DBHDD Support Coordination Performance Report

Georgia Department of Behavioral Health and Developmental Disabilities

June 30, 2018

Table of Contents

DBHDD Support Coordination Performance Report 6

Purpose of Support Coordination Performance Report 6

Utilization of Support Coordination Performance Report Findings 6

About DBHDD 6

Vision 6

Mission 6

About DBHDD Intellectual and Developmental Disability Services 7

Scope of this Report 8

Interpreting Statistical Tests 8

About Support Coordination and Intensive Support Coordination 9

Support Coordination Reform 9

Support Coordination Caseload 10

Individual Service Plans 11

Statewide Clinical Oversight 12

Analysis of IDD Waiver Data Related to Support Coordination and Intensive Support Coordination 13

Agency Enrollment 13

Caseload Size 14

Face-to-Face Visits by Month 18

Health Care Level Scores 20

Coaching and Referrals 22

Coaching and Referral Summary 30

Outcomes of Support Coordination and Intensive Support Coordination 31

Health Care Level Scores 31

IQOMR Outcomes 33

Individual Support Plan Quality Assurance by Support Coordination Agency 36

Category Ratings 37

National Core Indicators 42

NCI Data Analysis 42

2017 NCI Results 43

Health Focused Outcome Area 43

Community Life Focused Outcome Area 43

Community Outings Focused Outcome Area 44

Rights Focused Outcome Area 44

Person-Centered Focused Outcome Area 44

Safety Focused Outcome Area 44

Choice Focused Outcome Area 44

Support Coordination-Specific Questions 45

ISP-Specific Questions 47

DBHDD, ASO, and NCI: Combining Findings 48

Summary of Support Coordination Performance Findings 49

Caseload Size: 49

Face-to-Face Visits: 49

Coaching and Referrals: 49

Evidence of Outcomes: 50

Validation of DBHDD-collected Data: 51

Appendix A: Individual Quality Outcome Measure Review (IQOMR) 52

Table of Tables

Table 1: SC/ISC Agency Attributes as of January 2018 13
Table 2: Overall Compliance with SC Caseload Policy by Month 16
Table 3: Maps of Georgia, Intensive Support Coordination, Support Coordination Populations as of March 2018 17
Table 4: Number of Face-to-Face Visits January through March 2018 (SC) 19
Table 5: Number of Monthly Face-to-Face Visits January to March 2018 (ISC) 20
Table 6: Poisson Regression Model of Number of Face-to-Face Visits Associated with Age and HCL (Overall Population) 21
Table 7: Poisson Regression Model of Number of Face-to-Face Visits Associated with Age and Level of Support Coordination (Overall Population) 21
Table 8: Mean Difference between Expected and Observed Numbers of Face-to-Face Visits for January through March 2018 22
Table 9: Coachings and Referrals Statistics for the System July 2017 through March 2018 24
Table 10: Coachings and Referrals: Appearance/Health, July 2017 through March 2018 25
Table 11: Coachings and Referrals: Supports and Services, July 2017 through March 2018 26
Table 12: Coachings and Referrals: Environment, July 2017 through March 2018 26
Table 13: Coachings and Referrals: Home/Community Opportunities, July 2017 through March 2018 27
Table 14: Coachings and Referrals: Financial, July 2017 through March 2018 27
Table 15: Coachings and Referrals: Behavioral and Emotional, July 2017 through March 2018 28
Table 16: Coachings and Referrals: Satisfaction, July 2017 through March 2018 28
Table 17: Coachings and Referrals: Critical Incident Follow-Up, July 2017 through March 2018 29
Table 18: Difference in HCL between 2017 and 2018 31
Table 19: Increase/Decrease in HCL between 2017 and 2018 31
Table 20: HCL Summary Statistics 2017 and 2018 31
Table 21: Difference in HCL between 2017 and 2018 by Agency 32
Table 22: HCL Summary Statistics 2017 and 2018 by Agency 32
Table 23: IQOMR Area Proportion Positive Answer March 2018 33
Table 24: SC IQOMR Area Proportion Positive Answer as of March 2018 34
Table 25: Intensive Support Coordination IQOMR Area Proportion Positive Answer as of March 2018 35
Table 26: ISP QA Combined Scores 37
Table 27: ISP QA Checklist State Average, January through March 2018 38
Table 28: ISP QA Checklist Ratings: Benchmark, January through March 2018 38
Table 29: ISP QA Checklist Ratings: CareStar, January through March 2018 39
Table 30: ISP QA Checklist Ratings: Columbus, January through March 2018 39
Table 31: ISP QA Checklist Ratings: Compass, January through March 2018 40
Table 32: ISP QA Checklist Ratings: Creative Consulting, January through March 2018 40
Table 33: ISP QA Checklist Ratings: Georgia Support Services, January through March 2018 41
Table 34: ISP QA Checklist Ratings: Professional Case Management, January through March 2018 41
Table 35: NCI Results 2017 46

