DBHDD Support Coordination Performance Report

Georgia Department of Behavioral Health and Developmental Disabilities

February 16, 2018

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Purpose of Support Coordination Performance Report

DBHDD seeks to review data regularly supplied by support coordination agencies and performance data collected by DBHDD on support coordination agencies. The purpose of this report is to analyze data to assess the performance of support coordinators, their agencies, and Medicaid Waiver support coordination services provision.

Utilization of Support Coordination Performance Report Findings

The observations and findings in this report will be presented to leadership of DBHDD and Division of Intellectual/Developmental Disabilities (IDD) for consideration in identifying issues that need additional analysis, investigation, and interpretation to improve the quality of care.

The director of the Division of IDD is responsible for the utilization of the information within this report. The IDD division director will consider these and other performance data to develop and implement quality improvement initiatives, including those to improve performance and increase the quality of services for individuals with IDD in the community. DBHDD's organizational alignment provides a platform for clarified roles and responsibilities in addressing support coordination performance issues for the DBHDD IDD population, including analysis, implementation of targeted action steps, and determination of the impact of selected initiatives. Both expertise and responsibility exist in other areas within the department to assist the Division of IDD to accomplish improvement strategies; the Division of IDD has the responsibility to utilize these resources. The Division of IDD has at its disposal department resources to accomplish improvement initiatives with the assistance of support functions provided by the Divisions of Accountability and Compliance and Performance Management and Quality Improvement.

About DBHDD

The Georgia Department of Behavioral Health and Developmental Disabilities provides for treatment and support services for people with mental health challenges and substance use disorders, and assists individuals who live with intellectual and developmental disabilities.

Vision

Easy access to high-quality care that leads to a life of recovery and independence for the people we serve.

Mission

Leading an accountable and effective continuum of care to support Georgians with behavioral health challenges, and intellectual and developmental disabilities in a dynamic health care environment.

About DBHDD Intellectual and Developmental Disability Services

DBHDD is committed to supporting opportunities for individuals with intellectual and developmental disabilities (IDD) to live in the most integrated and independent settings possible. A developmental

disability is a chronic condition that develops before a person reaches age 22 and limits his or her ability to function mentally or physically. DBHDD provides services to people with intellectual and other disabilities, such as severe cerebral palsy and autism, who require services similar to those needed by people with an intellectual disability. State-supported services help families continue to care for a relative at home or independently in the community when possible. DBHDD also contracts with providers to provide home settings and care to individuals who do not live with their families or on their own. For individuals needing the highest level of care, DBHDD operates five state hospitals across Georgia.

Services are designed to encourage and build on existing social networks and natural sources of support, to promote inclusion in the community, and promote safety in the home environment. Contracted providers are required to have the capacity to support individuals with complex behavioral or medical needs. The services a person receives depend on a professional determination of level of need.

DBHDD serves as the operating agency for two 1915c Medicaid waiver programs, initially approved in 2007, when the two programs transitioned and expanded into their current form. The Medicaid waiver programs operate under the names New Options Waiver (NOW) and Comprehensive Supports Waiver (COMP). Both waiver programs provide home- and community-based services to individuals who, without these services, would require a level of care comparable to that provided in intermediate care facilities for people with intellectual and developmental disabilities, the costs of which would be reimbursed under the Medicaid State Plan. The Centers for Medicare and Medicaid Services offers the waiver option to states through application, which must be renewed minimally every five years. As in all Medicaid programs, the services and administrative costs are funded through a federal/state match agreement. A complete description of waiver services can be found at www.dbhdd.ga.gov.

Scope of this Report

Performance review of support coordination occurs on an ongoing basis, and performance metrics are examined regularly (e.g., monthly or quarterly reports). Formal support coordination reports (such as this one) are not created except on at least an annual basis. This is an update and expansion of the first support coordination performance report that was created June 30, 2017.

The focus of the support coordination performance review and analysis for this report includes children and adults with a primary IDD diagnosis who received services funded by NOW and COMP waivers (IDD waiver services) during the period of October 1, 2016 through October 1, 2017. Data within report are from January 1st, 2017 to October 1st, 2017, except for health care level data, which extends back to October 2016.

About Support Coordination and Intensive Support Coordination[1]

Support coordination (described by the Centers for Medicare and Medicaid Services as "Case Management"), as a Medicaid waiver service, began in Georgia with the introduction of the New Options Waiver (NOW) and the Comprehensive Supports (COMP) waiver. The service, as described at the time, included several disparate functions including the following: evaluation of provider compliance; assessment of waiver participants through such instruments as the Health Risk Screening Tool (HRST) and the Support Intensity Scale; and administration of the National Core Indicator Survey; in addition to the common case management tasks of advocacy and service coordination.

Reform of support coordination was implemented with the input of a consultant from the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and other stakeholders. Recommendations included the following:

- Redefining the scope of responsibilities
- SIS and conflict of interest - remove the SIS administration as a responsibility
- Re-focus support coordinator activities on personal outcomes and service "fit" and quality
- Consider moving some of the types of monitoring currently done by support coordinators to other program areas such as licensing, field office oversight, division of IDD central office program compliance, or external quality and compliance reviews
- Intensive support coordination implementation
- Improve relationships between support coordinators and field offices
- Improving support coordination through continuous training is essential to developing the skills of new coordinators and maintaining the competencies of those already providing services
- Caseload size is always of concern and needs to be defined by policy

Support coordination reform implementation began, in earnest, in July 2016 with the introduction and implementation of the new service evaluation tool, the "Individual Quality Outcome Measure Review (IQOMR)," using the evaluation method identified as "Recognize, Refer, and Act (RRA)." (Note: an example of the IQOMR can be found in Appendix A.) Along with other Medicaid and DBHDD policy changes, the role of the support coordinator moved to improving outcomes based on advocacy, planning, and service evaluation. In addition to redefining this service to achieve better outcomes for waiver participants, there was intent to improve the relationship among other Medicaid providers of services (residential, day services, and others). The reform intended to move support coordination and other waiver services into complementary roles that would better reflect collaborative partnerships in service delivery with a shared emphasis on producing quality outcomes for waiver participants.

Comprehensive training with all support coordination agencies was held on this new role and on the IQOMR. Additionally, extensive training was offered on how to utilize the HRST and the Supports Intensity Scale to improve outcomes based on evaluating risk and needed supports for people to live safely and successfully in the community.

[1] This report, based on Medicaid guidelines and terminology, references "support coordination" and "intensive support coordination." When referring to a service, "support coordination" (SC) is used to reference the lower level of these two services; "intensive support coordination" (ISC) is used to refer to the more-intensive form of support coordination.

In 2016, DBHDD began recruiting providers for a new waiver service called intensive support coordination (ISC). Three new provider agencies were enrolled to provide support coordination and intensive support coordination services to waiver participants in Georgia. Intensive support coordination includes all the activities of support coordination (See Chapter 600 of the SC-ISC Medicaid waiver manual[2]) and includes specialized coordination of waiver, medical and behavioral support services on behalf of waiver participants with exceptional medical or behavioral needs. Key benefits of this service include smaller caseloads (up to 20) and clinical supervision of the intensive support coordinator. (See Chapter 700 of the SC/ISC Medicaid manual.) Transition activities, from both inpatient settings and crisis respite homes, including pre-transition engagement, are included in the intensive support coordination service, which follows best practice and promotes continuity of intensive support coordination services.

Intensive support coordination services began in October 2016, with the three new agencies serving the sub-population of individuals with IDD who have transitioned into the community from state hospitals since July 2010. Continued enrollment of eligible waiver participants into intensive support coordination services began in November 2016. Total enrollment as of July 2017 was 1,549. As of December 18, 2017, total enrollment was 1,812. Enrollment is ongoing based on the following:

- Change of condition for individuals receiving NOW/COMP waiver services such that eligibility criteria is met,
- Individuals added to the active list for transition from state hospitals into community residences, or
- Admission of eligible participants to NOW/COMP waiver services from the IDD Planning List.

Intensive support coordination participants benefit from the inclusion of clinical supervision from the beginning of intensive support coordination service provision. Based on anecdotal reports, most intensive support coordination agencies have elected to assign their clinical supervisors to complete an introductory visit to assess the intensive support coordination participant's clinical baseline, identify risks, and provide recommendations to the intensive support coordinators for follow-up activities.

Ongoing telephonic or face-to-face training and technical assistance on a variety of topics is supplied to all support coordination agencies. Preliminary training for the newly-enrolled agencies, included an introduction to Georgia systems such as Medicaid State plan, IT systems, waiver service delivery, Medicaid eligibility, and other training topics. Comprehensive web-based training is also available to all support coordination agency staff through an access point on the DBHDD website[3] that directs them to the Relias Online Learning Library.[4] Content from web-based trainings offered by the Office of

[2] Part III Policies and Procedures for Support Coordination Services and Intensive Support Coordination Services (COMP & NOW Waiver Programs) https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/HANDBOOKS/Part%20III%20Policies%20and%20Procedures%20for%20Support%20Coordination%20and%20Intensive%20Support%20Coordination%20Services%2020170421192316.pdf

[3] DBHDD Developmental Disabilities Training Announcements http://dbhdd.georgia.gov/developmental-disabilities-training-announcements-0;

[4] DBHDD University, Relias Online Learning Library, http://dbhdduniversity.com/developmental-disabilities-library.html

Community Supports is recorded to add to the library within the Relias portal. Additional training has been developed focusing on how the HRST and Supports Intensity Scale may be used by support coordination for service planning purposes.

DBHDD is working to optimize support coordination caseloads of 40 for support coordination and 20 for intensive support coordination. With the rapid enrollment of waiver participants into intensive support coordination services, it was difficult for agencies to identify where these new enrollees would be located geographically and which agencies they would choose. Consequently, there was a disruption in the ability for agencies to identify areas in which new hires should be recruited. In consideration of the period of ongoing enrollment, DBHDD elected to utilize a short-term "caseload mix strategy," whereby an intensive support coordinator could have a combination of intensive support coordination and traditional support coordination participants assigned in a manner where, with each addition of an intensive support coordination participant, the total caseload maximum reduces based on a 1:3 ratio (1 ISC = 3 SC). As a result, DBHDD anticipates that intensive support coordination participants will continue to benefit more as caseloads align with policy requirements, which was intended based on the initial service definition. Following the conclusion of the initial enrollment process in October 2017, DBHDD amended their policy on support coordination caseloads to include a more conservative caseload mix strategy effort to continue optimization of caseload sizes.

DBHDD regularly reviews the creation of individual service plans (ISP). DBHDD compared its ISP with several ISPs used by other states. The comparison showed that Georgia's ISP for participants in IDD services was considerably longer and more complex than the ISPs in those states. The existing plan was developed to be comprehensive, as the participant's team typically may only meet on an annual basis to develop the plan. Any mid-year changes to the plan result in the completion of an ISP addendum, which only addresses the discrete changes to be implemented but does not require a review and update of the ISP in its entirety. Georgia is developing a new IT system, which will include a new ISP format that was developed in a strategic manner to resolve many of the challenges experienced with the ISP in the current system. The format is planned to be much more condensed, have information that populates directly from assessments and screenings, and will be more easily editable as changes occur. Consequently, it is intended to become customary for the team to complete ISP reviews and updates with a frequency that is more responsive to the needs and desires of the participant.

The division of IDD recognized these challenges and hosted workgroup sessions for support coordination agency quality assurance staff, field office ISP reviewers, and IDD divisional leadership. The intent of the workgroups was to discuss what is working and not working with the current ISP document and decide upon changes that could be made to the current ISP, while awaiting the development of the new IT system. System-wide improvement efforts relating to the ISP are intended to achieve the following results:

1. Streamlining of the current ISP document within the web-based system, to eliminate the support coordinators' completion of any sections that have overlapping functions;
2. Removal of the expectation that support coordinators address content that does not serve a meaningful purpose within the ISP and would be better documented elsewhere;
3. Changes in the verbiage of certain section titles to yield better understanding of the intent;
4. Development of new procedural instructions for the ISP that will clearly outline the intent of each section and itemize what should and should not be included.

