Developmental Disabilities
Collaborative Outcomes Review and Enhancement
Protocol
3-6-07

An Outcome is defined as a result that reflects communicated choices and preferences that matter most to the person. Goals are defined as the identified outcomes as stated in the person's support plan. *Requirements as specified in the Family and Supported Living and Developmental Disabilities Waiver Services Florida Medicaid Coverage and Limitations handbook (Handbook) must still be met.*	**The vision of this consult is to enhance the effectiveness of the provider's service delivery system, to produce results that reflect communicated choices and preferences that matter most to the person. The consult is designed to be person driven and outcome based.** An integral component of your service delivery is to provide to the person served: • **a range of educational opportunities,** • **exposure to a variety of ideas; and** • **a range of opportunities for practical experiences** **The "educate, expose and experience" (EEE) theme is woven throughout the entire consultative process.** **During the consultation process, the Quality Improvement Consultant (QIC) will conduct the following activities:** • **Interviews with persons selected and/or their legal representative, guardian etc...** • **Interviews with other parties selected by the individual including their circle of support.** • **Interviews with the provider and agency staff as necessary.** • **Record review, to include the person's record, personnel records, policy and other documentation supporting/demonstrating the systems and practices of the provider.** • **Observation of environments and interactions between the person and provider/agency staff.** • **Review results of Person Centered Reviews for the review period** **Each element relates to all services rendered and to each person served. This information will be used to make determinations regarding the persons' outcome expectations and related supports.** **Agency for Persons with Disabilities expects the service system to ensure best possible services and outcomes on behalf of each person served, not just in aggregate.**

General Instructions

CORE RESULTS ELEMENTS (CRE): They are elements number 1 through 8. These elements focus on the organizational practices of the provider and how they are supporting individuals to achieve the results that matter most to them. There are 4 different determinations which identify where the provider is in regards to practices that support each element title.

PROBES: Guidelines to be used by the QIC and the provider in order to gather information to assist in making a determination of the provider's success in achieving each element. The QIC will use the probes in the tool as guidelines to elicit necessary information from the provider regarding all supports and services rendered.

DETERMINATION GUIDE: Guidelines to assist the QIC in determining the performance level of the provider's systems and organizational practices. This is a tool to also assist the provider in gauging their current practices and systems. It is not all-inclusive of the practices the provider would implement to assist the person in obtaining outcomes. The determination guide includes some of the attributes of *Achieving* providers, as well as a sampling of what the person served by an *Achieving* provider would be experiencing and the type of documentation of an *Achieving* provider would include. For even further assistance to the provider in determining their current status and defining potential strategies for enhancing service provision, examples of *Implementing, Emerging, and Not Emerging* practices are included as well.
Using a person-directed review approach necessitates some subjectivity on the part of the consultant; however, each consultant is required to meet standards for inter-rater reliability when executing this document.

MINIMUM SERVICE REQUIREMENTS (MSR): They are elements number 9 through 12. Elements that relate to basic documentation requirements for the service as identified in the DD and FSL HCBS Waiver handbook. Minimum service requirements will be scored as Met or Not Met, based on available provider documentation. If one required document is missing or does not meet content requirements, the element will be scored as Not Met.

CORE ALERT: A core alert will be activated when the QIC determines that a person's health, safety and/or rights are placed in jeopardy and immediate corrective interventions are needed. Elements subject to a core alert are identified by the bell (🔔) under the element number.

LEVEL II BACKGROUND SCREENING ALERT: If at the time of the consultation a provider does not have the required documentation, this element (number 9) will be identified as an alert.

RECOUPMENT: Recoupment is identified at the time of the consult when the provider does not have the required documentation to bill for services. Elements subject to recoupment are identified by the "R" under the element number. Delmarva does not recoup funds. Those determinations are made by the Agency for Persons with Disabilities.

Use of "person" or "the person" in this document refers to individuals receiving services through the waivers.

	Results Elements	Probes	Determination Guide
1	Person Directed Planning	• **This is not a "readiness model". We learn by doing. The focus should be on individual growth and development.** • The person drives the service not vice versa. • The person "owns" their goals/IP. They dictate their own services. • Circles of support are used to enhance person directed planning. • How does the provider get to know the person? Is this a thorough or cursory knowledge of the person? Does the provider consider and respect the person's preferences on how much information the person wants to share? But, is there a minimum amount of information the provider needs, and how do they go beyond if they need that information from the person? • Provider/staff "know" the person. The information gathered is easily shared with other staff or new staff within the agency. In the event a new provider is chosen information can be shared with the new provider with the person's permission, • Provider recognizes that every person changes and has systems in place to find out about these changes and what matters most to the person. • The provider has a way to find out about hopes/dreams/etc and actively assists the person to make those happen (this is how IP should be developed, as a system, not solely an end result). o If goals are not met – it's not because of the provider…natural consequences, etc. o Does the provider get to bottom of what matters most to the person? o Is the focus on what the person could be or what the person has been doing? o The provider's focus is not simply on increasing skills or decreasing behaviors. o Are the person's strengths, preferences,	ACHIEVING: The person is driving and managing supports and services. Expectations are defined by each person; the person's expectation of success is identified and understood by all. The person participates in all aspects of service delivery through development, interview, observation, and evaluation. The provider has various methods and processes in place to learn about what really matters most to each person. The provider focuses supports on what matters most to the person and provides services and supports to teach skills needed to achieve the person's outcomes. Provider and staff are knowledgeable about key aspects of the person and this information is used to develop person driven supports. Effective discussions are held with the person and other individuals important to them about their supports and services resulting in updates/changes based upon the person's timelines. The principles of self determination are continuously implemented. Circles of support are strongly encouraged and routinely used to effectively enhance person directed planning. The plan evolves as the person's life evolves. Creativity is employed (such as the use of visual aids/graphs, etc. when warranted), during plan review to ensure everyone is aware of the status. The person "owns" their goals/support plan/IP. Documentation captures and reflects the person including their learning style, communication style and continuous updates are made as the person changes. IPs are individualized; the person's names could be removed from the IP and it would still be evident to whom the plan belongs. IMPLEMENTING: Expectations are defined by most individuals, but not all. The person is involved in the development of aspects of their service delivery system, but not all. Individualized methods and processes to gather information are systematic and occur frequently, however, do not capture expectations for all the persons served. Provider and staff know the person as evidenced by the provider and staff interview(s) but, the documentation review does not reflect this information or knowledge Modifications to service delivery occur, but are too slow to meet the person's expectations due to delays in implementation by the provider. Documentation reflects some

