Florida Statewide Quality Assurance Program

Annual Report
Contract Year 8
July 2008 – June 2009

Submitted by
Delmarva Foundation

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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 (DD) and Family and Supported Living (FSL) Home and Community-Based Services Waivers through the Florida Statewide Quality Assurance Program (FSQAP).

Communication with AHCA, APD, our partner the Council on Quality and Leadership (CQL) and other stakeholders is of primary importance to Delmarva. Therefore, the Vice President of Disability Related Programs, Bob Foley, conducts monthly Status Meetings with all participating agencies and partners. Regional Managers conduct quarterly meetings with Area APD administrators and conduct education/training sessions across the state on topics requested by each Area. These and other contract initiatives are described in Section Three and Appendix 1 of this report.

Delmarva’s Quality Improvement Consultants (QIC) use three different types of reviews:

- Waiver Support Coordinators (WSC) participate in an onsite Waiver Support Coordination Consultation (WiSCC), which includes the Personal Outcome Measures (POM) interviews as part of the Person-Centered Review, a health and behavioral assessment, and a medical peer review;
- Providers who render Adult Day Training, 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);
- All other providers who do not receive a CORE or WiSCC and render a service that is subject to a Delmarva QA review are eligible for a Desk Review. These are not onsite reviews but do include phone interviews with individuals.

Through June 30, 2009, Delmarva QICs have conducted over 13,500 Person-Centered Reviews with individuals who were receiving services and supports through the DD or FSL Waiver. Over 14,500 annual Provider Performance Reviews/CORE have been completed along with over 6,500 Follow-up reviews/consultations for these reviews/consults. Over the past five years consultants conducted approximately 2,400 WiSCC that included a review of over 3,400 Waiver Support Coordinators (WSC).
Desk Reviews

QICs have completed 631 Desk Reviews during the 12 month period ending June 30, 2009. This represents almost 100 percent of providers who were eligible for a Desk Review (663).\(^1\) Results for Desk Reviews indicate (Figure ES-1):

- The Statewide score has remained fairly consistent over the eight years of the FSQAP contract.
- On average, solo providers have scored somewhat higher than agency providers.

![Figure ES-1: Desk Review Scores by Provider Type](image)

Desk Review results for the first two quarters in Year Seven also indicate the following:

- Approximately 32 percent (204) of the providers received at least one Background Screening alert, indicating documentation was not present verifying background screening for one or more employees;
- Only 52 percent of background screening citations were rectified by the time of the Documentation Follow-up Reviews completed in Year 8;
- Close to 48 percent of providers with a Desk Review in Year 8 received a recoupment.

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\(^1\) The number of eligible providers changes from month to month. The number listed here was obtained from Claims Data and is as of October 2008.
Collaborative Outcomes Review and Enhancement (CORE)

Quality Improvement Consultants completed 1,006 CORE consults between July 2008 and June 2009. Data indicate the proportion of providers evaluated as Achieving or Implementing has increased every year since Year 6 (beginning March 13, 2007, with the revised CORE tool). The overall provider CORE Results Element (CRE) evaluation scores across APD Areas are shown in Figure ES-2. On average about 67 percent of the 1,006 providers scored Achieving or Implementing, up from 46.5 percent in Year 6, with quite a bit of variation across the Areas. Providers in Areas 4, 8, and 14 were more likely to score Emerging or Not Emerging, each with fewer than 50 percent of providers in the higher evaluation levels.

![Figure ES-2: CORE Results by APD Area](image-url)

Achieving/Implementing, Emerging/Not Emerging
Year 8: June 2008 - July 2009
Information at the element level in Figure ES-3 informs us that:

- The percent of each element scored as Achieving or Implementing has increased, compared to Year 7.
- Providers were most likely to score Achieving on the elements that measure the provider’s systems that ensure Collaboration (services are rendered to “the whole person, across all settings”) and that systems address Abuse/Neglect training and education for all individuals receiving services.
- Close to 10 percent of providers reviewed in Year 8 scored Not Emerging on Achieving Results, which measures how well system ensure communicated goals and desires for individuals are met.

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2 Throughout this report, total percents may not sum to 100% due to rounding.
Results on the Minimum Service Requirements are presented in Figure ES-4 for Year 8, by provider type.

- Providers statewide scored approximately 65 percent of the MSRs at Met, up from 61 percent in Year 7.
- Agency providers showed their best performance on the element indicating they are authorized to render the service, and solo provider were most likely to be compliant with background screening.
- Neither agency nor solo providers performed well maintaining documentation on required training or billing documentation. However, solo providers were less likely to have billing documentation in place but more likely to have required training completed.

**Figure ES-4: CORE MSR Elements, Percent Met by Provider Type and Element**

**July 2008 - June 2009**

<table>
<thead>
<tr>
<th>Element</th>
<th>Agency (838)</th>
<th>Solo (168)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background Screening</td>
<td>77.2%</td>
<td>86.9%</td>
</tr>
<tr>
<td>Training</td>
<td>44.2%</td>
<td>54.2%</td>
</tr>
<tr>
<td>Authorization</td>
<td>80.9%</td>
<td>71.4%</td>
</tr>
<tr>
<td>Billing Documentation</td>
<td>58.5%</td>
<td>44.6%</td>
</tr>
<tr>
<td>Total</td>
<td>65.2%</td>
<td>64.3%</td>
</tr>
</tbody>
</table>
Results from the CORE indicate a majority of alert citations were for noncompliance with background screening requirements, 47.5 percent of the alerts, involving 21.1 percent of the 1,006 providers reviewed in Year 8. Close to 14 percent of providers were cited with a health and safety alert, representing close to 36 percent of the total number of CORE alerts.

In addition, CORE results in this report indicate:

- The percent of MSRs Met varies across the Areas from a low of 41 percent in Area 8 to a high of 84 percent in Area 11.
- Approximately 41 percent of providers who had a CORE consult received at least one recoupment citation, down slightly from 44 percent in Year 7.
- Providers in Areas 8 and 15 were most likely to have a recoupment citation; 85.7 percent and 79.5 percent of providers reviewed in these Areas, respectively, had at least one recoupment.
- 78 percent of background screening non-compliance had been rectified by the time of the Follow-up review.
Waiver Support Coordination Consultation (WiSCC)
QICs completed 501 WiSCC evaluations that included a review of 666 Waiver Support Coordinators (WSC) and 1,331 Person-Centered Reviews. Performance overall has remained fairly consistent, with a significant increase over time in the percent scoring Achieving or Implementing. However, results in Figure ES-6, comparing Year 8 to the two year average for Years 6 and 7, indicate a great deal of variation across the Areas.

Figure ES-6: WSC Results by APD Area
Achieving or Implementing
Years 6 - 7 (July 2006 - June 2008)
Year 8 (July 2008 - June 2009)
Results for each WiSCC Results Element (WRE) are shown in the following graph (Figure ES-7) for Year 8, with the state averages for Years 7 -7 and Year 8.

- On average, a majority of the elements (72.9%) were evaluated as Achieving or Implementing in Year 8.
- WSCs continue to show their best performance on Element 1, having systems in place that allow them to know the people they are serving.
- WSCs are most likely to score Not Emerging on the element that measures how well they facilitate results for individuals they serve.

![Figure ES-7: WiSCC Results Elements (Year 8)](image-url)
Minimum Service Requirements (MSR) compliance information for Waiver Support Coordinators is presented in Figure ES-8 for Years 6 - 7 and Year 8. Modifications were made to the WiSCC process during Year 7: the scoring methodology was modified; additional information is now required regarding billing documentation; and specifications for each element were clarified.

- The total percent of MSRs scored as Met in Year 8 is approximately the same as the average for the previous two years.
- However, compared to Year 7 alone, compliance on Element 9 (Authorized to Render the Service) and Element 11 (Maintains Documentation), has improved, up 10 and 15 percentage points respectively.
- Close to 98 percent of WSCs reviewed in Year 8 had the proper background screening documentation.
Personal Outcome Measures

Outcome results from the POM interviews for Year 8 are provided in Figure ES-9 by APD Area and for the State for Years 6 - 7 and Year 8.

- Some improvement in the percent of outcomes present is noted over the time period.
- There is wide variation across the Areas.
The criterion of 13 or More Outcomes Present has been a measure used by the legislature to track the progress of individuals receiving services through the waiver programs. Data indicate the overall results for the percent of individuals with 13 or More Outcomes and 13 or More Supports Present have shown a slow and steady increase since the 3rd year of the contract (Figure ES-10), remaining fairly level between Year 7 and Year 8.
Finally, WSC performance levels appear to be tied directly to the quality of life of individuals receiving services. As indicated in the following Figure, WSCs performing at higher levels (Achieving and Implementing) are likely to have individuals with a much higher number of outcomes and supports present, compared to WSCs performing at lower levels (Emerging and Not Emerging).

- The average number of outcomes present for individuals working with a WSC who was evaluated as Achieving is 15.1.
- The average number of outcomes present for individuals working with a WSC who was evaluated as Not Emerging is 5.3.

**Figure ES-11: WSCC Performance Level by Average Number of Outcomes and Supports Present (N=# WSC)**

<table>
<thead>
<tr>
<th>Performance Level</th>
<th>Ave # Outcomes</th>
<th>Ave # Supports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieving</td>
<td>15.10</td>
<td>17.40</td>
</tr>
<tr>
<td>Implementing</td>
<td>13.00</td>
<td>13.80</td>
</tr>
<tr>
<td>Emerging</td>
<td>9.70</td>
<td>9.30</td>
</tr>
<tr>
<td>Not Emerging</td>
<td>5.30</td>
<td>4.60</td>
</tr>
</tbody>
</table>

In 2007, the Florida Legislature required APD to create four new Medicaid developmental disability waivers called Tiers. The Legislature established criteria for each of the four waiver tiers, to incorporate the individual’s needed level of service, along with other important characteristics, and take into consideration the person’s current living situation. The new tier system establishes financial limits for three of the tiers.

- Tier One – Current DD Waiver with no cap on expenses, and limited to individuals with intensive medical, behavioral and adaptive needs that cannot be met in other tiers.
➢ Tier Two – Cap of $55,000, and limited to individuals whose service needs include a licensed residential facility and greater than five hours a day of Residential Habilitation as well as individuals in Supported Living who receive more than six hours of In-Home Support Services.

➢ Tier Three – Cap of $35,000, to include all individuals who do not fall into Tier 1 or Tier 2.

➢ Tier Four – Current FSL Waiver with a cap of $14,792

Tiers were implemented October 15, 2008. The percent of outcomes present by Tier assignment is presented in ES-12. Data indicate the average percent of outcomes increases with each Tier, from 42.7 percent in Tier 1 to 56.4 percent in Tier 4.

Other results in this report indicate:

• Compared to the previous two year average, the only two POM items that demonstrated a decline in the percent of individuals with them present were measures of their connection to natural support networks and experiences of continuity and security.

• Being satisfied with services showed the greatest increase over the same time period.
• The percent of individuals with all seven Foundational Outcomes Present (the last seven POMs focused on health, safety and general wellbeing) had decreased every year for several years. However, in Year 8 this increased to 9.1 percent, up from 8.1 percent in Year 7.
• Similar to other year, children and individuals in Family Homes or Independent/Supported Living were most likely to show a greater percent of 13 or More Outcomes Present in Year 8.
• Elderly individuals, age 55 and over, showed a substantial improvement in the percent with 13 or more outcomes present.

The following recommendations have been provided to the state:

1. Because the desk review process has not helped improve provider performance, APD and AHCA may want to explore other methods that may impact the performance of these providers.
2. Providers have continued to improve on the elements measuring the extent to which their organizational systems utilize a person-centered approach to service delivery, positively impacting most of the individuals they serve. As APD moves into a new contract period, we recommend a continued emphasis on individual outcomes and the extent to which providers’ service delivery systems help individuals achieve results and goals they desire.
3. Administrators in Areas 4, 8 and 14 should further explore why providers are not, on average, moving into the higher evaluation levels on the CORE onsite review. Technical assistance and/or training should be provided as indicated.
4. The Interagency Quality Council has not met for several quarters due to budgetary constraints. However, when this important group is reinstated, it is recommended that representatives from Areas 15 as well as 10, 11, 12, and 23 present initiatives they have implemented that have resulted in the improved CORE scores reflected by providers in their Areas.
5. APD should consider developing a standard satisfaction survey providers can distribute to the individuals they serve. Each Area could have the option to include additional questions to the survey as appropriate. The survey should be easy to use and be available as hard copy or via a link to an internet copy. Standard reports could be developed and generated for many items to help providers more clearly understand the results and apply them to their systems.
6. APD should offer training on the meaning of evidence-based service delivery systems. Each Area should work with providers to help them develop systems that require documented evidence of individuals’ activities and communicated goals.
7. APD central office should ensure each Area offers all the necessary training sessions required by providers and that sessions are easily accessible to all providers in the Area.
8. APD should work with local APD offices, perhaps through a Quality Management Workgroup, to develop standard Follow-up methods to help ensure provider training has been completed and other service specific requirements are upheld.

9. Providers clearly struggle with billing documentation requirements. APD is currently streamlining and standardizing much of the paperwork required for providers, including billing documentation. The templates will help ensure each component of the documentation is completed, thereby improving overall documentation compliance. It is recommended APD continue to develop these templates, pilot test them in several Areas, and implement them as soon as possible.

10. As indicated in Recommendation 4 for service providers, Waiver Support Coordinator representatives from Areas 9, 14, 15, and 23 should present, to the Interagency Quality Council, methods they have used to improve their service systems and best practices that could be shared in other Areas.

11. APD and AHCA should continue to monitor a random selection of “unannounced” records for all Waiver Support Coordinators to ensure compliance with service authorization and billing documentation for all individuals served by the support coordinator.