Support coordination staff, relevant field office staff, service provider network, and DBHDD's external review organization were trained on the revised procedural instructions and quality standards for the ISP. The anticipated outcome of these changes is that ISPs will be completed in a comprehensive manner, resulting in an expedited review and approval process conducted by the support coordination quality assurance staff and field office quality assurance staff. The increased efficiency in the ISP review process will lead to participants' experiencing continuity of care during ISP approval periods. Furthermore, participants will benefit from having ISPs that are meaningful to the participant and clearly understood by all team members responsible for ISP implementation.

DBHDD sees the value of providing support coordinators with department-generated incident reports, investigative reports, and corrective action plans regarding any participant to whom they are assigned. The associated policy was implemented on June 30, 2017. Training of the seven support coordination agencies occurred in June 2017, and the necessary IT builds with the two systems (Consumer Information System (CIS) and the Reporting of Critical Incidents (ROCI)) were completed.

Support coordination has a role in the statewide clinical oversight protocol for waiver participants who have been identified as having a heightened level of need or risk. This protocol includes the provision of episodic or ongoing monitoring, multi-level and multidisciplinary assessments, training, technical assistance, and mobile response. Support coordinators have been specifically identified as having a role in identifying changes in health status or risk for participants served, notifying indicated parties for assistance with intervention and stabilization efforts, collaborating with the service providers to obtain needed healthcare resources or referrals, and confirming the implementation of recommended risk mitigation activities. Training on the statewide clinical oversight protocol occurred in June 2017, and implementation occurred in July 2017. Ongoing training has been provided to support coordinators and direct service providers since the initial implementation.

The regional quality review teams, who provide clinical oversight to waiver participants who have transitioned from state hospitals (including those on the high-risk surveillance list), interface regularly with intensive support coordinators. The primary reporting tool, the Service Review and Technical Assistance (SRTA), previously used a platform that did not allow ease of access for intensive support coordinators to enter follow-up notes on completed action steps. To remedy this deficit, DBHDD contracted with an IT provider to develop a secure, web-based application for entry of the SRTA by regional quality review team clinicians and access to intensive support coordinators to enter pertinent information to resolve and document identified health risks and service delivery concerns.

DBHDD is evaluating the performance of support coordination agencies and the support coordination system as a whole, as well as looking at the benefit and effectiveness of intensive support coordination. For example, out of over 30,000 issues opened since July 1, 2016, through the recognize-refer-act evaluation method, less than 1 percent of issues remained unresolved and required follow-up by Division of Accountability and Compliance (DAC). DAC holds service providers accountable for meeting contractual obligations, and they may intervene as a result of ongoing concerns to prompt action and resolution. Additionally, 90 percent of identified issues were resolved through the coaching process without requiring elevation to a referral status. These are two indicators of a functional recognize-refer-act method that focuses the resolution of identified issues through collaborative efforts between support coordinators, providers, and other stakeholders.

The Division of IDD will continue to evaluate support coordination agencies, individual support coordinators, outcomes for provider agencies (CRA, day services), as well as outcomes for waiver

participants, and the support coordination system. While the findings within this report are favorable in most sections, it should be noted that when an agency is not meeting targets, DBHDD actively engages to understand challenges and support performance achievement.

Analysis of IDD Waiver Data Related to Support Coordination and Intensive Support Coordination

The Individual Quality Outcomes Measure Review tool (IQOMR) is the services and support evaluation tool used for support coordination and intensive support coordination documentation. At a minimum, all participants receive a quarterly face-to-face visit and one IQOMR per quarter; additional face-to-face visits and IQOMR administration may occur during this time but are not required, except for intensive support coordination recipients. Intensive support coordination participants have at least one face-to-face visit and IQOMR monthly.

The IQOMR is divided into seven focus areas: Environment; Appearance/Health; Supports and Services; Behavioral and Emotional; Home and Community Opportunities; Financial; and Satisfaction. Each focus area contains one or more questions that guide the support coordinator to do the following:

- Observe and interact with the participant as it relates to the elements of the item reviewed;
- Observe the setting for evidence pertaining to the item reviewed;
- Review any pertinent documentation relating to the item reviewed;
- Engage in discussion with staff members or natural supports who may have information on the item reviewed; and
- Observe staffs' or natural supports' interaction with the individual as it relates to the item reviewed.

Based on the support coordinators' completion of the above steps, each focus area question is evaluated based on the following standards:

- Acceptable standards are reached when elements of the focus area question have been fully evaluated by the support coordinator, and there are no concerns to report. All elements of the focus area question have been met satisfactorily and services/supports are being provided in an adequate manner; or
- Coaching is required when a concern, issue, or deficit is discovered in an element of a focus area question, and, in the support coordinator's professional judgment, he/she determines that the concern/issue/deficit can be resolved in collaboration with the staff members or natural supports without intervention by the field office or clinical staff; or
- Referrals are made to DBHDD or clinical staff to address serious concerns or untimely responses to coaching in the areas of the IQOMR.

Support coordination agencies are listed below, and will be referenced throughout the report. All agencies provide support coordination and intensive support coordination.

- Benchmark
- CareStar
- Columbus
- Creative
- Georgia Support
- Professional Case Management Services of America

Total Number of Individuals at Each Agency

Figure 1: Total Number of Individuals at Each Agency

Table 1: SC/ISC agency Attributes as of October 2017

SC/ISC Agency	ISC	SC	Proportion ISC	Mean HCL as of 10/2017	Mean HCL SC	Mean HCL ISC
Benchmark	274	93	74.66	4.25	2.72	4.60
CareStar	130	11	92.2	4.66	1.00	4.71
Columbus	410	3,597	10.23	2.25	1.92	5.17
Compass	144	27	84.21	4.16	2.14	4.37
Creative	381	3,128	10.86	2.25	1.88	5.17
Georgia Support	130	1,409	8.45	2.33	2.04	5.29
PCSA	214	2,231	8.75	2.18	1.90	5.18

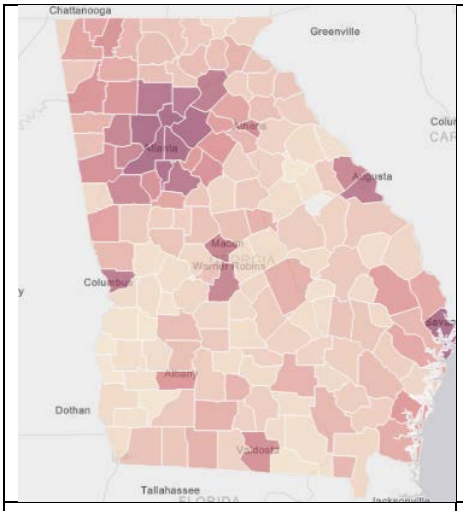
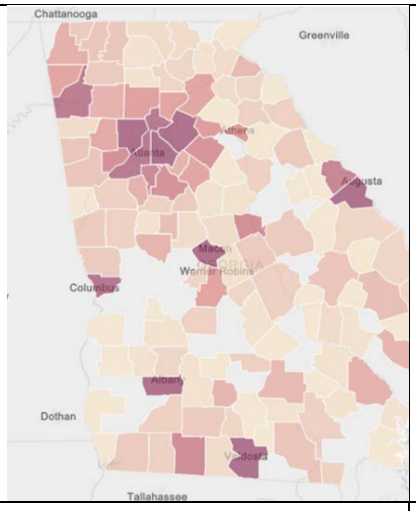
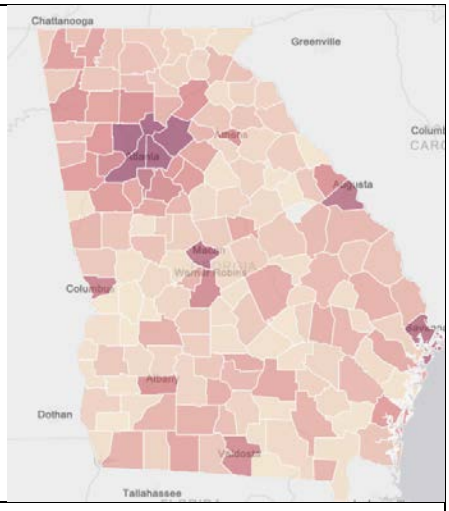
Support coordination and intensive support coordination enrollment numbers per agency are displayed in Table 1: SC/ISC agency Attributes. The size of each agency has bearing on the results of some of the statistics used in this report. For example, smaller agencies will have a greater change in percent compliance if even one infraction is cited. Most of the waiver participants are enrolled in support coordination as opposed to intensive support coordination. It should be noted that Benchmark, CareStar, and Compass each primarily serve individuals on intensive support coordination.

Table 1 also shows the average Health Care Level (HCL) for each of the agencies. The HCL is a score on a scale of 1-6 generated by a form called the Health Risk Screening Tool (HRST). The HCL estimates an individual's vulnerability to potential health risks, and draws attention to the supports he or she needs to enable early identification deteriorating health. The HCL of an individual can be any integer from 1 (low risk) to 6 (highest risk). The risk level is directly related to individual's or caregivers' responses to a series of detailed questions related to functional status, behaviors, physiological condition, safety, and frequency of services. The average health care level of all individuals is around 2, which indicates a relatively lower health risk level. It can also be seen that the average health care level for intensive support coordination is much higher, between 4 and 5. These are important factors to keep in mind throughout the remainder of this report, as we know that increasing health risk levels require additional support and visit frequency to support the health of individuals.

Caseload Size

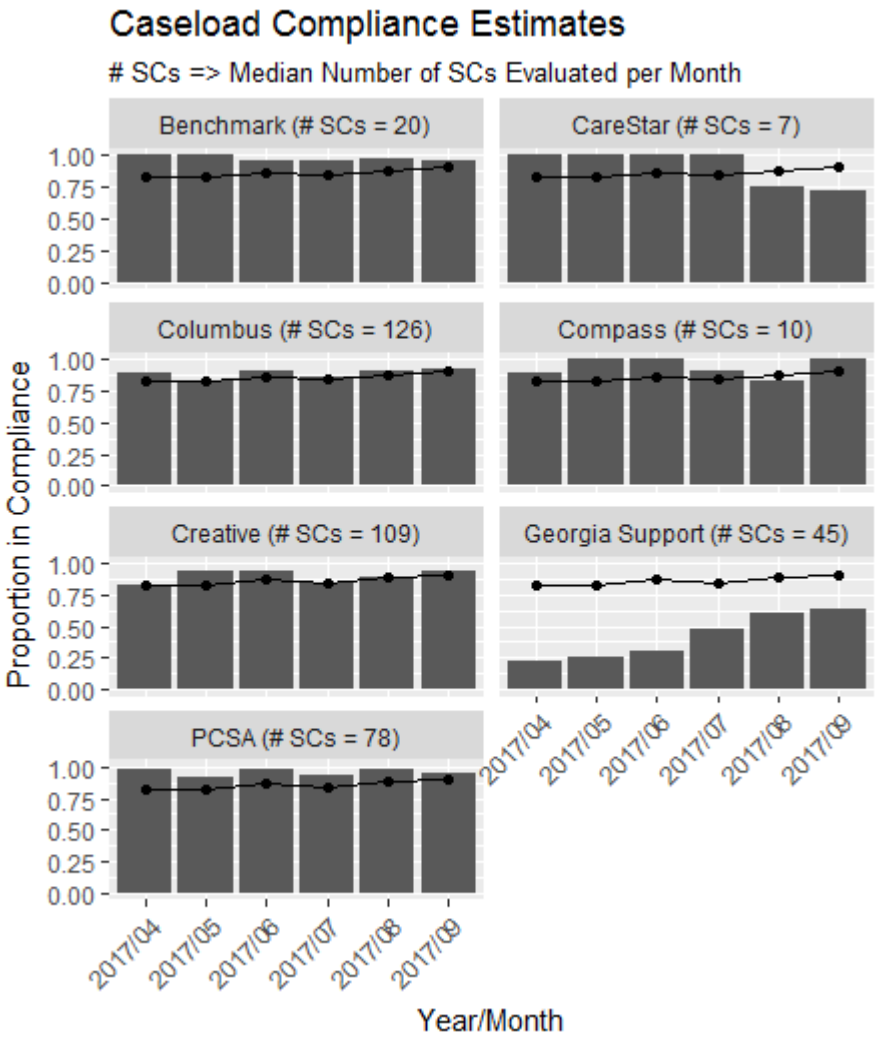
DBHDD policy regarding the caseload size of support coordinators (*Support Coordination Caseloads, Participant Admission, and Discharge Standards, 02-432*) states that support coordinators providing intensive support coordination must have no more than 20 individuals in their caseload, and those providing standard support coordination must have no more than 40. If a support coordinator has a mixed caseload with both support coordination and intensive support coordination individuals, the 1:3 rule applies, counting each intensive support coordination individual as being equal to three support coordination individuals. If a mixed caseload has more than 10 individuals receiving intensive support coordination, then they may have no more than 20 individuals, and the 1:3 rule no longer applies. The aforementioned policy specifies how caseload ratios may be adjusted to accommodate having support coordination and intensive support coordination recipients on individual support coordinator's caseload, which has been used for these analyses. Furthermore, it is important to consider the challenges of caseload size compliance given the population distribution in rural and more-sparsely-populated regions of Georgia. Consider the table below, where darker shades indicate higher density or higher population.