Table of Figures

Figure 1: Caseload Compliance by Month 15
Figure 2: Number of Support Coordination Face-to-Face Visits January through March 2018 for One Quarterly Visit Requirement 18
Figure 3: Number of Intensive Support Coordination Face-to-Face Visits January through March 2018 for Monthly Visit Requirements 19
Figure 4: Proportion of NCI Responses Significantly Higher or Lower than National Average 47

DBHDD Support Coordination Performance Report

Purpose of Support Coordination Performance Report

DBHDD seeks to review data regularly supplied by support coordination agencies and performance data collected on support coordination agencies. The purpose of this report is to report on data analysis and to assess the performance of support coordinators, their agencies, and Medicaid waiver support coordination service 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 (DD) for consideration in identifying issues that need additional analysis, investigation, and interpretation to improve the quality of care.

The director of the Division of DD is responsible for the utilization of the information within this report. The DD 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 DD in the community. DBHDD's organizational alignment provides a platform for clarified roles and responsibilities in addressing support coordination performance issues for the DBHDD DD 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 DD to accomplish improvement strategies; the Division of DD has the responsibility to utilize these resources. The Division of DD 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

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 January 1, 2017 through April 1, 2018. Data within this report are from July 1, 2017 to April 1, 2018, except for health care level data, which extends back to January 1, 2017.

Performance review of support coordination occurs on an ongoing basis, and performance metrics are examined regularly (e.g., monthly or quarterly). Formal support coordination reports are created on at least an annual basis. This is an update and expansion of earlier support coordination performance reports that were started June 30, 2017. The most recent Support Coordination Performance Report was released in February 2018. Not surprisingly, the findings in the current report are similar to the findings in the February 2018 report because the reports were conducted so closely in time.

It often makes sense to conduct statistical comparisons to look at change over time; that these two reports have been released so closely in time, however, statistical comparisons are not useful to determine change over time, given only a few months have passed. In fact, statistical comparisons may mislead and give the impression that change is not occurring, which may not be true. Statistical comparisons of metrics over time will occur in later reports.

Interpreting Statistical Tests

The following sections report statistical analyses. Statistical analyses are useful to identify associations and trends among variables that may be associated. Statistics commonly refers to "statistical significance." Sometimes associations or patterns occur due to random chance. A statistically significant difference for a result or relationship has a likelihood that it is caused by *something* other than mere random chance. It is a natural tendency to assume when there is a statistically significant difference or association that it *must* result from the *something* other than a random chance and that the difference *must* have a specific cause. It is important to exercise caution when interpreting statistical significance in this manner, as sufficient facts may not necessarily be present to conclude a specific idea of what that *something* is. It is important that statistical significance should be studied further by gathering additional information and by completing a more extensive analysis through additional steps. It also should be noted that statistical significance does not equate to *importance* or *meaningful significance*. Meaning and importance of findings can only be determined by more careful examination of additional information.

This report does not make conclusions about any differences or statistically significant findings. As such, the statistical findings will be presented to DBHDD to be considered along with other information for further exploration to understand the causes and implications of the statistical findings. Where there are specific information, findings, observations, cases, and issues that warrant additional investigation, analysis, and consideration, work is underway to examine possible strategies to address these concerns within DBHDD.

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 Supports Intensity Scale (SIS); and administration of the National Core Indicator (NCI) Survey; in addition to the common case management tasks of advocacy and service coordination.