12. Area 1 has shown a decline in support coordinator performance on the WiSCC Results Elements, the MSRs, and the Personal Outcome Measures results. It is recommended the APD Area explore any changes that may have taken place among Support Coordination providers, and initiate quality improvement activities where appropriate.

13. If APD continues to use the Tier system, a quality improvement study should be completed to determine if individuals are receiving the services they need, based on their Tier assignment. If individuals in lower Tiers require additional services to live an everyday life, modifications to the current system should be recommended to the legislature.

14. Administrators in Areas 8 and 13 should further explore why waiver support coordinators are not, on average, moving into the higher evaluation levels on the WiSCC onsite review. Technical assistance and/or training should be provided as indicated. Administrators in Area 1 should explore possible reasons for the decline in performance over the past two years.

In this report we explore in more detail the results presented above. In Section II we provide discussion and recommendations to the State based on the information contained in the analysis presented in Section I, and in Section III we include a review of contract activity over the past year.
Introduction

This is the annual report for Year Seven of the Florida Statewide Quality Assurance Program (FSQAP) contract, July 2008 – June 2009. Information in this report includes fourth quarter activity (April – June 2009), data analysis and trends over the years as appropriate, as well as recommendations to the state. The report is divided into three sections. The first section, **Data Analysis and Results**, provides analysis and interpretation of the data, including annual trends when possible. 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. In this section we detail the activities and accomplishments of the Delmarva Staff and partners, including:

- Contract Amendments and Monitoring;
- Medical Peer Review;
- Training and Education Activities;
- 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 of Supported Living Coaching (SLC), Supported Employment (SE), Adult Day Training (ADT), Residential Habilitation (ResHab), In-Home Support Services (IHSS), or Specialized Medical Care Services (SMCS) receive an onsite CORE consult (Collaborative Outcomes Review and Enhancement). Providers who do not render one of the seven services subject to an onsite review as listed above and provide at least one other service through the DD or FSL waiver that is subject to a review, are eligible for a Desk Review. Providers of Support Coordination receive a Waiver Support Coordination Consultation (WiSCC), and are included in the WiSCC section of the report.3

The following table shows the number of annual provider reviews and CORE consultations completed each year during the first eight years of the contract. Delmarva has conducted close to 14,600 annual reviews with service providers (not including reviews of Waiver Support Coordinators) for the Medicaid DD or FSL Waiver. During the current Fiscal Year, 631 desk reviews were completed for providers of all DD/FSL Waiver Services that do not require a CORE, with the exception of services that are not reviewed by Delmarva: Adult Dental Services, Consumable Medical Supplies, Durable Medical Equipment and Supplies, Personal Emergency Response System, and Environmental Modifications. This exceeded the targeted number of 600, to be completed for the year. The 1,006 completed CORE consults also exceeded the 972 targeted for the year.

| Table 1: Number of Provider Performance Reviews and CORE Consults | July 2001 - June 2009 |
|---|---|---|---|---|---|
| Review Type | Years 1-4 | Year 5 | Year 6 | Year 7 | Year 8 |
| Onsite | 2,692 | N/A | N/A | N/A | N/A |
| CORE | 657 | 850 | 886 | 992 | 1,006 |
| Desk | 4,545 | 1,051 | 624 | 651 | 631 |
| Total | 7,894 | 1,901 | 1,490 | 1,643 | 1,637 |

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. Subsequent to a CORE, providers receive a Follow-up with Technical Assistance (FU w/ TA) if the overall finding from the onsite is Not Emerging or Emerging, or if the finding is Implementing and the provider requests a FU w/ TA through the APD Area office. If the finding is Achieving no Follow-up is required. Additionally, any CORE in which an Alert is identified generates a FU w/ TA. FU w/ TA reviews may include the following:

- Assistance in the development of the Quality Enhancement Plan (QEP), as needed.
- Assistance with the development of organizational practices key to 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. A CORE may be followed by a Documentation Review if the score is Implementing and some documentation for the Minimum Service Requirements is needed. 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. In the CORE process, Reconsiderations can only be requested on the Minimum Service Requirement elements. Table 2 shows the number of each Follow-up review activity completed from July 2001 – June 2009.

<table>
<thead>
<tr>
<th>Table2: Number of Provider Follow-up Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Follow-up Type</strong></td>
</tr>
<tr>
<td>Follow-up</td>
</tr>
<tr>
<td>Documentation Follow-up</td>
</tr>
<tr>
<td>Follow-up w/ TA</td>
</tr>
<tr>
<td>Reconsideration</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>
Desk Reviews

Volumes and Scores by APD Area

The number of desk reviews in each APD Area, completed throughout the FSQAP contract, is presented below in Table 3. The number of reviews completed in some APD Areas is quite small, most with fewer than 50. Therefore, comparisons of average scores across the Areas or over time should be done with caution.

<table>
<thead>
<tr>
<th>APD Area</th>
<th>Years 1-4</th>
<th>Year 5</th>
<th>Year 6</th>
<th>Year 7</th>
<th>Year 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>100</td>
<td>24</td>
<td>25</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>2</td>
<td>507</td>
<td>117</td>
<td>64</td>
<td>76</td>
<td>95</td>
</tr>
<tr>
<td>3</td>
<td>267</td>
<td>51</td>
<td>29</td>
<td>42</td>
<td>43</td>
</tr>
<tr>
<td>4</td>
<td>359</td>
<td>97</td>
<td>62</td>
<td>73</td>
<td>67</td>
</tr>
<tr>
<td>7</td>
<td>425</td>
<td>99</td>
<td>57</td>
<td>63</td>
<td>51</td>
</tr>
<tr>
<td>8</td>
<td>109</td>
<td>30</td>
<td>13</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>9</td>
<td>179</td>
<td>36</td>
<td>25</td>
<td>26</td>
<td>17</td>
</tr>
<tr>
<td>10</td>
<td>182</td>
<td>63</td>
<td>28</td>
<td>42</td>
<td>23</td>
</tr>
<tr>
<td>11</td>
<td>435</td>
<td>116</td>
<td>57</td>
<td>64</td>
<td>59</td>
</tr>
<tr>
<td>12</td>
<td>237</td>
<td>76</td>
<td>55</td>
<td>36</td>
<td>20</td>
</tr>
<tr>
<td>13</td>
<td>241</td>
<td>61</td>
<td>30</td>
<td>31</td>
<td>45</td>
</tr>
<tr>
<td>14</td>
<td>109</td>
<td>20</td>
<td>21</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>15</td>
<td>197</td>
<td>46</td>
<td>29</td>
<td>18</td>
<td>36</td>
</tr>
<tr>
<td>23</td>
<td>1,198</td>
<td>215</td>
<td>129</td>
<td>128</td>
<td>132</td>
</tr>
<tr>
<td>Total</td>
<td>4,545</td>
<td>1,051</td>
<td>624</td>
<td>651</td>
<td>631</td>
</tr>
</tbody>
</table>

Figure 1 shows the average Desk Review scores for Years 1 through 4, Years 5 through 7 and Year 8 for each Area and for the State.

- The statewide average has remained fairly consistent over the eight year time period, between 74 percent and 75 percent.
- There is quite a bit of variation across the Areas.
- Nine Areas showed the same or higher average Desk Review scores in Year 8 when compared to the previous three year average, Areas 12 and 14 showing the greatest increase.
- The greatest declines in average Desk Review scores in Year 8, when compared to the previous three year average, were seen in Areas 1, 8 and 13.
Desk Review Scores by Provider Type

Desk reviews are more often completed for solo providers, but the percent has decreased over the years. On average, for Years 1 – 4 (July 2001 – June 2005) 78 percent of 4,545 desk reviews were solo providers compared to 68 percent of 631 desk reviews completed in Year 8 (July 2008 – June 2009). 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:
Solo providers have consistently scored higher than agency providers.

While the scores for solo providers have remained fairly constant since 2001, around 75 to 76 percent, scores for agency providers have declined somewhat from the average in the first four years to the most current year, from 74 percent to 71 percent.

**Figure 2: Desk Review Scores by Provider Type**

*July 2001 - June 2009*

![Graph showing Desk Review Scores by Provider Type from Yrs 1-4 to Yr 8.]

**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 this critical screening, they inform the APD Area office and 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/or re-screening present. The analysis indicates:

- Over the eight year period, background screening was documented for over 70 percent of providers who received a Desk Review.
- Compliance is lowest during Year 7 (61.1%), over 10 percentage points lower than compliance in Year 6.
- Compliance with background screening in Year 8 has increased to close to 78 percent.
Information from the Documentation Follow-up review informs us if the elements scored as Not Met during the annual review were rectified by the time the Follow-up review was completed. Table 4b gives the number of providers who had at least one background screening alert at the time of the Annual Desk Review, the number of background screening elements recorded as Not Met, and the results of the Documentation Follow-up reviews completed during the contract year. Only elements scored as Not Met during the Annual Review are scored again during the Follow-up.

It is important to note there is not a one-to-one correspondence for the results in Table 4 to the results in Table 4b. For example, in Year 7 there were 651 Desk Reviews and 553 Documentation Follow-up reviews completed. The Follow-up activity is often linked to an Annual review that was completed in the previous year, and at the time the analysis was performed, many providers had not yet received a Follow-up review. Information from Table 4b indicates:

- Since July 2002, 1,485 providers had a Documentation Follow-up Review following a Desk Review, with at least one background screening element scored as Not Met during their Annual review.
- 2,993 background screening elements had been scored as Not Met for these providers during the annual Desk Review.
- Of these elements, close to 55 percent (1,631) were scored as Met at the time of the Follow-up review.
- The percent of background screening elements scored as Met at the Follow-up peaked in Year 5 at 62.5 percent, dropping to a low in Year 7 of 47 percent. However, this increased again to close to 52 percent in Year 8.
Table 4b: Background Screening Elements Scored Not Met at Annual Desk Review (DR)

<table>
<thead>
<tr>
<th>Contract Year</th>
<th>Total Providers</th>
<th>Scored Not Met at DR</th>
<th>Met</th>
<th>Not Met</th>
<th>Percent Met at FU</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>134</td>
<td>293</td>
<td>142</td>
<td>151</td>
<td>48.5%</td>
</tr>
<tr>
<td>3</td>
<td>358</td>
<td>656</td>
<td>371</td>
<td>285</td>
<td>56.6%</td>
</tr>
<tr>
<td>4</td>
<td>287</td>
<td>577</td>
<td>314</td>
<td>263</td>
<td>54.4%</td>
</tr>
<tr>
<td>5</td>
<td>218</td>
<td>445</td>
<td>278</td>
<td>167</td>
<td>62.5%</td>
</tr>
<tr>
<td>6</td>
<td>126</td>
<td>281</td>
<td>161</td>
<td>120</td>
<td>57.3%</td>
</tr>
<tr>
<td>7</td>
<td>194</td>
<td>400</td>
<td>188</td>
<td>212</td>
<td>47.0%</td>
</tr>
<tr>
<td>8</td>
<td>168</td>
<td>341</td>
<td>177</td>
<td>164</td>
<td>51.9%</td>
</tr>
<tr>
<td>Total</td>
<td>1,485</td>
<td>2,993</td>
<td>1,631</td>
<td>1,362</td>
<td>54.5%</td>
</tr>
</tbody>
</table>

Recoupment

Elements of Performance for Desk Reviews subject to Recoupment are service specific requirements related to reimbursement documentation. Providers may have more than one recoupment per review. Data in Table 5 provide a summary of recoupments documented in the previous three years of the FSQAP contract.

Table 5: Summary of Recoupment by Provider Type and Contract Year

<table>
<thead>
<tr>
<th></th>
<th>Agency Providers</th>
<th>Solo Providers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers Subject to Recoupment</td>
<td>Year 6</td>
<td>Year 7</td>
<td>Year 8</td>
</tr>
<tr>
<td></td>
<td>150</td>
<td>175</td>
<td>205</td>
</tr>
<tr>
<td>Number of Citations</td>
<td>183</td>
<td>243</td>
<td>252</td>
</tr>
<tr>
<td>Number of Providers w/ a Citation</td>
<td>70</td>
<td>106</td>
<td>104</td>
</tr>
<tr>
<td>Percent of Providers w/ a Citation</td>
<td>46.7%</td>
<td>60.6%</td>
<td>50.7%</td>
</tr>
<tr>
<td>Average per Provider</td>
<td>1.22</td>
<td>1.39</td>
<td>1.23</td>
</tr>
</tbody>
</table>
A summary of results for Desk Reviews (Table 5) indicates:

- On average, close to 48 percent of the providers who received a Desk Review was cited with a recoupment. This is close to the Year 6 proportion and down approximately six percentage points since from Year 7.
- Providers have approximately two recoupments per Desk Review, agency providers averaging slightly more than solo providers.
- The percent of both solo and agency providers with a recoupment has decreased since Year 7, and this appears to be greater for agency providers, from 61 percent in Year 7 to 51 percent in Year 8.

**Documentation Follow-up**

Of the 631 Desk Reviews completed during Year 8, a total of 4,272 performance elements were scored as Not Met during the annual review. On average over the seven year time period, just over half remained Not Met at the Follow-up review. However, for some elements it is not possible to score Met at the Follow-up, such as if the provider was not billing as authorized. The percent of elements scored as Not Met at the Follow-up was highest in Year 7, at 65 percent. This dropped to close to 58 percent in Year 8.