Table 2: Maps of Georgia, Intensive Support Coordination, Support Coordination Populations

		
This map shows Georgia's population is concentrated in a few larger city areas, such as Atlanta, Savannah, Augusta, Columbus, etc. As also can be seen, these more-densely-populated areas are separated with vast areas of lower-density populations.	Now, considering the distribution of intensive support coordination across Georgia, one will notice that intensive support coordination is also most common to the larger, more-densely populated areas. In these areas, support coordination agencies (and support coordinators) more easily achieve caseload size compliance.	On the other hand, one should notice that individuals requiring intensive support coordination reside between these more-densely-populated areas, and sometimes, only a few individuals requiring intensive support coordination live within hundreds of square miles. Thus, support coordinators face extraordinary challenges in achieving caseload size and mix compliance, especially in less-populated areas, which is most of Georgia.

The proportion of support coordinators in compliance with caseload requirements is above 85 percent in five of the seven support coordination agencies. The overall caseload size compliance for the population is above 85 percent, which both are considered findings of positive performance and substantial compliance. The following section takes a closer look at how DBHDD is performing well with caseload sizes for support coordinators, and the section below looks beyond evidence of positive performance and substantial compliance to examine how DBHDD is performing well given the challenges of population density needed to support the business model that underlies support coordination caseload size performance.

Figure 2: Caseload Compliance by Month



As of September 2017, the proportion of support coordinators in compliance with caseload requirements is above 85 percent for five of seven support coordination agencies. The overall caseload size compliance for the population is above 85 percent, which both are considered findings of positive performance.

The dark boxes in Figure 2 show the proportion of support coordinators in compliance at each support coordination agency. The black line with dots displays the population proportion of support coordinators in compliance over time; this line is replicated across the support coordination-specific graphics so support coordination agencies can be compared to the overall proportion in compliance over time.

CareStar and Georgia Support do not currently have 85 percent compliance. Further inspection reveals that Georgia Support, though below 85 percent, is steadily increasing over time, which is a positive trend toward caseload size requirement compliance. Upon closer inspection of CareStar, one should notice two points that need to be considered for evaluating caseload size requirements. First, it should be noticed that CareStar has a positive trend of having 100 percent compliance with support coordination

caseload size. Second, it should be noted that CareStar has only seven intensive support coordinators, which means that, as in this case, when one or two intensive support coordinators are not in compliance with caseload size requirements, the overall proportion of the support coordination agency falls precipitously. DBHDD has evaluated the reasons for being below 85 percent, and in most instance, they are limited in duration and were not determined to be indicative of a systems-level risk.

Despite the geographic challenges in rural, sparsely-populated areas of Georgia, support coordinators, support coordination agencies, and DBHDD have demonstrated good performance in meeting caseload size requirements. Concomitantly, most support coordination agencies have over 85 percent of their support coordinators meeting the caseload size requirement.

Face-to-Face Visits by Month

As has been and will continue throughout this report, support coordination will be presented first, followed by intensive support coordination. Those receiving intensive support coordination are inherently more medically complex, and thus require more face-to-face visits from support coordinators. Intensive support coordination recipients must receive at least one face-to-face visit per month; to demonstrate this, there is one figure (Figure 4) for each of the three months in a quarter. Support coordination requires only one visit per quarter, hence one figure (Figure 3).

In Figure 3, the distribution of frequencies per individual is presented, and these individuals need one visit per quarter. Each of the bars in the plot represents the number of individuals who received the corresponding number of visits. For example, approximately 1,500 individuals receiving support coordination were visited twice between the beginning of July and the end of September in 2017. The plot shows that well over a majority of individuals receiving this service were visited a number of times that complies with policy requirements. Table 3 buttresses this result in its “Percent Compliance” column. Each unique provider has greater than 85 percent compliance with the deliverable item; this implies the vast majority of individuals are seen at the proper frequency according to policy.

Note that the Total Individuals column in this table is only meant to be an estimate of the number of individuals enrolled at each support coordination agency. These numbers will fluctuate slightly throughout the report due to variations in data availability and sources.

Figure 3: Number of Support Coordination Face to Face Visits July through September 2017 for One Quarterly Visit Requirement

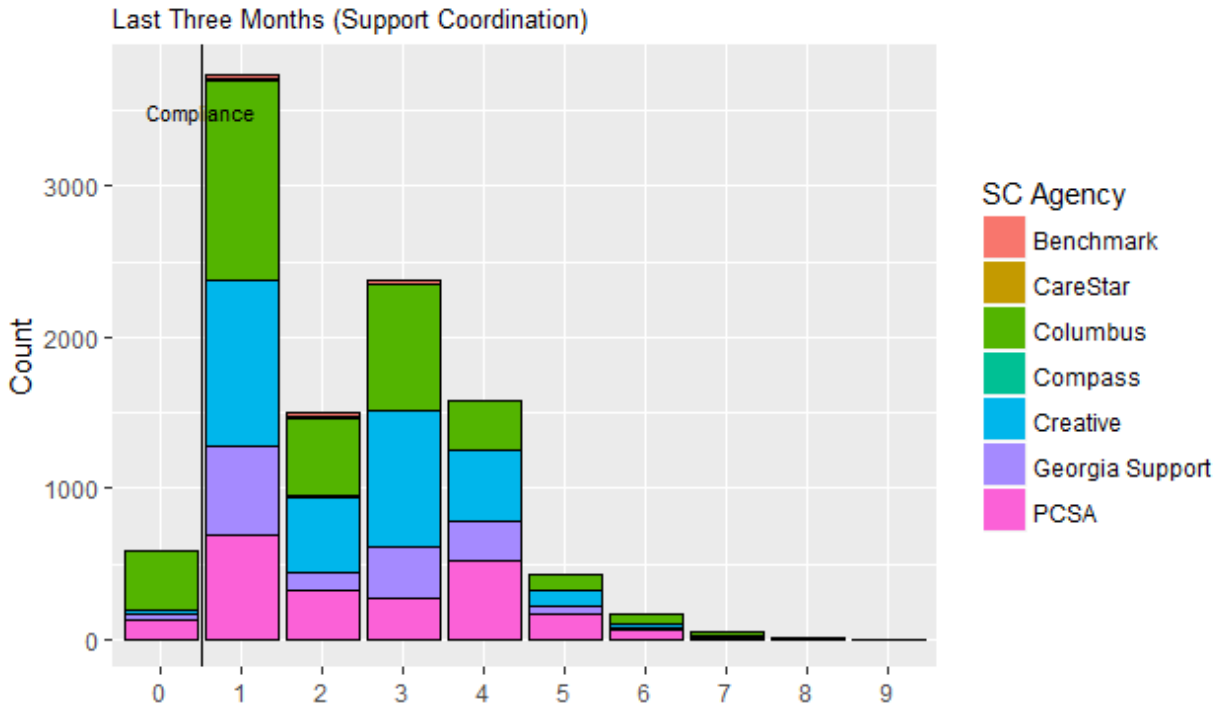


Table 3: Number of Face to Face Visits July through September 2017 (SC)

SC/ISC Agency	Mean Visits per quarter	In Compliance	Total Individuals	Percent Compliance
Benchmark	1.97	93	101	92.08
CareStar	1.88	16	17	94.12
Columbus	2.04	3,190	3,577	89.18
Compass	2.00	27	30	90.00
Creative	2.37	3,098	3,129	99.01
GA Support	2.31	1,368	1,403	97.51
PCSA	2.55	2,073	2,202	94.14

Figure 4: Number of Intensive Support Coordination Face to Face Visits July through September 2017 for Monthly Visit Requirements

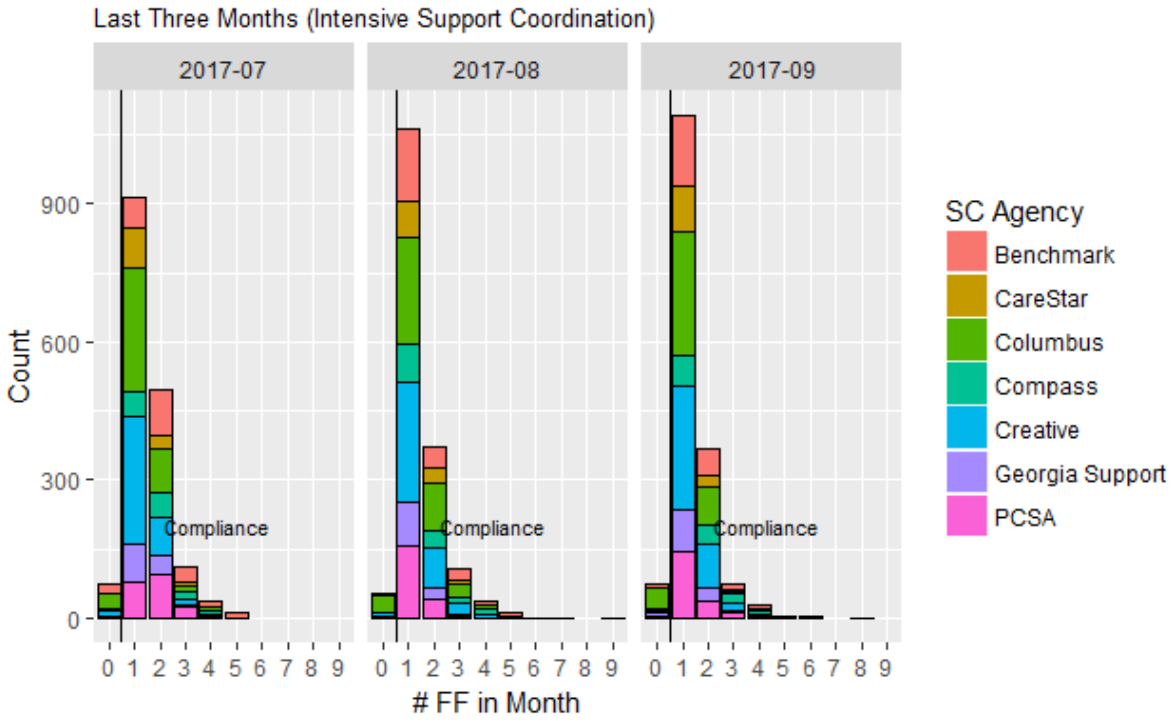


Table 4: Number of Monthly Face-to-Face Visits July to September 2017 (ISC)

SC/ISC Agency	Month	Mean Visits per month	In Compliance	Total Individuals	Percent Compliance
Benchmark	2017-07	1.93	225	244	92.21
	2017-08	1.58	238	244	97.54
	2017-09	1.51	237	244	97.13
CareStar	2017-07	1.37	125	127	98.43
	2017-08	1.5	126	127	99.21
	2017-09	1.22	126	127	99.21
Columbus	2017-07	1.25	376	409	91.93
	2017-08	1.39	373	409	91.20
	2017-09	1.17	363	409	88.75
Compass	2017-07	1.82	140	144	97.22
	2017-08	1.69	143	144	99.31
	2017-09	1.8	140	144	97.22
Creative	2017-07	1.27	375	387	96.90
	2017-08	1.42	382	387	98.71
	2017-09	1.34	382	387	98.71
Georgia Support	2017-07	1.42	128	130	98.46
	2017-08	1.27	128	130	98.46
	2017-09	1.28	124	130	95.38
PCSA	2017-07	1.74	203	206	98.54
	2017-08	1.24	202	206	98.06
	2017-09	1.33	200	206	97.09

Both Figure 4 and Table 4 display statistics on the number of face-to-face visits individuals in intensive support coordination received each month. These results were displayed by month so they could demonstrate compliance with monthly as opposed to quarterly visits. As can be seen above, like those receiving support coordination, the vast majority of intensive support coordination recipients are receiving the minimum number of required visits as evidenced by the percent compliance.