		and/or non-negotiables represented? • The provider gathers historical information related to past goals, dreams, hopes, etc. and progress on those.	changes to service delivery with the person's participation, but not in all instances. Circles of support are encouraged, however, their use and frequency fall short of that found in the achieving category. Person directed planning is being implemented and the principles of self determination are being adhered to, but not yet for everyone served. EMERGING: Most expectations are defined by the provider, rather than the individual. The person is involved in the development of initial services and supports; however, their participation is not continued throughout the year. The Support Plan goals are utilized to develop supports and services, but strategies and methods are standardized rather than being based upon the person's learning style as identified in "Implementing" category above. When IP is applicable, the implementation plan is standardized, does not reflect what matters most to the person and is not updated as directed by the person. There are limited or no changes to the plan from the previous year. Initial plan is missing the date and/or updates to plan are not dated. Circles of support are sometimes encouraged, but seldom used. NOT EMERGING: Expectations are defined by the provider, rather than the person. The person is not involved in the development of the supports and services beyond their involvement in developing the support plan. The provider does not have a system to learn about what matters most to the person. The strategies and methods used are not person driven. If progress is not made, the provider does not try other approaches. There is no documentation of the person's participation in the development and design of the supports and services. When IP is applicable, there is no implementation plan developed or changes to the plan from the previous year. Circles of support are not encouraged or used.

2 **ON/** **OFF**	Health and Safety	• The provider is knowledgeable of the person's health/safety needs. • The provider tracks or has a system to advocate for the health and safety needs of the person as applicable and appropriate. • The person is encouraged to take responsibility for his/her own health and safety as much as possible or according to his/her preference. • The person is provided with education related to his/her own health and safety needs (i.e. medications, side effects of medications, medication reviews, preventative health care, natural disasters, community safety, work safety, home safety, such as evacuations, etc.). Learning styles are taken into consideration. • Pharmacy reviews/therapies/reports are available and provider/staff are aware of them. • Provider/staff are trained on current medications/side effects/specific protocols. Staff are trained on the state's current medication administration and supervision of self-administration policy if they handle medications in any way. • Supervision and support levels are appropriate to the person while providing dignity of risk without jeopardizing the person's health and safety. • Providers have systems to evaluate and identify trends for incident reports. Modifications, interventions and system changes are made based upon the analysis of the reports • The person is making informed decisions about their diagnoses, healthy eating, medications, medical treatment, equipment/adaptation needs, etc. • Circles of support or appointed citizen advocates are used when appropriate to oversee health and safety. • Preventative health care is addressed or advocated for by the provider/staff.	ACHIEVING: The person is educated and supported to take responsibility for their own healthcare and safety (i.e. Medication awareness, opportunity to make own appointments, evacuation procedures). The person has developed home, work and community safety skills, and is encouraged regularly to enhance these skills. Individuals who need supports in healthcare decisions have a citizen advocate, circle of support actively assisting in the oversight of health and safety. Provider and staff are fully knowledgeable of health needs and safety systems, and have actively encouraged the person to assume responsibility for these areas. The provider and staff have full knowledge of diagnoses, health needs/concerns, including all aspects of medication and side effects. The provider recognizes that health is not simply limited to physical well-being, but includes behavioral, mental, preventative, and adaptive equipment needs and has encouraged the person to direct all aspects of their health care. Proactive and on-going training for the person and staff occur and the provider fully understands the concept of dignity of risk without placing the person in potential harm. Documentation and assessment reflect accurate health and safety information, which is updated regularly. The provider uses documentation systems (including tracking, corrective measures and follow up) to identify health and safety trends and proactively initiates corrective measures where needed. Training documentation in health and safety topics of both the person and provider staff is also present. Vehicles used to transport the person meet all minimum state and federal safety requirements and drivers are appropriately trained (first aid, emergency procedures, etc). IMPLEMENTING: Most individuals are educated and supported to take responsibility for their own healthcare and safety (i.e. Medication awareness, opportunity to make own appointments, evacuation procedures). The provider and staff are knowledgeable of the person's health needs but are not encouraging all individuals to take responsibility for their own health needs. Safety systems are in place, but not all persons' needs are covered or alternatives considered. Not all circumstances are addressed to support self preservation and safety systems. The person knows what to do, but all opportunities for them to demonstrate these skills have not been

