

Qlarant Review for Qualified Organizations

Empower Florida Conference

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Session Purpose

- Overview of Qlarant Tools and Discovery Review process
- Discussion of lower scoring standards trends
- Provide suggestions on how to avoid common errors
- Highlight role and importance of Progress Notes

Quick Refresher on the basics

Discovery Process

Person Centered Review (PCR)

- Person Centered Reviews assess outcomes and support delivery systems from the perspective of persons receiving services

Provider Discovery Review Support Coordinator (PDR SC)

- Provider Discovery Reviews evaluate person's satisfaction and provider performance, based on service delivery measures and program standards

Provider Discovery Review Support Coordinator Tools

- Administrative
 - General Administrative
 - Qualifications & Training
- Service Specific Tools
 - Standard
 - Protocol
 - Not Met (NM) Reasons
 - (B) after a NM Reason means its a Potential Billing Discrepancy if scored out
 - (A) after a NM Reason means its an Alert if scored out

A Qualified Organization is eligible for a PDR SC Review
in each Region in which they render Support
Coordination and/or CDC+ Consultant services.

Tips for a Positive Qlarant Review

- ✓ Prepare all year long not just when you get your letter/email/phone call to schedule
 - ✓ Respond to QAR email and calls promptly
 - ✓ Ensure email, address, and phone numbers are current with AHCA, APD and in iConnect
- ✓ Study the Handbook and read requirements for services you provide
- ✓ Most current Handbook: **September 2021** – Find it here:

https://apd.myflorida.com/ibudget/docs/September%202021%2059G-13.070_DD_iBudget_Waiver_Services.pdf

- ✓ Review Qlarant tools found at <https://florida.qlarant.com/>
 - **Resource Center > Provider Resources > FSQAP Discovery Review Tools**

Tips for a Positive Qlarant Review

- ✓ Make sure you are using iConnect
- ✓ Conduct your own self-assessment using Qlarant tools
- ✓ Have systems to organize your documentation including
 - ✓ Administrative, Employee and Individual Service Records
- ✓ Read the APD WSC and QO Advisories –
 - <https://apd.myflorida.com/waiver/support-coordination/>
 - <https://apd.myflorida.com/waiver/support-coordination/qo/>

Review of select Qualified Organization (QO) SSRR Standards

Lower Scoring SSRR Standards

- The Support Plan includes supports and services consistent with assessed needs. 66.7%
- The Support Plan reflects support and services necessary to address assessed risks. 68.5%
- Support Coordinator Progress Notes demonstrate pre-Support Plan planning activities were conducted. 68.7%
- The Support Plan has all required components complete. 74.3%
- Level of care is completed accurately using the correct instrument/form. 77.6%

Medicaid Waiver Eligibility Worksheet

- Must be created in Forms in iConnect
 - See applicable APD Advisories
- Then word merged, printed, signed, and uploaded to Notes
- **There must be a "form" for every printed, signed and uploaded MWEW**
- Supporting documentation can be uploaded to notes tab or sent via secure methods to QAR for review
 - Best Practice: Upload to iConnect

Pre-Support Plan planning activities - Most Common Not Met Reasons:

- did not document review of status of current goals/outcomes and discussions of potential changes/updates to goals/outcomes for the next year.
 - *Just stating “reviewed goals and asked to think of new ones for next year” is not the intent of the requirement. Use details of the discussion.*

Pre-Support Plan planning activities - Most Common Not Met Reasons:

- did not document discussions of potential dates, times, and locations for the meeting.
- did not document review of current services and providers.
- did not document discussions of whom the person would like to invite to the meeting.
 - ❖ *Be specific and include details specific to the person vs. Broad generic statements such as...*
“asked if current services and providers are ok” or “discussed date and time for meeting, where they wanted to have it and who they wanted to invite”