<table>
<thead>
<tr>
<th>Year</th>
<th>Not Met on Desk Review</th>
<th>Not Met at FU</th>
<th>Percent Not Met at FU</th>
<th># Not Met per Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>3,584</td>
<td>1,894</td>
<td>52.8%</td>
<td>1.6</td>
</tr>
<tr>
<td>3</td>
<td>10,136</td>
<td>5,160</td>
<td>50.9%</td>
<td>4.7</td>
</tr>
<tr>
<td>4</td>
<td>8,261</td>
<td>3,954</td>
<td>47.9%</td>
<td>3.2</td>
</tr>
<tr>
<td>5</td>
<td>7,934</td>
<td>3,564</td>
<td>44.9%</td>
<td>3.4</td>
</tr>
<tr>
<td>6</td>
<td>4,594</td>
<td>2,270</td>
<td>49.4%</td>
<td>3.6</td>
</tr>
<tr>
<td>7</td>
<td>4,909</td>
<td>3,192</td>
<td>65.0%</td>
<td>4.9</td>
</tr>
<tr>
<td>8</td>
<td>4,272</td>
<td>2,467</td>
<td>57.7%</td>
<td>3.9</td>
</tr>
<tr>
<td>Total</td>
<td>43,690</td>
<td>22,501</td>
<td>51.5%</td>
<td>3.5</td>
</tr>
</tbody>
</table>

The data in Table 7 below show a summary analysis of Documentation Follow-up Reviews for Year 5 through Year 8 of the contract. Findings indicate the following:
• Of the 332 Desk Reviews requiring a Documentation Follow-up in Year 8, only 29 (8.7%) received an evaluation of Met on 100 percent of elements that were previously scored as Not Met, similar Year 7.

• 70 providers (21%) scored Met on 75 percent or more of the elements previously scored as Not Met.

• 28 Percent (94) of reviews requiring a Documentation Follow-up in the current contract Year received an evaluation of Met on fewer than 25 percent of elements that were previously Not Met. This reflects a decrease compared to Year 7.

| Table 7: Documentation Follow-up Reviews  
Percent Changed to MET from Initial Review  
July 2005 - June 2009 |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Year</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Percent Met</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100%</td>
<td>26.7%</td>
<td>22.0%</td>
<td>7.0%</td>
<td>8.7%</td>
</tr>
<tr>
<td>&gt;=75%, &lt;100%</td>
<td>15.5%</td>
<td>12.1%</td>
<td>8.1%</td>
<td>12.3%</td>
</tr>
<tr>
<td>&gt;=50%, &lt;75%</td>
<td>18.9%</td>
<td>19.5%</td>
<td>22.4%</td>
<td>25.6%</td>
</tr>
<tr>
<td>&gt;=25%, &lt;50%</td>
<td>17.2%</td>
<td>23.7%</td>
<td>27.5%</td>
<td>25.0%</td>
</tr>
<tr>
<td>&lt;25%</td>
<td>21.7%</td>
<td>22.7%</td>
<td>35.0%</td>
<td>28.3%</td>
</tr>
</tbody>
</table>

| Number Reviews  | 645             | 405             | 371             | 332             |

CORE Consultations

Background and Updates

The following section summarizes results from the Collaborative Outcomes and Review Enhancement (CORE) consults, and recommendations from these results are included in Section Two of this report. Providers of Adult Day Training (ADT), Residential Habilitation (ResHab), Supported Employment (SE), Supported Living Coaching (SLC), In-Home Support Services (IHSS) and Special Medical Home Care Services (SMHC) are subject to a CORE consultation. Many providers offer more than just these services. Therefore, during the CORE consult any service the provider offers is included in the review process.

During Year 6 the CORE tool and procedures were modified, reducing the number of elements from 25 to 12. None of the information that was previously being collected was lost, but was condensed into fewer elements. As part of the revisions, some changes were implemented into the overall CORE Results Element (CRE) scoring methodology (Elements 1 – 8) and within each element the various levels of performance (Achieving, Implementing, Emerging and Not Emerging)
were clarified to help providers better understand the criteria that must be met within each performance level. The revised procedures were implemented March 13, 2007. Because of the differences between the original and the revised CORE procedures, comparisons of results in this report will include only reviews completed since March 13, 2007.4

Each provider is evaluated on 12 elements. The first eight 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. To briefly summarize, an evaluation of Achieving indicates the provider has systems in place that provide optimal services to all individuals served, with a focus on person centered approaches to care. In addition, areas of health and safety, choice, rights and community integration are effectively addressed, and the provider has all training, billing, documentation, and background screening requirements met. Implementing providers may adequately address many of these areas but the benefits are not yet consistently applied for all individuals receiving services. Emerging providers have begun to build the necessary organizational systems and Not Emerging providers have very poor service delivery systems.5

The provider’s CORE Results evaluation level is based upon a compilation of CRE results (Elements 1-8). Providers are also evaluated on four process oriented elements referred to as the Minimum Service Requirements (MSR). These are scored as Met or Not Met, with a focus on requirements such as background screening, documentation for billing, and service specific training requirements. To receive Achieving, the provider must have all the MSR elements scored as Met.

CORE Results Elements (CRE) by Year

Figure 3 shows the overall CRE performance level for providers on average, from March 13, 2007, through the current contract year. The percent of providers evaluated as Achieving or Implementing has increased since Year 6, from 46.5 percent to 67.4 percent. The percent evaluated as Achieving has increased by 113 percent since implementation of the revised CORE tool in March 2007.

4 The second quarter report from Year 7 includes some comparisons to the original CORE results.
5 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_wiscc_tools.htm).
From the graph above, it is apparent that most providers reviewed since the revised CORE tool was implemented performed at one of two levels, Emerging or Implementing. In order to provide a finer distinction of performance on the CREs, Figure 4 shows the distribution of providers along the numeric score each received on these elements. The numeric score is calculated by simply summing results on each of the eight elements using the following scale, for a range of 0 to 24 (the range of CRE scores within each performance level is listed in parentheses):6

- Achieving = 3 (21 – 24)
- Implementing = 2 (12 – 20)
- Emerging = 1 (4 – 11)
- Not Emerging = 0 (0 – 3)

---

6 The final designation depends upon some additional criteria. Please see the CORE Scoring and Follow-up procedures on the FSQAP web site for details (http://www.dfmc-florida.org/provider/resources/core_wiscc_tools.htm).
Data in Figure 4 above show the CORE Results Elements score for providers who received a consult between March 13, 2007, and June 2009. While the bulk of the providers score Implementing or Emerging, there is a gradation of scores within these broader categories each year. Results along the continuum have clearly shifted to the right, with more providers scoring higher even within the broader evaluation categories.

**Core Results Elements (CRE) by APD Area**

Table 8 shows the distribution of CORE consults across APD Areas since implementation of the CORE process, a total of 4,379 completed in that time, July 2004 – June 2009. It is important to note that several Areas have fewer than 50 consults over the time period, so comparisons of results across APD Areas and over time should be viewed with some caution.
The following chart displays the percent of providers with performance levels on the CREs as Achieving or Implementing (A/I) and Emerging or Not Emerging (E/NE) by APD Area for Year 8 (Figure 5).7 Highlights include:

- Statewide, the percent of providers with performance in the top two levels (A/I) is much greater than in the bottom two levels (E/NE), 67 percent compared to 33 percent respectively.
- On average, Area 1 has proportionately more providers scoring as Achieving or Implementing than in any other Area.
- Providers in Areas 4, 8, and 14 were more likely to score Emerging or Not Emerging, each with fewer than 50 percent of providers in the higher evaluation levels.

7 See Appendix 2, Exhibit 1 for results by Area and performance level for previous years.
The following chart (Figure 6) shows the percent of providers, by APD Area, who were Achieving or Implementing in Year 8 compared to results from Year 7.

- Statewide, the percent of providers who received a CORE and scored as Achieving or Implementing improved by over eight percentage points.
- Area 15 demonstrated the greatest improvement in Year 8 when compared to Year 7, a 34 percentage point increase.
- Five other Areas improved by over 10 percentage points.
- Three Areas showed some decline in the percent of providers scoring Achieving or Implementing, with Area 4 demonstrating the greatest decrease of close to 17 percentage points.
During Year 8, 838 Agency and 168 Solo providers received a CORE consult. The graphic depiction below (Figure 7) shows the distribution of these consults by provider type. Results from Year 7 are provided for comparison and indicate the following:

- Both types of providers improved somewhat between Year 7 and Year 8, each reducing the percent scored as Emerging and increasing providers scored as Achieving or Implementing.
- The percent of solo providers who scored as Not Emerging increased somewhat from Year 7 to Year 8.

---

8 See Appendix 2, Exhibit 2 for results 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 4 - 6 for the original CORE tool, and for Year 6, 7, and 8 for the revised tool, and results are graphically depicted below for Year 8 (June 2008 – July 2009). A summary of findings from Figure 8 indicates:

- Improvement in the overall CRE scores documented above is apparent across each of the eight Results Elements. The percent scored as Achieving or Implementing increased for each element from 3.8 percentage points (Choice) to over 12 points (Abuse/Neglect, Achieving Results).
- About 30 percent of providers scored Achieving on Collaboration, meaning the providers render services “to the whole person, across service and support settings” and recognize the person as the “captain of the circle of supports”.

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9 See Appendix 1 Attachment 2 for a brief description of the elements, but please see the procedures, protocol and tools on the Delmarva website for a detailed description of the elements, evaluation levels, and expectations within each element (http://www.dfmc-florida.org/provider/resources/core_wiscc_tools.htm).
• 30 percent of providers scored Achieving on the element measuring how well systems address abuse and neglect training and education for all people receiving services.

• Consistent with previous results, the element that measures Achieving Results is the area providers are most likely to score Not Emerging. This indicates close to 10 percent of providers reviewed in Year 8 had no organizational systems in place to ensure individual results and outcomes are achieved and the outcomes actually reflect communicated choices and preferences that matter most to the person.

![Figure 8: CORE Results Element Evaluation by Element](image)

**CORE Minimum Service Requirements**

Each provider is evaluated on four Minimum Service Requirement (MSR) elements. Providers must supply documentation of the required background screening, required training, proof of

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10 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.dfmc-florida.org/provider/resources/core_wisce_tools.htm).
meeting service limitations, and proper billing procedures. MSR elements are evaluated as Met or Not Met.

**CORE Minimum Requirement Results by APD Area**

In the following chart (Figure 9), the distribution of the percent of Minimum Service Requirement (MSR) elements scored as Met is shown across APD Areas and Statewide, for Years 7 and 8.

**Figure 9: CORE Minimum Service Requirements**

**Percent Met by APD Area**

*Year 7 and Year 8 (July 2007 - June 2009)*

Highlights from the information given in Figure 9 include the following:
• On average, providers have performed better on the MSRs in Year 8 when compared to Year 7, 65 percent and 60 percent Met respectively.
• Area 11 demonstrated the greatest percent of MSRs Met in Year 8 (84%, up from 79% in Year 7).
• Areas 8, 13, and 15 showed the most improvement over the time period, with percentage point increases of 19 percent, 14 percent and 12 percent respectively.

CORE Minimum Service Requirements by Element and Year

Results for each MSR are presented in Figure 10, for Years 7 and 8. Some improvement has been demonstrated across each of the elements. Providers have shown the greatest increase in the percent with background screening documentation in place, improving from 70 percent in Year 7 to 79 percent in Year 8.

Figure 10: CORE MSR Elements, Percent Met by Element
July 2007 - June 2008

<table>
<thead>
<tr>
<th></th>
<th>Year 7 (992)</th>
<th>Year 8 (1,006)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>69.8%</td>
<td>78.8%</td>
</tr>
<tr>
<td>Screening</td>
<td>41.7%</td>
<td>45.8%</td>
</tr>
<tr>
<td>Authorization</td>
<td>77.1%</td>
<td>79.3%</td>
</tr>
<tr>
<td>Billing</td>
<td>53.2%</td>
<td>56.2%</td>
</tr>
<tr>
<td>Documentation</td>
<td>60.5%</td>
<td>65.0%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CORE Minimum Requirement Elements by Provider Type

Figure 11 shows the percent met for the CORE MSR elements, by MSR element and provider type, for Year 8. A great majority of service providers operate as an agency, 838 compared to only 168 solo providers. On average, the agency and solo providers had approximately the same percent of
MSRs Met over the time period, 65.2 percent and 64.3 percent respectively. Trends across the elements for each provider type are similar to past years.

**Figure 11: CORE MSR Elements, Percent Met by Provider Type and Element**  
*July 2008 - June 2009*

Highlights from Figure 11 include:

- On the Minimum Service Requirements, providers showed the best performance on background screening and documentation pertaining to service authorizations.
- Providers were least likely to meet requirements pertaining to billing and training documentation.
- Agency providers were less likely to have training requirements than were Solo providers, 44.2 percent compared to over 54.2 percent.
- Agency providers were also less likely to have documentation for background screening present at the time of the annual consult.
- However, solo providers were less likely than agencies to maintain proper billing documentation or documentation showing authorization to provide the service and/or billing as authorized.
CORE Alerts

Several elements in the CORE evaluation are Alert items.\textsuperscript{11} CORE Results Elements (CRE) are cited as an alert if it is determined by the consultant that issues surrounding abuse, neglect or exploitation; rights, including dignity, respect and privacy; or health and safety warrant immediate corrective action. Failure to meet the requirements for background screening is also cited as an alert item—the only MSR element that can be cited as an alert. When an alert is cited the APD Area office is notified. Results for alerts for Year 8 are presented in Figure 12. The number of alerts is given in parentheses.

Data in Figure 12 show the percent of alerts each alert category represents and the percent of providers who had each specific alert.\textsuperscript{12} Results indicate:

- During Year 8 there were a total of 446 alerts involving 306 different providers. Therefore, over 30 percent of the 1,006 providers reviewed during the year were cited with at least one alert. This is down from 36 percent of providers cited during Year 7.
- Similar to previous years, the greatest percent of alerts was for background screening, representing over 47 percent (N=212) of all of the alerts and over 21 percent of the 1,006 providers reviewed. However, this is down from over 55 percent of the alerts in Year 7 (N=296), which involved close to 30 percent of the 992 providers reviewed that year.
- Close to 36 percent of the alerts (N=139) involved a health or safety citation, up from 27 percent in Year 7. Of the 1,006 providers reviewed, 139 providers (13.8%) were cited with a health or safety alert. This is up somewhat from 12.5 percent of providers in Year 7.