		• Vehicles used for transportation have the required safety equipment. (See page 2-111 to 2-115 in the DD Waiver Services Coverage and Limitations Handbook). For those providers who do not bill for transportation services but do transport the person, the provider's vehicles have the safety standards required by federal law. • The provider has a system to gather historical information about the person's and families' medical, behavioral, and emotional health. This is to also include safety issues identified in the past. The system includes obtaining consent from the person/guardian to gather this information.	addressed. The provider and staff are fully knowledgeable of health and safety systems; however, this information is not fully utilized to provide training to the person. The emphasis has been on meeting the immediate health needs of the person; preventive and behavioral health care have not been emphasized to the fullest extent. Community, home and/or work safety systems have not been fully developed. The provider uses documentation systems (including tracking, corrective measures and follow up) to identify health and safety trends and proactively initiates corrective measures, but not in all instances. Vehicles used to transport the person meet all minimum state and federal safety requirements. EMERGING: Most individuals are not educated and supported to take responsibility for their own healthcare and safety (i.e. Medication awareness, opportunity to make own appointments, evacuation procedures). The person has not been included in all aspects of health management, and the emphasis has been on ensuring that all health and safety needs are addressed on behalf of the person rather than with the person. The provider addresses basic health and safety needs of the person, and the person is a passive participant in the process. Health and safety systems in place are developed reactively rather than proactively. Health systems focus only on physical health, with no real consideration of behavioral, mental, preventative or adaptive equipment needs. The provider does not consider the person has the potential to participate in their own health care. The provider and staff have cursory knowledge of health and safety systems, and documentation is not being updated regularly. Safety systems have been inconsistently implemented with the emphasis only on meeting documentation/licensure requirements and provider/staff are largely unaware of safety systems in place. The emphasis is on keeping the person safe through supervision; the provider is unaware of the dignity of risk. Documentation systems address medication and medical appointments and are not used to track trends or needs. Vehicles used to transport the person do not meet all state and federal safety requirements. Some but not all staff have been trained in areas related to health, safety and characteristics of those being transported. NOT EMERGING: The person has a health need(s) that is not

			being addressed by the provider. The provider has no knowledge of the health needs of the individuals other than diagnosis and the medications taken. There is no system to provide education to staff or the individual about health, safety, medications, side effects, etc.. The provider has not really thought about safety or health needs in the home, work or community. Observation and documentation review reveal no tracking system in place for any health and safety procedures. Vehicles used to transport the person are unsafe and fall short of meeting minimum state and federal safety requirement. Drivers are not qualified to transport individuals.

3 **ON/** **OFF**	Free From Abuse, Neglect and Exploitation	• Abuse, neglect and exploitation information is shared in a way that is meaningful and accessible to the person. The person's understanding is solicited. Training and education is tailored to each person's learning style and circumstances. • The person with communication challenges is presented ways to report abuse. • If it becomes known by the provider that the individual receiving services is experiencing significant unresolved issues related to a past abuse, the provider has taken action to obtain assistance for the individual. • The provider has practices in place to prevent abuse, neglect and exploitation. • The provider is reporting suspicion of abuse, neglect or exploitation and there is evidence that this was documented in individual records, a log, or in other documentation. This includes "client on client" incidents. (See Zero Tolerance requirements.) • If reported to the abuse registry and not accepted, the provider investigates and implements appropriate safeguards. • There is evidence the provider investigates complaints/accidents/incidents to determine cause and if there is any suspected abuse, neglect or exploitation. The provider takes appropriate corrective action per provider's investigation findings. Data are evaluated to determine trends and needed corrective measures. • Staff receive training about abuse, neglect and exploitation, sexual assault and domestic violence, and are knowledgeable about these topics when interviewed, as well as, reporting procedures. A validation process is included as part of the training. This area requires a great deal of sensitivity and decorum. If the person refuses to discuss this issue,	ACHIEVING: At the time of the consultation, the person is free from abuse, neglect, and exploitation associated with the provider. There are no founded incidences of abuse, neglect or exploitation associated with the provider in the review period. Along with staff, the person has been trained on sexual assault, domestic violence, abuse, neglect and exploitation and reporting practices. The provider has a way to determine the person's understanding in order to determine if additional and tailored training is necessary. All incidents of suspected abuse, neglect, and exploitation are reported to the abuse registry number. The provider consistently uses organizational practices for reporting, evaluating, safeguarding and taking corrective actions if abuse, neglect or exploitation is suspected. Trends specific to abuse, neglect and exploitation are identified and addressed. The provider takes immediate action to safeguard the person. The provider consistently follows the unusual incident reporting procedures. IMPLEMENTING: At the time of the consultation, the person is free from abuse, neglect, and exploitation associated with the provider. If there has been a single founded incident of abuse, neglect or exploitation associated with the provider in the review period, the provider's systems ensured identification and reporting of the incident and all appropriate safeguard measures were taken. Along with all staff, most individuals have been trained on sexual assault, domestic violence, abuse, neglect and exploitation and reporting practices. The provider has a way to determine most individuals' understanding in order to determine if additional and tailored training is necessary. All incidents of suspected abuse, neglect, and exploitation are reported to the abuse registry number. The provider uses organizational practices for reporting, evaluating and safeguarding, however, not all incidents are evaluated or have the appropriate corrective actions if abuse, neglect or exploitation is suspected. Trends specific to abuse, neglect and exploitation are identified but not all are adequately addressed. The provider takes immediate action to safeguard the person. The provider consistently follows the unusual incident reporting procedures. EMERGING: At the time of the consultation, not all individuals are free from abuse, neglect, and exploitation associated with the