Support Plan

- When you receive a “new” file...
 - When does the SP and Eligibility Worksheet need to be done?
 - Internal File Transfers: Same QO - if not present/correct would be not met
 - External File Transfers: Different QO - if not present/correct, there is a 30 day grace period using the date APD notified QO/WSC in iConnect of file transfer in the provider selection or notes tab
- New person to Waiver: Complete within 45 days of WSC selection
- New due to crisis determination: Complete within 30 days of WSC selection

Support Plan

- Support Plan must be completed in iConnect
 - Current: Person Centered Plan version 11/2021
 - Reference: Person Centered Plan Manual 11/2021
- Signature page must be completed and uploaded into iConnect
 - Person, witness if needed, Legal Representative if applicable, and WSC must sign and date
 - Other SP meeting participants should also sign

Support Plan

- Support Plan Effective Dates
 - Need documented APD approval for a SP Extension
 - Support Plan effective dates are not typically changed even with an extension and are always the 1st of a month.
 - Support Plan effective dates are set by APD and can only be changed by APD.
 - If shifting SP effective dates with APD approval, remember there cannot be a gap. So if one is May 2022 and the effective date is changed to September, then there will need to be a May 2023 and then one for September 2023.

Standard 5a- The Support Plan has all required components complete

- Reference: Person Centered Plan version 11/2021
 - If old version (8/2019) is used- all required components are not present since they were not there.
 - WSC ADVISORY #2021-040
- Complete, individualized and updated annually
 - 1) Identifying information and demographics
 - 2) Person-Centered Information
 - 3) Significant Needs and Risks
 - 4) Past Accomplishments and Future Goals
 - 5) Health

Most Common Not Met Reasons for Standard 5a

- Support Plan section:
 - Identifying information and demographics had components not present on the Plan.
 - Health had components not present on the Plan.
 - Person-Centered Information did not change from one Support Plan to the next.
 - Future Goals did not change from one Support Plan to the next.
 - Health did not change from one Support Plan to the next.

Most Common Not Met Reasons for Standard 5a

- Identifying information and demographics
 - Accurate Legal Status
 - Legal representative paperwork on file
 - Up to date address and contact information for person and supports
 - Other Funding Sources for Support
 - Up to date living setting

Most Common Not Met Reasons for Standard 5a

- Health
 - If gaps in information, have conversations and meeting to get an accurate picture of health and update
 - Should correlate to items reported in needs and risks
 - Includes significant events, diagnoses, medications

- Person Centered Information and Future Goals
 - Cut and paste in these sections allows for errors, as well as being generic vs. individualized
 - Information is from perspective of person and what is important to and for them

Most Common Not Met Reasons: Standards 12 & 13 Support Plan includes supports and services consistent with assessed needs and address assessed risks.

- Current Support Plan did not include:
 - strategies for assessed needs and assessed risks
 - supports/services identified for assessed needs and assessed risks
 - back up plan for assessed needs and assessed risks
 - documentation related to the assessed needs and assessed risks
 - applicable strategies identified for other needs and other risks related to me
 - documentation related to some, but not all assessed needs and assessed risks

Documenting Assessed Needs and Assessed Risks

- In the Sections, provide a specific description of the supports and services for the assessed need and how assessed risk will be addressed.
 - Be specific and describe what is going on for that person that results in the need or risk.
 - Specific concern/need/risk, strategies in place to address, who is responsible, source of funding.
 - One word answers, vague descriptions or restatement of the QSI result is not sufficient.
 - When filling in this section, always ask: Is this information clear?
 - Does it provide a good understanding of actual needs and potential risks?

