Quality Services Review Assessment

Year 1 Annual Report
June 2015 - June 2016

Virginia Department of Behavioral Health & Developmental Services

Submitted by Delmarva Foundation
September 7, 2016

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List of Acronyms

DBHDS – Department of Behavioral Health and Developmental Services

DD – Developmental Disability

DFMC – Delmarva Foundation for Medical Care

DOJ – Department of Justice

FGI – Family Guardian Interview

HCBS – Home and Community-Based Services

ID – Intellectual Disability

IRR – Inter-rater Reliability

ISP – Individual Support Plan

IT – Information Technology

KPI – Key Performance Indicator

NCI – National Core Indicators

OBS - Observations

P&P – Policy and Procedure

PCR – Person Centered Review

PCR II – Person Centered Review Individual Interview

PM – Program Manager

PPD – Partnership for People with Disabilities

PQR – Provider Quality Review

PQR II – Provider Quality Review Individual Interview

PRR – Provider Record Review

Q&T – Qualifications and Training

QA – Quality Assurance

QAR – Quality Assurance Reviewer

QI – Quality Improvement

QSR – Quality Service Review

SC – Support Coordinator

SCI – Support Coordinator Interview

SI – Staff Interview

SSRR – Service Specific Record Review

TL – Team Lead

Executive Summary

Delmarva contracts with the Virginia Department of Behavioral Health and Developmental Services (DBHDS) to conduct Quality Service Reviews (QSRs) for individuals with an intellectual disability (ID) or developmental disability (DD) receiving services under the Department of Justice (DOJ) settlement agreement. This includes individuals receiving services through the Medicaid Home and Community-Based (HCBS) Services ID and DD waivers, in communities, intermediate care facilities (ICFs), Training Centers operated by DBHDS, and nursing facilities. The purpose of the QSRs is to evaluate the quality of services and determine if individuals are achieving outcomes, i.e., getting their needs met, particularly in the areas of person centered planning, integrated settings and community inclusion. The QSR consists of Person Centered Reviews (PCR) and Provider Quality Reviews (PQR). The person receiving services has a voice as part of each process.

This is the first annual report presented to the DBHDS summarizing the results of the QSRs completed between June 2015 and June 2016. QSR reports are completed on a quarterly basis to help DBHDS evaluate performance on a set of process and outcome indicators, particularly within four Key Performance Areas:

1. Individuals' needs are met, including health and safety (Needs are Met)
2. Person centered thinking is applied and individuals are given choices and are supported in self-direction and in managing individual health and safety (Person Centered)
3. Services and supports are provided in the most integrated setting appropriate to individuals' needs and consistent with their informed choice (Integrated Setting)
4. Individuals are provided opportunities for community engagement and inclusion in all aspects of their lives (Community).

Section 1 of the report is dedicated to the data analysis and results for the PCRs and PQRs performed during the review period. Findings for each are summarized on each of the eight data collection tools and then from performance measured against the specific indicators within each of the four Key Performance Areas (KPA). Section 2 of the report outlines the strengths, improvement opportunities, and recommendations gleaned from the results documented in Section 1.

PCR Results by Tool and KPA

The primary purpose of the PCR is to determine the quality of the person's service delivery system and the quality of the person's life from the perspective of the person receiving services. PCR data were collected using eight different data collection tools. Four instruments were used to interview the person and others close to the person: the Individual Interview (II), Family/Guardian Interview (F/GI), Support Coordinator Interview (SCI), and Provider Interview (PI). Records maintained by

providers and support coordinators were reviewed using the Provider Record Review (PRR) and Support Coordinator Record Review (SCRR) tools; data on the observations of the person's daily activities were collected through the Observation (Residential and/or Day Program) (OBS) tool; and an assessment of the completeness of the person's Individual Support Plan (ISP) was conducted using the Individual Support Plan Quality Assurance **(**ISP QA**)** Checklist.

Figure A summarizes performance on all the data collections tools for the PCR. Average results on the PCR in general were positive:

- Average results on all PCR tools exceeded 80 percent met.
- Data collected during the onsite observations showed performance exceeding 90 percent met.

A review of the person's ISP during the PCR also reflected a 90 percent met.
Some detailed findings from interview, record review, and observation data in the PCR are positive. These include
- Creating an Individual Support Plan (ISP) that is strengths based and individualized to reflect a person's needs and desires
- Support coordinators and providers generally offer choice of services, and support individuals in achieving their dreams and goals

However, education is not always provided in some individualized health and safety areas, is only offered in broad areas of health. Choice is often not reported or documented in terms of the person's roommates and housemates. Social role development for individuals is not always ensured.

Figure A. PCR Results by Tool
June 2015 – June 2016

II   Individual Interview
FGI   Family Guardian Interview
PI   Provider Interview
PRR   Provider Record Review
OBS   Observation
ISPQA   Individual Support Plan
          Quality Assurance Checklist
SCRR   Support Coordinator Record
          Review
SCI   Support Coordinator Interview
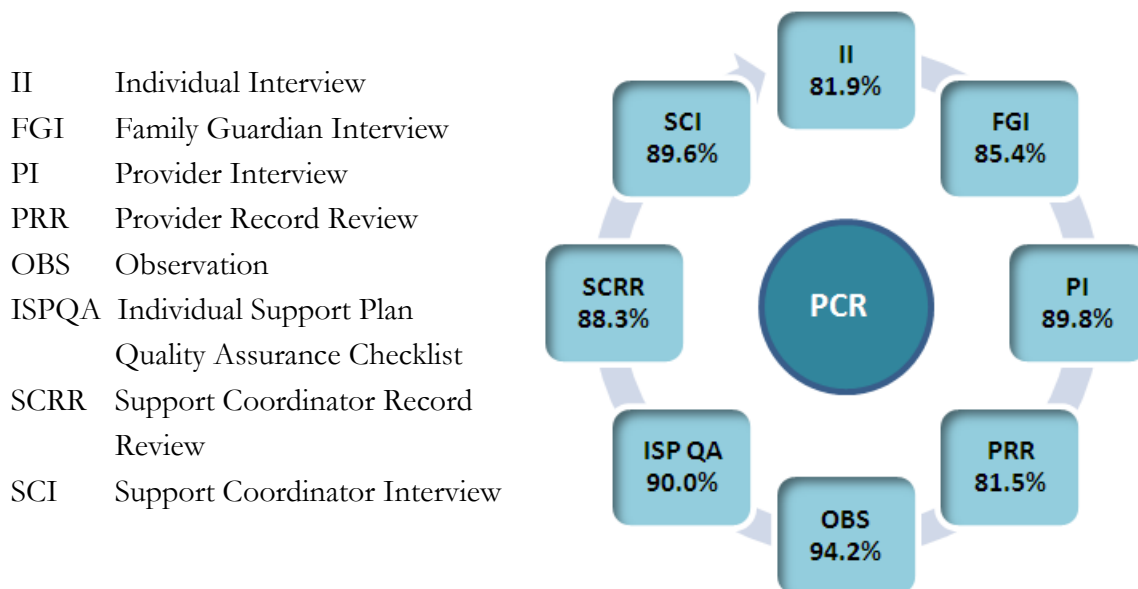
Aggregate results for the PCR within each of the four Key Performance Areas show numerous areas of strength in addition to areas where opportunities for improvement exist (Figures B). Because Health and Safety are critical components of the Person Centered and Needs Met KPAs, results for Health and Safety are shown separately (see boxes at top corners at the pie diagram).

As illustrated in Figure B, PCR results indicate individuals with ID/DD routinely had their needs met (93.3%). However, a person centered approach was not always employed (76.9%). Though people's basic needs in health (90.9%) and safety (94.6%) are met, they are not always supported and educated to direct their own health and safety through a person centered approach, 71.3 percent and 62.6 percent respectively. Individuals were not always receiving services in the most integrated setting appropriate to the person's desires and abilities (84.3%) or engaging in the community as desired (84.5%).

Figure B. PCR Results by Key Performance Areas
June 2015 – June 2016

- Health Needs Met 90.9%
- Safety Needs Met 94.6%
- General Needs Met 95.1%

- Health Person Centered 71.3%
- Safety Person Centered 62.6%
- General Person Centered 87.0%

Needs Are Met 93.3%

Person Centered 76.9%

Community 84.5%

Integrated Setting 84.3%
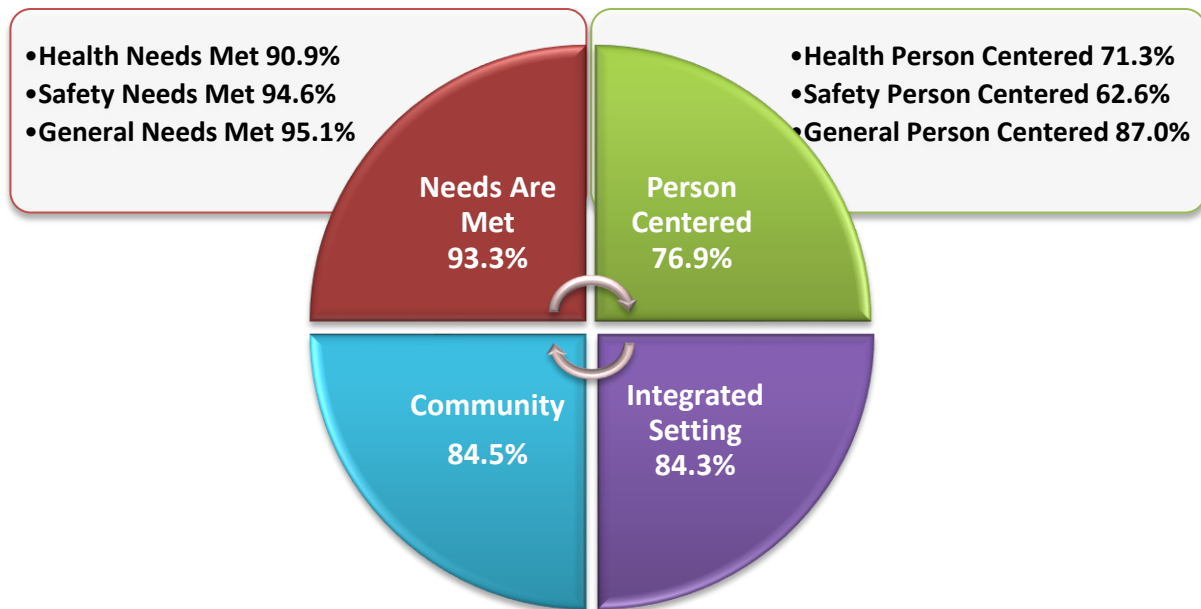
PQR Results by Tool and KPA

The focus of the PQR is to review provider compliance with requirements and standards, identify best practices and assess the quality of services rendered. The PQR uses most of the same tools as the PCR; however, the focus of the individual interviews is on the specific services a person received from the provider rather than the total service system surrounding the person, as in the PCR. The PQR review also includes an administrative review to assess the organization's compliance with Qualifications and Training (Q&T) and Policies and Procedures (P&P).

Average results for performance on the PQR were positive (Figure C):

- Performance on all PQR tools exceeded 80 percent.
- Lower scores were mostly seen in provider record reviews.
- Findings from the administrative reviews indicated a Q&T score of 86.8 percent and P&P score of 84.9 percent.