		move on and use other sources to determine if issues are present.	provider. If there have been confirmed incidents of abuse, neglect and/or exploitation associated with the provider, the provider responded through correction and developed procedures to prevent incidents from occurring in the future. Along with all staff, most individuals have been trained on sexual assault, domestic violence, abuse, neglect and exploitation and reporting practices. The provider has a way to determine most individuals' understanding in order to determine if additional and tailored training is necessary. All incidents of suspected abuse, neglect, and exploitation are reported to the abuse registry number. The provider uses organizational practices for reporting, evaluating and safeguarding, however, not all incidents are evaluated or have the appropriate corrective actions if abuse, neglect or exploitation is suspected. Trends specific to abuse, neglect and exploitation are identified but not all are adequately addressed. The provider takes immediate action to safeguard the person. The provider consistently follows the unusual incident reporting procedures. NOT EMERGING: At the time of the consultation, not all individuals are free from abuse, neglect, and exploitation associated with the provider. If there have been suspected or confirmed incidents of abuse, neglect and/or exploitation associated with the provider, the provider failed to respond. The provider does not have a practice to find out if the person is still affected by a history of abuse and/or the provider does not have a system to seek professional assistance for individuals still affected by past issues. The provider does not have practices related to education about abuse, neglect or exploitation for staff or the person receiving services. There is no system for tracking incident reporting for abuse, neglect or exploitation. The provider's policy does not include all necessary components or the provider does not have a written policy in place.

4 **ON/** **OFF**	Rights	• The provider has a means to identify what rights are most important to the person. • All rights are explored with the person using an approach designed for each person's communication style. • The provider uses creative and effective approaches to provide rights education to all, based on their learning styles/legal status, etc. This training will include rights referenced in Chapter 393.13 of the Florida Statutes. • The provider has a means of soliciting information about the person's understanding of information presented. • The provider solicits information about what dignity/respect mean to the person and respects that. • The provider solicits information about privacy through interviews and consents, and respects preferences. • Privacy is respected; if the person does not have enough privacy, ideas are brainstormed for negotiated privacy. • Staff receive training about rights, dignity, and privacy and are knowledgeable about topics when interviewed. A validation process is included as part of the training. • Provider and agency staff have received training on HIPAA regulations and keeping Protected Health Information confidential and are knowledgeable on the basics of this topic when interviewed. • The provider respects the person's choices by allowing for the dignity of risk while providing support, guidance, and EEE to assist with informed choice. • Person first language is used in spoken and written communication. • Circles of support are used to offer safeguards in promoting and protecting the person's rights.	ACHIEVING: The person is fully aware and exercises their rights. The person is treated with dignity and respect. The person has received information to help them make informed decisions when fully exercising their rights, and includes the consequences of decisions made. In addition to receiving a copy of the "Bill of Rights for Persons with Developmental Disabilities" and the person and their legal representative (if appropriate) has had training on these rights based upon their unique learning style. The person has full access to their environments, both in the home, work and community and has been an active participant in the development of rules and responsibilities. The person, their circle of support or legal representative are active participants in supporting rights decisions, review of rights restrictions and attempts to reduce restrictions. The provider regularly presents information about rights in a manner that is meaningful to the person, and updates their systems to prioritize training according to the person's preferences, learning style and needs. Information about the person's preferences for rights is continuously sought. If rights restrictions are necessary, due process and oversight has been provided, and there are written goals in place to fade restrictions. The provider is aware of available community resources that address barriers to exercising rights. Documentation reveals continuous education of the person, their legal representatives (as appropriate) and provider staff regarding exercising of rights in a variety of situations IMPLEMENTING: The person is aware of their rights, but does not fully understand or exercise them, despite training efforts from the provider. The person is treated with dignity and respect. The person has consented to rights restrictions, but is not an active participant in rights restoration. Most have full access, but environmental adaptations or supports have not been made. The provider assists the person to understand their rights using a variety of tools and techniques. The provider has a means to assess the person's understanding of the information presented, but this is not occurring for all persons served or the training is not yet effective. The provider has organizational systems in place to determine individual preferences; however, these preferences are not updated routinely. The provider recognizes the ability of the person to make an informed consent, even if the provider

		• The provider has procedures in place for compliance with electronic HIPPA regulations, including establishing a log when Protected Health Information is released on a person, documenting/reporting HIPAA violations, etc. The log includes the date of the occurrence, to whom and what information is released.	disagrees with the final decision; however, there may not be 100% support from all staff members. The person, their circles of support or legal representative are active participants in supporting rights decisions, review of rights restrictions and attempts to reduce restrictions. If rights restrictions are necessary, due process and oversight has been provided, and there are written goals in place to fade some but not all restrictions. The provider actively addresses most barriers to support the person to fully exercise their rights, but some barriers remain unaddressed. Documentation reveals education of most people, their legal representatives (as appropriate) and provider staff regarding exercising of rights in a variety of situations. Overall, rights are supported, encouraged and exercised, but not to all and not all the time. EMERGING: The person is familiar with only the most basic rights. The provider has basic rights training in place, but the same tools are used regardless of each person's learning style. A copy of The Bill of Rights may have been presented to the person, however, an explanation and interpretation of these rights was not provided. There is no system to determine the person's understanding of the information presented. Interview with provider/staff reveals limited understanding of rights. There is infrequent use of circles of support or legal representatives to oversee the preservation of rights. Health and safety always takes priority over rights, regardless of the person's ability to give informed consent. Restrictions to rights do not always follow due process and are inconsistently implemented. If rights restrictions are occurring, the provider is unaware of them. Documentation supports very basic requirements (policy, education on rights and abuse and consents for release of information). NOT EMERGING: The person has no understanding of their rights, or their limited understanding and exercising of rights occurs with no assistance from the provider. The provider has no tools to assist the person to understand their rights. Meaningful rights information has not been presented to the person. Interview, observation, and/or documentation refer to on-going rights restrictions without due process or need.