\textbf{Figure 12: CORE Alerts (N in Parentheses)}

Percent of Alerts and Percent of Providers with Each Alert

\textit{July 2008 - June 2009}

<table>
<thead>
<tr>
<th>Alert Category</th>
<th>% of alerts</th>
<th>% w/ alert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health/Safety</td>
<td>35.7%</td>
<td>13.8%</td>
</tr>
<tr>
<td>Abuse/Neglect</td>
<td>4.5%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Rights</td>
<td>12.3%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Background Screening</td>
<td>47.5%</td>
<td>21.1%</td>
</tr>
</tbody>
</table>

\textsuperscript{11} Alert items are Elements 2, 3, 4 and 9.
\textsuperscript{12} Appendix 2, Exhibits 3 and 4 have detailed information on alerts by type of alert, APD Area, and provider type.
CORE Recoupment

Elements are cited as a Recoupment if the provider is not in compliance with the monitoring and billing documentation or with authorization and service limits requirements for the services rendered. Table 9 displays Recoupment information by APD Area for Year 8. Of the 1,006 providers reviewed between July 2008 and June 2009, 435 (43.9%) received a Recoupment citation, with a total of 572 citations. The percent of providers cited with a Recoupment ranged from 12 percent in Area 11 to almost 86 percent in Area 8. Data indicate that for providers reviewed with a CORE consult in Areas 2, 3, 4, 8, 15, and 23, 50 percent or more had at least one Recoupment citation.\(^ {13}\)

<table>
<thead>
<tr>
<th>APD Area</th>
<th>Number of Consults</th>
<th>Number of Recoups</th>
<th>Provider w/ Recoups</th>
<th>Pct Providers w/ Recoupment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Year 8</td>
</tr>
<tr>
<td>1</td>
<td>46</td>
<td>20</td>
<td>17</td>
<td>37.0%</td>
</tr>
<tr>
<td>2</td>
<td>68</td>
<td>55</td>
<td>40</td>
<td>58.8%</td>
</tr>
<tr>
<td>3</td>
<td>67</td>
<td>45</td>
<td>36</td>
<td>53.7%</td>
</tr>
<tr>
<td>4</td>
<td>78</td>
<td>77</td>
<td>48</td>
<td>61.5%</td>
</tr>
<tr>
<td>7</td>
<td>70</td>
<td>21</td>
<td>16</td>
<td>22.9%</td>
</tr>
<tr>
<td>8</td>
<td>28</td>
<td>41</td>
<td>24</td>
<td>85.7%</td>
</tr>
<tr>
<td>9</td>
<td>42</td>
<td>23</td>
<td>17</td>
<td>40.5%</td>
</tr>
<tr>
<td>10</td>
<td>78</td>
<td>38</td>
<td>31</td>
<td>39.7%</td>
</tr>
<tr>
<td>11</td>
<td>161</td>
<td>25</td>
<td>20</td>
<td>12.4%</td>
</tr>
<tr>
<td>12</td>
<td>54</td>
<td>17</td>
<td>16</td>
<td>29.6%</td>
</tr>
<tr>
<td>13</td>
<td>56</td>
<td>19</td>
<td>13</td>
<td>23.2%</td>
</tr>
<tr>
<td>14</td>
<td>23</td>
<td>6</td>
<td>5</td>
<td>21.7%</td>
</tr>
<tr>
<td>15</td>
<td>39</td>
<td>40</td>
<td>31</td>
<td>79.5%</td>
</tr>
<tr>
<td>23</td>
<td>196</td>
<td>145</td>
<td>98</td>
<td>50.0%</td>
</tr>
<tr>
<td>Total</td>
<td>1,006</td>
<td>572</td>
<td>412</td>
<td>41.0%</td>
</tr>
</tbody>
</table>

Table 9 also shows the percent of providers reviewed in Year 7 and Year 8, by APD Area, who had a recoupment. A slightly smaller percent of providers were cited in Year 8 than in Year 7, 41 percent and 44 percent respectively. Eleven of the 14 Areas showed some improvement over this time period. Areas 13, 3, and 14 demonstrated the greatest percentage point decrease in the percent of providers with a recoupment, 31, 14, and 12 points respectively. While the overall difference from Year 7 to Year 8 is not statistically significant, the 31 percentage point change in Area 13 does represent a statistically significant improvement.

\(^ {13}\) Appendix 2, Exhibit 3, has detailed information on recoupsments by APD Area.
**CORE Follow-up**

During Year 8 of the contract, 324 providers who previously had a CORE consult received a Follow-up with Technical Assistance (FU w/ TA), 221 received a Documentation Follow-up, and three providers were coded as having a regular Follow-up. The only “scores” subject to change during the Follow-up are the Minimum Service Requirements (MSR) elements. A Follow-up can be completed for providers who scored all the MSR elements as Met, but needed a Follow-up for a results element.

It is also important to remember that some consults completed during the year that required a Follow-up have not yet had that review, and some Follow-up reviews were for annual CORE consults completed in Year 7. Also, not all elements will be scored as Met at the FU w/ TA, even if documentation has been added. For example, the element pertaining to service authorizations may be rescored during the FU w/ TA if the issue was a missing authorization but not if there were issues regarding providing services outside the parameters the service requirements.

<table>
<thead>
<tr>
<th>MSR</th>
<th>Elements Not Met at Annual</th>
<th>Met At Follow-up</th>
<th>Percent Met at FU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background Screening</td>
<td>137</td>
<td>107</td>
<td>78.1%</td>
</tr>
<tr>
<td>Required Training</td>
<td>251</td>
<td>109</td>
<td>43.4%</td>
</tr>
<tr>
<td>Service Authorization</td>
<td>126</td>
<td>46</td>
<td>36.5%</td>
</tr>
<tr>
<td>Billing Documentation</td>
<td>212</td>
<td>37</td>
<td>17.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>726</strong></td>
<td><strong>299</strong></td>
<td><strong>41.2%</strong></td>
</tr>
</tbody>
</table>

Table 10 above shows results for the Follow-up reviews completed in Year 8 of the contract, for each MSR:

- For the 776 MSR elements scored as Not Met at the time of the Annual CORE review, 299 were scored Met during the Follow-up review, 41 percent. This is down somewhat from 48 percent in Year 7.
- Background screening documentation was most likely to be fixed and documentation concerning billing was least likely to be present. However, not all changes in billing documentation will result in a Met at the Follow-up review.
• Just over 43 percent of training documentation issues was shown to be addressed at the Follow-up review.

Reconsiderations

Because the Reconsideration process did not change with the implementation of the revised CORE, we present data for Reconsiderations for Desk Reviews and CORE consults by year (Table 11) for the most current three years of the contract. Information in the table includes the number of reviews/consults completed each year, the number and percent of reconsiderations accepted, the number denied, and the percent of providers who requested a Reconsideration for a Desk Review or CORE.

• The percent of reconsiderations requested for a Desk Review in Year 7 had increased considerably over the previous years, to over 11 percent. This has declined somewhat in Year 8, to 6.7 percent.
• Approximately half of Desk Review considerations are accepted each year.
• The percent of CORE reconsiderations accepted has declined from close to 24 percent in Year 6 to only seven percent in Year 8.14

<table>
<thead>
<tr>
<th>Table 11: Reconsiderations for Desk and CORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year Six: July 2006 - June 2007</td>
</tr>
<tr>
<td>Review Type</td>
</tr>
<tr>
<td>Desk</td>
</tr>
<tr>
<td>CORE</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

| Year Seven: July 2007 - June 2008          |
| Review Type | Number Reviews | Accepted | Denied | Percent Recon | Percent Accepted |
| Desk      | 651            | 37       | 35     | 11.1%         | 51.4%            |
| CORE      | 992            | 4        | 45     | 4.9%          | 8.2%             |
| Total     | 1,643          | 41       | 80     | 7.4%          | 33.9%            |

| Year Eight: July 2008 - June 2009          |
| Review Type | Number Reviews | Accepted | Denied | Percent Recon | Percent Accepted |
| Desk      | 631            | 20       | 22     | 6.7%          | 47.6%            |
| CORE      | 1,006          | 2        | 27     | 2.9%          | 6.9%             |
| Total     | 1,637          | 22       | 49     | 4.3%          | 31.0%            |

14 See reports for details.
Waiver Support Coordination Consultation (WiSCC) Results

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

WiSCC Distribution by APD Area

A total of 501 WiSCCs were completed and approved in Year 8. As part of these consults, 666 Waiver Support Coordinators (WSC) were reviewed and 1,331 individuals participated in a Person-Centered Review (PCR) that includes the Personal Outcome Measures interview and a health and behavioral risk assessment. (Consultants were expected to interview approximately 1,416 individuals by June 30, 2009). The WiSCC consults and WSCs were distributed across the APD Areas as shown in the following table for the July 2006 – June 2009 time period.

<table>
<thead>
<tr>
<th>Area</th>
<th>WiSCCs</th>
<th>WSCs</th>
<th>WiSCCs</th>
<th>WSCs</th>
<th>WiSCCs</th>
<th>WSCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>17</td>
<td>31</td>
<td>11</td>
<td>24</td>
<td>13</td>
<td>26</td>
</tr>
<tr>
<td>2</td>
<td>42</td>
<td>56</td>
<td>35</td>
<td>48</td>
<td>39</td>
<td>51</td>
</tr>
<tr>
<td>3</td>
<td>23</td>
<td>35</td>
<td>21</td>
<td>30</td>
<td>25</td>
<td>33</td>
</tr>
<tr>
<td>4</td>
<td>66</td>
<td>76</td>
<td>62</td>
<td>69</td>
<td>51</td>
<td>60</td>
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<tr>
<td>7</td>
<td>89</td>
<td>101</td>
<td>73</td>
<td>85</td>
<td>69</td>
<td>81</td>
</tr>
<tr>
<td>8</td>
<td>19</td>
<td>27</td>
<td>19</td>
<td>23</td>
<td>21</td>
<td>23</td>
</tr>
<tr>
<td>9</td>
<td>12</td>
<td>12</td>
<td>17</td>
<td>23</td>
<td>20</td>
<td>31</td>
</tr>
<tr>
<td>10</td>
<td>32</td>
<td>47</td>
<td>40</td>
<td>53</td>
<td>39</td>
<td>47</td>
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<tr>
<td>11</td>
<td>74</td>
<td>90</td>
<td>60</td>
<td>74</td>
<td>71</td>
<td>92</td>
</tr>
<tr>
<td>12</td>
<td>18</td>
<td>31</td>
<td>24</td>
<td>31</td>
<td>21</td>
<td>25</td>
</tr>
<tr>
<td>13</td>
<td>19</td>
<td>39</td>
<td>16</td>
<td>32</td>
<td>24</td>
<td>36</td>
</tr>
<tr>
<td>14</td>
<td>18</td>
<td>29</td>
<td>16</td>
<td>26</td>
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<td>21</td>
</tr>
<tr>
<td>15</td>
<td>12</td>
<td>12</td>
<td>23</td>
<td>25</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td>23</td>
<td>81</td>
<td>136</td>
<td>85</td>
<td>128</td>
<td>71</td>
<td>116</td>
</tr>
<tr>
<td>Total</td>
<td>522</td>
<td>722</td>
<td>502</td>
<td>671</td>
<td>501</td>
<td>666</td>
</tr>
</tbody>
</table>
Waiver Support Coordinator Results Element Score by Year

Each Waiver Support Coordinator (WSC) is evaluated on six WiSCC Results Elements (WRE) and five Minimum Service Requirements (MSR). The MSRs are compliance oriented and scored as Met or Not Met. For 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 each of the six elements similar to the way CORE providers are evaluated, as Achieving, Implementing, Emerging and Not Emerging.15

Beginning in Year 7, it was decided to assign a WSC evaluation level to each support coordinator, and to each WSC entity (agency or solo provider), based upon the WRE score and several other related factors. A WRE score is calculated for the WREs using the same values for each evaluation level as described earlier for CORE (with the WRE Score range at each performance level in parentheses):16

- Achieving = 3 (15 – 18)
- Implementing = 2 (9 – 14)
- Emerging = 1 (3 – 8)
- Not Emerging = 0 (0 – 2)

The WRE score ranges between zero (0) and 18 and is used to determine an overall WRE evaluation level, with some additional criteria included. For example, to receive an overall WRE score of Achieving the WSC may have no alerts, must score above Not Emerging on all the WREs, and must score Met on all the MSRs.17

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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, as well as the scoring criteria (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.

17 See the scoring protocol on the Delmarva web site for a detailed description of scoring criteria (http://www.dfmc-florida.org/provider/resources/core_wiscc_tools.htm).
For this analysis, we have applied the new scoring criteria retroactively to WSCs who were reviewed in Year 6. Results are presented in Figure 13.

- Since the WiSCC was implemented in July 2004, most WSC have scored at the Implementing or Emerging level.
- The percent of WSCs scoring Achieving increased from 18 percent in Year 7 to close to 24 percent in Year 8.
- The percent of WSCs scoring as Achieving or Implementing has increased from 64.6 percent in Year 6 to almost 74 percent during the most recent fiscal year. This represents a statistically significant improvement (Z=3.72, p<.000).