Figure C. PQR Results by Tool
June 2015 – June 2016

II   Individual Interview
PI   Provider Interview
PRR   Provider Record Review
OBS   Observation
P&P   Policy & Procedure
          Administrative Review
Q&T   Quality & Training
          Administrative Review
SCRR   Support Coordinator Record
          Review
SCI   Support Coordinator
          Interview
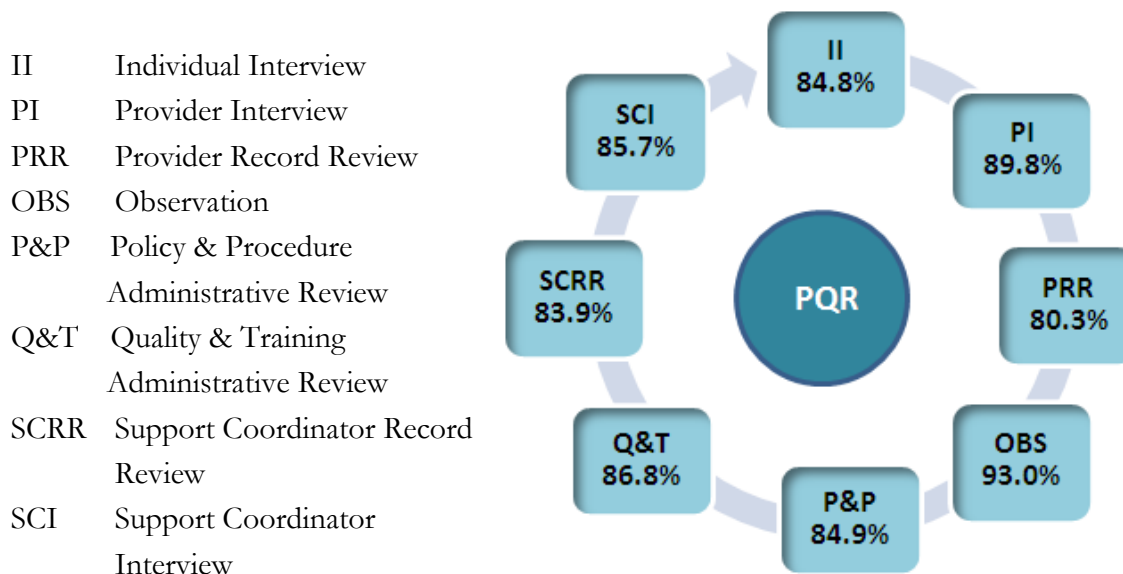
Figure D shows the distribution of provider results within each of the Key Performance Areas of the PQR indicates a pattern similar to the PCR results. Individuals' needs were generally met (93.4%) but a person centered approach was not always part of the service delivery system (71.6%), particularly in terms of health (64.1%) and safety (63.0%). Services were not always provided in the most Integrated Settings (80.4%). Community inclusion was not always practiced (77.0%).

More detailed analyses of results from the PQR indicate

- Approximately 76 percent of the 40 providers reviewed had results at or above 90 percent for meeting an individual's needs.
- A majority of providers (32; 65.3%) scored between 71 percent and 89 percent on person centered practices and approximately 80 percent of providers had results above 90 percent in promoting more integrated settings.
- With respect to community inclusion, 12 providers (24.5%) performed above 90 percent and 12 providers scored below 80.

Figure D. PQR Results by Key Performance Areas
June 2015 – June 2016

- Health Needs Met 91.0%
- Safety Needs Met 94.6%
- General Needs Met 94.9%

- Health Person Centered 56.8%
- Safety Person Centered 60.3%
- General Person Centered 80.4%

Needs Are Met 93.4%

Person Centered 71.6%

Community 77.0%

Integrated Setting 80.4%
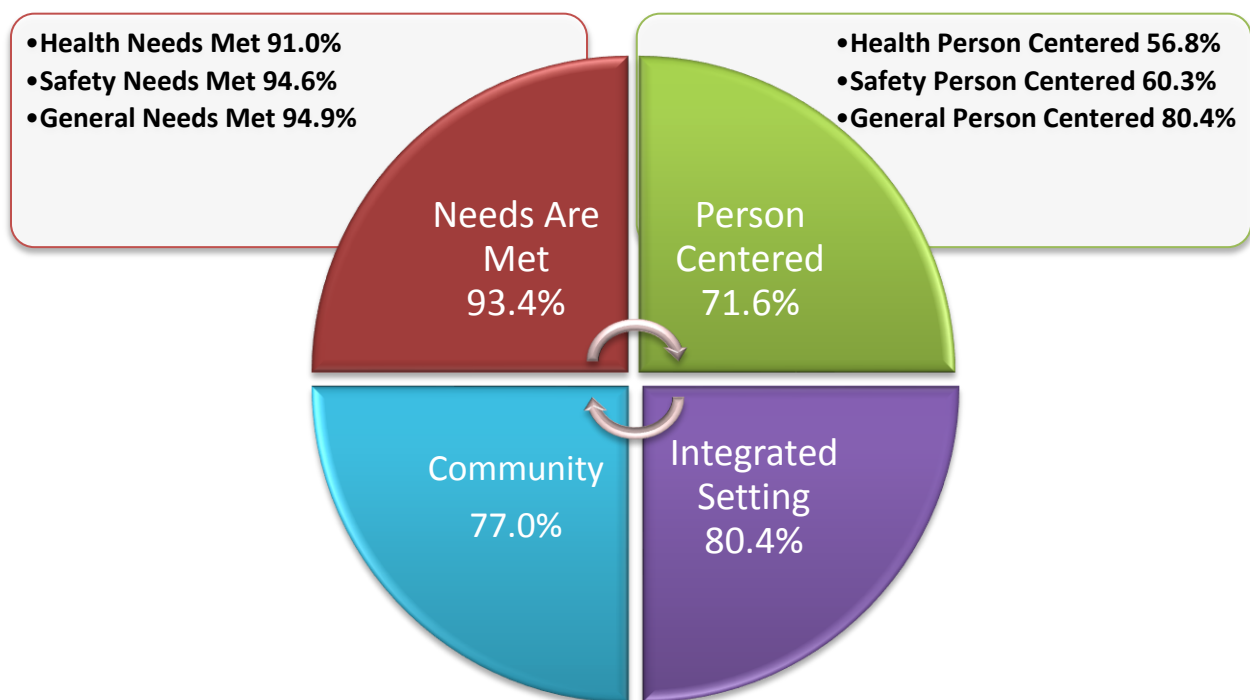
Overall Findings

In general, some key findings emerged from the Year 1 QRS data.

- On average, information from interviews with support coordinators, providers, and family/guardians was more positive than information obtained directly from individuals or from data collected through the record review processes.
- A difference is evident in perceptions between service providers and individuals on the degree to which an individual has control over directing how the ISP is translated into action.
- While individuals report they participate in service planning, the ISP does not effectively document how the person actually directs this activity, and individuals often do not feel they are able to direct their own daily routines.
- Individuals' preferences and goals are actively pursued around independent living and community activities and relationships, yet not as much so with respect to integrated living and employment or community engagement.
- Most SCs and providers understand the meaning of person-centered planning, self-direction and self-determination, but not all are applying these principles so that individuals can have

greater involvement in decisions affecting their lives, including planning their own health care and dental care.

- Most individuals are free from abuse, neglect, and exploitation (ANE), but most don't understand what ANE is and what to do in case of ANE.
- Education is needed, for individuals, on how to address different types of safety concerns, fire or weather related emergencies, prescribed medication and potential side effects

Greater detail on the QRS methodology, analyses of results, and lists of strengths and opportunities within each the four Key Performance Areas is included in the sections that follow. Discussion of results and evidence based recommendations are offered in Section 2.

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Introduction

Delmarva Foundation contracts with the Virginia Department of Behavioral Health and Developmental Services (DBHDS) to conduct Quality Service Reviews (QSRs) as part of the Virginia Quality Management System (VQMS). One of the focuses of the QSR is individuals who transitioned from an institution as part of the Department of Justice (DOJ) Settlement Agreement with the state and are being served in their communities. Delmarva has worked closely with DBHDS to develop measurement tools to conduct interviews and record reviews that will best meet the needs of the state to track provider performance, system performance, and individual outcomes. The Partnership for People with Disabilities (PPD), a sub-contractor to Delmarva, is involved in conducting the PCR interviews with individuals and has worked closely as part of the team toward timely implementation of the QSR process.

Purpose of Report

The purpose of this report is to provide DBHDS with QSR review results and recommendations to help improve practice and service quality, determine compliance with regulatory requirements, and provide other results as mutually agreed upon. The Annual Report is to also evaluate the following Key Performance Areas:

1. Individuals' needs are met, including health and safety (Needs are Met)
2. Person centered thinking is applied and individuals are given choices and are supported in self-direction and in managing individual health and safety (Person Centered)
3. Services and supports are provided in the most integrated setting appropriate to individuals' needs and consistent with their informed choice (Integrated Setting)
4. Individuals are provided opportunities for community engagement and inclusion in all aspects of their lives (Community).

Review Processes

The QSR is composed of two review processes: Person Centered Reviews (PCR) and Provider Quality Reviews (PQR). Both processes ensure the person receiving services has a voice.[1]

The primary purpose of the PCR is to determine the quality of the person's service delivery system from the perspective of the person receiving services and the quality of the person's life. During the PCR Quality Assurance Reviewers (QAR) utilize the following tools to interview the person and others close to the person, review records maintained by providers and support coordinators, observe the person's daily activities, and assess the completeness of the person's Individual Support Plan (ISP):

- Individual Interview **(II)**

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[1] See Appendix 7 for a detailed description of the review processes.

- Family/Guardian Interview **(F/GI)**
- Support Coordinator Interview **(SCI)**
- Individual Support Plan Quality Assurance **(ISP QA)** Checklist
- Provider Interview **(PI)**
- Provider Record Review **(PRR)**
- Support Coordinator Record Review **(SCRR)**
- Observation (Residential and/or Day Program) **(OBS)**

The focus of the PQR is to review provider compliance with requirements and standards and to assess the quality of services rendered. The PQR utilizes the following tools:

- Individual Interview **(II)**
- Administrative Record Review
    - Policies and Procedures **(P&P)**
    - Qualifications and Training (Employee Record Review) **(Q&T)**
- Staff Interview **(SI)**
- Provider Record Reviews **(PRR)**
- Support Coordinator Interview and Record Review, if applicable **(SCI, SCRR)**
- Observations (Licensed Residence and/or Day Program) **(OBS)**

If at any time during the review the Quality Assurance Reviewer (QAR) deems an action or situation is a danger to a person, the QAR takes appropriate action that may include calling the abuse hotline and staying with the person until the proper authority arrives. Additionally, if abuse, neglect and exploitation are uncovered or suspected an alert is activated in conjunction with notification to appropriate authorities.

Sampling Methodology

At the onset of this contract year, 400 eligible individuals were randomly selected to participate in the PCR. The sample was stratified by region and randomly selected proportionate to the eligible population in each region. From the 400 individuals selected for the PCR, 50 eligible providers were randomly selected to participate in the PQRs. To compensate for individuals or providers who are unable or unwilling to participate, each sampling process (PCR and PQR) uses an oversample appropriately designed to help preserve the integrity of the original sample.[2] Due to various delaying factors in the review process, at the end of the contract year 380 PCRs and 49 PQRs were completed.

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[2] See Appendix 6 for a detailed explanation of both sampling processes.

Report Format

This report provides findings from all PCRs and PQRs completed during the contract year (June 2015 – June 2016), and contract activities completed during the fourth quarter of the year (April – June 2016). Information is presented in three broad sections.

- **Section 1, Data Analysis and Results**, provides graphic and tabular displays of data from all review tools, as well as comparative and trend analyses as possible and as appropriate.
- **Section 2, Discussion and Recommendations,** offers interpretation and discussion of findings and evidence based recommendations for the state.
- **Section 3, Significant Review Activity and Accomplishments,** provides a summary of contract activity for the quarter.