5	Choice	• **Without options, there is no choice. For most people, knowing about options requires exploring these options. Education, exposure and experience are critical when addressing decision-making and informed choice.** • The provider actively solicits information about preferences rather than waiting for a discussion of preferences to be initiated by the person. • The person is regularly (continuously) presented with information in a variety of ways (EEE) to increase awareness of options of daily activities and services. • For agencies – if staff changes, the person is not only made aware of options of new staff at the agency, but also of other service providers. • The person is given every opportunity to make decisions regarding the conduct of their lives, including daily routines. • The person is given the opportunity to explore and participate in relevant cultural, traditional and social events, such as, holidays, birthdays, celebrations, religious observances, anniversaries, etc.. • Provider searches to expand communication capacity consistent with each person's needs. • The person is included in all decision making despite communication styles or guardianship. • The person's opinions are consistently and continuously solicited about satisfaction more than once a year. • Provider utilizes feedback from the person about their services to assist them in making informed choices about supports and services. • If issues exist, they are addressed in a timely fashion according to the person's preferences. • Providers never respond "we tried that…once" • Is the person knowledgeable about what to expect from the service? If so, is this the result of the provider's education efforts?	ACHIEVING: The person is included in all decisions (including staffing/provider options, paid/unpaid supports, daily routines, traditional, social and cultural experiences, etc.) and their opinions are solicited despite communication style or legal status. The person understands and exercises the right to say no. The person is actively listened to, responded to, and supported in decisions. Staff at all levels understand and implement informed choices through on-going EEE, which is used to develop further interests, facilitate informed choice, and develop awareness of consequences. The provider encourages and provides education on all the possibilities, followed by exposure to a variety of ideas and/or settings, and actual experience of the options. When the person's choices cannot be readily determined, the provider initiates innovative ways to determine and support the person's right to choose. The provider educates the person on not only the intent of the services they receive, but other available support options (paid and unpaid) as well. Documentation indicates choices and options explored. IMPLEMENTING: The person is included in most decisions despite communication style or legal status, and has a say in staffing decisions. The person has the right to say no, but do not exercise it as freely as desired. The person is actively listened to, responded to, and their decisions are honored in most instances. Provider/staff at all levels understand informed choice through EEE, and it has been applied in most, but not all areas to facilitate informed choice. When choices cannot be readily determined, there are efforts to support the right to choose, but when results are not achieved, the provider does not pursue other efforts. The provider educates the person on the intent of the services provided, however not all support options are addressed or not all persons are educated. Documentation indicates most choices and options explored. EMERGING: The person is included in some decisions despite communication style or legal status. The person acknowledges they have a right to say no, but do not always feel supported to exercise choices. The provider understands informed choice through EEE; however, the concept of choice is limited to asking the person about their already known preferences or offering

		• The person knows the provider's responsibilities and how to hold the provider accountable. • The person knows who to contact if the current provider is not meeting expectations and a new provider is desired. • Knowledge of the intent and scope of the service is discussed regularly as a means of seeking more meaningful and useful feedback from the person. • Choices include those available to the general population and according to the geographic location.	limited options. Example: Do you want to go to the park or Walmart? The provider and staff usually listen to the person when he/she is communicating. The provider's practice for determining if the person is just going along with the group, or exercising free will, is informal and inconsistent. When choices cannot be readily determined, the provider is inconsistently supporting and enabling choice. Documentation references simple, not informed choices. NOT EMERGING: The person does not feel they are involved in decisions regarding their life, and does not know they have the right to say no. The concept of EEE as a vehicle for informed choice is unknown to the provider/staff. The provider/staff's concept of choice is limited to inquiries regarding preferences for food, clothing, and outings, etc. Provider/staff are not actively listening to the person when they are communicating. There is no practice for determining if the person is just going with the flow to avoid conflict, or exercising free will. When choice cannot be readily determined, the provider gives up. The person has not received education on what to expect from the services they receive. Documentation does not indicate choice on any level.

6	Community Life	• The person goes to places of his/her choice besides service delivery settings. The person determines how and with whom they want to access the community. • The provider ensures that life in the community reflects the person's preferences, lifestyle, and interests. • The person is provided with opportunities to receive services in the most integrated settings appropriate to his/her needs and according to his/her choice. • Services are provided with other members of the community. Within segregated settings, there are opportunities for interaction between different individuals with varying interest. • The person decides where to go, when and how often. Does the person participate in community activities in large groups? If so, how are options presented and varied experiences offered? In group situations, how is compromise addressed? • The provider addresses barriers to the person's participation in the community, e.g. transportation, money, communication style, legal restrictions. • The provider supports the person to become a visible citizen of his/her community and to interact with others. • Social roles are defined by the person and the meaning it has for the person. An example of a social role could be, but is not limited to, a church member, a member of a club or group, an employee and so on. The provider supports the person to develop and maintain valued social roles. • The provider/staff are aware of their role in assisting the person to become part of the community, as opposed to just going out into it. Do they support and focus on recurring situations in which the person would be missed? • The provider promotes opportunities for friendship building or more personal, cherished relationships	ACHIEVING: The person accesses the community, has friends and/or acquaintances (unpaid) with whom they interact in more than one environment and continue to meet people and develop lasting/meaningful relationships. They identify and participate in roles that reflect their interest. The provider and staff understand the value of social roles as well as community integration and inclusion, and the difference between becoming a part of the community versus just going out into the community. Through their knowledge of the person, the provider pursues community inclusion and social roles based upon the person's preferences and new community activities are being introduced (EEE). Community resources related to the person's interests are sought and utilized to promote community integration and recurring community activities are pursued (e.g.: clubs, groups, organizations, volunteer positions, and/or classes, etc). Documentation supports the person and provider's efforts and helps identify trends or needs for change. IMPLEMENTING: The person is going out in the community, meeting people and has begun to work on developing lasting relationships. The majority of activities are individualized; however, one or two the person does not have the opportunity for separate activities. Although the person can identify some roles for themselves, they want more. Roles identified reflect the majority of their interests, but all opportunities have not been capitalized upon. The person has friends and acquaintances (unpaid) in more than one environment, but they would like more interaction across environments. The provider and staff are knowledgeable of social roles and community integration but do not support all opportunities. The provider/staff introduce new community activities however, some opportunities are missed. Recurring community activities are pursued consistent with the person's expectation, but not a priority. The provider identifies community activities and contacts, but not social interaction. Documentation identifies trends, but changes are not occurring as quickly or as frequently as the information would indicate. EMERGING: The person is going out in the community, but the majority of activities occur in groups and there is little emphasis on developing relationships. The person describes their relationships