An obvious question is addressed next: "Are people receiving the number of visits based on their need?" This next section demonstrates that the number of support coordination visits are based on a person's need level, in that those individuals with higher need levels receive more frequent support coordination and intensive support coordination services.

Mortality analyses over the past several years have demonstrated the importance that should be focused on a person's health risk level and age to understand the intensity of services they should receive. In other words, people with higher health care levels should be receiving more frequent visits,

while those with lower health care levels are indicated to have less measured health risk and may need fewer visits.

A Poisson regression model was generated to show that age and HCL are associated with the number of face-to-face visits received by individuals enrolled in support coordination and intensive support coordination. The model estimates are presented in Table 5 and Table 6. Each value in the "Exp Estimate" column can be interpreted as a multiplicative increase in the estimated number of face-to-face visits when compared to baseline. For example, the HCL 3 row holds a value of 1.41. That value implies that individuals with HCL 3 have a 1.41-times (or 41-percent) increase in the estimated number of face-to-face visits compared to individuals with HCL 1. (Note: HCL 1 and SC are the reference variables. All other HCLs are compared with HCL, and ISC is compared with SC. The reference variables, therefore, do not have data within their cells, for this would be akin to comparing them with themselves.)

Table 5: Poisson Regression Model of Number of Face-to-Face Visits Associated with Age and HCL (Overall Population)

	Estimate	Exp Estimate	Std. Error	Z value	P value
(Intercept)	0.36	1.44	0.02	18.60	<.001
HCL 1	-	-	-	-	-
HCL 2	0.20	1.22	0.02	12.89	<.001
HCL 3	0.34	1.41	0.02	19.13	<.001
HCL 4	0.41	1.51	0.02	18.57	<.001
HCL 5	0.69	1.99	0.02	30.15	<.001
HCL 6	0.75	2.12	0.02	34.96	<.001
Age	0.01	1.08	0.00	20.60	<.001

Table 6: Poisson Regression Model of Number of Face-to-Face Visits Associated with Age and Level of Support Coordination (Overall Population)

	Estimate	Exp Estimate	Std. Error	Z value	P value
(Intercept)	0.49	1.64	0.02	27.35	<.001
Age	0.01	1.09	0.00	21.19	<.001
SC	-	-	-	-	-
ISC	0.60	1.83	0.01	43.65	<.001

The results in Table 5 and Table 6 indicate that the number of support and intensive support coordination visits increase with increasing health care level, increasing age, and intensive support coordination. These very positive findings imply that as health risk (represented by HCL and increasing age) rises, the number of face-to-face visits also generally rises. Therefore, it is reasonable to conclude that increased face-to-face visits are related to individuals' needs.

Using the results from this statistical model, furthermore, we calculated the number of support coordination and intensive support coordination visits a person would be expected to have based on their risk level and age and compared it with the number of actual number of visits they received. As can be seen below, on average, the support coordination agencies are delivering support coordination and intensive support coordination visits based, as expected, upon need; in fact, on average, the support coordination agencies are within one visit of what would be expected when you take into consideration person's health care need levels and age (after adjusting for whether the person is receiving intensive support coordination). It should be noted that though Benchmark and Compass have high compliance with the number of face-to-face visits requirements (earlier in this section), they are, on average, delivering less face-to-face visits than would be expected when considering the level of need and age of the individuals they serve, but still delivering within one visit of what would be expected based on need.

Table 7: Mean Difference between Expected and Observed Numbers of Face-to-Face Visits for July through September

SC/ISC Agency	Difference of Expected & Observed
Benchmark	-0.66
CareStar	0.46
Columbus	0.25
Compass	-0.73
Creative	-0.10
Georgia Support	0.09
PCSA	-0.23

The section above clearly demonstrates that support coordination agencies have positive performance overall not only for delivering the number of face-to-face visits but also are visiting individuals more frequently as their health risk and age increase.

Coaching and Referrals

Previous analyses indicated that the vast majority of individuals are receiving the required number of face-to-face visits, and the face-to-face visits are based on increasing risk posed by increasing age and increasing health risk levels. These findings underline the support coordinators' workload in delivering at least the required number of visits, tailored to increasing risk. Beyond the number of visits individuals receive, another way of understanding better the productivity and workload performance of support coordination agencies is to examine a key component of support coordinator value that they deliver: referrals and coaching.

According to DBHDD policy, support coordinators can report and record concerns using Coaching and Referral (*Outcome Evaluation: "Recognize, Refer, and Act" Model, 02-435*). Coaching is defined in the policy as follows:

> Coaching is required when a concern, issue or deficit is discovered in an element of a focus area question and, in the Support Coordinator's professional judgment, he/she determines that the

concern/issue/deficit can be resolved in collaboration with the staff members and/or natural supports without intervention by the Field Office or Clinical staff.

Referrals are performed for more serious risks than those addressed by coaching. Referrals can also be used to escalate the urgency of a coaching due to slow response or worsening circumstances.

Table 8 highlights the amount of effort and productivity of support coordinators in working with providers to assist individuals. When taken together, support coordination agencies provided 14,839 coaching sessions aimed at addressing issues to provide improved outcomes for the individual from January 1st, 2017 to October 1st, 2017. Support coordinators also provided 3,712 referrals in response to individuals' needs in order to facilitate positive outcomes. To understand more fully the tremendous efforts beyond achieving face-to-face requirements, consider that combined, support coordinators initiated and followed up on 18,551 actions to improve the outcomes of individuals they serve. From a performance perspective, Compass delivered the largest number of coaching and referral activities per individual; conversely, Columbus delivered the fewest coaching and referral activities per individual.

One should exercise great caution before proceeding to draw conclusions on number and frequency comparisons for several reasons. First, this is a new performance metric for DBHDD. The number and rate of referral metrics needs additional analyses and testing before conclusions can be drawn about performance. One should consider a critical point before drawing conclusions about performance based on variations in these metrics: positive outcomes were recognized for most individuals across the system (discussed later). Therefore, people are achieving positive outcomes, regardless of the variation in these metrics. One should also consider alternative explanations that must be examined more closely. For example, it could be that some support coordinators and support coordination agencies are not documenting their coaching and referral instances as frequently as others, which is a different performance issue than not delivering. Additional investigation is warranted to understand these metrics better and how best to use them to monitor support coordination performance.

Table 8: Coachings and Referrals Statistics for the System January 1 through October 1, 2017

	Overall							
Agency	Number of Individuals	Number of Coachings	Average Number of Coachings	Number of Referrals	Average Number of Referrals	Number of Open Referrals	Number of Open Referrals Beyond Date	Average Number of Open Referrals Beyond Date
Benchmark	371	971	2.62	144	0.39	79	34	0.09
CareStar	141	170	1.21	90	0.64	12	8	0.06
Columbus	4,008	1,988	0.50	496	0.12	125	62	0.02
Compass	172	702	4.08	141	0.82	29	12	0.07
Creative	3,509	5,741	1.64	1,807	0.52	36	8	0.00
Georgia Support	1,539	1,708	1.11	511	0.33	93	17	0.01
PCSA	2,429	3,559	1.47	523	0.22	105	61	0.03
Grand Total	12,169	14,839	1.22	3,712	0.31	479	202	0.02

From Table 8, it is clear that support coordinators are working productively toward positive outcomes, as evidenced by the number and rates of coaching sessions and referrals. These metrics show productivity of support coordinators' work and productivity. Support coordinators resolved 3,233 (3712 – 479 = 3,233) referrals during this period. As of October 1, 2017, support coordinators were actively working to resolve towards positive outcomes on 479 open referrals; 277 (479 – 202) open referrals are within the expected period of resolution. On the other hand, 202 (of the 479 open) referrals remain open beyond the expected date. Though the number of coaching sessions and referrals indicate productivity towards positive outcomes, the 202 unresolved referrals beyond the expected date indicate that support coordinators have reached barriers to resolution toward positive outcomes in these instances. An open referral beyond an expected date does not indicate lack of support coordinator performance or effort; in fact, this indicates support coordinators may need additional, external support to resolve these issues. Additional analysis is needed to understand better the nature of these barriers to address them effectively.

The coaching and referral performance metrics for each outcome area are provided below. The main points of the information and analysis follow:

- Coaching and referral activities (combined) are ordered from highest to lowest are listed below, and the order of the tables below follow this order. As can be seen, appearance/health and supports/services, not surprisingly, are the areas where support coordinators have focused the highest volume of coaching and referral activities.
    1. Appearance/health
    2. Supports/services
    3. Environment
    4. Home and community options
    5. Financial
    6. Behavioral and emotional
    7. Satisfaction
- As with the overall system performance perspective, Compass most frequently delivered the largest number of coaching and referral activities per individual across most area; conversely, Columbus most frequently delivered the fewest coaching and referral activities per individual across most areas.
- Appearance/health is the busiest area of activity for support coordinators, and appearance/health has over half of all open referrals beyond the expected close date. This indicates that support coordinators are experiencing barriers to resolving appearance/health issues for individuals, and support coordinators may need additional support to facilitate improved appearance/health outcomes.
- Support coordinators also dedicated substantial resources towards producing positive outcomes for supports/services areas by delivering coaching and referral activities second most frequently in this area. Almost 25 percent of all open referrals beyond the expected close date are also in this area, which suggests that support coordinators may need additional support to facilitate improved supports and services outcomes.
- DBHDD is interested in and currently is investigating ways to determine if support coordination activities (e.g., face-to-face visits, coaching sessions, referrals, ancillary activities, etc.) are related to outcomes. For example, DBHDD is interested to learn and is investigating (1) if

support coordination activities increase following a negative outcome or (2) reduction in negative outcomes being associated with increased actions.