Results are similar to the CORE results in that most of the WSC score Emerging or Implementing, 75 percent in Year 8. However, by examining the distribution of scores along the WRE results (Figure 14) we see a great deal of variation among support coordinators. The distributions are fairly normal bell shaped curves each year, with somewhat more WSCs at the high end than scoring zero to three or four. While the distributions are similar each year, there is a noticeable shift to the higher end from Year 6 to Year 8, particularly among providers scoring in the high Implementing range (13 and 14).
Waiver Support Coordinator Results by Provider Type

Figure 15 shows results for WSCs since July 2006 (Year 6), comparing support coordinators’ WiSCC Results Elements (WRE) evaluation levels by provider type. The proportion of solo support coordinators has increased every year since July 2004 (Year 4), from 46.2 percent to close to 57 percent (304) in Year 8. Information in Figure 15 indicates the following:

- In each year, WSCs working for an agency were more likely than solo providers to score Achieving.
- The proportion of Support Coordinators evaluated as Achieving or Implementing has increased each year for both agency and solo entities. However, this increase has been considerably greater among agencies. The proportion of agencies scoring Achieving or Implementing increased by 14.4 percentage points, compared to a 4.9 point increase among solo WSCs.
- Solo providers are consistently more likely to be evaluated as Not Emerging.
Waiver Support Coordinator Results by APD Area

Figure 16 shows the WSC results by APD Area for WiSCCs completed in Year 8 of the FSQAP contract (July 2008 - June 2009). Data for the 666 WSCs reviewed indicate the following:

- Statewide, 74 percent of the WSCs scored as Achieving or Implementing.
- In six Areas (2, 9, 10, 11, 15 and 23) over 80 percent of the providers who received a WiSCC scored as Achieving or Implementing.
- Areas 8 and 13 each had a higher proportion of providers performing at Emerging or Not Emerging, than at the higher performance levels.
The following graph (Figure 17) gives a comparison of WiSCC results for the current year (July 2008 – June 2009) to the combined results from the two previous years (July 2006 – June 2008). The percent of providers who scored Achieving or Implementing in each APD Area is presented. The most significant improvement is seen in Areas 14, 15 and 23, with 16.8, 17.5 and 20.1 percentage point increases respectively. Six APD Areas have shown a decline in the proportion of providers scoring Achieving or Implementing. Areas 8, 11, and 12 showed a decrease of over six points and Area 1 of over 16 percentage points in Year 8 compared to the previous 2-year average.
Figure 17: WSC Results by APD Area
Achieving or Implementing
Years 6 - 7 (July 2006 - June 2008)
Year 8 (July 2008 - June 2009)

WSC Results for WRE by Element

The 666 WSCs reviewed during contract Year 8 received an evaluation of Achieving, Implementing, Emerging or Not Emerging on each of the six WiSCC Results Elements (WRE). The distribution of results on these elements is displayed in the next figure, with Year 8 and the two year average from Years 6 - 7 as a point of comparison.
Information from the data in Figure 18 indicates the following:

- The pattern for Year 8 is similar to results for the previous two year average, but with a higher percent of results elements scored as Achieving and/or Implementing, 66.04 percent compared to 72.9 percent.
- Providers remain most likely to score Achieving on Element 1 (59.8%), indicating they often have an effective method for learning about the people they serve. This is up from 52 percent in
Year 7, and from just over 35 percent in Year 4, the greatest gain among all the results elements at the Achieving level.

- The percent of providers scoring Achieving has increased on each element in Year 8, compared to Year 7, by the following percentage points (* indicates significance at p < .05).
  - Knows the Person – 8.0*
  - Health and Safety – 6.7*
  - Support Plan – 5.7*
  - Evaluated Supports – 9.2*
  - Facilitates EEE – 1.0
  - Facilitates Results – 4.7*

**WiSCC Minimum Service Requirements**

To be in compliance with the Minimum Service Requirement (MSR) elements providers must supply documentation of the required background screening, required training, service authorization, 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 Years 6 – 7 (July 2006 – June 2008) and Year 8 (July 2008 – June 2009). The numbers zero through five represent the number of MSR elements Met and the percent is the percent of providers for each number Met.
Highlights from Figure 19 include the following:

- There were no WSCs in this time period with all of the MSRs scored as Not Met.
- The proportion of support coordinators with all five of these elements scored as Met has increased somewhat compared to the average over the previous two years, from 51.2 percent to 53.0 percent.
- At the same time, the percent of WSCs with three MSRs Met has decreased from 15.7 percent to just below 13 percent.

**WiSCC Minimum Service Requirements by Year and Element**

In the following figure, the number and percent of MSR elements scored as met is given at the element level for the average over two years (Years 6 – 7) and for Year 8. Highlights from Figure 20 include:

- The average Percent Met on the MSR elements for support coordinators has increase somewhat from 84.8 percent to 86 percent in Year 8. This shows a positive shift from a downward trend over the previous few years.
- Close to 98 percent of support coordinators reviewed during Year 8 had the appropriate background screening documentation.
- Support Coordinators were somewhat more likely to maintain proper billing and training documentation in Year 8 than in Year 7.
- On average, WSCs appear to perform better maintaining documentation for the minimum service requirements than do the other service providers (see Figure 11).
**WiSCC MSR Results by APD Area**

The average percent of MSRs scored as Met in each APD Area is shown in Figure 21 for Years 6 – 7 and Year 8.

- On average, the percent of MSRs met has increased from 84.8 percent to 93.7 percent.
- Most Areas showed an increase in the MSR performance rate.
- While Area 8 reflected a decline in MSR performance in Year 7, compared to previous years, in Year 8 WSCs in this Area have demonstrated a great improvement.
- Only Area 1 showed a decline in MSR performance, from a 95.6 percent two year average (Years 6 and 7) to 79.8 percent in Year 8.
Figure 21: WSC MSR Results by APD Area
Years 6 - 7 (July 2006 - June 2008)
Year 8 (July 2008 - June 2009)

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 support coordinator 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. Expectations are determined to be Met or Not Met during the Follow-up Review, and results are included only if the Follow-up has been completed. In addition, the Follow-up activity in one year may be part of a WiSCC that was completed in the previous year. In Year 8, there were 427 expectations/recommendations provided for 354 support coordinators as part of a FOCUS plan. During the Follow-up, 273 of these (approximately 64%) were found to be Met.

**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 was one Reconsideration addressed during Year 8, with no changes made from the original results.

**Personal Outcome Measure Sample Description**

For many years the Florida Developmental Disabilities Program has used of the Personal Outcomes Measures (POMs), developed and published by The Council on Quality and Leadership (CQL), to report Performance Indicators to the State of Florida. The Person Centered Review (PCR) is a component of the WiSCC process, conducted as part of the FSQAP consultation functions. The focus of the review is 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 that includes a health and behavioral risk needs assessment.

PCRs were completed on 1,331 randomly selected recipients of Developmental Disabilities (DD) (Now Tiers 1-3) or the Family and Supported Living (FSL) Waiver (Tier 4) services during contract Year 8. The sample is a random cluster design, stratified by provider type. For all solo WSCs, two

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18 Go to [http://www.thecouncil.org](http://www.thecouncil.org) for information on the history of CQL, their mission statement and the development of the POM tool.
individuals they served at the time of their consultations were randomly selected for the PCR/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 agency are selected to participate in the WiSCC, four with each consultation.

**Personal Outcome Measures Volume and Results**

The POM interview is a valid assessment tool that determines if personal outcomes are present 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) and conducts other random observations throughout the year. 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 following table provides information on the outcomes and supports present for individuals interviewed since the FSQAP contract activities began in September of 2001.

- Over 13,600 POM interviews have been completed throughout the state.
- While POM results have fluctuated somewhat since the first year of the contract, changes have not been great.
- The percent of outcomes and supports present in Year 8 is similar to Year 7, which represented a consistent increase since a low in Year 4.
### Table 13: Personal Outcome Measures

**Average and Percent Outcomes and Supports Present**

<table>
<thead>
<tr>
<th></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>Year 7</th>
<th>Year 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Person</td>
<td>1,907</td>
<td>2,539</td>
<td>2,456</td>
<td>1,313</td>
<td>1,356</td>
<td>1,443</td>
<td>1,341</td>
<td>1,331</td>
</tr>
<tr>
<td>Centered Reviews</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average # Outcomes</td>
<td>13.2</td>
<td>12.4</td>
<td>11.2</td>
<td>11.3</td>
<td>12.1</td>
<td>11.6</td>
<td>12.5</td>
<td>12.5</td>
</tr>
<tr>
<td>per Consumer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Percent</td>
<td>52.8%</td>
<td>49.6%</td>
<td>44.9%</td>
<td>45.2%</td>
<td>48.3%</td>
<td>46.6%</td>
<td>50.2%</td>
<td>50.1%</td>
</tr>
<tr>
<td>of Outcomes Present</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average # Supports</td>
<td>14.9</td>
<td>13.4</td>
<td>12.2</td>
<td>12.1</td>
<td>13.2</td>
<td>12.8</td>
<td>13.6</td>
<td>13.3</td>
</tr>
<tr>
<td>per Consumer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Percent</td>
<td>59.5%</td>
<td>53.6%</td>
<td>48.9%</td>
<td>48.2%</td>
<td>52.7%</td>
<td>51.3%</td>
<td>54.3%</td>
<td>53.3%</td>
</tr>
<tr>
<td>of Supports Present</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**POM Results by APD Area**

The distribution of individuals on the Developmental Disabilities (DD) or Family and Supported Living (FSL) Waiver as of October 2008, and the distribution of PCRs conducted during Year 8 are shown below in Table 14. Close to 30,000 individuals were receiving services through the two Waivers. The proportion of PCRs across the districts is very similar to the population.

---

19 The DD Waivers are now Tiers 1 – 3 and the FSL Waiver is Tier 4.
Table 14: Distribution by APD Area
Enrolled Population as of October 1, 2008
Person Centered Reviews (PCR) July 2008 – June 2009

<table>
<thead>
<tr>
<th>APD Area</th>
<th>DD Waiver</th>
<th>FSL Waiver</th>
<th>Waiver Enrollees</th>
<th>Year 8 PCRs</th>
<th>Percent Enrolled</th>
<th>Percent PCRs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1,162</td>
<td>243</td>
<td>1,405</td>
<td>52</td>
<td>4.7%</td>
<td>3.9%</td>
</tr>
<tr>
<td>2</td>
<td>1,678</td>
<td>305</td>
<td>1,983</td>
<td>102</td>
<td>6.7%</td>
<td>7.7%</td>
</tr>
<tr>
<td>3</td>
<td>1,208</td>
<td>219</td>
<td>1,427</td>
<td>66</td>
<td>4.8%</td>
<td>5.0%</td>
</tr>
<tr>
<td>4</td>
<td>1,891</td>
<td>346</td>
<td>2,237</td>
<td>120</td>
<td>7.5%</td>
<td>9.0%</td>
</tr>
<tr>
<td>7</td>
<td>2,286</td>
<td>750</td>
<td>3,036</td>
<td>162</td>
<td>10.2%</td>
<td>12.2%</td>
</tr>
<tr>
<td>8</td>
<td>914</td>
<td>270</td>
<td>1,184</td>
<td>46</td>
<td>4.0%</td>
<td>3.5%</td>
</tr>
<tr>
<td>9</td>
<td>1,226</td>
<td>294</td>
<td>1,520</td>
<td>62</td>
<td>5.1%</td>
<td>4.7%</td>
</tr>
<tr>
<td>10</td>
<td>2,020</td>
<td>572</td>
<td>2,592</td>
<td>94</td>
<td>8.7%</td>
<td>7.1%</td>
</tr>
<tr>
<td>11</td>
<td>3,276</td>
<td>1,019</td>
<td>4,295</td>
<td>184</td>
<td>14.5%</td>
<td>13.8%</td>
</tr>
<tr>
<td>12</td>
<td>827</td>
<td>126</td>
<td>953</td>
<td>50</td>
<td>3.2%</td>
<td>3.8%</td>
</tr>
<tr>
<td>13</td>
<td>1,398</td>
<td>301</td>
<td>1,699</td>
<td>72</td>
<td>5.7%</td>
<td>5.4%</td>
</tr>
<tr>
<td>14</td>
<td>845</td>
<td>196</td>
<td>1,041</td>
<td>42</td>
<td>3.5%</td>
<td>3.2%</td>
</tr>
<tr>
<td>15</td>
<td>802</td>
<td>182</td>
<td>984</td>
<td>47</td>
<td>3.3%</td>
<td>3.5%</td>
</tr>
<tr>
<td>23</td>
<td>4,256</td>
<td>1,104</td>
<td>5,360</td>
<td>232</td>
<td>18.0%</td>
<td>17.4%</td>
</tr>
<tr>
<td>State</td>
<td>23,789</td>
<td>5,927</td>
<td>29,716</td>
<td>1,331</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The following two graphs display the average percent of POM Outcomes Present (Figure 22) and Supports Present (Figure 23), by APD Area for the two year average in Years 6 – 7 (July 2006 – June 2008) and for Year 8 (July 2008 – June 2009).

- Nine Areas showed approximately the same or an increased percent of POM outcomes present or POM supports present in Year 8, when compared to the previous two year average.
- Area 1 showed the greatest decrease in outcomes present, from 67.0 percent to 50.8 percent in Year 8, and also in supports present, from 70.7 percent for the Years 6 and 7 average to 47.5 percent in Year 8.
- Area 13 also showed a decrease in the percent of supports present, from 34.5 to only 25.3 percent present.
- Areas 9, 10, and 15 appear to have the greatest increases in the percent of outcomes present.
- Area 10 showed the greatest increase in the percent of supports present.
Figure 22: Percent POM Outcomes Present by APD Area
Years 6 - 7 (July 2006 - June 2008)
YTD 8 (July 2008 - June 2009)

APD Area

State

Yrs 6 - 7 (2,784)
Year 8 (1,331)
Figure 23: Percent POM Supports Present by APD Area
Years 6 - 7 (July 2006 - June 2008)
YTD 8 (July 2008 - June 2009)

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 Support is 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.\textsuperscript{20} Figures 24 and 25 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 6 - 7 (average for July 2006 – June 2008) and Year 8 (July 20078 - June 2009). Data indicate the following: \textsuperscript{21}

- \textit{Is free from abuse and neglect} continues to show the highest percent present for both outcomes (89.2\%) and supports (88.9\%). Approximately 51 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).