		according to the person's preferences. • The provider offers continuous information to the person to promote informed decision-making and new experiences in the community. • EEE is fully integrated into the provider's delivery system.	and friendships as predominantly paid supports. The person can't identify any roles for themselves or roles identified reflect only some of their interests. Existing social roles are maintained, but the provider does not support the person to pursue new roles. The person is interacting with people across environments, but has not been encouraged to expand or build on interactions to develop relationships, friendships, membership. Provider/staff is knowledgeable about inclusion, but not social roles. The provider has a basic understanding of person's interests; however, this is not the driving force behind community activities. When barriers to community inclusion exists, the provider/staff view community resources as a last resort and do not encourage the person to explore other opportunities. Transportation and/or staffing are consistently identified by the provider as a barrier to participation in community activities and the provider does not pursue alternatives. The provider tracks only community outings and documentation is not reviewed for trends; no changes are made. NOT EMERGING: The person has limited to no exposure to community life or social roles of value to them. The person's life is compartmentalized and the person is not being supported to develop relationships with anyone other than the provider/staff. The person has not been presented opportunities to develop social roles and community connections. The provider/staff does not really understand the concept of inclusion/social roles and they do not learn about a person's preferences. They introduce what they think should be happening and activities do not go beyond activities specifically designed for the person with developmental disabilities. The provider does not promote regular or recurrent activities. As a result of staffing and/or transportation barriers, no community activities are occurring. Other community resources are not being utilized. Documentation of community integration is not maintained.

7	Collaboration	**Personal Outcomes apply to the whole person across service and support settings. "They are everyone's responsibility."** •□ The person recognizes themselves as the captain of the circle of support. •□ The provider recognizes him/herself as part of the circle of support and the person as the leader. •□ The provider supports the person to self-advocate through prompting and education to help the person recognize and build the role as a self-advocate. •□ All members of the team are communicating. The provider interacts and communicates with the person, support coordinators, other service providers, and natural supports regarding known desires, expectations, barriers, etc. •□ How does the provider use information to support and ensure cohesive planning and collaboration for the person being served? •□ The provider makes referrals and follows through to completion and the satisfaction of the person. •□ If it appears that informed choice may lead to potential health and safety concerns for the person, the provider has sought assistance and referrals to other professionals or Area Office personnel. •□ Board and advisory teams include self-advocates, family members and/or other 3rd party advocates as active participants. •□ Documentation systems are used as tools for the purpose of communication. •□ When sharing information, the person is supported to understand personal information, records, how it is used to communicate and collaborate with their circle of support and what it means to approve release of information in each instance.	ACHIEVING: The person is heard. The person knows the provider's system for coverage and scheduling. The person knows who to go to if they have identified a need or problem. The person actively participates in relevant meetings and/or information sharing and including referrals and follow up. The provider/staff discuss all matters with the person and the guardian, continues to educate, inform and validates their understanding of what is being told. The provider uses documentation as a tool and resource to communicate to the person and their circle of support. The provider/staff share and solicit information continuously among the circle of support. The provider proactively communicates through either discussions or documentation concerning the person, such as support plan, IEP meetings, and new information, needs or barriers identified, etc. If the provider cannot address the person's need themselves, the provider knows the "go to" person who can address the need. The provider promotes self-advocacy within the referral and follow up process and the person actively advocates for themselves. As appropriate to the provider's structure, the boards or advisory boards have active participants (self-advocates) who influence and can act as a change agent for the provider's systems. The provider has a forum for continuous brainstorming within and outside of the person's circle of support to facilitate ongoing communication. The provider educates the person about the contents of their records and assists them with maintaining their own documentation. The provider maintains documentation to support the IPs, case notes, monthly summary, etc. Provider's documentation for referral process includes follow up on the issue until resolution. IMPLEMENTING: The person knows those who provide services and are aware of the backup staff, but are not informed of staff changes. The person knows who to go to if they have identified a need and is involved in the referral process, but not the follow up. Most individuals participate in all relevant meetings and are asked for opinions. The provider and staff discuss all matters with the person and/or guardian and validate their understanding. Most documentation is used as a tool to communicate to the person and their circle of support; however not all opportunities have been maximized. The provider participates in discussions concerning the person and shares information with other supports, but does