Table 9: Coachings and Referrals Statistics (Appearance and Health) January 1 through October 1, 2017

	Appearance/Health							
Agency	Number of Individuals	Number of Coachings	Average Number of Coachings	Number of Referrals	Average Number of Referrals	Number of Open Referrals	Number of Open Referrals Beyond Date	Average Number of Open Referrals Beyond Date
Benchmark	371	331	0.89	64	0.17	34	12	0.03
CareStar	141	80	0.57	77	0.55	9	8	0.06
Columbus	4,008	752	0.19	235	0.06	58	30	0.01
Compass	172	258	1.50	73	0.42	12	6	0.03
Creative	3,509	2,743	0.78	1,111	0.32	23	5	0.00
Georgia Support	1,539	709	0.46	305	0.20	44	8	0.01
PCSA	2,429	1,915	0.79	336	0.14	70	34	0.01
Grand Total	12,169	6,788	0.56	2,201	0.18	250	103	0.01

Table 10: Coachings and Referrals Statistics (Supports and Services) January 1 through October 1, 2017

	Supports and Services							
Agency	Number of Individuals	Number of Coachings	Average Number of Coachings	Number of Referrals	Average Number of Referrals	Number of Open Referrals	Number of Open Referrals Beyond Date	Average Number of Open Referrals Beyond Date
Benchmark	371	254	0.68	35	0.09	23	9	0.02
CareStar	141	50	0.35	10	0.07	2	0	0.00
Columbus	4,008	586	0.15	117	0.03	37	17	0.00
Compass	172	135	0.78	16	0.09	6	2	0.01
Creative	3,509	1,569	0.45	310	0.09	6	1	0.00
Georgia Support	1,539	553	0.36	128	0.08	26	7	0.00
PCSA	2,429	648	0.27	78	0.03	15	11	0.00
Grand Total	12,169	3,795	0.31	694	0.06	115	47	0.00

Table 11: Coachings and Referrals Statistics (Environment) January 1 through October 1, 2017

	Environment							
Agency	Number of Individuals	Number of Coachings	Average Number of Coachings	Number of Referrals	Average Number of Referrals	Number of Open Referrals	Number of Open Referrals Beyond Date	Average Number of Open Referrals Beyond Date
Benchmark	371	109	0.29	16	0.04	11	8	0.02
CareStar	141	7	0.05	0	0.00	0	0	0.00
Columbus	4,008	258	0.06	33	0.01	10	1	0.00
Compass	172	62	0.36	8	0.05	1	0	0.00
Creative	3,509	528	0.15	134	0.04	1	1	0.00
Georgia Support	1,539	145	0.09	23	0.01	8	0	0.00
PCSA	2,429	381	0.16	38	0.02	9	7	0.00
Grand Total	12,169	1,490	0.12	252	0.02	40	17	0.00

Table 12: Coachings and Referrals Statistics (Home/Community Opportunities) January 1 through October 1, 2017

	Home/Community Opportunities							
Agency	Number of Individuals	Number of Coachings	Average Number of Coachings	Number of Referrals	Average Number of Referrals	Number of Open Referrals	Number of Open Referrals Beyond Date	Average Number of Open Referrals Beyond Date
Benchmark	371	87	0.23	6	0.02	4	0	0.00
CareStar	141	6	0.04	2	0.01	0	0	0.00
Columbus	4,008	58	0.01	15	0.00	2	2	0.00
Compass	172	111	0.65	15	0.09	5	2	0.01
Creative	3,509	321	0.09	63	0.02	2	0	0.00
Georgia Support	1,539	102	0.07	9	0.01	0	0	0.00
PCSA	2,429	206	0.08	21	0.01	2	2	0.00
Grand Total	12,169	891	0.07	131	0.01	15	6	0.00

Table 13: Coachings and Referrals Statistics (Financial) January 1 through October 1, 2017

	Financial							
Agency	Number of Individuals	Number of Coachings	Average Number of Coachings	Number of Referrals	Average Number of Referrals	Number of Open Referrals	Number of Open Referrals Beyond Date	Average Number of Open Referrals Beyond Date
Benchmark	371	81	0.22	14	0.04	5	5	0.01
CareStar	141	7	0.05	0	0.00	0	0	0.00
Columbus	4,008	110	0.03	30	0.01	7	6	0.00
Compass	172	66	0.38	2	0.01	1	0	0.00
Creative	3,509	151	0.04	46	0.01	3	1	0.00
Georgia Support	1,539	108	0.07	13	0.01	6	0	0.00
PCSA	2,429	238	0.10	21	0.01	3	2	0.00
Grand Total	12,169	761	0.06	126	0.01	25	14	0.00

Table 14: Coachings and Referrals Statistics (Behavioral and Emotional) January 1 through October 1, 2017

	Behavioral and Emotional							
Agency	Number of Individuals	Number of Coachings	Average Number of Coachings	Number of Referrals	Average Number of Referrals	Number of Open Referrals	Number of Open Referrals Beyond Date	Average Number of Open Referrals Beyond Date
Benchmark	371	82	0.22	9	0.02	2	0	0.00
CareStar	141	17	0.12	0	0.00	0	0	0.00
Columbus	4,008	77	0.02	34	0.01	5	1	0.00
Compass	172	53	0.31	22	0.13	4	2	0.01
Creative	3,509	184	0.05	113	0.03	1	0	0.00
Georgia Support	1,539	53	0.03	20	0.01	2	0	0.00
PCSA	2,429	106	0.04	29	0.01	6	5	0.00
Grand Total	12,169	572	0.05	227	0.02	20	8	0.00

Table 15: Coachings and Referrals Statistics (Satisfaction) January 1 through October 1, 2017

	Satisfaction							
Agency	Number of Individuals	Number of Coachings	Average Number of Coachings	Number of Referrals	Average Number of Referrals	Number of Open Referrals	Number of Open Referrals Beyond Date	Average Number of Open Referrals Beyond Date
Benchmark	371	27	0.07	0	0.00	0	0	0.00
CareStar	141	3	0.02	1	0.01	1	0	0.00
Columbus	4,008	147	0.04	32	0.01	6	5	0.00
Compass	172	17	0.10	5	0.03	0	0	0.00
Creative	3,509	245	0.07	30	0.01	0	0	0.00
Georgia Support	1,539	38	0.02	13	0.01	7	2	0.00
PCSA	2,429	65	0.03	0	0.00	0	0	0.00
Grand Total	12,169	542	0.04	81	0.01	14	7	0.00

Outcomes of Support Coordination and Intensive Support Coordination

Previous analyses (within this report and previous reports) have shown that support coordination agencies are achieving compliance with the processes and requirements associated with caseload sizes, number of face-to-face visits, and delivering increased visits based on the increasing needs of individuals. The report now turns to answering the question: "What are the outcomes of support coordination services?"

This report examines outcomes by looking at change in health risk levels, IQOMR outcomes, and comparison of support coordination performance on National Core Indicator (NCI) Survey sections. Though measured health risk levels is not a direct measure of outcomes, the analyses below reports on changes over time in this indirect indicator, and a discussion for each ensues concerning work that DBHDD is doing to improve outcomes measurement in these areas.

Health Care Level Scores

The analysis below indicates that the average health care level (health risk) has increased over time for those receiving support coordination and intensive support coordination. This is not a surprising finding. Mortality analyses from 2013-2016 has shown that the average heath care level for the intellectual and developmental disability population has increased over time. Therefore, these analyses support that health risk is increasing over time for this population, and the population, as a whole, is at increasing risk for adverse health outcomes.

Analyses also show that increases in health care level occurred across support coordination and intensive support coordination, as well as across support coordination agencies. These increases are within expected ranges. Taken together, the increase in health risk levels across services and agencies does not indicate discriminant performance; instead, it likely indicates that health risk is increasing over time for the entire population, as show in previous mortality analyses.

Table 16: Difference in HCL between 2016 and 2017

SC Type in 2017	Mean	SD	Median	N
Support Coordination*	0.06	0.57	0	10,338
Intensive Support Coordination*	0.31	1.17	0	1,626
***Indicates statistical significance of $\alpha = .01$**				

Figure 5: Difference in HCL between 2016 and 2017

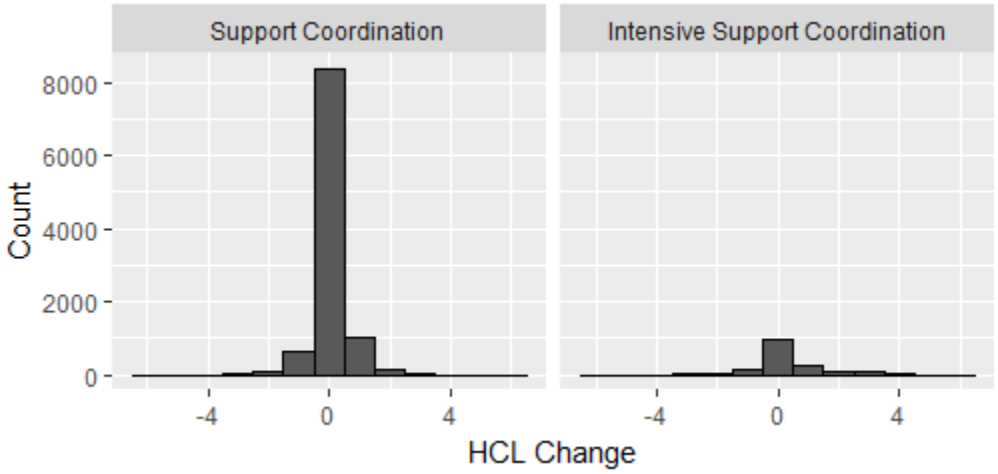


Table 17: Increase/Decrease in HCL between 2016 and 2017

SC Type 17 in 2017	HRST Decreased	Same	HRST Increased
Support Coordination*	730 (7.1%)	8,355 (80.8%)	1,253 (12.1%)
Intensive Support Coordination*	214 (13.2%)	957 (58.9%)	455 (28.0%)
***Indicates statistical significance of χ^2, $\alpha = .01$**			

Table 18: HCL Summary Statistics 2016 and 2017

SC Type in 2017	Avg HCL Before Oct 16	Avg HCL After Oct 16	SD HCL Before Oct 16	SD HCL After Oct 16	Median HCL Before Oct 16	Median HCL After Oct 16
Support Coordination	1.86	1.93	1.01	1.03	2	2
Intensive Support Coordination	4.69	4.99	1.37	1.18	5	5

Table 19: Difference in HCL between 2016 and 2017 by Agency

SC/ISC agency	Mean	SD	Median	N
Benchmark	0.24	1.01	0	292
CareStar	0.16	0.85	0	131
Columbus	0.08	0.72	0	4,057
Compass	0.07	0.82	0	153
Creative	0.11	0.66	0	3,324
Georgia Support	0.12	0.72	0	1,553
PCSA	0.07	0.58	0	2,454

Table 20: HCL Summary Statistics 2016 and 2017 by Agency

SC/ISC agency	Avg HCL Before Oct 16	Avg HCL After Oct 16	SD HCL Before Oct 16	SD HCL After Oct 16	SD HCL Before Oct 16	SD HCL After Oct 16
Benchmark	4.02	4.25	1.64	1.62	4	5
CareStar	4.50	4.66	1.49	1.36	5	5
Columbus	2.17	2.25	1.38	1.43	2	2
Compass	4.10	4.16	1.62	1.59	4	4
Creative	2.14	2.25	1.36	1.41	2	2
Georgia Support	2.20	2.33	1.35	1.40	2	2
PCSA	2.11	2.18	1.33	1.38	2	2

Though it may seem that health risk should decrease over time with more intensive support coordination services, one must keep in mind that there is a difference between "health risk" and "health status." The health care level is a measure of risk; when one becomes at risk for adverse health, the risk tends to persist, especially in this population. On the other hand, health status (e.g., symptoms, functioning, physiological outcomes) are more likely to vary over time and be a better indicator of outcomes versus health risk. Health risk is a critical factor for managing service provision to this populations, and health risk will remain prominent in DBHDD analyses and planning. DBHDD currently is conducting additional analyses into ways to capture indicators of health status and outcomes, which may be a better measure than health risk in measuring outcomes for this population.