Support Coordination Reform

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
- Remove the SIS administration as a responsibility to support conflict free case management
- 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
- Define caseload size in 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)." 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 was refined to focus on improving outcomes based on advocacy, planning, coordination of waiver and nonwaiver services, 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 the refined responsibilities and on the IQOMR. Additionally, extensive training was offered on how to utilize the HRST and the SIS

[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 less-intensive level of these two services; "intensive support coordination" (ISC) is used to refer to the more-intensive form of support coordination.

to improve outcomes based on evaluating risk and needed supports for people to live safely and successfully in the community.

In 2016, DBHDD began recruiting providers for a new waiver service called intensive support coordination (ISC). Intensive support coordination includes all the activities of support coordination (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 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. Intensive support coordination participants benefit from the inclusion of clinical supervision from the beginning of intensive support coordination service provision.

Enrollment of additional eligible waiver participants into intensive support coordination services began in November 2016. Total enrollment as of July 2017, was 1,549. As of May 17, 2018, total enrollment was 1,940. Enrollment is ongoing based on the following:

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

Telephonic, web-based 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] which includes content from web-based trainings offered by the DBHDD Office of Community Supports. Additional training has been developed focusing on how the HRST and the SIS may be used by support coordination for service planning purposes.

Support Coordination Caseload

DBHDD is working to optimize the maximum caseload size 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 and continues to be difficult for agencies to identify where these new enrollees would be located geographically and which agencies they would choose. Consequently, there

[2] Part III Policies and Procedures for Support Coordination Services and Intensive Support Coordination Services (COMP & NOW Waiver Programs)
[3] DBHDD Developmental Disabilities Training Announcements
[4] DBHDD University, Relias Online Learning Library

was a disruption in agencies' ability to identify areas in which new hires should be recruited. In consideration of ongoing enrollment, DBHDD utilizes a short-term "caseload mix strategy," whereby an intensive support coordinator may have a combination of intensive support coordination and traditional support coordination participants assigned. With each addition of an intensive support coordination participant, the total caseload maximum reduces based on a 1:3 ratio (1 Intensive Support Coordination participant = 3 traditional Support Coordination participants). Following the initial enrollment process in October 2016, DBHDD amended its policy on support coordination caseloads to include a more conservative caseload mix strategy effort to continue optimization of caseload sizes.

Individual Service Plans

DBHDD regularly reviews the creation of individual service plans (ISP). DBHDD compared its ISP template with several ISP templates 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 other 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.

The Division of DD recognized these challenges and hosted workgroup sessions for support coordination agency quality assurance staff, field office ISP reviewers, and DD divisional leadership. The intent of the workgroups was to discuss what is working and not working with the current ISP document and decide which changes could be made to the current ISP, while awaiting the development of a new IT system.

System-wide improvement efforts relating to the ISP are intended to achieve the following results:

- Streamlining of the current ISP document within the web-based system, to eliminate the support coordinators' completion of any sections that have overlapping functions;
- 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;
- Changes in the verbiage of certain section titles to yield better understanding of the intent;
- 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;
- Make ISP and the ISP process more person-focused through person-centered philosophy application

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 more 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 provide continuity of care during ISP approval periods.

Participants will benefit from having ISPs that are meaningful to the participant and clearly understood by all team members responsible for ISP implementation. Guidelines utilized by DBHDD's external quality review agency for evaluation of ISP quality were also revised by the Division of IDD to promote completion of reviews that are aligned with the revised directives on ISP development provided to support coordination.

Statewide Clinical Oversight

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.

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

Seven support coordination agencies make up the population of providers currently offering support coordination and intensive support coordination. Support coordination agencies are listed below and will be referenced throughout the report. All agencies provide support coordination and intensive support coordination.

- Benchmark Human Services
- CareStar of Georgia
- Columbus Community Services
- Creative Consulting Services
- Compass Coordination
- Georgia Support Services
- Professional Case Management Services of America (PCSA)

The following sections contain analyses that are meant to be executed periodically so outcomes can be evaluated. The aim of these analyses is ultimately to assess compliance with policy and improve the performance of support coordination agencies in providing quality services.

Agency Enrollment

Support coordination and intensive support coordination enrollment numbers per agency are displayed in Table 1 below. The size of each agency has a 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 ISC recipients.

Most of the waiver participants are enrolled in support coordination as opposed to intensive support coordination.