			not solicit information from others. A system is in place to assess needs and advocate for them, and knows the "go to" person for most issues but not all. A system of referral and follow up is in place; however, the provider has not followed through to completion on all referrals. Solicitation of the person's understanding of the information is not occurring in all situations. The provider promotes self-advocacy within the referral and follow up process. The provider educates the person about the contents of their record and other documentation, but has not fully assisted the person to maintain copies of documentation of their choice. As appropriate to the provider's structure, the boards or advisory boards have active participants (self advocates). Documentation supports these activities; however, there is no documentation on follow up activities. EMERGING: The person knows the primary staff but not the back up staff. They know who to go to if they have identified a need, but are not involved in the referral process or the follow up. Although issues/information are discussed and shared with the person, the provider/staff do not validate the person's understanding of the information. The provider only shares information with other supports when requested or required, i.e. IPs, monthly summaries and service logs. The provider participates in discussions concerning the person only when there is a crisis or identified need. A system is in place to assess needs, however, the provider does not advocate for supports for those needs. The provider promotes self advocacy among persons who are able to verbally communicate. The provider has a system of referral but there is no follow up process or documentation. The provider tells the person about the contents of their records. As appropriate to the provider's structure, the boards or advisory boards have participants (self advocates). NOT EMERGING: The person is unaware of who will be providing services and is not included in any discussions. The provider is not educating or sharing information with the person. The provider does not use documentation as a means to communicate with the person and their circle of support. The provider/staff do not share or solicit information from the circle of support or they do not know the members of the circle of support. The provider does not

			participate in discussions concerning the person, unless required. There is no system in place to assess the person's needs or to advocate for them. The provider does not promote self advocacy. There is no system of referral and follow up. The provider does not educate the person about the content of their records. As appropriate to the provider's structure, the boards or advisory boards have no participation from self advocates. No documentation is available to support the provider's collaborative activities.

8	Achieving Results	Results that reflect communicated choices and preferences that matter most to the person are being achieved on a regular and consistent basis. **Increments may be achieved toward success of the overall outcome. "It's about the journey and what is learned along the way."** Regarding the person's goals: •□ Provider ensures active involvement on the part of the individual and the person's supports relative to attaining the desired results. •□ Provider encourages a cooperative and supporting relationship between the person, the person's supports, the Area Office, and all other entities striving to achieve the desired results. •□ Provider ensures the person is making progress towards and achievement of outcomes for individuals being served. •□ The provider ensures there is a system to evaluate whether the person is achieving outcomes and objectives identified, changing organizational practices and strategies, and resource utilization as needed. Regarding the provider's service goals: Evaluate the provider quality management system. Assessment process includes the following information at a minimum: •□ Tracking Projected Service Outcomes •□ Conducting Satisfaction Survey (the person served and personnel) •□ Record Reviews (the person served and personnel) •□ Interviews with the individual/guardian to determine the extent to which the provider's	ACHIEVING: The person is achieving the results that matter most to them. There is a quality management system that transcends the once a year evaluation and becomes a continuous evaluation and improvement process. The provider's quality management process evaluates and enhances the effectiveness of their service delivery system and produces results expected by the person served. The person's and the organization's successes are recognized and celebrated. IMPLEMENTING: The person is making progress on what matters most to them and is achieving some but not all of their desired results. The person is educated on the provider's quality management systems. Most issues/concerns are, or have been, addressed to the person's satisfaction. The provider's quality management processes, transcends the minimal requirements. All administrative and supervisory staff, and all direct service staff are educated about the quality management systems. A formal written plan for quality improvement is developed based on the results of the quality management processes. This plan is implemented, periodically reviewed, but all aspects of the plan are not followed through to completion. There is a system to track incidents, complaints or grievances and this information is being analyzed to make improvements and reduce these events. Most of the person's and the organization's successes are recognized and celebrated. EMERGING: The person is making incidental (not consistent) progress on their outcomes, but the outcomes are defined by the system or provider, not the person. The person participates in an annual satisfaction survey. Issues/concerns are inconsistently addressed by the provider, and not always to the person's satisfaction. The provider does not consistently utilize internal resources to determine whether the person is achieving their desired goals/outcomes throughout the year. Only administrative & supervisory staff are educated on the quality management systems. The self-assessment includes only the minimal requirements: satisfaction survey, record review and interviews. Based upon the results of the self-assessment, plans for improvement have not been developed, or if developed, they are not reviewed periodically and/or not followed-through to

		actions support outcome achievement and to get suggested changes to supports, services, daily activities and similar expectations. • Policy and Procedures are followed, reviewed and updated as necessary to reflect the provider's current practices. • The person, staff, other providers, and family are involved in the provider's quality management process. • The person's opinions are consistently and continuously solicited about satisfaction regularly, rather than once a year. • The organization has a process for collecting, aggregating and analyzing information. • Information analysis results in strategies for organizational quality improvement. • Tracking Service Outcomes is an administrative process to ensure the organization is focused on the intent and scope of the service. • Provider reviews data periodically and corrective measures are put in place if the data indicate the goal is not being achieved. • Provider has a system to track incidents, complaints, and grievances, as well as resolutions. • The provider can use existing methods of documentation as data/resources to evaluate quality of supports and services. • The process is a comprehensive administrative review to objectively assess the supports and services rendered. • The provider actively supports the person in celebrating and/or recognizing achievements. The provider also recognizes and celebrates staff and organizational achievements.	completion. The provider has a process to track projected service outcomes, but does not conduct it for all services rendered or all outcomes identified per service, nor is it used to evaluate and enhance services. There is a system to track incidents, complaints or grievances but this information is not being analyzed to make improvements and reduce these events. The person's and the organization's successes are inconsistently recognized and celebrated. NOT EMERGING: The person is not making any progress on outcomes. The person does not know if the provider has quality management systems, and may not recall having been asked about their satisfaction. The provider does not utilize internal resources to determine whether the person is achieving their desired goals/outcomes throughout the year. There is limited to no quality management system. Satisfaction surveys may have been conducted but there is no evaluation of the information to determine if action is warranted. There is no documentation to determine if issues and concerns were addressed and resolved. There is no system to track incidents, complaints or grievances. The provider does not have a system to track projected service outcomes and does not have an understanding of the process. The provider can describe their quality management process but cannot produce evidence demonstrating their results. The person's and the organization's successes are not recognized and celebrated.