IQOMR Outcomes

DBHDD implemented the Individual Quality Outcomes Measure Review tool (IQOMR) in October 2016. Baseline IQOMR area scores are compared between October 2016 and October 2017 below by type of support coordination. This section proceeds by first looking at current scores as an indicator of current outcomes. Attention is then turned towards changes over time.

Currently, support coordination recipients are scoring above 90 percent positive in the following areas:

- Appearance / health,
- Support and services, and
- Home / community options.

Currently, intensive support coordination recipients are scoring above 90 percent positive in the following areas:

- Environmental,
- Appearance / health, and
- Home / community options.

Data indicate support coordination and intensive support coordination recipients are having positive outcomes in most areas. Most notably, both types of support coordination demonstrated high levels of outcomes in appearance / health and home / community options. In other words, individuals are

enjoying improved health and experiencing positive rewards in their homes and communities. These are very positive outcomes.

Conversely, support coordination recipients are currently scoring below 90 percent positive in the areas of environmental and behavioral and emotional outcomes; intensive support coordination recipients are scoring below 90 percent in supports and services and behavioral and emotional outcome areas. Behavioral and emotional outcomes are the lowest scoring area for both types of support coordination. The upwards-pointing, green arrow indicates a significant increase; a downwards-pointing, red arrow indicates a significant decrease.

Table 21: IQOMR Area Proportion Positive Answer

	Baseline October 1, 2016	As of October 1, 2017	Statistically Significant Change
SC			
Environmental	87.1%	88.9%	⇧
Appearance / Health	98.9%	98.9%	Not Significant
Supports and Services	94.6%	93.3%	⇩
Behavioral and Emotional	82.7%	78.8%	⇩
Home / Community Options	89.5%	94.3%	⇧
ISC			
Environmental	96.3%	97.1%	Not Significant
Appearance / Health	98.4%	98.3%	Not Significant
Supports and Services	93.3%	89.6%	⇩
Behavioral and Emotional	70.6%	67.0%	Not Significant
Home / Community Options	84.7%	90.1%	⇧

Changes over time for support coordination indicate the following findings:

- Though environmental is currently below 90 percent, there is significant improvement over time in this area. Home and community options also has increased significantly over time and now is above 90 percent.
- Appearance / health outcomes remained unchanged; this is not surprising given that health outcomes are very high.
- Supports and services outcomes decreased by 1.3 percent. Though this is a significant decrease, it should be noted that supports and services is currently above 90 percent, which is a positive finding.
- The area of behavioral and emotional outcomes area, as mentioned earlier, is the lowest-scoring area, and it has decreased significantly over time.

Changes over time for intensive support coordination indicate the following findings:

- Home / community options outcomes have increased significantly over time. Though environmental and health outcomes areas did not change significantly over time, these are the highest-scoring areas, and these areas had little room for positive change. Therefore, there are positive findings over time in most areas for intensive support coordination.
- Though behavioral and emotional outcomes area did not change significantly over time, it remains the lowest-scoring area.
- Supports and services outcomes have decreased significantly over time.

Overall, two main findings stand out from the above outcomes areas analysis for support coordination and intensive support coordination, on the whole:

- Decreasing positive outcomes are evident in supports and services.
- Individuals receiving support coordination and intensive support coordination are not achieving positive behavioral and emotional outcomes. That this is the lowest-scoring area, also demonstrating difficulty to improve over time, indicates that this may be the most challenging area.

The report now turns to looking at IQOMR outcomes area performance by provider, first for support coordination and then by intensive support coordination. The upwards-pointing, green arrow indicates a significant increase; a downwards-pointing, red arrow indicates a significant decrease. Overall, of course, the findings below match those above.

Table 22: IQOMR Area Proportion Positive Answer

Support Coordination	Current: <90%	Current: At least 90%
Benchmark	Supports and services (81%) Behavioral and emotional (81%)	Environmental (95%) Appearance / health (97%) Home/community (90%)
CareStar		Environmental (100%) Appearance / Health (100%) Supports and services (100%) Behavioral' and emotional (100%) Home/community (100%)
Columbus	Behavioral and emotional (83%) Environmental (82%) ↓	Appearance / health (99%) Supports/services (96%) Home/community (93%) ↑
Compass	Behavioral and emotional (75%) Home/community (88%)	Environmental (100%) Appearance / health (100%) Supports and services (100%)
Creative	Behavioral and emotional (76%) ↓	Appearance / health (99%) Environmental (97%) ↑ Home / community (95%) ↑ Supports and services (90%)
Georgia Support	Behavioral and emotional (85%)	Appearance / health (99%) Support and services (95%) Environmental (94%) Home/community (93%)
PCSA	Environmental (83%) Behavioral and emotional (74%) ↓	Appearance / health (99%) Home/community (95%) Supports and services (95%) ↓

The most notable finding all agencies providing support coordination have at least 90 percent positive outcomes in most areas. Provider level findings are reported below:

- CareStar had 100 percent outcomes in all areas. CareStar had only 11 support coordination participants at the time of this report; therefore, this is not an extreme finding.
- Columbus and Creative demonstrated significant increases in outcomes in at least one area.
- Columbus, Creative, and PCSA produced significant decreases in at least one area; PCSA had significant decreases in two areas (supports/services and behavioral/emotional).

Similar outcomes performance was exhibited for intensive support coordination by agency. The major findings include the following:

- Three providers (CareStar, Creative, and PCSA) demonstrated significant increases in outcomes in at least one area; CareStar had significant increases in two areas.
- All intensive support coordination providers had at least one outcome area below 90 percent. Benchmark had the most outcome areas that indicated performance below 90 percent.
- Compass and Creative had significant decreases, both in behavioral/emotional outcomes area.

Table 23: IQOMR Area Proportion Positive Answer

Intensive Support Coordination	Current: <90%	Current: At least 90%
Benchmark	Supports/services (87%) Home/community (84%) Behavioral/emotional (74%)	Health (97%) Environmental (95%)
CareStar	Behavioral/emotional (81%) 	Environmental (100%) Home/community (99%)  Health (98%) Supports/services (98%)
Columbus	Behavioral/emotional (70%)	Health (98%) Environmental (95%) Supports/services (94%) Home/community (92%)
Compass	Home/community (89%) Behavioral/emotional (60%) 	Health (100%) Environmental (98%) Supports/services (91%)
Creative	Supports/services (83%) Behavioral/emotional (60%) 	Environmental (98%) Health (98%) Home/community (90%) 
Georgia Support	Home/community (84%) Behavioral/emotional (66%)	Environmental (99%) Health (99%) Supports/services (90%)
PCSA	Behavioral/emotional (65%)	Health (100%) Environmental (97%) Home/community (92%)  Supports/services (90%)

The findings and analyses above are limited in several ways. First, the IQOMR contains multiple questions per item. Consider this item: "Are ISP, healthcare plans, nursing plans, medical crisis plans current and available to staff? Are they being implemented? Are nursing hours being provided as indicated on the ISP?" An affirmative response to this item indicates that all elements, and all three questions have an affirmative response. A negative response, however, makes it impossible to discern what elements are missing, and it is impossible to discern if and what portion of item contributes to change over time. In January 2018, DBHDD revised the IQOMR to address this limitation.

National Core Indicator Adult Consumer Survey Results by Support Coordination Agency

Whenever possible, DBHDD attempts to cross-validate and combine findings from multiple areas and data systems to create a more complete understanding of the performance and outcomes of support coordination. The previous findings in this report have relied on DBHDD data. Much of the data are self-reported, and self-reported data have limitations. To overcome some of these limitations (as well as cross-validate findings), DBHDD incorporated benchmark data from a nationally-recognized, CMS-approved survey. These findings are presented below.

DBHDD's Division of Developmental Disabilities participates in the National Core Indicators (NCI) survey.[5] The core indicators are used to assess the outcomes of intellectual and developmental disability services provided to individuals and families. They address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety. An example of a national core indicator would be, "The proportion of people who have a paid job in the community." A great deal of overlap exists between the NCI areas and the areas measured by the IQOMR and other data in this report.

The core indicators also provide information for quality improvement and programmatic management. They are intended to be used in conjunction with other state data sources, such as regional level performance data, results of provider monitoring processes, and information gathered at the individual service coordination level.

A component of the NCI survey is the Adult Consumer Survey (ADS). The ADS was developed for the purpose of collecting information directly from individuals with intellectual/developmental disabilities and their families or advocates. In Georgia, the ADS is administered by the Georgia Collaborative Administrative Service Organization (ASO) as part of the DBHDD quality management system. The ADS collects information from a stratified, randomly-selected sample of individuals across the DBHDD delivery system to be representative of the population served by DBHDD.

NCI Data Analysis

What can DBHDD learn about the overall impact of support coordination? The following section takes a look at how DBHDD and support coordination agencies are performing compared to national NCI averages.

Table 26 (below) presents 2016 ADS scores for national, state, and support coordination agency averages in seven focused outcome areas (FOA): Health, Safety, Person Centered Practices, Community Life, Community Outings, Choice and Rights. The indicators within the FOAs were selected as approximate indicators of the IQOMR items, in order to validate IQOMR items.[6] Scores are also included for seven survey questions directly related to the provision of support coordination services. Support

[5] To see the entire list of Core Indicators, please visit http://www.nationalcoreindicators.org/indicators.

[6] To reduce threats to internal and external validity and to allow for validation and comparison of findings of DBHDD and NCI items, DBHDD presented the IQOMR to the ASO quality management program, who are expert NCI assessors. DBHDD requested the ASO quality management program to identify NCI items would be indicative of the IQOMR areas or items. The ASO quality management program was unaware that DBHDD would use the items selected by the ASO to compare IQOMR findings. The ASO also produced the identified NCI data.

coordination-specific items were chosen because they are national indicators of support coordination performance, allowing for national benchmark comparisons on the important functions, processes, and outcomes association with support coordination.

During 2016, only five support coordination agencies provided services in Georgia. Four agencies (Columbus Community Services, Creative Consulting Services, Georgia Support Services, and Professional Case Management) provided support coordination services; while one agency (A. W. Holdings / Benchmark) provided intensive support coordination services. During this time, Benchmark's caseload was not sufficiently large to gather significant data through the NCI survey. As a result, data is only reported for the four agencies providing support coordination. Support coordination agency scores and state scores for 2016 were compared to the NCI national average for each indicator listed.

This report presents analysis of 484 reviews that occurred in FY16; analysis of the 481 reviews that occurred in FY17 will presented once the NCI comparison data become available. The stratified, randomly-selected samples were statistically valid and representative of the IDD population serviced by DBHDD.

2016 NCI Results

In Table 26, Georgia's statewide and support coordination agency-specific scores for 2016 indicators are color coded for performance comparisons against the national averages. Once 2017 data become available, similar analyses will be conducted.

Indicator scores highlighted in green are those scores where statistical testing indicated that the state or individual support coordination agency overall score was statistically **above** the NCI national average for that particular indicator.

Indicator scores highlighted in red are those scores where statistical testing indicated that the state or individual support coordination agency overall average was statistically **below** the NCI national average for that particular indicator.

Indicator scores with no highlighting are those scores where statistical testing indicated that the state or individual support coordination agency overall score was within the **average** range of the NCI national average for that particular indicator.

Health Focused Outcome Area

For the purpose of this report, one indicator was utilized to assess the level of performance for the Health FOA: "Person reports being in poor health." All support coordination agencies were performing as well as the national average; three out of four providers were performing significantly above the national average for this one indicator.

Community Life Focused Outcome Area

Community life was assessed using six indicators related to employment, friendships, and availability of transportation. Support coordination agencies overall were performing on average or significantly above the national average 71 percent of the time in 2016. All agencies were performing significantly below the national average in the area of transportation.

Community Outings Focused Outcome Area

Community outings were assessed using four indicators related to types of outings. Support coordination agencies overall were performing on average or significantly above average 88 percent of the time in 2016. Two agencies performed significantly below the national average concerning individuals going out to complete errands.