Section 1: Data Analysis and Results

Person Centered Reviews

Introduction

In this section results from the PCRs conducted during the contract year are presented: a demographic description of the sample of individuals selected for the PCR; results for each tool as described in the Review Process section; findings based upon the Key Performance Areas described in the Purpose of the Report; and other significant results from review activities are presented, including high and low scoring indicators.

PCR Demographics

Individuals selected to take part in the PCR have the right to decline to participate.[3] If so, an individual is selected from the oversample. Between June 2015 and June 2016, Delmarva completed 380 PCRs.[4] Individuals interviewed to date were mostly men, had a primary disability of intellectual disability, and were most likely to have lived in a Family or Group Home. The greatest proportion of the sample, by age group, was between the ages of 18 and 30 (Figures 1 – 4).

Figure 1. PCR by Gender (N=379)[5]
June 2015 – June 2016

44.4%
Women

➕

54.6%
Men

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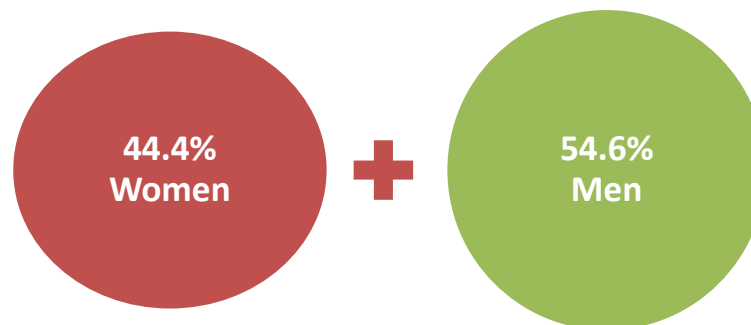
[3] See Appendix 6 for a detailed description of the PCR Sample.
[4] Numbers in tables and graphs may vary due to missing data.
[5] The gender information on one PCR was missing.

Figure 2. PCR by Primary Disability (N=380)
June 2015 – June 2016

Intellectual Disability   87.9%

Autism 5.8%

Down Syndrome 2.4%

Cerebral Palsy 1.6%

Other 2.4%
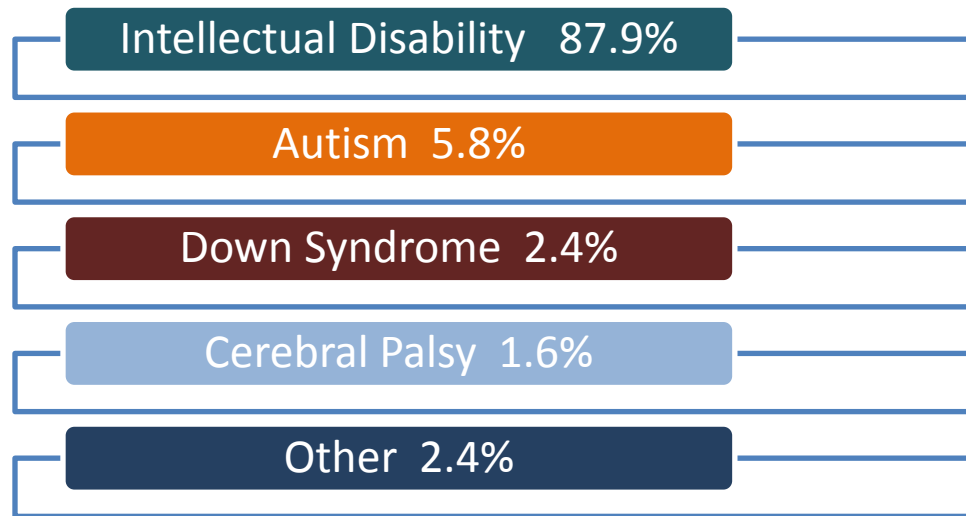
Figure 3. PCR by Age Group
June 2015 - June 2016

3.9%	25.5%	23.7%	18.9%	14.5%	13.4%
< 18 (15)	18-30 (97)	31-40 (90)	41-50 (72)	50-60 (55)	61 + (51)
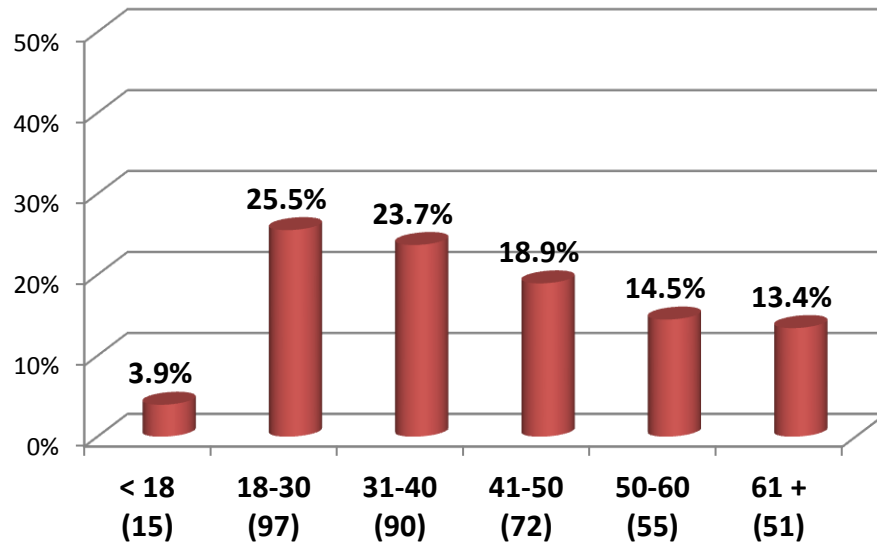
Figure 4. PCR by Residential Type
June 2015 - June 2016

- Family Home (132)
- Group Home (162)
- Intermediate Care Facility (18)
- Nursing Home (18)
- Own Home/Supported Living (7)
- Sponsored Residential (38)
- Supported Residential (4)
- Training Center (1)
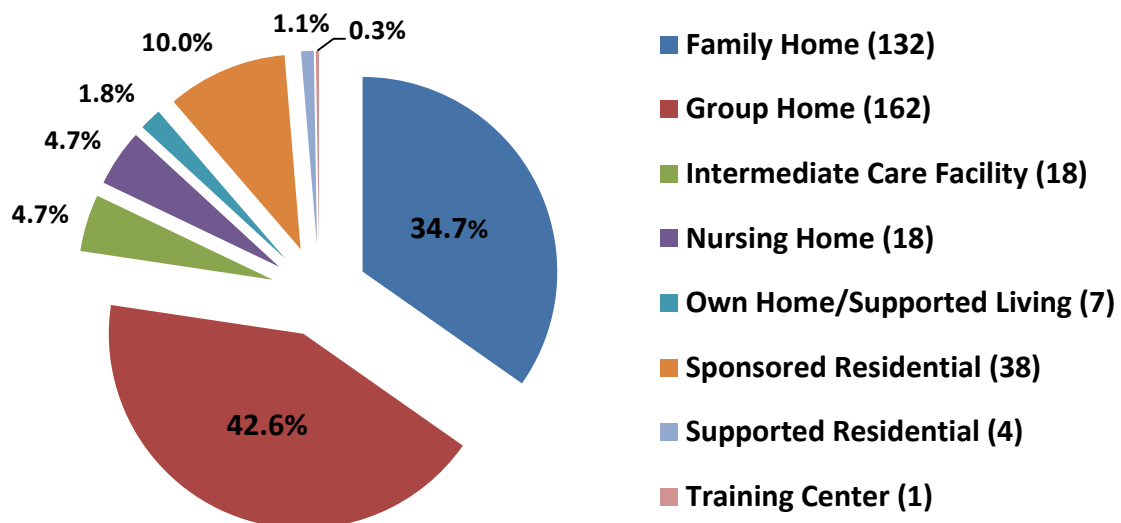
Close to 44 percent of individuals had a legal guardian and 38.4 percent were Legally Competent (Figure 5). Individuals often use multiple types of communication. Figure 6 shows the most commonly used communication styles for individuals. All types that applied to the person could be selected, with Body Language most often chosen (77.1%)[6].

Figure 5. PCR by Legal Status
June 2015 - June 2016

Legal Status (N=365)

- Legal Guardian 43.6%
- Legally Competent 38.4%
- Authorized Representative 18.1%
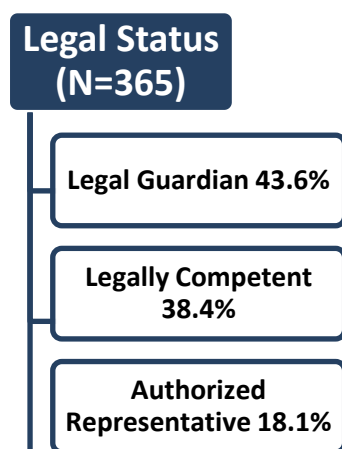
Figure 6. PCR by Communication Style[7]
June 2015 – June 2016

Communication (Select all that Apply) (N=380)

- Spoken Language 49.2%
- Body Language 77.1%
- Gestures 25.8%

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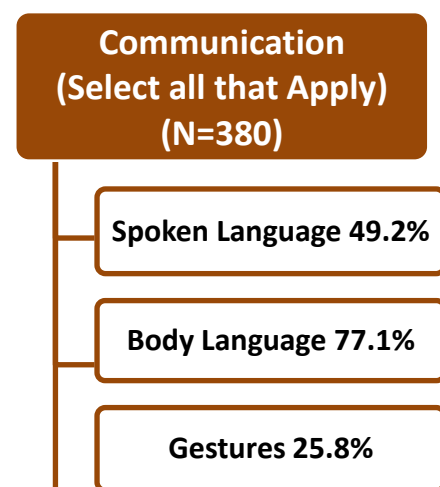
[6] Posture or changes in facial tones are interpreted as body language. Pointing, or tugging at objects are considered gestures.

[7] Small categories not listed in the graph: Communication Aid or Devise (N=6), Sigh Language (N=13), Written (N=6) and Other Method (N=1) which is freeform text.

The distribution of PCRs across regions is shown in Figure 7. Region 5 had the highest number of PCRs completed[8].

Figure 7. PCR by Region
June 2015 – June 2016

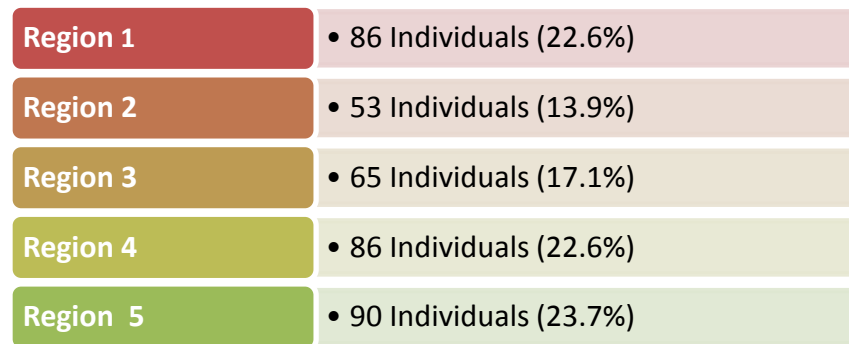| Region 1	• 86 Individuals (22.6%)
Region 2	• 53 Individuals (13.9%)
Region 3	• 65 Individuals (17.1%)
Region 4	• 86 Individuals (22.6%)
Region 5	• 90 Individuals (23.7%)

Individuals must receive one or more specific service to be eligible for a QSR process. As shown in Figure 8, most individuals receive Residential Support services and/or Day Support services. In addition to services shown in Figure 8, one individual was receiving Crisis Support and one was receiving Training Center Support.