	Minimum Service Requirements	Probes	Determination Guide
9	Level II background screening	Level II background screenings are completed for all direct service providers/employees. Provider has submitted the fingerprint card for processing within 10 days of the employment for solo providers and agency staff. Review available personnel files or records to ascertain compliance. Check for: • Notarized affidavit of good moral character; • Proof of local background check in the county where the employee resides. (This can be from any local law enforcement agency designated for this purpose.) • Documentation of finger prints submitted to FDLE for screening if results have not yet been received. • Screening results on file include FBI and FDLE. According to 435.05, an employee has five working days from the date of employment to get a complete set of information for the employer to conduct a screening under this section. The employer then has five working days from the date of receipt to get the screening to FDLE. Supervised employment: (393 F.S.) A direct service provider who is awaiting the completion of background screening may provide services and supports if the direct service provider is under direct and constant visual supervision of a person or persons who meet the screening requirements. This exemption expires 90 days after the direct service provider first provides care or services to individuals receiving supports from APD, has access to an individual's living area, or has access to an individual's funds or personal property. If the provider is following these procedures, score	Met: All required documentation is present demonstrating compliance with this element. Not Met: One or more parts of the required documentation are not present at the time of the consult. Results of the FBI and FDLE screening have not yet been received within 90 days of employment.

		this element as “met.” The provider is an active, not passive participant in obtaining results. Criminal records that include possible disqualifiers have been resolved through court disposition. All employees undergo background screening every 5 years. •□ Look for evidence of completion and submission of an FDLE Form. Results of the screening are on file. Note: Fingerprint cards are not required on resubmission.	

10	Provider/staff training	New Providers of Onsite services: New providers have the required training and qualifications required for the service. The provider/staff have received all of the identified training as outlined in the service specific requirements and the Core Assurances in the Handbook. Annual Onsite Consults: • Provider/staff have completed annual training as appropriate to the service rendered. • Provider/staff have completed the required pre-service training as appropriate to the service, prior to rendering services. • Independent providers and agency staff receive training specific to the needs or characteristics to the person as required to successfully provide services and supports. The provider and/or staff assigned to render services and supports to the person have received some orientation to a person and the person's unique characteristics and needs. o The family or guardian, a physician or nurse, other providers or the person who is in regular contact with and understands the unique characteristics and needs of the person can provide this orientation. o Examples of this training could include instruction on: • Communicating with the person; • Repositioning requirements for the person; • Instruction on a behavior program, if applicable to the person; • Specific training to implement a training program tailored to the person. • If provider renders intensive behavior services, the provider and staff have all required trainings. o This training may be one-on-one in	Met: All required documentation is present demonstrating compliance with this element Not Met: One or more parts of the required documentation are not present at the time of the consult

		nature, and therefore documentation may not take the form of an agenda, or curriculum with handouts and outline. Look also for evidence in the person's record, such as in progress notes or other provider documentation. • Provider and agency staff have received training on sexual assault, domestic violence, abuse, neglect and exploitation and reporting procedures. ○ The agency staff or the provider knows what to do when abuse, neglect or exploitation is suspected. • The provider and agency staff have current training in CPR and HIV/AIDS and Infection Control. • The provider and agency staff have received training on the Core Competency Training. • Ask the provider and agency staff about the in-service training they have received. • If this is an agency provider, staff are aware of the provider's policy and procedures, and knows whom to call. NOTE: A newly hired employee will be included as part of the sample for the annual onsite consult.	

11 R	Service authorization/billing as authorized	Verify the provider has on file a service authorization to provide the service for the period in review. •□ Interactively, with the provider, review a sample of approved cost plans and/or service authorizations in comparison with claims data, attendance logs, supporting data and monthly summaries. •□ Verify the provider has on file a service authorization for the services provided. •□ As appropriate to the service, observe the staffing ratios being provided. Note for QIC: If issues are identified, review staff schedules and payroll documentation to determine how many staff actually worked. •□ The provider bills for the service as defined and specified in the DD Waiver Services Medicaid Coverage and Limitations handbook and FSL Waiver Service Directory If rendering intensive behavioral services the required staffing ratios are maintained. Note: Check billing against service/attendance log and claims.	Met: All required documentation is present demonstrating compliance with this element Not Met: One or more parts of the required documentation are not present at the time of the consult Refer to reviewer Service Limitation Reference Sheet.
12 **R** **ON/ OFF**	Maintains billing documentation	Review records to determine the provider's compliance with documentation for billing and monitoring. NOTE: New providers maintain required documentation to include all required policy and procedures.	Met: All required documentation identified in the billing documentation requirements of the handbook is present demonstrating compliance with this element. Not Met: One or more parts of the required documentation are not present at the time of the consult. The IP is not in developed within the 30 day timeframes or not updated within 30 days. **Note for QIC: For all New Providers, refer to the New Provider Policy and Procedure Reference Sheet.** NOTE: For New Providers Recoupment should not be identified (turned on) if the provider does not have all of the required policy and procedures in place.