Documenting Assessed Needs and Assessed Risks

- Data reported to Centers for Medicare and Medicaid Services to keep HCBS iBudget Waiver in Florida
- Section focuses on supports and services important FOR the person and Addressing of the Assessed Risks
- Applicable Source Documents
 - QSI
 - Copied-Shared Response feature should be used to load QSI scores into SP
 - Incident Reports (past 12 months)
 - Medical Documentation (past 12 months)
 - Other Records (past 12 months)

TIP! For directions on how to use the copy-shared response feature in APD iConnect, please visit the [WSC iConnect Library](https://www.apd.myflorida.com/waiver/iconnect/wsc.htm) online at www.apd.myflorida.com/waiver/iconnect/wsc.htm

Documenting Assessed Needs and Assessed Risks

- Discuss the Other Risks/Needs Related to Me and Needs/Risks Related to My Caregiver
 - If you do not see these two sections, you are using an old SP version. Be sure to switch to 11/2021 version
 - Note; section for caregiver only needs to be completed for those in Family Home*
 - *It is a best practice to include this information when needed for persons in Supported or Independent Living

Other Risks/Needs Related to Me (Choose all that apply)

Other Risks/Needs Related to Me (Choose all that apply)

Identified Need/Risk Area	Specific issue and measures in place to address/minimize risk	Service/Support	Source of Support
<input checked="" type="checkbox"/> Requesting and Getting Help, if needed	Steven needs help with multistep tasks, such as putting groceries away or doing laundry. He needs verbal prompts to finish tasks. Sometimes he uses a timer to keep focused because he will stop in the middle of chores to start watching TV.	Personal Supports to give verbal prompts and some guidance to complete tasks throughout the day	iBudget Waiver
<input checked="" type="checkbox"/> Medication Management	Steven remembers to take his medication if it is organized in his weekly pill box. If this is not done, he will not take his medication. Father will sit with Steven and help him review and organize his medication on Sunday nights.	Natural Supports	Natural Supports

Needs/Risks Related to My Caregiver (Family Home)

<input checked="" type="checkbox"/> Caregiver Health Needs	Father has had two knee replacements surgeries in the past 5 years. Steven requires physical assistance and supervision while using the kitchen.	Personal Supports for Steven training and assistance with household chores	iBudget Waiver
<input type="checkbox"/> Limited Relief for Caregiver			
<input checked="" type="checkbox"/> Caregiver Needing Additional Assistance	Steve's father will need to provide additional help to his mother.	Personal Supports is currently helping when parents are unavailable.	iBudget Waiver
<input checked="" type="checkbox"/> Aging Caregiver	Mother has dementia. She also uses a walker for long distances and bathroom is ADA accessible. Steven does not grocery shop or manage finances independently. Steven's parents are unable to provide physical assistance throughout his day, but they can offer words of encouragement and prompts to keep him on track with chores.	Extended family assists with grocery shopping and light housework	Natural Supports

Documenting Assessed Needs and Assessed Risks

- Procedures/Strategies
 - Should also list the document name so it is clear where others can find the specific steps/strategies staff should follow and this should be in iConnect notes tab.
 - If supports vary per setting, this should be clearly stated for each setting and described in back up plan.
- Service/Support/Source of Support
 - If QSI is 1+ --then information should not be marked N/A
 - In addition if QSI is marked 0 meaning no functional limitations but you know assistance is required you must add this information.
 - QSI's are done every 3 years, needs change. If drastic changes request a new QSI through "Notes".

Documenting Assessed Needs and Assessed Risks

- Back Up Plan
 - Required for all
 - Include specific strategies not generic or vague
 - Comprehensive including back up plan for natural, paid, community, assistive technology, environmental modifications, education
 - Back Up Plans and Personal Disaster Plans should be dated and uploaded to iConnect so they are available in the event they are needed

Progress Notes

Progress Notes – Where should these be in iConnect?

- Under Provider Documentation Tab in iConnect
- Make reference in Provider Documentation Progress Note when you want to reference information uploaded to the Notes section
 - WSC Advisory #2022-017, WSC Progress Notes APD iConnect Improvements
 - WSC Advisory #2020-043, WSC Progress Notes

Progress Notes - What can we write about?

- Standards 22 – 24 - Progress Notes – Demonstrate required monthly contacts based on living arrangement
 - Include who, why, what, where, when, and what next
- Standard 25 – Support Coordinator Progress Notes include meaningful information to effectively assist the person in achieving goals/outcomes
 - Rewriting the standard or not met reasons does not equate to an individualized Progress Note with meaningful information
 - Issues with cut and paste - errors in names, gender, living situation, services, other details, same note among all the files.