Figure 8. PCR by Service
June 2015 – June 2016

Personal Care (Agency Directed) 7 Individuals	Personal Assistance, Respite & Companion 21 Individuals	Skilled Nursing 22 Individuals
In-Home Residential Support 11 Individuals	Supported Employment 19 Individuals	Consumer-Directed (CD) Services 62 Individuals
Intermediate Care Facility 17 individuals	Residential Support 213 Individuals	Day Support & Prevocational 203 Individuals

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[8] This is consistent with the sampling method described in Appendix 6.

PCR Results by Tool

The PCR uses several different tools, composed of a number of indicators, to fully assess the person's service system and quality of life (See Review Process section above). Interviews are used to capture information directly from individuals, providers, support coordinators and family members or guardians. On average,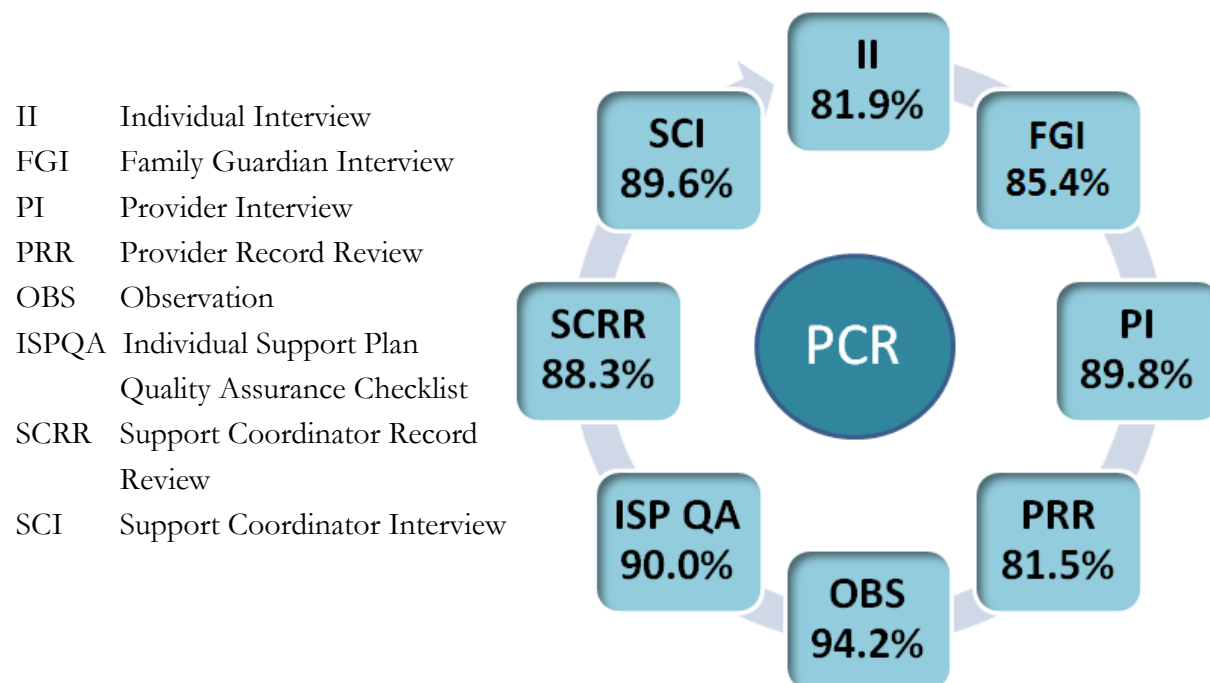 information from interviews with support coordinators (89.6%), providers (89.8%) and family/guardians (85.4%) appears to be more positive than information obtained directly from individuals (81.9%) or from data collected through the record review processes (Figure 9). Documentation results from the PRR showed the lowest compliance scores (81.5%). Findings from the Observations with individuals indicated over 94 percent of standards were met, the highest scoring area.

Figure 9. PCR Results by Tool
June 2015 – June 2016

II   Individual Interview
FGI   Family Guardian Interview
PI   Provider Interview
PRR   Provider Record Review
OBS   Observation
ISPQA Individual Support Plan
         Quality Assurance Checklist
SCRR   Support Coordinator Record
         Review
SCI   Support Coordinator Interview

PCR Key Performance Areas

Key Performance Areas (KPAs) are areas defined as critical to quality, which include:
1. Individuals' needs are met, including health and safety (Needs are Met)
2. Person centered thinking is applied and individuals are given choices and are supported in self-direction and in managing individual health and safety (Person Centered)
3. Services and supports are provided in the most integrated setting appropriate to individuals' needs and consistent with their informed choice (Integrated Setting)
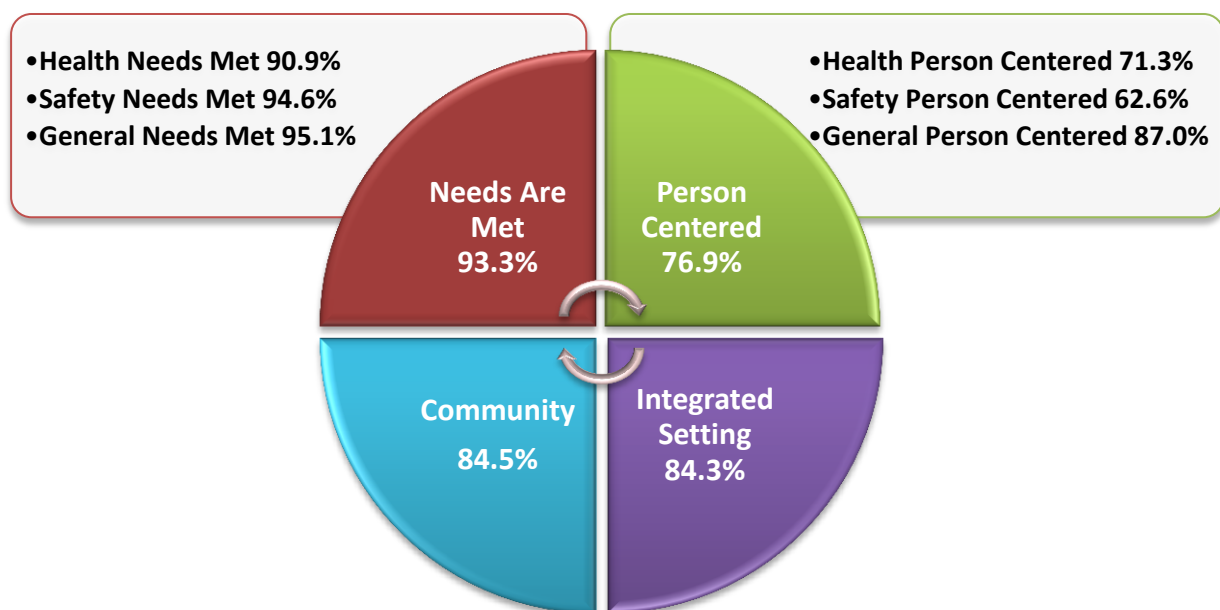
4. Individuals are provided opportunities for community engagement and inclusion in all aspects of their lives (Community).

Applicable indicators, the Primary Indicators, were selected from each of the eight data collection tools and grouped into each of the respective performance areas and categories to help address strengths and improvement opportunities. Unless otherwise stated, all percentages displayed are based upon the percentage of positive, i.e., Yes responses.

The overall scores in each Key Performance Area from the PCR, the aggregate of all indicators within the area, are shown in Figure 10. While needs in general appear to have been met for individuals (93.3%), a Person Centered approach was not always employed (76.9%), individuals were often not receiving services in the most integrated setting appropriate to the person (84.3%) or participating in the community as desired (84.5%)

Because Health and Safety are crucial components of the Person Centered and Needs Met KPAs, results for Health and Safety are shown specifically, separately from the general Needs Met and Person Centered KPAs. Results indicate Health and Safety needs are generally met, but a Person Centered approach is often not used in meeting those needs, particularly for issues surrounding safety.

Figure 10. PCR Results by Key Performance Areas
June 2015 – June 2016

- **Health Needs Met 90.9%**
- **Safety Needs Met 94.6%**
- **General Needs Met 95.1%**

- **Health Person Centered 71.3%**
- **Safety Person Centered 62.6%**
- **General Person Centered 87.0%**

Needs Are Met 93.3%

Person Centered 76.9%

Community 84.5%

Integrated Setting 84.3%

Detailed Results by Key Performance Areas

In this section a detailed description of the results for each Key Performance Area is provided. Each Area consists of two to eight general themes. A table listing a summary of the average result for each theme within the Key Performance Areas is presented in Appendix 1. Results by theme within each area are presented in Appendix 2 through Appendix 5. Each table contains the following:

- Description of the specific indicators used to measure the area
- Number (Indicator #) to identify where the indicator is located (in which tool)
- The number of times the indicator was scored (Total)
- The Percent Met for each indicator and theme.

Needs are Met
Whether person's basic needs are met; barriers to meeting person's needs are addressed; whether person is supported to be in best health; whether person is safe, and free from abuse, neglect, exploitation, seclusion or restraint.

Needs Are Met is a Key Performance Area that address the needs of individuals from several different perspectives: are they **getting needed services**, are they **satisfied** with them and are providers **responsive** to their needs; are supports and services properly **implemented** and are individuals prepared for **crisis and emergency** situations? Health needs are addressed including: **untreated pain**; **education**; visits to **physicians and specialists**; and **preventative care**. Safety needs addressed include: issues surrounding **abuse, neglect and exploitation**; **environmental** needs; **restrictions** and **medications**; **risk** and **emergency backup** systems.

Results indicate most individuals received needed services and were satisfied with supports and services, 93.1 percent and 96.0 percent respectively. Staff and support coordinators followed up on expressed needs and ensured those needs were addressed (above 90%). However, not all individuals were able to access needed crisis services (73.2% successfully accessed). Most individuals were able to contact or talk to the support coordinator when needed (85.2%; Appendix 2, Table 1). On average services were implemented according to the person's ISP (94.7%; Appendix 2, Table 2), the system appears to be addressing risk (98.1%; Appendix 2, Table 3), and individuals were afforded privacy (96.3%; Appendix 2, Table 4).

Results show efforts have been made to keep individuals healthy and without untreated pain or concerns (Appendix 2, Table 5). Findings from observations, interviews and record reviews with providers and support coordinators were all positive indicating individuals have little untreated pain

(96.2 %) and ISP QA results indicated health-related education is provided (93.6%). Most individuals had not been hospitalized, had not been to an emergency room, or fallen the 12 months prior to the interview (85.3%). It is important to note, however, that approximately 16 percent of individuals mentioned untreated pain or health concerns did exist and close to 18 percent of individuals had experienced three or more falls.

Almost all individuals were supported to see a primary care physician or specialist, 94.8 percent and 95.6 percent respectively, but a smaller percent was supported to see a dentist (78.0%) (Appendix 2, Table 6). While support coordinators and providers generally help ensure individuals receive routine preventative screenings (over 90% met), the care is not always personalized based on age or gender (approximately 83%) (Appendix 2, Table 7).

Individuals appear to feel safe at home, school and in the community and are free from harm including abuse, neglect and exploitation (98.5%). Environmental needs, including adaptive equipment, were generally met (95.8%) (Appendix 2, Table 8).

In general, restrictions appeared to be used appropriately by providers. Most providers were using appropriate behavioral interventions (99.4%) and in many ISPs safety restrictions were described (88.6%); reasons were explained (88.9%); and informed consent was present (87.7%) (Appendix 2, Table 9). However, this also means approximately 11 percent of ISPs did not include these important safety-related measures and in addition, there was a lack of documentation in provider (64.2%) and support coordinator (58.2%) records regarding informed consent for psychotropic medication (Appendix 2, Table 10).