- Some individual POM items have shown an improvement in Year 8 when compared to the previous two year average:
  - \textit{Satisfied with services}: 8.6 point increase on outcomes and 7.9 on supports. This element showed a sizeable increase in Year 7 as well, compared to the previous three year average (Year 7 Annual Report).
  - \textit{People are respected}: 4.7 percentage point increase on outcomes and 4.8 percentage point increase on supports;
  - \textit{People exercise rights}: 5.2 point increase on outcomes and 4.0 percentage point increase on supports.
  - \textit{People have the best possible health}: 4.8 percentage point increase on outcomes and 3.3 percentage point increase on supports.

- The greatest losses in the percent of supports present for individuals were seen in connecting individuals to natural supports (5.5 point decrease) and experiencing continuity and security (4.6 point decrease).

- 14 of the 25 outcome items reflected an average of under 50 percent present for individuals interviewed during Year 8, higher than Years 3 – 6 but the same as Year 7.

- \textit{Has friends} and \textit{Performs different social roles} continue to show 30 percent or fewer individuals with the outcomes present, as in previous years.

The top four POM items for which the outcome is most frequently present in Year 8, with over 75 percent present on average, are:

- \textit{Free from abuse and neglect}
- \textit{Satisfied with personal life situations}
- \textit{Is Safe}
- \textit{Satisfied with services}


\textsuperscript{21} See Appendix 2, Exhibit 5 for a list of the reasons outcome/supports are not present.
Figure 24: Percent Outcomes Present by POM Element
Years 6 - 7 (July 2006 - June 2008) and Year 8 (July 2008 - June 2009)

0% 25% 50% 75% 100%

- 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
- Total

Legend:
- Year 6 - 7 (2,784)
- Year 8 (1,331)
Figure 25: Percent Supports Present by POM Element
Years 4 - 6 (July 2004 - June 2007) and Year 7 (July 2007 - June 2008)

- 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

Total

Years 6 - 7 (2,784) Year 8 (1,331)
POM Results by Tier

In 2007, the Florida Legislature required APD to create four new Medicaid developmental disability waivers called Tiers. The Legislature established criteria for each of the four waiver tiers, to incorporate the individual’s needed level of service, along with other important characteristics, and take into consideration the person’s current living situation. The new tier system establishes financial limits for three of the tiers.

- Tier One – Current DD Waiver with no cap on expenses, and limited to individuals with intensive medical, behavioral and adaptive needs that cannot be met in other tiers.
- Tier Two – Cap of $55,000, and limited to individuals whose service needs include a licensed residential facility and greater than five hours a day of Residential Habilitation as well as individuals in Supported Living who receive more than six hours of In-Home Support Services.
- Tier Three – Cap of $35,000, to include all individuals who do not fall into Tier 1 or Tier 2.
- Tier Four – Current FSL Waiver with a cap of $14,792

Tiers were implemented on October 15, 2008. The percent of outcomes present by Tier is presented in the following graph for individuals who had been assigned a Tier (N=1,279). Results show a clear increase in outcomes and supports from Tier 1 to Tier 4. The increase is greater for outcomes, moving from an average of 42.7 percent present in Tier 1 to over 56 percent in Tier 4.

Figure 25a: Outcomes Present by Tier
Figure 25b: Supports Present by Tier

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 Interagency Quality Council (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 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.22 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.23 Results for these driver outcomes and driver supports are presented in the following table.

---

22 Outcome Results Analysis: Best Predictors of Percent of Outcomes Met, submitted by Delmarva to AHCA and APD, June 30, 2005.
Year 8 results indicate are similar to Year 7, with a few exceptions. Individuals were somewhat more likely to feel respected, but somewhat less likely to decide when to share personal information or to feel connected to family and other natural support networks.

Reasons Supports and Outcomes were Not Present

For several years, the QICs have collected information on the reasons outcomes and supports are not present 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. During Year 7, a work group analyzed the “other” category often used in place of the drop down menu items and provided a list of additional reasons that have been added to the choices readily available.

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 are sometimes not addressing barriers to this outcome. In terms of Choosing services, choices are often made by the family or others and all options are not always explored. Supports are not presents because the family and staff continue to make choices for the person and choices are made for the convenience of others.

---

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

While individuals most often have outcomes and supports present on *Free from abuse and neglect*, 144 individuals served in the program were not achieving this important outcome when interviewed in Year 8, and 148 had a lack of supports in place to address issues of abuse and neglect. These may or may not be the same people. A majority of individuals were “out” on this outcome due to distress over past abuse (50.6%). This is similar to results from previous years. Among supports, counseling and training for protection are often not being addressed and Reporting Training (training people how to report mistreatment) is missing.

**13 or More Outcomes Present 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 1 of the project.

Results for this indicator are presented below since the second year of the contract. Both measures dropped from Year 2 to Year 3, but have trended upward since that time. The percent of individuals with 13 or more outcomes present was higher in Year 7 than in any of the previous five years, and about the same in Year 8 as in Year 7.

**Figure 26: 13 or More Outcomes or Supports Present**

*July 2002 - June 2009*

<table>
<thead>
<tr>
<th>Year</th>
<th># of Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>(2,496)</td>
</tr>
<tr>
<td>Year 3</td>
<td>(2,456)</td>
</tr>
<tr>
<td>Year 4</td>
<td>(1,313)</td>
</tr>
<tr>
<td>Year 5</td>
<td>(1,356)</td>
</tr>
<tr>
<td>Year 6</td>
<td>(1,443)</td>
</tr>
<tr>
<td>Year 7</td>
<td>(1,329)</td>
</tr>
<tr>
<td>Year 8</td>
<td>(1,331)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Type</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Year 6</th>
<th>Year 7</th>
<th>Year 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pct Outcomes</td>
<td>49.3%</td>
<td>39.8%</td>
<td>41.4%</td>
<td>46.2%</td>
<td>43.8%</td>
<td>50.4%</td>
<td>50.6%</td>
</tr>
<tr>
<td>Pct Supports</td>
<td>56.3%</td>
<td>46.0%</td>
<td>46.4%</td>
<td>50.4%</td>
<td>50.9%</td>
<td>55.6%</td>
<td>55.0%</td>
</tr>
</tbody>
</table>
13 or More Present Results by Home Type, Area, and Age Group

The following three graphs show the distribution of individuals who had 13 or more outcomes present across APD Areas, age groups and type of living arrangement for Years 6 – 7 (July 2006 – June 2008) and Year 8 (July 2008 – June 2009). When reviewing the data, be aware that some categories have a small number of individuals who received a POM interview, particularly Assisted Living Facilities (52 in Year 8) and Foster Homes (38 in Year 8). Therefore, the point estimates may be fairly unstable and the results should be interpreted with caution. Some highlights from the information include the following:

- The data suggest a fairly large variation across the APD Areas, with the most significant increases demonstrated in Areas 9, 10 and 15 in Year 8 compared to the previous two years.
- In five Areas the percent of individuals who had 13 or more outcomes present has decreased. However, the greatest decline was in Area 1, from 82 percent to 56 percent.
- Individuals in Independent or Supported Living or in a Family Home have been consistently more likely to have 13 or more outcomes present than individuals in any other residential setting.
- The greatest improvement among all the Home Types was for individuals in Assisted Living Facilities. However, the number of individuals living in these facilities is relatively small, 28 residents in Year 8 and 52 in combined Years 6 and 7 (See Exhibit 7a in Appendix 2 for details).
- Children have been consistently more likely to have 13 or more outcomes present in their lives, and the percent of children achieving this has increased in Year 7 compared to the previous three year average.
- Individuals age 55 and over have shown a considerable increase in the percent with 13 or more outcomes present.

---

26 See Appendix 2, Exhibits 6 and 8 for additional details for outcomes and supports. Missing values on key demographic variables creates some differences across tables and graphs.
Figure 27: 13 or More Outcomes Present by APD Area
Years 6 - 7 (06 - 08) (N=2,784)
Year 8 (08-09) (N=1,331)

<table>
<thead>
<tr>
<th>Year 6 - 7</th>
<th>Year 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>82%</td>
</tr>
<tr>
<td>2</td>
<td>71%</td>
</tr>
<tr>
<td>3</td>
<td>46%</td>
</tr>
<tr>
<td>4</td>
<td>50%</td>
</tr>
<tr>
<td>7</td>
<td>29%</td>
</tr>
<tr>
<td>8</td>
<td>24%</td>
</tr>
<tr>
<td>9</td>
<td>80%</td>
</tr>
<tr>
<td>10</td>
<td>61%</td>
</tr>
<tr>
<td>11</td>
<td>70%</td>
</tr>
<tr>
<td>12</td>
<td>31%</td>
</tr>
<tr>
<td>13</td>
<td>27%</td>
</tr>
<tr>
<td>14</td>
<td>21%</td>
</tr>
<tr>
<td>15</td>
<td>72%</td>
</tr>
<tr>
<td>23</td>
<td>33%</td>
</tr>
</tbody>
</table>

Figure 28: 13 or More Outcomes Present by Home Type
Years 6 - 7 (06 - 08) (N=2,784)
Year 8 (08-09) (N=1,331)

<table>
<thead>
<tr>
<th>Home Type</th>
<th>Year 6 - 7</th>
<th>Year 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Home</td>
<td>52.8%</td>
<td>58.0%</td>
</tr>
<tr>
<td>Independent/Sup Living</td>
<td>69.7%</td>
<td>70.2%</td>
</tr>
<tr>
<td>Small Group Home</td>
<td>21.5%</td>
<td>23.9%</td>
</tr>
<tr>
<td>ALF</td>
<td>19.2%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Foster Home</td>
<td>44.7%</td>
<td>38.5%</td>
</tr>
<tr>
<td>Large Group Home</td>
<td>27.6%</td>
<td>37.5%</td>
</tr>
</tbody>
</table>
**Figure 29: 13 or More Outcomes Present by Age**
*Years 6 - 7 (06 - 08) (N=2,784)*
*Year 8 (08-09) (N=1,331)*

<table>
<thead>
<tr>
<th>Age</th>
<th>Years 6 - 7</th>
<th>Year 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-17</td>
<td>64.3%</td>
<td>65.3%</td>
</tr>
<tr>
<td>18 - 21</td>
<td>38.8%</td>
<td>42.6%</td>
</tr>
<tr>
<td>22 - 25</td>
<td>40.8%</td>
<td>44.6%</td>
</tr>
<tr>
<td>26 - 44</td>
<td>48.0%</td>
<td>47.8%</td>
</tr>
<tr>
<td>45 - 54</td>
<td>43.1%</td>
<td>49.8%</td>
</tr>
<tr>
<td>55 - 64</td>
<td>35.6%</td>
<td>55.1%</td>
</tr>
<tr>
<td>65+</td>
<td>35.5%</td>
<td>61.2%</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. The seven Foundational Outcomes are listed in Table 16 for Years 2 – 8. *Experiences continuity and security* is the Foundational Outcome least likely to be present. The average of 35.2 percent is lower than in any other year since the second year of the FSQAP contract.27

---

27 See Appendix 2, Exhibits 9 and 10 for results on Foundational Outcomes for previous years.
Table 16: Foundational Outcomes
Percent Present 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>
<th>Year 7</th>
<th>Year 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 - Is connected to natural support networks</td>
<td>70.5%</td>
<td>64.6%</td>
<td>64.7%</td>
<td>68.4%</td>
<td>67.0%</td>
<td>63.1%</td>
<td>63.2%</td>
</tr>
<tr>
<td>20 - Is safe</td>
<td>67.7%</td>
<td>67.3%</td>
<td>61.6%</td>
<td>68.2%</td>
<td>69.2%</td>
<td>76.6%</td>
<td>73.3%</td>
</tr>
<tr>
<td>21 - Exercises rights</td>
<td>36.6%</td>
<td>33.9%</td>
<td>35.1%</td>
<td>37.6%</td>
<td>35.3%</td>
<td>37.9%</td>
<td>41.8%</td>
</tr>
<tr>
<td>22 - Is treated fairly</td>
<td>60.5%</td>
<td>60.1%</td>
<td>52.9%</td>
<td>61.4%</td>
<td>57.5%</td>
<td>59.6%</td>
<td>60.4%</td>
</tr>
<tr>
<td>23 - Has the best possible health</td>
<td>50.2%</td>
<td>39.5%</td>
<td>40.9%</td>
<td>45.9%</td>
<td>47.3%</td>
<td>55.5%</td>
<td>56.2%</td>
</tr>
<tr>
<td>24 - Is free from abuse and neglect</td>
<td>84.6%</td>
<td>83.0%</td>
<td>83.2%</td>
<td>84.1%</td>
<td>84.4%</td>
<td>88.9%</td>
<td>89.2%</td>
</tr>
<tr>
<td>25 - Experiences continuity and security</td>
<td>49.2%</td>
<td>37.2%</td>
<td>38.3%</td>
<td>41.4%</td>
<td>35.6%</td>
<td>40.0%</td>
<td>35.2%</td>
</tr>
</tbody>
</table>

The following graph shows the distribution of individuals across the number of Foundational Outcomes scored as Present—individuals who have zero to three of the foundational outcomes present and those with four to seven present, comparing Year 8 (July 2008 – June 2009) with Years 6 – 7 (July 2006 – June 2008).
The percent with four or more present has increased (Figure 31). It is also encouraging that proportionately fewer individuals are at the lower end of the scale (0-3 present), indicating some improvement over the years for individuals in basic health, safety and well-being.

Figure 32 displays the Percent of individuals with a cumulative number of the Foundational Outcomes met, 7, 6 or more, 5 or more, and 4 or more, for the same time periods. The percent of individuals with all seven of the Foundational Outcomes present has remained somewhat stable over the last four years, but has increased from 8.1 percent in Year 7 to 9.2 percent in Year 8. Over 25 percent of individuals interviewed in Year 8 had six or seven of these important outcomes present in their lives. The pattern remains the same over the years.