Table 1: SC/ISC Agency Attributes as of January 2018

SC/ISC Agency	SC	ISC	Proportion ISC	Mean HCL 1/18/18	Mean HCL SC	Mean HCL ISC
Benchmark	131	294	69.18	4.00	2.35	4.45
CareStar	21	134	86.45	4.51	2.12	4.7
Columbus	3,589	425	10.59	2.20	1.87	4.95
Compass	38	146	79.35	4.15	2.3	4.31
Creative	3,131	395	11.2	2.27	1.87	5.02
Georgia Support	1,405	133	8.65	2.28	1.96	5.16
PCSA	2,196	217	8.99	2.16	1.86	5.07

Shading is used to illustrate individual agency enrollment numbers relative to other agencies.

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 of 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 individuals' or caregivers' responses to a series of detailed questions related to functional status, behaviors, physiological condition, safety, and frequency of services. In the February 2018 Support Coordination Performance Report, the average HCL 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

The following section takes a closer look at how DBHDD is performing 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.

DBHDD policy[5] regarding the caseload size of support coordinators 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 an individual support coordinator's caseload, which has been used for these analyses.

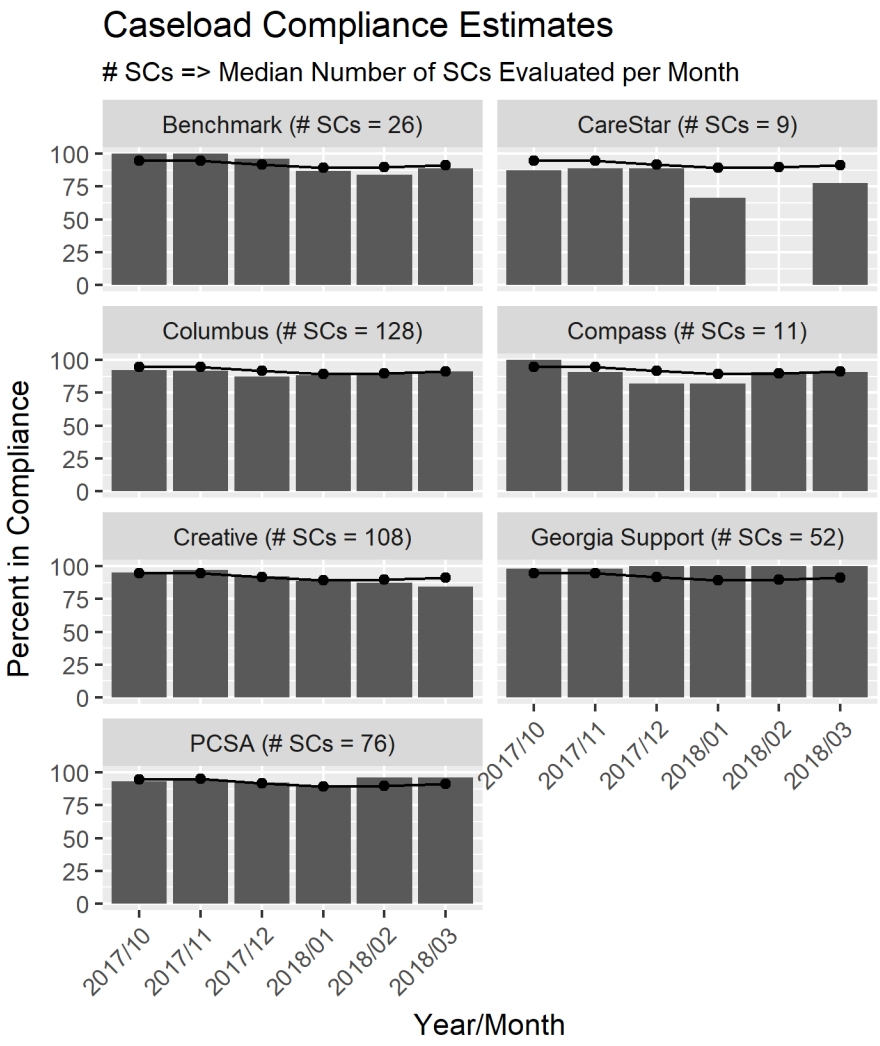
As of March 2018, the proportion of support coordinators in compliance with caseload requirements is above 85% for six of the seven support coordination agencies. The overall caseload size for the population is 91%. Both these results are considered findings of positive performance.