Providers and support coordinators are doing well keeping emergency back-up plans (94.4%) and addressing safety risks (97.7%) (Appendix 2, Table 11).

Person Centered
Whether person-centered thinking and planning are applied (including building on the individuals' strengths, preferences, and goals); whether choice is visible throughout person's life; whether person is driving and managing supports and services, and participates in all aspects of service delivery, including managing their own healthcare and safety

The Person Centered Key Performance Area encompasses most all components of the VQMS. Primary Indicators are organized in Appendix 3 Table 1 – 8, and measure: the degree to which individuals **participate in the ISP** and **achieve goals**; how well providers **know the person**, including **communication** preference; if individuals are offered informed **choice** and if they direct

their **daily routines**. In addition, this area measures how much individuals are directing their own health care and safety, including: being provided a **choice of physicians**, **Getting the Life I Want** (ISP) and having **education** to help them understand their own health and the health care system. Are **safety issues addressed in the ISP**, is **safety education** provided and do individuals know what to do in **emergency** situations? Finally, safety regarding **abuse, neglect and exploitation** is addressed.

Individuals were supported well to participate in planning services and supports, including goals and achieving those goals. Most individuals were active participants in and were included in the planning and development of their ISPs (91.9%), but they were not always noted as the directors of this process in "My Meeting" of the ISP (78.7%). Most individuals were also supported to identify and achieve their desired outcomes and goals (95.5%) (Appendix 3, Table 1).

Providers and support coordinators appeared to know the person, offering supports and services that are individualized based on the person's strengths, interests, preferences and abilities (95.9%, with all 6 indicators above 90%). They were also doing very well in soliciting and respecting the person's preferred communication methods (99.2%) (Appendix 3, Table 2).

Data indicated choice is offered to individuals in some areas but not others. Most individuals interviewed reported they were offered a choice of services and supports (95.7%), observations and interviews indicated staff and support coordinators almost always support the person's choices, 99.3 percent and 95.7 percent respectively. Many individuals reported they make informed choices about where to work (83.5%) or their community activities (86.6%). However, almost half of individuals indicated not choosing with whom to live (51.7%) (Appendix 3, Table 3).

Interview data indicated support coordinators generally ensure choice for individuals is offered in terms of where to work (93.9%) and community activities (88.0%), but they were not as likely to ensure individuals had a choice of roommates (75%). Provider interviews showed the same pattern with only 58.5 percent showing support for choice of a roommate for the person. On average, support coordinators and providers have not documented informed choice, particularly for housemates and roommates, indicators scoring approximately 32 percent to 50 percent. In addition, although most providers and support coordinators appear to understand what informed choice is, the person is not always educated about the meaning of informed choice and self-determination. Four indicators about education range from 67.8 percent to 84.4 percent (Appendix 3, Table 3).

Providers and support coordinators indicated they are supporting individuals to direct their daily routines, with indicators from both interviews showing more than 90 percent met in this area. However, from the individual's perspective this was not always happening (75.1%) (Appendix 3, Table 4).

Support coordinators (86.6%) and providers (82.9%) reported they provide advocacy resource to support individuals in learning about rights and self-advocacy. Many individuals (79.1%) also indicated they are provided with these advocacy resources, but only 42.2 percent felt they actually had a self-advocacy connection (Appendix 3, Table 5).

Indicators to help determine if individuals are self-directing their health care are shown in Appendix 3, Tables 6. Data show most ISPs addressed how to support the person to receive the overall health and wellness they desire (Getting the Life I Want 92.3%), but providers and support coordinators were not always ensuring individuals are given the opportunity to choose their own medical providers (74.5%). Most individuals (85.3%) reported they are provided with education to learn about health and 89.1 percent of ISPs documented discussion about medication use. However, interviews and record reviews with providers and support coordinators indicated they do not always ensure the provision of individualized education about the persons' health, preventive health care or information about medications. Nine indicators measuring these areas showed scores of between 41.7 percent and 72.8 percent, an average of 71.3 percent.

Indicators to help determine if individuals are self-directing safety are shown in Appendix 3, Tables 7. According to documentation in the ISP, individuals' preferences typically are supported in choosing providers or natural supports to help keep them safe (87.2% and 95.8%). Data from interviews and record reviews indicate individuals, providers and support coordinators vary widely in education about different types of safety concerns, including fire or weather related emergencies, with an average score of 81.5 percent. Approximately 25 percent of individuals did not know what to do in case of a fire and 39 percent did not know what to do in a weather related emergency.

Indicator results about safety concerns surrounding abuse, neglect and exploitation (ANE) varied from 5.6 percent to 97.1 percent (Appendix 3, Table 8). While most Family or Guardians (97.1%) indicated the person knows what to do in case of ANE, 29 percent of individuals interviewed did not know what to do if faced with ANE. In addition, providers (78.1%) and support coordinators (74.0%) often do not ensure the person knows what to do in these circumstances. In general, through interviews and documentation review with providers and support coordinators, it appears education about different types of ANE is generally not provided to individuals: 10 indicators ranged from 5.6 percent to 53.6 percent. Improvement on providing education about ANE would help raise the overall score in the Person Centered KPA.

Integrated Setting
Person is offered options or support to explore more integrated living, work, and educational settings; goals and outcomes related to integration are actively pursued; Barriers are identified and addressed.

Integrated Setting has three different focuses as presented in Tables 1 - 3 in Appendix 4: **Integration Efforts** in the ISP, **Skill Development**, and ensuring **Preferences and Goals are Actively Pursued**. The Key Performance Area addresses resources for and goals of integration and if the person is supported to **achieve a more integrated life**, **preferences and goals for employment, independent living, integrated living/working**, and **education**, and if **barriers** to these are being addressed.

Data indicated most ISPs address efforts for integrated living and employment, as well as goals for integrated day activities, each about 90 percent. However, ISPs often do not have specific employment goals developed and discussed (20.5% not met), or measureable outcomes (32.7% not met) to increase integration. Providers and support coordinators appear to be helping most individuals build skills that help with increased integration in their lives (92.2%).

Based upon documentation and interviews, most providers and support coordinators are supporting individuals in pursuing their employment goals and outcomes (88% to 92%). However, from the individual's perspective only 72.1 percent reported goals of employment are being actively pursued. Close to 86 percent of individuals report the goals for independent living are being actively pursued. Most individuals are offered day support opportunities if employment goals are not developed, but these opportunities do not always include regular integrated activities (only 80.2% included). In addition, not all ISPs included a plan of self-sufficiency (81.8% included).

Individuals were less likely to indicate integrated work (74.4%) and living (70.8%) settings were explored than reflected in results from interviews and record reviews with support coordinators and providers. Similarly, only 58.2 percent of individuals reported barriers to integrated educational opportunities are assessed, but almost providers and support coordinators stated in interviews barriers have been assessed (95.2%-100%) (Appendix 4, Tables 1, 2 and 3).

Community
Person is actively engaged and connected in the community; meeting people and developing meaningful relationships with non-paid individuals; developing social roles identified by the person that reflect personal interests.

The Community Performance Area has two different focuses as shown in Tables 1 and 2 of Appendix 5: **Community Activities and Relationships**, and **Community Engagement**. The first measures the degree to which choices are offered and preferences are upheld for community activity, how much providers support the person to build community relationships, and how the ISP is written to help the person get the community life desired. Community Engagement is about ensuring the person is offered opportunities for community involvement, that active community participation is supported and social roles are being developed.

Results indicate providers and support coordinators are supporting individuals' choices and preferences to participate in community activities (92.2%), for most individuals ISPs address what is working and not working for getting the life the person wants in the community, and what's important to and for the person (91.1%). Individuals are not as likely to be building meaningful relationships (88.8%). However, most individuals were supported to establish a circle of support beyond paid supports and provided with opportunities to develop new friendships and relationships, more than 90 percent each.

Community Engagement scores were generally lower, with an average score of 78.3 percent. The Active Participation section shows the highest performance in this area, 85.5 percent. However, most of the active community participation appeared to have been limited to leisure and not participation in civic or volunteer groups, or attending the preferred church or synagogue. Only 56.2 percent of individuals are a member of community groups, such as a church, the YMCA, a neighborhood association or community clubs.

The Opportunities for Involvement in community activities were often not offered, on average 74.4 percent. However, 82.5 percent of individuals (Individual Interview) indicated having the opportunity to be involved in and contribute to the community. Individuals were least likely to be supported to develop social roles, 71.1 percent on average. Both support coordinators and providers were supporting people to develop social roles, 87.7 percent and 77.0 percent respectively. However, support coordinators were not doing as well advocating for the person (67.2%) and providers were often not providing education about social roles (56.0%).

Provider Quality Review

Introduction and Demographics

The PQR is used to monitor a provider's full array of services offered to individuals as part of the QSR. Between June 2015 and June 2016, Delmarva completed 49 PQRs. Among them, six were Community Service Boards and two were Training Centers. Almost 50 percent of the providers who participated in a PQR served less than 30 people, 29 percent of providers served 31-100 people, and the remaining 20 percent served more than 100 people.

The PQR sample was drawn randomly from the providers who were serving any of the 400 individuals who were selected for the PCR. Providers who declined involvement or who were non-responsive to requests for participation were replaced by the next provider in the oversample. Providers were distributed across regions as follows:
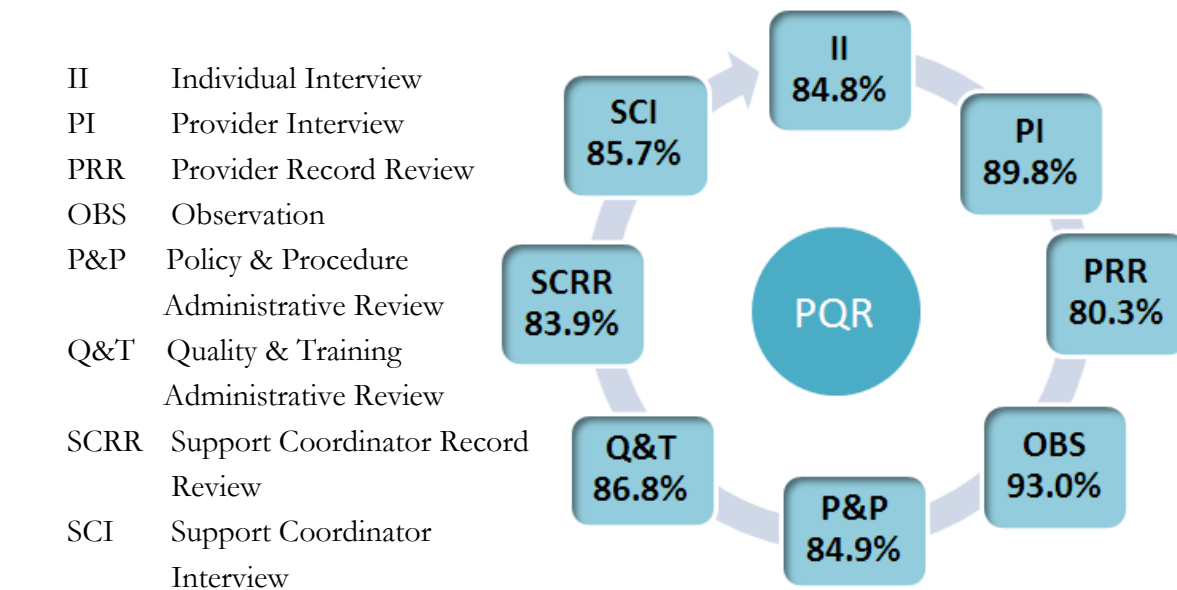
PQR: Number of Providers by Region	
	Region 1 -- **6**
	Region 2 -- **7**
	Region 3 -- **7**
	Region 4 -- **16**
	Region 5 -- **13**

PQR Results by Tools

The PQR utilizes most of the same tools as the PCR, including the Individual Interview (II), Provider Interview (PI), Provider Record Review (PRR), Observation (OBS), Support Coordinator Interview (SCI) and Support Coordinator Record Review, if the provider offers Support Coordination (SCRR). However, the focus of the individual interviews is on the specific services a person received from the provider rather than the total service system surrounding the person, as in the PCR. The PQR review also includes an administrative review to assess the organization's compliance with Qualifications and Training (Q&T) and Policies and Procedures (P&P).