![Figure 32: Foundation Outcomes Present-Cumulative](image)

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

The following three graphs show the distribution of the percent of individuals with all the foundational outcomes present, displayed for APD Area, home type, and age group. Results are provided for Year 8 (July 2008 – June 2009) and compared to the average for the previous two years (July 2006 – June 2008). Comparing the two time periods:

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28 See Appendix 2, Exhibits 9 and 10 for summary information on Foundational Outcomes by Area, age group and home type for Years 1, 2, and 3, and Years 4, 5 and 6.
• The distribution across Areas is similar to the overall distribution of POM outcomes present. The percent present in Area 1 has dropped, but gains were seen in Areas 9, 10 and 15.
• The differences across residential type for the presence of foundational outcomes were not as broad as for the percent of individuals with 13 or more of the outcomes present (Figure 28). Note the number of individuals in ALFs and Foster Homes is relatively small, only 28 in ALFs in Year 8 (See Exhibit 7a in Appendix 1 for details).
• Children and elderly people age 65 or over were most likely to have Foundational Outcomes present in their lives.

Figure 33: Percent of Foundational Outcomes Present by APD Area
Years 6 - 7 (July 2006 - June 2008)
Year 8 (July 2008 - June 2009)
Figure 34: Percent of Foundational Outcomes Present by Home Type
Years 6 - 7 (July 2006 - June 2008)
Year 8 (July 2008 - June 2009)

<table>
<thead>
<tr>
<th>Home Type</th>
<th>Year 8 (1,331)</th>
<th>Year 6-7 (2,784)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Home</td>
<td>65.3%</td>
<td>59.1%</td>
</tr>
<tr>
<td>Ind/Sup Living</td>
<td>59.4%</td>
<td>52.0%</td>
</tr>
<tr>
<td>Small Group Home</td>
<td>59.4%</td>
<td>49.8%</td>
</tr>
<tr>
<td>ALF</td>
<td>56.1%</td>
<td>47.8%</td>
</tr>
<tr>
<td>Foster Home</td>
<td>58.2%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Large Group Home</td>
<td>51.4%</td>
<td>52.6%</td>
</tr>
</tbody>
</table>

Figure 35: Percent of Foundational Outcomes Present by Age Group
Years 6 - 7 (July 2006 - June 2008)
Year 8 (July 2008 - June 2009)

<table>
<thead>
<tr>
<th>APD Area</th>
<th>Year 8 (1,331)</th>
<th>Year 6-7 (2,784)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 - 17</td>
<td>68.0%</td>
<td>65.4%</td>
</tr>
<tr>
<td>18 - 21</td>
<td>59.0%</td>
<td>56.0%</td>
</tr>
<tr>
<td>22 - 25</td>
<td>59.0%</td>
<td>56.2%</td>
</tr>
<tr>
<td>26 - 44</td>
<td>58.4%</td>
<td>58.8%</td>
</tr>
<tr>
<td>45 - 54</td>
<td>58.4%</td>
<td>55.7%</td>
</tr>
<tr>
<td>55 - 64</td>
<td>54.8%</td>
<td>54.8%</td>
</tr>
<tr>
<td>65+</td>
<td>62.7%</td>
<td>53.9%</td>
</tr>
</tbody>
</table>
**WSC Performance and Outcomes/Supports**

Figure 35 provides evidence that WSC performance is linked to the Outcomes and Supports present in the lives of individuals receiving services. Data show the performance level on the WiSCC Results Elements (Achieving, Implementing, Emerging, Not Emerging) for WiSCC entities (agency or solo), and the average number of Personal Outcome Supports or Outcomes that were present for the individuals receiving services from the WSCs.

- WSCs performing at the Achieving level had, on average, individuals with 15.1 outcomes present and 17.4 supports present.
- WSCs performing at the Not Emerging level had, on average, individuals with only 5.3 outcomes present and 4.6 supports present.

**Figure 36: WSCC Performance Level by Average Number of Outcomes and Supports Present (N=# WSC)**

<table>
<thead>
<tr>
<th>Level</th>
<th>Average # Outcomes</th>
<th>Average # Supports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieving (283)</td>
<td>15.10</td>
<td>17.40</td>
</tr>
<tr>
<td>Implementing (698)</td>
<td>13.00</td>
<td>13.80</td>
</tr>
<tr>
<td>Emerging (336)</td>
<td>9.70</td>
<td>9.30</td>
</tr>
<tr>
<td>Not Emerging (14)</td>
<td>5.30</td>
<td>4.60</td>
</tr>
</tbody>
</table>

**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 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>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Waiting for WSC review</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Waiting for Nurse Reviewer review</td>
<td>330</td>
<td>24.8%</td>
</tr>
<tr>
<td>Done - no additional concerns</td>
<td>950</td>
<td>71.4%</td>
</tr>
<tr>
<td>Done - additional concerns to WSC</td>
<td>22</td>
<td>1.7%</td>
</tr>
<tr>
<td>Done - no concern/no claims</td>
<td>26</td>
<td>2.0%</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>2</td>
<td>0.2%</td>
</tr>
<tr>
<td>Done - additional concerns to MCM</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>Total</td>
<td>1,331</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The distribution of Medical Dispositions is presented in Table 19. Because of the changes in the claims data and issues accessing claims data, the Nurse Reviewer, Linda Tupper, is using a newly developed program for the Medical Peer Review component of the POM/WiSCC. Therefore, Ms. Tupper has not yet completed reviews for POMs completed during Year 8.

The overwhelming majority show no additional concerns were noted (71.4%; 95% of the completed Medical Peer Reviews), consistent with previous years. The change in procedures with the implementation of WiSCC has allowed input from the Nurse Reviewer during the WiSCC process.

29 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.
For this reason, most concerns are addressed on site rather than sent to the WSC or Medical Case Manager.
Section Two: Discussion of Data Analysis Findings and Recommendations

Results from the review and consultative 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 by local and central APD staff as well as service providers 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.

Desk Reviews

The average score for Desk Reviews has changed very little over eight years of the contract, around 75 percent. The percent of Desk Reviewed providers who had documentation for their Level 2 Background screening has improved this year but is still less than 68 percent. At the same time, the percent of background screening elements that remained Not Met at the time of the Documentation Follow-up Review has averaged over 50 percent. The percent of desk reviewed providers who received a recoupment citation is less in Year 8 than in Year 7, but remains close to 50 percent.

Recommendation 1: Because the desk review process has not helped improve provider performance, APD and AHCA may want to explore other methods that may impact the performance of these providers.

CORE Results Elements

The revision of the CORE tool, implemented March 13, 2007, included a new scoring methodology as well as improved instructions for providers and Quality Improvement Consultants for determining the level of performance for each element. Compared to the 363 CORE completed in Year 6 with the revised tool, providers have consistently performed better, with a significant increase in the proportion scoring at the highest level (Achieving) and a steady increase in the proportion scoring in the highest two levels (Achieving or Implementing). In addition, evidence provided in Figure 4 informs us provider performance levels on the Results Elements (CREs) fall roughly along a normal bell-shaped curve, indicating a broad range of scores, and the curve has shifted up (to the right) each year since Year 6. Therefore, even within the broad performance categories, providers are moving to the upper tiers of performance.

Approximately 67 percent of the 1,006 providers reviewed in Year 8 scored either Achieving or Implementing on the CORE Results Element (CRE) component of the consult. This provides
evidence that a large majority of providers have strong systems in place to help individuals obtain goals and outcomes they desire, but that for many of these providers the systems are not yet reaching all of the individuals receiving services. However, providers reviewed in Areas 4, 8 and 14 did not do as well as the statewide average, with fewer than half scoring Achieving or Implementing, indicating most providers in these Areas scored as Emerging or Not Emerging.

**Recommendation 2:** Providers have continued to improve on the elements measuring the extent to which their organizational systems utilize a person-centered approach to service delivery, positively impacting most of the individuals they serve. As APD moves into a new contract period, we recommend a continued emphasis on individual outcomes and the extent to which providers’ service delivery systems help individuals achieve results and goals they desire.

**Recommendation 3:** Administrators in Areas 4, 8 and 14 should further explore why providers are not, on average, moving into the higher evaluation levels on the CORE onsite review. Technical assistance and/or training should be provided as indicated.

In the Year 7 report we noted that providers in Area 15 had not performed well on the CORE, but the Area’s support coordinators had greatly improved on the WiSCC and the Personal Outcome Measures results. However, in Year 8 providers who received an onsite CORE in Area 15 improved considerably. Only 25 percent were evaluated as Achieving or Implementing in Year 7. This has increased to close to 60 percent in Year 8. Areas 10, 11, 12 and 23 also showed marked improvement in the percent of providers scoring in the upper evaluation levels, each with greater than a 10 percentage point increase from Year 7 to Year 8.

**Recommendation 4:** The Interagency Quality Council has not met for several quarters due to budgetary constraints. However, when this important group is reinstated, it is recommended that representatives from Areas 15 as well as 10, 11, 12, and 23 present initiatives they have implemented that have resulted in the improved CORE scores reflected by providers in their Areas.

“Achieving Results” is the CORE Results Element providers were most likely to score as Not Emerging (10%). This is has been fairly consistent over the years. Components of this element include the provider’s system of self assessment, the use of data to improve service delivery systems (Projected Service Outcomes), and the provider’s ability to focus on helping individuals achieve goals important to the person. Anecdotal evidence suggests many providers have improved their self assessment systems but continue to struggle with interpreting data, creating systems to enhance their ability to use the data they collect.
In addition, providers often do not have evidence-based systems that enable them to track problem areas or specific issues that need to be addressed. If staff continues to provide medication without properly documenting it, the provider’s system should be able to track this and implement procedures to change the behavior. If a person’s primary goal is to be connected to the community, providers should have systems in place that track documentation of events the person attends or the time spent participating in other community activities.

**Recommendation 5:** APD should consider developing a standard satisfaction survey providers can distribute to the individuals they serve. Each Area could have the option to include additional questions to the survey as appropriate. The survey should be easy to use and be available as hard copy or via a link to an internet copy. Standard reports could be developed and generated for many items to help providers more clearly understand the results and apply them to their systems.

**Recommendation 6:** APD should offer training on the meaning of evidence-based service delivery systems. Each Area should work with providers to help them develop systems that require documented evidence of individuals’ activities and communicated goals.

**CORE Minimum Service Requirements Elements (MSR)**

Statewide, providers reviewed in Year 8 had 65 percent of the Minimum Service Requirement elements scored as Met, up from 60 percent in Year 7. Areas 8 and 15 demonstrated the lowest performance levels compared to all the APD Areas. However, their scores, 41 percent and 44 percent respectively, were substantially greater than in Year 7. Statewide, providers are least compliant on training (Agencies more so than Solo providers) and Documentation for Billing (Solo providers more so than Agencies).

A solid base in policy and procedural compliance is essential to provider performance, particularly for required training. In addition, providers must understand and follow requirements set forth in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook for each service. Documentation for billing includes not only what the provider did, but how this activity related to the person’s goal, the time in and time out, and other information specific to the service; and, if providers render multiple services, a service log must be maintained for each service.

**Recommendation 7:** APD central office should ensure each Area offers all the necessary training sessions required by providers and that sessions are easily accessible to all providers in the Area.

**Recommendation 8:** APD should work with local APD offices, perhaps through a Quality Management Workgroup, to develop standard Follow-up methods to help ensure provider training has been completed and other service specific requirements are upheld.
Recommendation 9: Providers clearly struggle with billing documentation requirements. APD is currently streamlining and standardizing much of the paperwork required for providers, including billing documentation. The templates will help ensure each component of the documentation is completed, thereby improving overall documentation compliance. It is recommended APD continue to develop these templates, pilot test them in several Areas, and implement them as soon as possible.

WiSCC Results Elements (WRE)
On average, Waiver Support Coordinators are performing quite well across the state. WRE results for providers of Support Coordination (WiSCC, first six elements) indicate the proportion receiving Implementing or Achieving has increased significantly since the WiSCC was implemented (Year 4), with 74 percent of WSCs scoring in the higher evaluation levels in Year 8. The proportion of WSCs scoring Achieving increased significantly from Year 7 (18%) to Year 8 (24%). WSCs working for an agency, compared to solo WSCs, have been consistently more likely to be evaluated as Achieving, but the proportion of WSCs working in a solo capacity has increased each year since Year 4 (July 2004), from 46 percent to 57 percent.

WiSCC Results show a great deal of variation across the APD Areas. The percent of support coordinators scoring Achieving or Implementing (A/I) ranges from 100 percent in Area 9 (31 WSCs) to 30.6 percent in Area 13 (36 WSCs). Areas 8 and 13 were the only Areas with fewer than half of the WSCs scoring in the higher evaluation levels, and these were each less than the percent using the previous two year average (Years 6 and 7). Compared to the previous two year average, Area 1 demonstrated the greatest decrease in the percent of A/I support coordinators and Areas 9, 14, 15 and 23 the greatest improvement.

Recommendation 10: As indicated in Recommendation 4 for service providers, Waiver Support Coordinator representatives from Areas 9, 14, 15, and 23 should present, to the Interagency Quality Council, methods they have used to improve their service systems and best practices that could be shared in other Areas.

Recommendation 11: Administrators in Areas 8 and 13 should further explore why waiver support coordinators are not, on average, moving into the higher evaluation levels on the WiSCC onsite review. Technical assistance and/or training should be provided as indicated. Administrators in Area 1 should explore possible reasons for the decline in performance over the past two years.
WiSCC Minimum Service Requirements (MSR)

WSCs performance on the MSR elements had declined over the years. However, this trend seems to have changed during Year 8. Over half of the 666 WSCs reviewed this year received a Met on all of the five MSR elements and over 82 percent were in compliance on at least four of the five elements.