Rights Focused Outcome Area

Seven indicators were used to assess when individuals' rights were being respected. Questions were related to people entering an individual's home or bedroom without prior notice, privacy, dating, and phone/internet use. Support coordination agencies overall were performing within the average or significantly above the national average 93 percent of the time in 2016. Two agencies performed significantly below the national average with respect to person's entering an individual's home without prior notice.

Person-Centered Focused Outcome Area

This outcome area was assessed using two indicators related individuals' satisfaction with employment and two questions related to individuals' satisfaction with their living arrangements. For the entire FOA, all support coordination agencies performed at or above the national average. Agencies performed significantly above average 62 percent of the time in the area related to a person's satisfaction with their living arrangements.

Safety Focused Outcome Area

This outcome area was assessed using six indicators related to a person feeling afraid while at home, in the community, at work, at their day program, or while be transported. An additional indicator asked specifically if the individual had someone to talk to when they were afraid. All support coordination agencies performed at or above the national average for all items. Two support coordinator agencies performed significantly above the national average in assuring that individuals had someone to talk to when they were afraid.

Choice Focused Outcome Area

The level of choice individuals have in making life decisions was assessed using eight indicators related to what to buy with their money, how to spend free time, day activities, etc. Support coordination agencies overall performed as well as the national average for 2016 for all items.

Support Coordination-Specific Questions

The NCI also captures support coordination-specific items. The provision of support coordination services was assessed using seven indicators related to familiarity with the support coordinator, support coordinator responsiveness, and individual service plan development, allowing for 24 points of comparison. (One item does not have a national average reported; therefore, it was not used in the comparison, but reported.) All support coordination agencies performed at least as well as the national averages on all NCI support coordination-specific items; support coordination agencies also scored above national averages on almost 30 percent of the points of comparison.

Table 24: NCI Results 2016

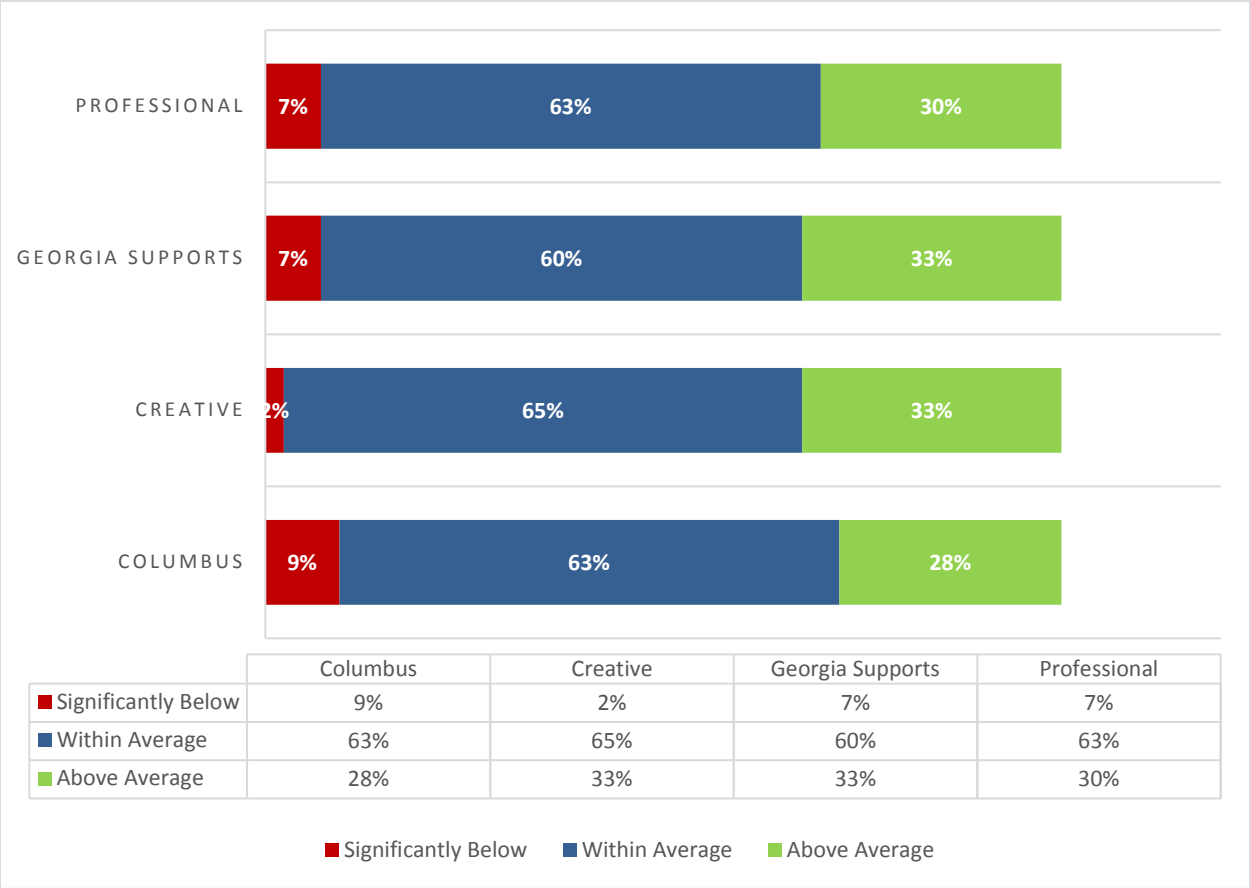
Selected NCI Adult Consumer Survey Results by SC Agency

National Core Indicator	FY 2016					
	% National	% Georgia	% Columbus Community Services	% Creative Consulting Services	% Georgia Support Services / MGBS	% Professional Case Management Services of America
Health						
Person reports being in poor health	3%	1%	1%	2%	0%	1%
Community Life						
Person has friends who are not paid staff or family members	77%	85%	80%	86%	95%	85%
Person has transportation when needed.	93%	82%	82%	82%	84%	78%
Do you participate in community groups?	37%	63%	65%	43%	78%	69%
Do you have a paid job in the community?	19%	25%	13%	33%	24%	11%
Do you volunteer?	30%	30%	32%	37%	15%	28%
Do you go to a program or workshop, where other people with disabilities work?	57%	70%	73%	72%	84%	69%
Community Outings						
Go out to eat?	88%	96%	97%	93%	96%	97%
Go out for entertainment?	77%	84%	80%	85%	85%	80%
Go out on errands?	88%	83%	80%	85%	85%	80%
Go shopping?	91%	95%	95%	95%	98%	94%
Rights						
Do people let you know before entering your home?	89%	87%	80%	94%	82%	89%
Do people let you know before entering your bedroom?	87%	88%	87%	87%	89%	89%
Can you go on a date if you want to?	70%	83%	82%	82%	83%	81%
Do you have enough privacy at home?	NA*	99%	99%	99%	100%	100%
People do not read mail or email without asking?	87%	91%	89%	90%	91%	98%
Can you be alone with guests?	83%	91%	96%	88%	86%	85%
Are you allowed to use the phone or internet?	89%	94%	96%	89%	100%	95%
Support Coordination						
Have you met your case manager/service coordinator?	95%	91%	93%	92%	92%	93%
Case Manager/Service Coordinator asks what you want?	88%	87%	88%	92%	83%	86%
Are you able to contact your case manager/service coordinator when you want to?	87%	88%	90%	84%	97%	93%
Do you have a service plan?	NA*	96%	97%	95%	95%	98%
At the service planning meeting, did you know what was being talked about?	83%	84%	84%	82%	78%	84%
Did the service planning meeting include the people you wanted to be there?	92%	97%	92%	97%	100%	100%
Were you able to choose the services that you get as part of your service plan?	75%	85%	86%	91%	78%	80%
Person Centered						
Do you like your job in the community?	92%	96%	91%	96%	100%	100%
Would you like to work somewhere else?	27%	25%	42%	74%	22%	50%
Do you like where you live?	89%	91%	89%	91%	97%	90%
Would like to live somewhere else? (Negative answer equals positive outcome)	27%	21%	24%	24%	3%	16%
Safety						
Ever afraid at home? (Positive answer indicates positive outcome. States are not ranked against NCI average for this indicator.)	93%	97%	97%	97%	100%	100%
Ever afraid in community? (Positive answer indicates positive outcome. States are not ranked against NCI average for this indicator.)	93%	99%	98%	98%	100%	99%
Ever afraid at day program? (Positive answer indicates positive outcome. States are not ranked for this indicator.)	97%	99%	99%	99%	100%	96%
Ever afraid while being transported? (Positive answer indicates positive outcome. States are not ranked against NCI average for this indicator.)	97%	99%	98%	100%	100%	100%
Ever afraid at work? (Positive answer indicates positive outcome. States are not ranked against NCI average for this indicator.)	99%	99%	100%	99%	100%	99%
If you ever feel afraid, do you have someone to talk to?	94%	95%	97%	99%	92%	90%

National Core Indicator	FY 2016					
	% National	% Georgia	% Columbus Community Services	% Creative Consulting Services	% Georgia Support Services / MGBS	% Professional Case Management Services of America
Choice						
Person chooses what to buy with his/her money. (States are not ranked against the National average for this indicator; however states are ranked against other states. In FY16, Georgia ranked first out of 35 NCI States.)	91%	59%	59%	60%	55%	58%
Person chose job. (States are not ranked against the National average for this indicator; however states are ranked against other states. For FY 16, Georgia ranked eighth out of 35 NCI States.)	87%	62%	55%	63%	44%	47%
Person chooses how to spend free time. (States are not ranked against the National average for this indicator; however states are ranked against other states. In FY16, Georgia ranked first out of 35 NCI States.)	92%	78%	76%	74%	83%	77%
Person chooses daily schedule. (States are not ranked against the National average for this indicator; however states are ranked against other states. In FY16, Georgia ranked first out of 35 NCI States.)	84%	65%	63%	60%	69%	62%
Person chose day activity. (States are not ranked against the National average for this indicator; however states are ranked against other states. In FY16 Georgia ranked second out of 35 NCI States.)	65%	46%	44%	29%	64%	46%
Person chose home. (States are not ranked against the National average for this indicator; however states are ranked against other states. In FY16 Georgia ranked third out of 35 NCI States.)	57%	38%	36%	26%	47%	31%
Person chose housemate. (States are not ranked against the National average for this indicator; however states are ranked against other states. In FY16, Georgia ranked fifth out of 35 NCI States.)	47%	35%	32%	30%	38%	25%
Person chose staff. (States are not ranked against the National average for this indicator; however states are ranked against other states. In FY16, Georgia ranked fourteenth out of 35 NCI States.)	69%	9%	13%	6%	9%	3%
*National percents were not calculated for the following indicators: "Do you have enough privacy at home?" and "Do you have a service plan?"						

Though there were some area for improvement in FY 2016, the support coordination system performed within or significantly above average when compared to national averages. In fact, as can be seen below in Figure 6, four support coordination agencies in 2016 were compared on 43 indicators, for a total of 172 evaluation points. The support coordination agencies performed as well as the national average or higher on 93 percent of all comparison points. This is a very positive performance level for the support coordination agencies in Georgia.

Figure 6: Proportion of NCI Responses Significantly Higher or Lower than National



	Columbus	Creative	Georgia Supports	Professional
Significantly Below	9%	2%	7%	7%
Within Average	63%	65%	60%	63%
Above Average	28%	33%	33%	30%

DBHDD and NCI: Combining Findings

Data and analyses indicate providers of support coordination and intensive support coordination are delivering positive outcomes to individuals. Clearly, caseload sizes are, by large measure, aligned with requirements. Furthermore, not only is the vast majority of individuals receiving the required face-to-face visits, but also the number of face-to-face visits is based on the level of need indicated by risk factors such as health risk and age. IQOMR data also indicate that support coordinator processes and procedures are being followed and producing positive outcomes in most areas, and some improvement can be made in some areas, especially behavioral and emotional outcomes area.