The average PQR results by tool are displayed in Figure 11. Results indicate on average each component of the PQR showed between 80 percent and 90 percent compliance, with one exception. Observations showed a score of 93 percent. The pattern is similar to PCR results, where results from interviews (with providers and support coordinators) are higher somewhat than for record reviews.

Figure 11. PQR Results by Tool
June 2015 – June 2016

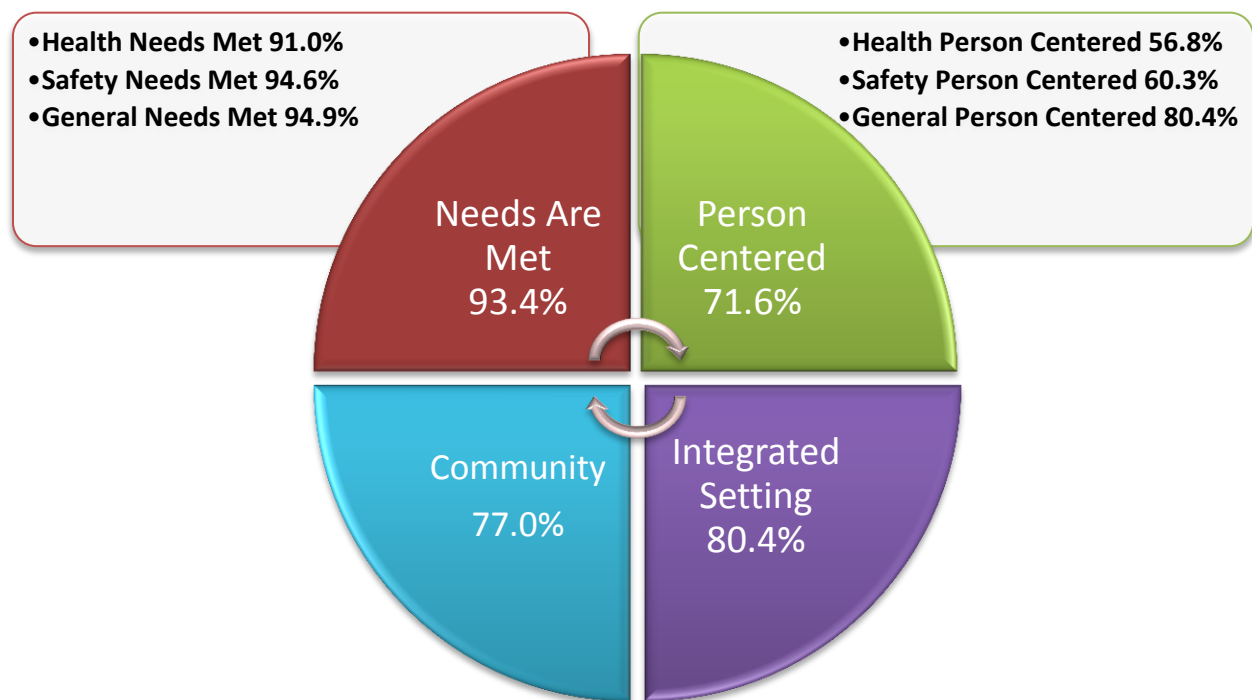|		
II	Individual Interview	
PI	Provider Interview	
PRR	Provider Record Review	
OBS	Observation	
P&P	Policy & Procedure Administrative Review	
Q&T	Quality & Training Administrative Review	
SCRR	Support Coordinator Record Review	
SCI	Support Coordinator Interview	

PQR Key Performance Areas

As described in the PCR section, information obtained from the various data collection tools is aggregated to address the Key Performance Areas. Applicable Primary Indicators were selected from each of the different tools and grouped into each of the respective performance areas. The scores in each Key Performance Area from the PQR are shown in Figure 12 and graphic results showing the number of providers by percent met in each area are shown in Figure 13.

While performance under the Needs are Met area appears to be high on average (93.4%), the use of a Person Centered approach in meeting needs was not always employed (71.6%). This is especially true for health and safety. Though people's basic needs in health and safety are met, they are not supported and educated to direct their own health and safety (56.8% and 60.3% respectively). Results regarding Integrated Settings and Community are also somewhat lower than for meeting needs.

Figure 12. PQR Results by Key Performance Areas
June 2015 – June 2016

•**Health Needs Met 91.0%**
•**Safety Needs Met 94.6%**
•**General Needs Met 94.9%**

•**Health Person Centered 56.8%**
•**Safety Person Centered 60.3%**
•**General Person Centered 80.4%**

Needs Are Met 93.4%

Person Centered 71.6%

Community 77.0%

Integrated Setting 80.4%

The distribution of provider scores within each of the Key Performance Areas, with the average score for each area provided (Figure 13), indicates the following:

- 37 of the 49 (75.5%) providers scored at or above 90 percent for **Needs Are Met**. Only two providers scored below 80 percent

- Provider results for the Key Performance Area of **Person Centered** show a fairly normal distribution with a majority of providers (32; 65.3%) having scored between 71 percent and 89 percent
- Many providers (16: 32.7%) scored above 90 percent in promoting more **Integrated Settings.** However, there are also a number of providers who scored below 70 percent (10; 20.0%)
- 12 providers (24.5%) scored above 90 percent for **Community** and 12 scored below 80 percent

Figure 13. PQR Results by Key Performance Areas
Histogram of Provider Scores
**June 2015 – June 2016**
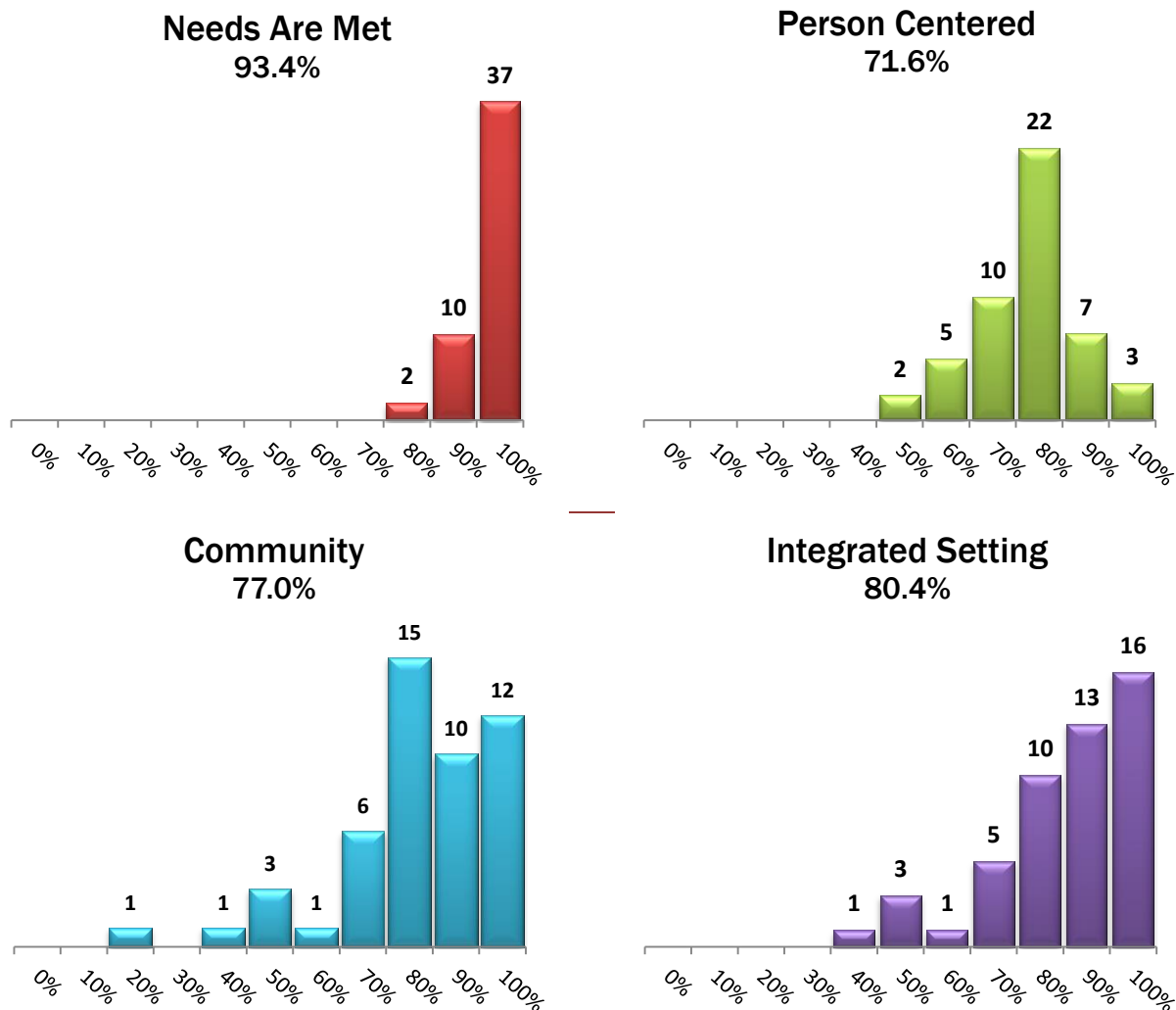
One of the primary indicators for the Integrated Setting Key Performance Area is to ensure that for individuals who live in a Training Center, the person's desire to transition out of the center is solicited and addressed. During the two PQRs conducted at a Training Center, 27 individuals who were living in the centers were interviewed:

- 22 individuals answered the question whether their desire to transition to the community was solicited; 18 (81.8%) said it was solicited
- 15 individuals answered the question whether their desire to transition to the community was addressed; 11 (73.3%) said it was addressed

Other Findings

The Qualifications and Training (Q&T) and Policy and Procedure (P&P) Administrative Reviews are two unique components of the PQR process. Each provider receives one P&P review of the organization's current policies and compliance with regulations. A sample of staff/employee records is selected for the Q&T review. The sample size is based upon the size of the provider organization. Ten Background Check and General Training standards are reviewed, as well as some service specific requirements.

Qualifications and Training	Policies and Procedures
• 86.8%	• 84.9%
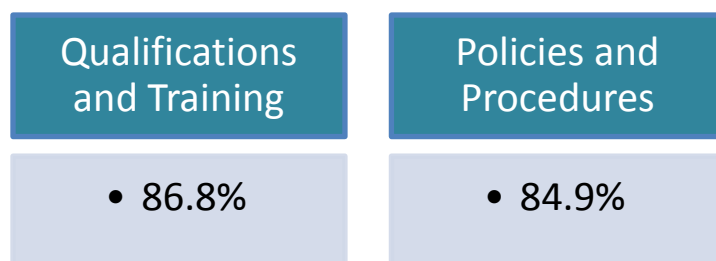
Findings from the Q&T review were generally positive, with an average score of 86.8 percent. Records indicated staff was least likely to have required orientation training (within 15 business days before starting) on the principle of Person Centeredness (64.4%).