Performance on the elements measuring authorization to render services and billing documentation, Elements 9 and 11, was particularly important and, in conjunction with an APD request, Delmarva implemented the review of two additional “unannounced” records that specifically target these two elements to help ensure compliance with billing and service authorization in all records. In Year 7, after implementation of the new policy, compliance results for Elements 9 and 11 dropped significantly when compared to the previous years. However, in Year 8, WSCs appeared to have implemented procedures to ensure proper documentation for billing and service authorization for all individuals. Element 9 increased from 63.4 percent in Year 7 to 73.4 percent in Year 8. Element 11 increased from 55.8 percent to over 71 percent during the same time period.

**Recommendation 12:** APD and AHCA should continue to monitor a random selection of “unannounced” records for all Waiver Support Coordinators to ensure compliance with service authorization and billing documentation for all individuals served by the support coordinator.

Personal Outcome Measures

Data from the Personal Outcome Measures have been regularly presented to IQC, the APD central office, local APD offices, and the legislature. Data from Year 8 reflect results that are similar to results from Year 7, and indicate some improvement in the overall percent of outcomes and supports present in people’s lives compared to the previous four years. However, the average percent of outcomes present is approximately 50 percent and has not improved above 52.8 percent in the past eight years.

Results vary widely across APD Areas, from 30 percent in Area 13 to over 71 percent in Area 9. Compared to the previous two year average, the greatest decrease is seen in Area 1, while Areas 9, 10, and 15 showed some improvement.

**Recommendation 13:** Area 1 has shown a decline in support coordinator performance on the WiSCC Results Elements, the MSRs, and the Personal Outcome Measures results. It is recommended the APD Area explore any changes that may have taken place among Support Coordination providers, and initiate quality improvement activities where appropriate.

Demographic results have remained fairly consistent throughout the eight years of the contract. Children and individuals living in a family home or independent/supported living are, on average,
more likely to have outcomes present in their lives. However, in the previous report it was noted that people receiving services who are age 65 or older were the only age group to show a decline in 13 or More Outcomes present. This trend appears to have stopped as individuals age 55 and older showed significant improvement in the percent with 13 or more outcomes present during Year 8.

An additional analysis for this report included the distribution of the percent of outcomes present by Tier assignment, showing a steady increase from Tier 1 to Tier 4. While results are only preliminary, and do not include controls for other factors such as age, residential setting, or type of disability, it is clear that individuals in Tier 4 are more likely to have a better quality of life, as measured through the POM process, than individuals in any other Tier. If individuals are assigned to a Tier by level of need, and services are provided to help each individual achieve an “everyday life”, the system may not be working as well for some individuals as it is for others.

**Recommendation 14:** If APD continues to use the Tier system, a quality improvement study should be completed to determine if individuals are receiving the services they need, based on their Tier assignment. If individuals in Tiers 1 and 2 require additional services to live an everyday life, modifications to the current system should be recommended to the legislature.
Section Three: Summary of Quarterly and Annual Project Compliance Activities

In this section we summarize activities pertaining to contract compliance and any modifications to the processes or procedures that were implemented during Year 8 of the FSQAP contract. We also report on training activities, liaisons with stakeholders, customer service activity, internal quality assurances and other activities related to contract compliance.

Contract Amendments
A contract amendment was signed extending Delmarva FSQAP activities through December 2009.

Training and Education Activities
During the contract year, Delmarva offered 17 formal training sessions, including one in each APD Area. Topics were decided upon by a collaboration of Delmarva and APD staff, using information from consultants, stakeholders and a review of quarterly and monthly data. Over the last quarter of the year, formal training and educational sessions were conducted in eight APD Areas and two sessions were provided at the annual Family Café.

- Mastering the Minimum Service Requirements and Excelling Beyond the Basics was presented in Area 3 by Theresa Skidmore and Gwen Williams.
- Desk Review Process Results and Interpretation was presented in Area 9 by Robyn Moorman and Charmaine Pillay.
- CORE and WiSCC Overview and Best Practices was presented in Area 10 by Carol McDuff and Avril Wilson.
- Excelling Beyond the Basics was presented in Area 13 by Kristin Allen and Theresa Skidmore.
- Functional Documentation was presented in Area 15 by Mario Arreaga.
- How to Prepare for Your Consultation was presented in Area 23 by Kristin Allen with several other Delmarva consultants in attendance to help with the presentation.
- Two sessions were conducted at Family Café: Getting the Most from Your Medicaid Waiver Services was presented by Bob Foley, Kristin Allen and Charmaine Pillay; Linda Tupper presented My Personal Preventive Health Plan.
Processes

Claims Data
In July 2008 AHCA transitioned the Medicaid Claims database warehouse from APD to Electronic Data Systems (EDS). Lori Reid, the Delmarva analyst, attended several classes in preparation for the transition so Delmarva would be able to continue to download claims data on a monthly basis. However, several major problems accessing and using the FMMIS data have ensued. This back log in claims data impacted Delmarva’s ability to identify providers currently eligible for a review as well as individuals who are receiving services from each provider. During the last quarter, Delmarva was able to facilitate downloading the data and identifying providers, particularly providers who needed a desk review, and the individuals receiving services from them.

In addition, due to a modified client identifier, the Nurse Administrator was no longer able to effectively generate claims data for the Medical oversight portion of the PCR and for the Medical Peer Review activity. Delmarva is currently working on a new system for these activities. It is expected to be in place during the first quarter of the six month extension period.

The lack of claims data also impacted Delmarva’s ability to update information on the Public Reporting Website. This has been resolved and we began updating provider information May 29, 2009.

Delmarva meets internally and with AHCA in a continued effort to resolve remaining access and/or utilization problems.

CORE and WiSCC Tools
Some minor revisions to the WiSCC tool were completed this year. However, there were no CORE or WiSCC tool revisions or updates during the last quarter of the year.

Liaison/External Communication Modalities
During the fourth quarter of Year 8 of the contract, 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.30

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30 See Appendix 1, Attachment 4 for a list of activities.
Interagency Quality Council

Delmarva managers, the Vice President of Disability Related Programs, the IT/Database Manager, the executive Vice President, and the Scientist generally attended each Interagency Quality Council (IQC) meeting as active participants and presenters. However, due to recent budget constraints within the Agency for Persons with Disabilities the meetings have been discontinued.

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. During the past quarter, it was decided to hold the meeting at APD at least once every quarter. This will allow additional participation by relevant APD personnel who can not travel to Delmarva for the meeting. During the last quarter, meetings were held on April 16 and May 21 at Delmarva and on June 18 at APD.

Area Quarterly Meetings

Regional Managers meet 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 usually include the liaison with Delmarva staff involved in the QI process, and on occasion, the APD Area Administrator or other representatives. Delmarva conducted a meeting in every Area during this quarter. Details are included in Appendix 1, Attachment 4.

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 or quarterly. 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 many Steering Committee meetings. Delmarva consultants typically attended these meetings as possible. However, because of discussions that may occur regarding the RFP, consultants have not attended any Steering Committee meetings this quarter.
Internal Quality Assurance Initiatives

Delmarva has many methods to monitor internal quality. These are discussed in detail in Appendix 1, Internal Quality Assurance Report, and include the following:

- Bi-weekly calls with all consultants,
- Quality assurance checks on production and billing processes,
- Bi-weekly manager’s meetings,
- Formal and informal reliability testing,
- Manager review of all reports,
- Manager review of approved reports,
- Feedback surveys.

Summary of Customer Service Activity

The Customer Service unit continues to serve as a liaison between Delmarva, Medicaid Waiver service providers and recipients, the APD Areas, and the business community. Responses are provided for inquiries about Onsite CORE and WiSCC consultations, Desk Reviews, Person-centered Reviews, related issues on Quality Enhancement Plans, Reconsiderations, online help, and other required follow up. The Customer Service Representative, Said Sanchez, has completed extensive training on the consultative and desk review processes, including observing a CORE and WiSCC. He is also trained to complete desk reviews and provides and/or arranges translation services when needed.

Mr. Sanchez maintains a daily log documenting the dates, caller’s information, nature of the contact, type of assistance needed/requested, complaints, and other miscellaneous questions. This quarter he interacted by telephone (or by e-mail) with 384 callers and 1,670 in Year 8, mostly with providers of Medicaid Waiver services. Desk Reviews, including a subsequent documentation follow up, continue to generate the most calls. Many providers need an explanation of the documents to be submitted for a review or consult, information about the Quality Improvement Plan, documentation needed for the Documentation Follow-up, timeframes for submission, requests for extensions, or the reason for the documentation request. Providers often have questions about a non-compliance letter when they fail to send the documentation on time.
### Table 18: Customer Service Contacts

#### July 2005 – June 2009

<table>
<thead>
<tr>
<th>Area</th>
<th>Year 5</th>
<th>Year 6</th>
<th>Year 7</th>
<th>Year 8</th>
<th>Year 5</th>
<th>Year 6</th>
<th>Year 7</th>
<th>Year 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desk Reviews</td>
<td>1,379</td>
<td>1,224</td>
<td>1,195</td>
<td>1,135</td>
<td>77.3%</td>
<td>71.5%</td>
<td>63.3%</td>
<td>68.0%</td>
</tr>
<tr>
<td>CORE</td>
<td>132</td>
<td>138</td>
<td>246</td>
<td>191</td>
<td>7.4%</td>
<td>8.1%</td>
<td>13.9%</td>
<td>11.4%</td>
</tr>
<tr>
<td>WiSCC</td>
<td>23</td>
<td>7</td>
<td>19</td>
<td>11</td>
<td>1.3%</td>
<td>0.4%</td>
<td>0.7%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Interpreting Services</td>
<td>35</td>
<td>21</td>
<td>17</td>
<td>7</td>
<td>2.0%</td>
<td>1.2%</td>
<td>1.6%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Complaints</td>
<td>35</td>
<td>19</td>
<td>45</td>
<td>38</td>
<td>2.0%</td>
<td>1.1%</td>
<td>2.5%</td>
<td>2.3%</td>
</tr>
<tr>
<td>On Line Assistance</td>
<td>68</td>
<td>69</td>
<td>71</td>
<td>61</td>
<td>3.8%</td>
<td>4.0%</td>
<td>3.6%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>111</td>
<td>233</td>
<td>300</td>
<td>227</td>
<td>6.2%</td>
<td>13.6%</td>
<td>14.5%</td>
<td>13.6%</td>
</tr>
<tr>
<td>Total</td>
<td>1,783</td>
<td>1,711</td>
<td>1,893</td>
<td>1,670</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

There were eight complaints logged this quarter. All complaints were resolved or forwarded to APD for further review. Examples include the following:

- A parent called to express disagreement with result of an individual interview and wanted to file a complaint. Mr. Sanchez referred the call to his coach for an explanation and resolution of the complaint. For a similar complaint, the parent was referred to the relevant Regional Manager.
- A provider was very upset about a Core element in a Follow-up report that showed “Not Met” with a Recoupment, and wanted to request a Reconsideration. The timeframe for a Reconsideration had passed, but she was referred to her APD contact to address the Recoupment.
- Two providers needed explanation of the required 85 percent on the review in order to expand, that criteria are set by APD.
- A provider questioned the results of a Personal Outcomes Measure interview and was referred to the Regional Manager.

### Quality Improvement Initiatives

#### Area Quarterly Data Reports

Statewide data, as well as information specific to each APD Area, is being posted to the Delmarva Website. Some provider information is updated monthly while APD Area data from the WiSCC and CORE consults and Desk Reviews are updated quarterly. Since posting the data to the website, access to the data for local APD offices as well as relevant Central Office personnel has improved.
and no problems have been noted, regarding access or accuracy of the information. Quarterly data reports were posted this year the end of August, November, February, and May.

Public Reporting Workgroup

The Public Reporting Web site APD, www.flddresources.org, was updated this past year to include one to four stars signifying if providers received Achieving (4 stars), Implementing (3 stars), Emerging (2 stars), or Not Emerging (1 star) on their most recent CORE or WiSCC consult. The stars are accompanied with an explanation. If the provider received a Desk Review the most recent score for that review is displayed. Other information posted refers to requirements for background screening, training, and compliance with billing documentation and authorization. Information was not updated for many months due to the Claims data issues noted in section on Processes. Current information is now available and being posted.

Quality Improvement Studies

Three quality improvement studies were completed this contract Year. A summary of the studies is given below.

- **Analysis of Health and Safety Alerts and Provider Performance on the Health and Safety CORE Element:** As part of the CORE consult, providers are monitored on a variety of health and safety issues, with an alert generated if there is a situation present that could result in immediate danger to an individual. In this study we explored provider performance on the Health and Safety element of the consult as well as trends and predictors of health/safety alert citations noted during the annual CORE consult. This study has been approved by AHCA and APD and is posted on the Delmarva Website at http://www.dfmc-florida.org/public/quality_improvement_studies/2008_2009.aspx.

- **Personal Outcome Measure: “Person is Free from Abuse, Neglect and Exploitation” Demographic Patterns and Predictors:** In this study we examine results for the POM item “People are free from abuse and neglect”, and provide an update of the earlier analysis to determine whether:
  - Observed levels of past and current potential abuse, neglect, or exploitation (AND) have changed subsequent to the release of findings and recommendations from the previous study.
  - Factors associated with possible past and current ANE have changed or remained the same.
  - A unique set of factors are associated with lingering effects of Past Abuse.

- **Impact of Social Capital as Measured by Eight Personal Outcome Measures Items:** The purpose of this study was to examine the impact of Social Capital on various health related indicators, such as emergency room visits, admission to the hospital, and overall health.
status, as well as the impact on various Personal Outcomes, including those which measure choice and the foundational outcomes.

- With approval from AHCA and APD and a contract amendment, Delmarva will no longer produce the annual psychotherapeutic medication study but will complete an additional QI study or some other related activity in its place. Resources for this study will be combined with resources to complete a study in the six month extension period. This study will explore the CDC+ program using Focus Groups and surveys to gather information from individuals on the CDC+ program, Representatives, Consultants, Area Administrators and family members. The current tool used to monitor providers will be assessed.