So, what does the NCI data add to these analyses? Recall that for 2016, Georgia support coordination agencies performed as well as average or better than average on 93 percent of the 172 comparisons that were made. In other words, externally-collected data validate DBHDD data. Consider, for example, that the IQOMR reported extremely high health outcomes data for most individuals; the NCI data do also. Consider also the home and community outcomes area of the IQOMR; it ranges from 84 percent to 99 percent. NCI data on similar questions as the areas of the IQOMR also show similar findings. Therefore, the NCI data are important in that they (1) provide a means of comparing support coordination with national performance and (2) also substantiate and validate DBHDD data that shows similar findings.

The NCI data provide additional outcomes information that are not captured by other DBHDD data sources. For example, consider the support coordination evaluation items. These data are not collected by the IQOMR directly; however, the NCI data highlight that Georgia support coordinator agencies are performing as well as, and better in some categories, as other support coordination agencies in 2016.

The NCI data analysis are important for several reasons. First, the NCI items have demonstrated reliability, validity, and have been accepted nationally as benchmarks for performance. (DBHDD is confident data presented in previous sections are useful, though DBHDD is still in the process of establishing reliability, validity, and benchmarks for many of the data reported earlier.) Second, the NCI data are collected independent of other data.

The NCI data provide not only information from a different perspective, but also, in this manner, whenever NCI and DBHDD indicate similar findings, the findings can be considered more likely to be valid. Though percentages are not exact matches and some variances exist across specific performance data, as can be seen above, the NCI and DBHDD data analyses converge to similar findings. In this manner, the NCI data validate many of DBHDD findings, as well as provide additional support the positive performance of support coordination.

Summary of Support Coordination Performance Findings

This section summarizes the findings from support coordination performance. The major findings are listed below. It is concluded that even though there are areas improvement, all support coordination agencies are performing well and demonstrating positive performance with requirements and delivering positive outcomes in most areas.

While the findings within this report are favorable in most sections, it should be noted that when an agency is not meeting targets, DBHDD actively engages to understand challenges and support performance achievement.

Caseload Size:

- Five support coordination agencies have achieved positive performance with caseload size requirements. Of the two that have not achieved performance compliance, one (CareStar) has a record of having 100 percent compliance, and the other (Georgia Support) evidences increasing trend towards achieving compliance.
- Sections of Georgia are sparsely populated with some sections having relatively few individuals receiving support coordination and intensive support coordination for hundreds of square miles, resulting in large distances and travel times to deliver services. The caseload size requirement places difficulty for support coordination business operations to achieve efficiencies needed to operate. Despite the challenges of having to travel miles and added time to comply with caseload size requirements, as mentioned above, support coordination agencies are already achieving or increasing compliance with caseload size requirements.

Face-to-Face Visits:

- The vast majority of individuals receiving support coordination and intensive support coordination are receiving the required number of face-to-face visits; though few are receiving fewer visits than required, many are receiving more visits than required.
- The number of face-to-face visits correlates well with need and risk of individuals. Individuals with increasing health risks and increasing age (known risk factors for adverse outcomes) receive more frequent visits.
- All support coordination agencies (of both support coordination and intensive support coordination) are delivering within one support coordination visit compared with what would be expected based on increasing health risk and age.

Coaching and Referrals:

- Support coordinators initiated and followed-up on 18,550 coaching and referral activities to facilitate positive outcomes. Where positive outcomes are noted in this report, it is most evident that much of what has been achieved is from the coaching and referral activities of support coordinators.
- Support coordinators expended the most resources and efforts towards producing positive outcomes in two primary areas: appearance/health and supports/services. These two areas also have the highest proportion of all referrals that are beyond their expected close date (appearance/health: 103/202 = 51%; supports/services: 47/202 = 23%). That appearance/health and supports/services comprise almost 75 percent of all referrals open

beyond the expected close date indicates that support coordinators may need additional assistance to facilitate positive outcomes in these areas.

- Behavioral and emotional outcomes received the second-lowest number of combined coaching and referral activities (reviewed in next section). This finding is concerning given that behavioral and emotional outcomes was the area that most consistently demonstrated declines over time for individuals.
- Reported metrics provide evidence of support coordinators' productivity. Compass consistently had the highest metrics across areas; Columbus consistently had among the lowest across areas. However, positive outcomes in most areas were noted for these providers. Therefore, additional investigation is warranted to understand these metrics better and how best to use them to monitor support coordination performance towards producing positive outcomes for individuals.

Evidence of Outcomes:

- Change in health risk: The health risk level (as measured by the Health Care Level—HCL) increased over the past year. This is neither surprising nor concerning given that 2013-2016 mortality analyses have demonstrated a steady increase in the health risk of this population.
- Change in health risk: Health risk differs significantly from health status. Health status (e.g., symptoms, functioning, physiological status, medical inpatient admissions, emergency department utilization, etc.) may be a more valid and reliable measure of health outcomes than health risk, which is persistent and changes little over time (as measured by the HCL of the HRST). While measuring and using health risk measures will continue to play an important role in managing the health of this population, DBHDD is pursuing developing other measures to provide information about health status and outcomes.
- Health outcomes: Individuals receiving both types of support coordination have benefitted from high levels of positive health outcomes.
- Home and community options: Individuals receiving both types of support coordination have benefitted from high levels of home and community outcomes. This indicates that individuals' home life is positive, beneficial and community integration is occurring in a very positive manner.
- Environmental and supports and services outcomes: Support coordination recipients also have benefitted from positive outcomes in their supports and services, and intensive support coordination recipients have benefitted significantly from positive environmental outcomes.
- Behavioral and emotional outcomes: Positive outcomes, overall, are evident in the above-mentioned areas with exception to behavioral and emotional outcomes. Whereas other areas have some demonstrated significant gains and high levels of positive outcomes, behavioral and emotional outcomes, on the other hand, have persisted at the lowest level, and significant decreases in behavioral and emotional outcomes was found. Decreases in behavioral and emotional outcomes is the only area of performance concern found within this report. As stated earlier, this outcome area received the second lowest number of combined coaching and referral activities by support coordinators.
- National Core Indicator outcomes and performance data:

- NCI data analyses demonstrates that the support coordination agencies in Georgia are performing at or above the national averages on outcomes areas measured by the NCI (93%).
- NCI data indicate that support coordination agencies in Georgia are performing as well as, and sometimes significantly higher than other states in the following areas:
  - Health
  - Community life
  - Community outings
  - Rights
  - Support coordination
  - Person centered
  - Safety
  - Choice

Validation of DBHDD-collected Data:

- Though variation exists between DBHDD-collected and NCI data, DBHDD-collected data align with NCI findings and outcomes. This means that DBHDD-collected data have convergent validity with NCI data, which have demonstrated reliability, validity, and have been accepted nationally as benchmarks of performance.
- Though DBHDD-collected data have demonstrated convergent validity with NCI data, DBHDD is continuing work to establish additional reliable, valid, and useful measures of performance, health status, and outcomes.
  - The IQOMR has been revised to create separate, discreet support coordination process and outcomes items (versus multiple questions being asked by single items).
  - DBHDD is working to create additional measures of health status.
  - DBHDD continues to analyze other DBHDD information to identify reliable, valid, and useful performance measures of compliance, processes, and outcomes.

Appendix A: Individual Quality Outcome Measure Review (IQOMR)

Individual Quality Outcome Measure Review					
Individual's Name:			CID#		
Physical Address:	(pulls from member page physical address not agency address)				
Location of visit:					
Date of Visit:		Start Time:		End Time:	
Note Code					
Contact Type:		Contact		Billable Event:	
ADA Population		Funding Source:		Exceptional Rate:	
Service Monitoring:					
HRST Score:		Date of Last:			

Individual Support Plan Focus Areas

Directions: For each section, check if the services/supports are being provided in an adequate manner or if there are concerns or deficits. In the *Comment/Actions Needed* box, list identified *Concerns, Barriers and Successes* for each section. Additionally, describe any steps being taken to address any concerns/issues observed.

	Focus Area:	Select:	Comments/Actions Needed
Environment			**Concerns, Barriers, Successes**
1	Is the home/site accessible to the individual?		
2	Does the individual have access to privacy; including, but not limited to, personal care, visitors, discussions, mail, and/or other communications?		
3	The home setting allows the individual the option to have a private bedroom.		
4	Are all assistive technologies being utilized as planned and in good working order?		
5	Does the individual have adequate clothing, food, and supplies available to accommodate the individual's needs and/or preferences/choices?		
6	Is the Residential/Day setting clean, safe and appropriate for the individual's needs and preferences?		

	Appearance/Health		
7	Does the individual appear healthy and safe? Describe appearance and any changes since the last visit.		
8	Have there been any changes observed or reported in health since the last visit? If yes, describe the change(s) and indicate if the HRST is aligned with the current health and safety needs of the individual.		

9	Are the ISP, healthcare plans, nursing plans, medical crisis plans current and available to staff? Are they being implemented? Are nursing hours being provided as indicated on the ISP?		
10	Are all medical/ therapeutic appointments and follow-up appointments, recommendations/orders and required assessments/ evaluations, being attended, followed, and/or completed, as ordered?		
11	Has the individual had any hospital admissions and/or emergency room visits since the last visit? If so, have discharge plan instructions been followed?		
Supports and Services			
12	Do the individual's paid staff and/or natural supports treat them with respect and dignity?		
13	Are supports and services being delivered to the individual, as identified in the current ISP? Are staff ratios in place, as indicated in the ISP?		
14	Is the individual being supported to make progress in achieving their goals (both ISP goals and informally expressed goals)? Indicate the status of the individual's progress toward achieving established goals.		
15	Are there any additional service/support needs not being met at this time? Describe.		

Behavioral and Emotional			
16	Since the last visit, are there any emerging or continuing behavioral/ emotional responses for the individual? If yes, are current supports adequate to prevent engaging external interventions?		
17	Does the individual currently have an implemented Behavioral Support Plan, Crisis Plan, and/or Safety Plan? Is/Are the plan(s) available on site for staff review? (Evidence of implementation includes staff being knowledgeable about plan and ability to describe how they are implementing the plan.)		

18	Since the last visit, has the individual accessed the DD crisis system, psychiatric hospital, crisis stabilization unit, ER, or had contact with law enforcement for behavioral issues? If yes, describe reason, frequency, duration of any admissions, and if discharge recommendations have been followed. As a result, has the BSP/Safety Plan/Crisis Plan been adapted to reflect any new recommendations or interventions needed?		

Home / Community Opportunities			
19	Does the individual have people in his/her life other than paid staff and do they have community connections? Describe current natural supports and how/where the individual is connected to that person or group. Describe steps being taken to further develop natural supports.		
20	Is the individual receiving services in a setting where he/she has the opportunity to interact with people who do not have disabilities (other than paid staff)? Is the individual being offered/provided documented opportunities to participate in activities of choice with non-paid community members?		
21	Does the individual have the opportunity to participate in activities he/she enjoys in their home and community? Describe steps being taken to increase opportunities to meet this objective and allow choices to be offered while in services.		
22	Is the individual actively supported to seek and/or maintain employment in competitive and integrated settings and/or offered customized opportunities, if desired? Is yes, note how he/she is supported to do so. If no, how is the issue being addressed?		
23	Does the individual have the necessary access to transportation for employment and community activities of his/her choice?		
Financial			
24	Are there barriers in place that limit the individual's access to spend his/her money, as desired?		
Satisfaction			
25	How did the individual communicate their overall satisfaction with their life activities during the visit (include providers, services, family, etc.)? Does the individual express/indicate satisfaction with current supports and services? Describe any dissatisfaction with current supports and services.		

Observations/Comments:

SC Signature

Date