Findings from the P&P review were slightly lower, with an average score of 84.9 percent. The lowest scores are in the areas of:

- Maintaining a risk management plan that includes steps to identify and address risk in the coming year (53.1%)
- Provider updates the risk management plans at least annually (49.0%)
- Provider has policy/procedure for conducting root cause analysis for all serious incidents that resulted in or had the potential to result in permanent impairment to an individual (59.2%)

During the PQR, Delmarva QARs work interactively with providers to collect feedback from and ensure the best overall assessment of the organization's systems. Throughout this process the provider's strengths are identified and barriers to service delivery are discussed. The most often identified strengths included the following:

- Staff is knowledgeable of the triggers that result in crises situations and able to describe how to manage those to achieve positive outcomes for individuals served
- Staff is knowledgeable of individuals health needs
- Individuals do not report any changes in supports and services related to provider convenience
- Individuals feel safe in their homes, day programs, communities and jobs
- Staff is required to demonstrate job proficiency through competency based training

Barriers identified by providers are collected in a narrative format. The most often mentioned barriers include:

- Staff turnover; difficulty in finding and maintaining qualified staff
- Limited employment opportunities for individuals with IDD
- Lack of behavior support resources and providers
- Difficulties in accessing mental health or crisis services
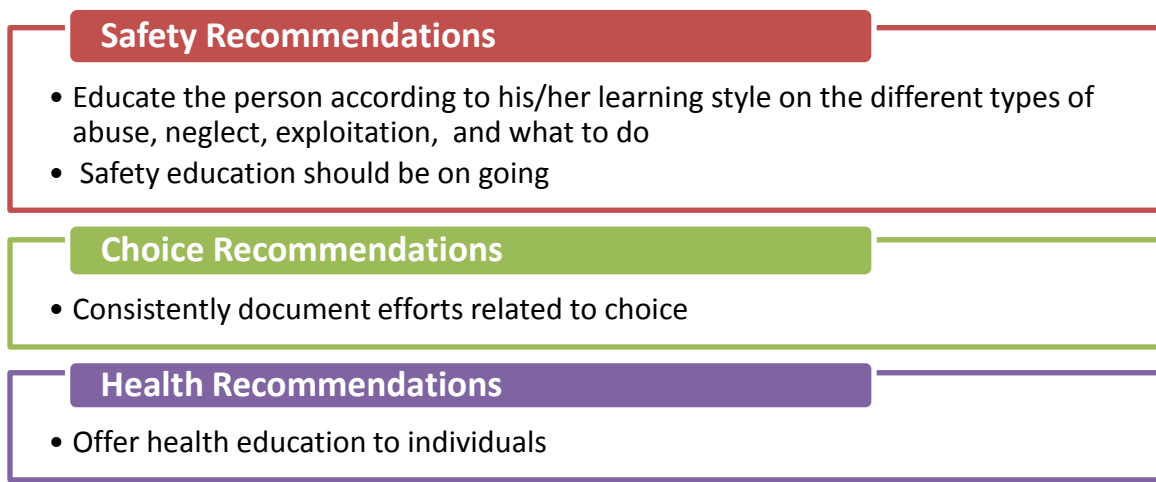- Lack of resources and choices in rural areas

Alerts

An alert is defined as any situation or behavior causing individuals to be at imminent or potential risk for harm. If at any time during the review process, the Quality Assurance Reviewer (QAR) determines a person's health and/or safety are placed in jeopardy and immediate corrective interventions are needed, the QAR takes appropriate action that may include calling the abuse hotline and staying with the person until the proper authority arrives. Additionally, if abuse, neglect and exploitation are uncovered or suspected an alert will be activated in conjunction with notification to appropriate authorities.

Between June 2015 and June 2016, 15 alerts were identified during a PQR involving providers and five individuals participating in a PCR. Thirteen of the 15 alerts were rights violations and two concerned safety. All alerts have been submitted to DBHDS using alert forms, and regional advocates were notified. In addition, Adult Protection Service was notified for one alert.

Recommendations from PCRs and PQRs

Recommendations based on the QAR findings were offered to providers during the PCR and PQR. Multiple recommendations could be provided regarding the same domain. A large proportion of recommendations focused on Safety and Choice. Figure 14 shows the specific recommendations most frequently cited: three of the four emphasize education for individuals.

Figure 14. Most Frequently Cited Recommendations in PCR and PQR
June 2015 – June 2016

Safety Recommendations

• Educate the person according to his/her learning style on the different types of abuse, neglect, exploitation, and what to do
• Safety education should be on going

Choice Recommendations

• Consistently document efforts related to choice

Health Recommendations

• Offer health education to individuals

Section 2: Discussion and Recommendations

The intent of the Annual Report is to provide the Virginia Department of Behavioral Health and Developmental Services (DBHDS) with a summary of Delmarva's Quality Service Review (QSR) results for the first year (June 2015 – June 2016). As part of improving its overall quality management system infrastructure, data from QSRs are used to help DBHDS:

- Review the care of individuals who are being served in communities and have transitioned from an institution as part of the Department of Justice (DOJ) Settlement Agreement with the state.
- Use a consistent set of process and outcome indicators to evaluate the quality of services provided to individuals with intellectual and developmental disabilities.
- Assess the extent to which these services are provided in the most integrated settings appropriate to individuals' needs and choice.
- Monitor provider fulfillment of state and federal regulatory requirements.
- Use the data to inform decisions for policy and procedure modifications and continuous quality improvement.

Throughout the first year of the contract, Delmarva has consulted with DBHDS staff on an ongoing basis to refine the data collection tools and clearly define what overarching questions the data should address. Based upon that input, there are four Key Performance Areas addressed in the report:

1. Individuals' needs are met, including health and safety (Needs are Met).
2. Person centered thinking is applied and individuals are given choices and are supported in self-direction, including managing individual health and safety (Person Centered).
3. Services and supports are provided in the most integrated setting appropriate to individuals' needs and consistent with their informed choice (Integrated Settings).
4. Individuals are provided opportunities for community integration in all aspects of their lives (Community).

General Conclusions

The following key positive findings are based upon data analyzed through the first year of the contract.

Overall PCR & PQR results were positive	**Onsite observations were above 90 percent**
	Provider and support coordinator interviews were between 85 percent and 90 percent
	Provider and support coordinator record reviews showed average scores at or above 80 percent
	Qualification & Training Reviews and Policy & Procedure Reviews scores were 85 and 87 percent

Findings also show some consistent themes emerging from the four Key Performance Areas.

- Interview, record review, and observation data indicate individuals with ID/DD are actively involved in planning their futures. This includes creating an Individual Support Plan (ISP) that is strengths based and individualized to reflect a person's needs and desires.
- Support coordinators and providers generally offer choice of services, and support individuals in achieving their dreams and goals. However, a choice of roommates and housemates is much less likely to occur.
- On average, information from interviews with support coordinators, providers, and family/guardians is more positive than information obtained directly from individuals or from data collected through the record review processes. Of significance, is the difference in perceptions between service providers and individuals on the degree to which an individual has control over directing how the ISP is translated into action.
- Data support the need for more training for individuals, their families, support coordinators, and providers as to what person-centered planning, self-direction and self-determination mean and how these principles are applied so that individuals will have greater involvement in decisions affecting their lives. For example, record reviews indicated staff did not always have required orientation training on the principle of person centeredness within 15 business days of starting employment. Individuals report the need for greater education and involvement in decisions affecting their lives, i.e., in exercising their rights and more opportunities to access advocacy organizations for support.
- Results indicate Health and Safety needs are generally met, but a Person Centered approach is often not used in meeting those needs, particularly for issues surrounding safety. For example, the data indicate individuals are free from abuse, neglect, and exploitation; however, individuals were not consistently provided with education on what to do if the person experiences various risks. Data from interviews and record reviews indicate individuals, providers and support

coordinators vary widely in providing education about different types of safety concerns, including fire or weather related emergencies, with an average score of 81.5 percent. Approximately 25 percent of individuals did not know what to do in case of a fire and 39 percent did not know what to do in a weather related emergency.

- Individuals' preferences and goals are actively pursued around independent living and community activities and relationships, yet not as much with respect to integrated living and employment, or community engagement

Strengths and Opportunities within the Four Key Performance Areas

More detailed conclusions may be drawn from the summary of strengths and improvement opportunity areas in each of the four Key Performance Areas outlined below.

Needs are Met
Whether person's basic needs are met; barriers to meeting person's needs are addressed; whether person is supported to be in best health; whether person is safe, and free from abuse, neglect, exploitation, seclusion or restraint.

Strengths
- Most individuals receive needed services that are planned for them and generally are satisfied with their supports and services
- Providers and support coordinators appear to be ensuring people access their primary care provider and specialists for needed healthcare. Of the 36 primary indicators reviewed to assess whether health needs of the individual are met, 26 scored above 90 percent. This includes high indicator ratings for support coordinator and provider roles in observing the person for evidence of changes in functional, behavioral and mental status to determine potential safety risks.
- In general, people's safety needs are being met. People are free from abuse, neglect, exploitation and unnecessary restraint. Plans are in place so that in the event of the absence of a scheduled paid staff or unpaid natural support, a natural disaster, a fire, a medical emergency, or loss of power for those needing powered medical support, processes are in place to reduce these risks and prevent harm.

Opportunities for Improvement
- Data indicate support may be needed to help people access age and gender specific preventative healthcare. Interview and record review data indicate opportunities for improving access to dental care[9].

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[9] There is no Medicaid coverage for dental care after age 19 when FAMIS coverage ends. There is no coverage for adults except pregnant women or medical coverage for extractions.

- While support coordinators and providers report health concerns and/or untreated pain are adequately being addressed, approximately 16 percent of individuals reported having untreated pain or health concerns.
- Not all individuals who needed crisis services were able to access the service.
- The P&P reviews indicate providers need improvement on maintaining and updating their risk management plans, and conducting root cause analysis for all serious incidents
- When applicable, the need for informed consent for psychotropic drugs was not always addressed in the ISP, nor did providers and support coordinators always have a copy or relevant documentation on this consent.

Person Centered

Whether person-centered thinking and planning are applied (including building on the individuals' strengths, preferences, and goals); whether choice is visible throughout person's life; whether person is driving and managing supports and services, and participates in all aspects of service delivery, including managing their own healthcare and safety

Strengths

- Both interviews and documentation reviewed indicated people are supported to use a person-centered planning process in determining how to improve their quality of life. Both individuals and their chosen natural supports are active participants in the planning and development of the ISP. People are supported to identify and reach their desired dreams and outcomes and the supports and services identified are individualized based on their personal strengths, interests, preferences and abilities.
- Individuals are offered choices about the services and supports that best meet their needs. This allows for greater flexibility for individuals to change services and supports when something is not working well for them.
- There is a high level of agreement across all data sources that support coordinators and providers are doing very well in soliciting and respecting the person's preferred communication methods.

Improvement Opportunities

- Providers and support coordinators differ from individuals on their perspective as to whether a person is actually directing the activities documented in their ISP. Providers and support coordinators report they are supporting the person to direct daily routines. However, from the individual's perspective it is not always the case. Data indicate the person is actively participating in planning but often the ISP does not show how the person is directing the process. Individuals do not routinely determine their own living arrangements such as where to live or with whom to live.

