuals receiving ADT or NRSS. However, the information did not take into account any other factors that may influence such a relationship, such as age, disability, number of services, or number of supports present. Therefore, this study examined the association between services and outcomes, controlling for many other factors. Results indicated that receiving a combination of Supported Employment and Supported Living Coaching was most beneficial for individuals.

Health-Related Service Needs Assessment: Analysis of Health/Behavioral Questionnaire Results. This was the first study to examine data from the Health and Behavioral Questionnaire survey used during the Person Centered Review process. Findings indicated that a majority of individuals may need additional health-related services such as male/female preventive health care or physical therapy and that Waiver Support Coordinators performing at higher levels (Achieving and Implementing) served individuals who were more likely to have outcomes present in their lives and less likely to need additional health-related services.

Evaluation of Impact of Selected Psychotherapeutic Drug Profiles and Medications on Waiver Service Usage and Personal Health. In this study we examined the associations that exist between psychotherapeutic drug use and services received, and the impact this has on personal health. Results indicated that using psychotherapeutic medication reduces the likelihood that an individual has the best possible health, that individuals with Waiver Support Coordinators who have high evaluations for awareness of health, safety and well-being (Element 2) are more likely to have the best possible health, and that even when controlling for the support coordinators’ performance on WiSCC Element 2, individuals who use medication are less likely to have the best possible health. In addition, individuals are also less likely to receive Supported Employment services when they fit a drug profile or when they use any of the psychotherapeutic medications identified in this study—a service linked to higher outcomes in general for individuals.