Progress Notes - What can we write about?

- Documentation is required; make it meaningful
 - Creating a “form” does not make documentation individualized
- Many standards can be discussed in the Progress Notes
- Communication should be two ways
 - Sent a text, email or left a message-----Not billable until return communication

Progress Notes - What can we write about?

- Describe efforts to:
 - ✓ Gather information about abuse, neglect and/or exploitation knowledge and history
 - ✓ Demonstrate details regarding pre- Support planning activities
 - ✓ Include meaningful information to effectively assist the person in achieving goals/outcomes including review of provider documentation
 - ✓ Demonstrate use of a person-centered approach in Support Coordinator documentation to define the personal goals/outcomes important to the person

Progress Notes – Handbook Requirements

- Face to Face visits should relate to or accomplish at least one of these per visit:
 - ✓ Assist the person to reach individually determined goals
 - ✓ Monitor the health and well being of the person
 - ✓ Obtain, develop, and maintain resources
 - ✓ Does not mean one resource emailed to all on your caseload
 - ✓ Increase the person's involvement in the community
 - ✓ Waiver is the Payer of Last Resort
 - ✓ Promote advocacy or informed choice
 - ✓ Follow up on concerns and conflicts
 - ✓ Next steps and make sure future notes close the loop

Progress Notes – Handbook Requirements

- Describe efforts to:
 - ✓ Assist the person/legal representative to know about and exercise rights
 - ✓ More than just stating a right- what does it mean to the person and in their life situation
 - ✓ Choose waiver services & supports including interviewing providers
 - ✓ Including grievance procedures and what to do if not satisfied with a service or provider
 - ✓ Assist with empowering for own health care needs and risks
 - ✓ Assist with behavioral/emotional health needs and risks
 - ✓ Assist with safety needs and risks

Progress Notes: CDC+ Consultants

- Same requirements as Waiver with specifics toward CDC+
 - Progress Note(s) must contain:
 - Documented monthly contact with the CDC+ Representative
 - All contacts made
 - Information about monthly budget and spending
 - Account reconciliation, claims submissions
 - Purchases consistent with Purchasing Plan
 - Use of EBU, if consistent resulted in update to Purchasing Plan
 - Savings being tracked and will be purchased in established timeframes
 - If applicable, APD contacted for adjustments, Consultant completed needed training needs for rep, or developed CAP

Progress Notes: CDC+ Consultants

- You must write the details of your contacts as Progress Note(s) under Provider Documentation tab in iConnect.
- Per CDC+ Consultant Advisory 2019-010 (dated July 1, 2019), the CDC+ Participant Review Form is no longer required for monthly Progress Notes.
- You can still choose to use the form to supplement your Progress notes by referencing it within your note and uploading it to the note tab.

Final Reminders

- iConnect is not optional, in most instances if it is not done in iConnect it is not done
- Do not use special characters in document file names uploaded to iConnect
- Document for the person you are rendering to vs. generic Progress Notes/Support Plan
- Do the Work; Show your work
- You don't have to write a novel- make what you write count
- Reciting Qlarant standards in the Progress Notes with no specific details for that person does not meet the requirement
 - Example of NOT meeting requirement:
“Met with consumer and we discussed his health and talked about Rights.”

Florida Statewide Quality Assurance Program

Customer Service Representative:

Email: FSQAPcustomerservice@qlarant.com

Phone Number: 1 (866) 254-2075

Secure Fax Number: 1 (888) 877-5526

Where to find the tools:

<https://florida.qlarant.com/index.html>

Sign up for e-notifications

The logo for Qlarant, featuring the word "Qlarant" in a white, sans-serif font. The letter "Q" is stylized with a white outline. To the right of the text is a graphic element consisting of four small yellow squares arranged in a 2x2 grid, with a white outline around the entire group. A registered trademark symbol (®) is located at the bottom right of the word "Qlarant".

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