- While most providers and support coordinators report understanding what informed choice is, not all persons are consistently offered educational opportunities about informed choice and self-determination.
- While people are provided with advocacy resources to help support learning rights and self-advocacy, many individuals reported not having a self-advocacy connection.
- Support Coordinators and providers reported they were able to define various types of abuse, neglect, exploitation, restraint and seclusion, but were not consistently providing education for individuals in these areas critical to their health and safety, especially what to do if the person experiences any safety risks.
- Provider and support coordinator interview data indicate individuals are not always supported to choose their own healthcare provider which could impact the individual's ability to drive personal health care.
- Individuals are not adequately educated about the potential side effects of the medications they are taking.

Integrated Setting

Person is offered options or support to explore more integrated living, work, and educational settings. Goals and outcomes related to integration are actively pursued. Barriers are identified and addressed.

Strengths

- Support coordinators and providers routinely support individuals to explore integrated living, employment, and day support options. These efforts are typically documented in the ISP.
- Based upon interviews and record reviews, support coordinators and providers also are making efforts to solicit and address the person's preference to transition from a training center to the community. During the two PQRs conducted at a Training Center, of the 22 individuals responding to questions, 81.8 percent indicated their desire to transition to the community was solicited while 73.3 percent said their desire to transition was addressed.

Improvement Opportunities

- As with person centered planning and meeting individual needs, individuals feel differently about how involved support coordinators and providers are in helping people to actively pursue goals for integrated living, and whether barriers to integrated educational opportunities are assessed and addressed. Individuals reported less than 60 percent of the time they were able to explore more integrated educational settings or address barriers to integration, while providers and support coordinators reported they supported individuals in this activity over 90 percent of the time.

<u>Community Inclusion</u>

Person is actively engaged and connected in the community; meeting people and developing meaningful relationships with non- paid individuals; social roles identified by the person reflect personal interests.

<u>Strengths</u>

- Individuals' choices and preferences to participate in community activities are solicited and supported by support coordinators and providers. Community connections seem to occur mostly through leisure activities and faith-based engagements.
- Circles of support include non-paid family and friends.
- Opportunities to develop new and to sustain existing circles of support, relationships, and friendships are provided.

<u>Improvement Opportunities</u>

- Community engagement scores were generally lower than participation in community activities. For example, only 56.2 percent of individuals are a member of a community groups such as a church, the YMCA, a neighborhood association or community clubs. Individuals are not always provided with opportunities for involvement in volunteer or civic groups.
- Individuals often do not feel supported to understand what social roles might be or supported to develop their desired social roles.

Recommendations

Improve Education on Person-Centered Planning and Self-Direction

1. To explore the reasons behind the differences in perceptions that individuals and providers have with respect to individuals' choice being supported, DBHDS might consider offering interdisciplinary collaboratives (with, for example, support coordinators, providers, individuals, families, CSBs, CRCs). This type of forum would allow for consistency in the dissemination of information on person-centered approaches such as choice, self-direction and self-determination, across all relevant groups as well as promote greater dialogue on barriers to improving outcomes in this key performance area.

2. As noted in the 3rd quarter report, DBHDS should consider exploring ways to help providers involve individuals in planning their own health care, to facilitate education and increase effectiveness. One potential method would be to offer incentives to providers to attend Person Centered Training, and ensure health and preventive health education are included in the training curriculum. Another method would be to involve providers in setting up a 'health fair' focused on providing education for individuals to plan their health care.

3. DBHDS may want to explore methods to increase provider awareness on providing education for individuals about prescribed medications and their potential side effects. Opportunities may exist to collaborate with retail pharmacies such as CVS, Walgreens, or Giant Food to generate suggestions. In another state, one of the managed care plans has established a relationship with CVS to address medication adherence for people receiving home-based services.

4. DBHDS should consider utilizing Community Resource Consultants (CRCs) and ID directors to assess the education used by providers and support coordinators to increase individuals' awareness of abuse (verbal, physical, sexual and emotional), neglect, exploitation (ANE) and the use of restraints and seclusion. This group could explore several standards including if: Educational ANE programs are in place for providers; current curricula for these programs are adequate; the methods used to share the information are reaching all individuals served by the provider. Alternatively, a statewide workgroup, including representatives from DBHDS, families and self-advocates, could be convened to help determine what the specific issues may be, and to develop materials and educational methods to improve awareness in this area.

Explore Best Practices in Community Living and Integration

5. Each region has its own resources, community-based organizations, employment options, as well as perceptions about interacting with individuals with a disability in the community. Community connections are based upon more than having individuals' access community clubs, organizations and activities but their ability to meet people and develop meaningful skills and relationships according to their strengths and abilities. An excellent resource for DBHDS to circulate to relevant stakeholders that will help increase community dialogue is by Amado, A.N. (2013). Friends: Connecting people with disabilities and community members. http://rtc.umn.edu/docs/Friends_Connecting_people_with_disabilities_and_community_members.pdf

6. The Research and Training Center on Community Living (RTC/CL) at the University of Minnesota's Institute on Community Integration has an abundant number of resources to address integration and community inclusion. As noted on the RTC/CL website: *"The Research and Training Center on Community Living provides research, evaluation, training, technical assistance and dissemination to support the aspirations of persons with developmental disabilities to live full, productive and integrated lives in their communities." http://rtc.umn.edu/rtc/index.php*

Section 3: Significant Review Activity and Accomplishments

Training/Education

On June 8, 2016, LaDonna Walters (DF Program Manager) and Challis Smith (DBHDS Case Management Coordinator), presented at the Virginia Beach CSB Sub Council meeting. Information was shared regarding the QSR process, and the role of DBHDS and providers in the QSR process. Feedback from participants was solicited.

Quality Assurance/Improvement Activities

Delmarva uses various methods to help ensure provision of effective and efficient QA processes that respond to the needs of the state while maintaining standards for providers that result in continuous improvement to the service delivery system.

Weekly Update Meetings

Delmarva continues to facilitate weekly meetings to bring together representatives of the state and Delmarva. Regular attendees include (Dev Nair – DBHDS, Challis Smith – DBHDS, Jodi Kuhn – DBHDS, Marion Greenfield – DBHDS, Susan Moon – DBHDS, Charmaine Pillay – DF, LaDonna Walters- DF, Anna Quintyne – DF, Yani Su – DF, Theresa Skidmore – DF, Dan Edris – DF. Deb Lochart, Director of Human Rights (DBHDS) has been invited to participate as she is able. Meetings are a forum to discuss QSR procedures, tool revisions if needed, and ongoing direction and clarification from DBHDS, and to brainstorm solutions to the implementation of the QSR process. Anecdotal information collected from the field during reviews, progress reports on various components of the VQMS contract, as well as discussion on any problems or issues that may need to be addressed are routinely discussed. DBHDS often invites subject matter experts, depending on the topic.

Manager Meetings

Manager meetings are conducted weekly with the Delmarva management staff including the director, program manager, team lead, data analyst and IT director. The meetings are used to review all follow up items from weekly meetings with DBHDS. It is also an opportunity to work through implementation and operational needs, and decide on priorities for upcoming weeks. Topics from these meetings often drive the agenda for weekly meetings with DBHDS staff. It has proven necessary to exercise much flexibility in executing reviews and these meetings have been essential in brainstorming potential solutions.

Staff Meetings

Staff meetings are conducted weekly with QARs, the Program Manager, and Team Lead, to enhance communication among all Delmarva staff. They are an informal forum for discussion of best practices and problems or challenges QARs encounter in the field. QARs are updated on the status of the project and provided ongoing training about the review processes, tools, and expectations.

Feedback, suggestions and comments are reviewed to help improve QSR processes, improve current training, and target additional training topics. In addition, reviewers may present on external training they have attended.

Subcontractor Meetings

Delmarva management meets biweekly with Partnership for People with Disabilities staff to provide subcontractor oversight, review processes and gather feedback. Additional training and feedback is provided as need arises. PPD feedback on interview processes is shared with DBHDS during weekly meetings.

Inter-rater Reliability (IRR)

Additional IRR testing was completed in June with one fulltime reviewer, and five part-time reviewers were tested in April and May. All reviewers have passed the inter-rater reliability requirements. Details on the IRR procedure can be found in Appendix 8.

International Organization for Standardization (ISO)

Delmarva conducts periodic internal training and audits to ensure all contract implementation processes and core procedures are compliant with the ISO 9001:2008 standards and Delmarva's Quality Management System policies. No new activity was conducted in the 4th quarter. The internal ISO contract implementation audit was already completed in November with Delmarva's Corporate Quality Officer. The audit report has not been issued but preliminary findings show all standards met.

Data Validation and Error Checks

When analyzing the data for regular QSR or Ad Hoc reports, two analysts work independently to ensure calculated results are accurate. A process has been established to routinely check for data entry errors and missing data elements. These errors are logged and corrected in the database. If the correction is made after the PCR or PQR report has been distributed, and the correction changes information in the report, a new report is generated and sent to all relevant parties.

Workgroup Activity

Key Performance Indicators (KPI)

A workgroup was formed by DBHDS and Delmarva to develop KPIs, facilitated by the Delmarva Lead Analyst. After initial discussions, six groups of KPIs were proposed, categorized by outcome areas:

1) Person Centered Planning and Thinking
2) Choice and Self Determination
3) Community Inclusion
4) Quality and Satisfaction

5) Access to Service and Capacity
6) Health, Safety, and Freedom from Harm.

Each category consists of a various number of indicators designed to represent three different areas: the individual, provider performance, and system performance. The Delmarva team has identified a list of data points collected in the PCR and PQR process that can be used to measure the KPIs, and is currently conducting final internal reviews. The DBHDS team is defining expectations to measure system performance.

Updates to Tools or Processes

Discussions have been ongoing about potential tool revisions based on feedback from DBHDS and other stakeholders, and the waiver changes.

The secure web-based application and database developed by Delmarva has been utilized for data entry, data storage, and report generation. In addition, reviewers are able to coordinate numerous scheduling components for the reviews. A webinar was used to train all reviewers including Partnership staff on the application and the data entry processes.

Secure Portal

A password secured portal has been fully developed to share information between different entities for the contract. Users from Delmarva, PPD, and DBHDS are granted different levels of access based on their roles. All tools and procedures have been posted on this portal. Communication has been thorough and ongoing through the use of an electronic team portal, electronic tools, computers, telephonic meetings and emails, and an annual face to face meeting for the entire team. Structured communication occurs via weekly contractor, management, subcontractor and team teleconference meetings, with some held biweekly, ensuring that all are constantly aware of the contract status, work in process, deliverables, barriers and potential risks.

Slow to Respond Providers/Non-Responsive Provider Procedure

A procedure addressing non-responsive providers was developed and approved by DBHDS. For providers involved in either a PCR or PQR, Delmarva QARs will make at least three contact attempts within a one-week period.[10] If there is no response, the case is submitted to a designated staff in DBHDS. Within a week of receiving the information, DBHDS will attempt to contact the provider. If there is still no response and the QAR is unable to schedule the review the provider is considered a decline. The non-responsive providers are documented in the "Non-Responsive Provider Log".

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[10] To address the prevalent slow-to-response problem, the contact period was modified in January 2016 from two weeks to one week.

Staffing Updates

Two Quality Assurance Reviewers resigned.

Appendices are included as separate documents:

Appendix 1: Summary Key Performance Indicator Results

Appendix 2: Needs Are Met, Primary Indicators, PCR Results

Appendix 3: Person Centered, Primary Indicators, PCR Results

Appendix 4: Integrated Setting, Primary Indicators, PCR Results

Appendix 5: Community Inclusion, Primary Indicators, PCR Results

Appendix 6: Quality Services Review Sampling Methodology

Appendix 7: Quality Services Review Processes and Procedures

Appendix 8: Inter-rater Reliability