As of March 2018, the proportion of support coordinators in compliance with caseload requirements is above 85 percent for six of the seven support coordination agencies. The overall caseload size compliance for the population is 91 percent as well. Both these results are considered findings of positive performance. Calculations are based on the number of support coordinators in and out of compliance on the first Monday of every month. The denominator counts the number of person-

[5] DBHDD Policy: Support Coordination Caseloads, Participant Admission, and Discharge Standards, 02-432

months[6] an agency had in the six-month period and the numerator shows the number of person-months in which support coordinators were not over their caseload counts.

Figure 1: Caseload Compliance by Month



The dark boxes in Figure 1 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.

[6] Person-month is a unit measuring the number of months a person was in services. It helps qualify the amount of time a person was in services, so someone in services for a long time is weighted more in terms of risk than someone in services for a short period of time.

Table 2: Overall Compliance with SC Caseload Policy by Month

Month	In Compliance	Total SCs	Percent Compliance
2017-10	383	405	95%
2017-11	393	414	95%
2017-12	377	411	92%
2018-01	362	405	89%
2018-02	369	411	90%
2018-03	380	417	91%

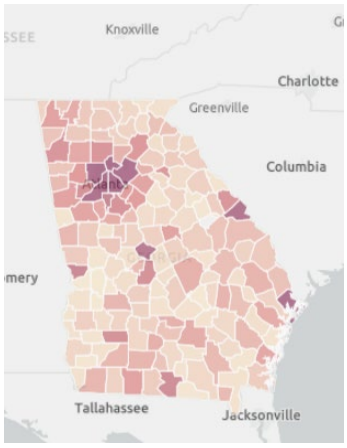
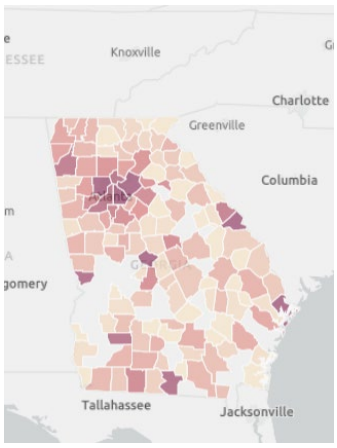
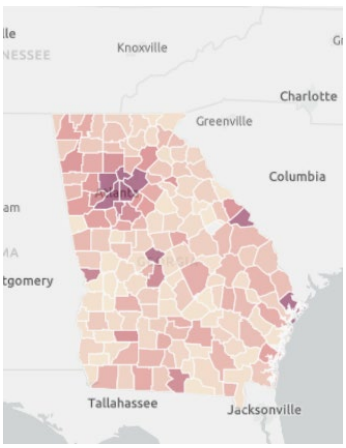
Caseload compliance for each support coordination agency as of March 2018, is listed below:

Benchmark	89%
CareStar	78%
Columbus	92%
Compass	91%
Creative	85%
Georgia Support	100%
PCSA	96%

CareStar does not currently have 85 percent compliance for the month of March; CareStar also substantially lacked compliance in February 2018. Upon closer inspection of CareStar, 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 instances, they are limited in duration and were not determined to be indicative of a systems level risk.

It is also important to consider the challenges of caseload size compliance given the population distribution in rural and more-sparsely-populated regions of Georgia.

Table 3: Maps of Georgia, Intensive Support Coordination, Support Coordination Populations as of March 2018

		
This map shows Georgia's population is concentrated in a few larger city areas, such as Atlanta, Savannah, Augusta, Columbus, etc. These more-densely-populated areas are separated with vast areas of lower-density populations.	This map shows the distribution of intensive support coordination providers across Georgia. Intensive support coordination is also most common to the larger, more-densely-populated areas. In these areas, support coordination agencies (and support coordinators) can more easily achieve caseload size compliance.	This map shows intense support coordination need. Individuals requiring intensive support coordination reside between the 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.

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

Individuals 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. Support coordination requires only one visit per quarter.

In Figure 2, 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 January and the end of March in 2018. The plot shows that well over a majority of individuals receiving this service were visited a number of times that complies with policy requirements[7].

Figure 2: Number of Support Coordination Face-to-Face Visits January through March 2018 for One Quarterly Visit Requirement

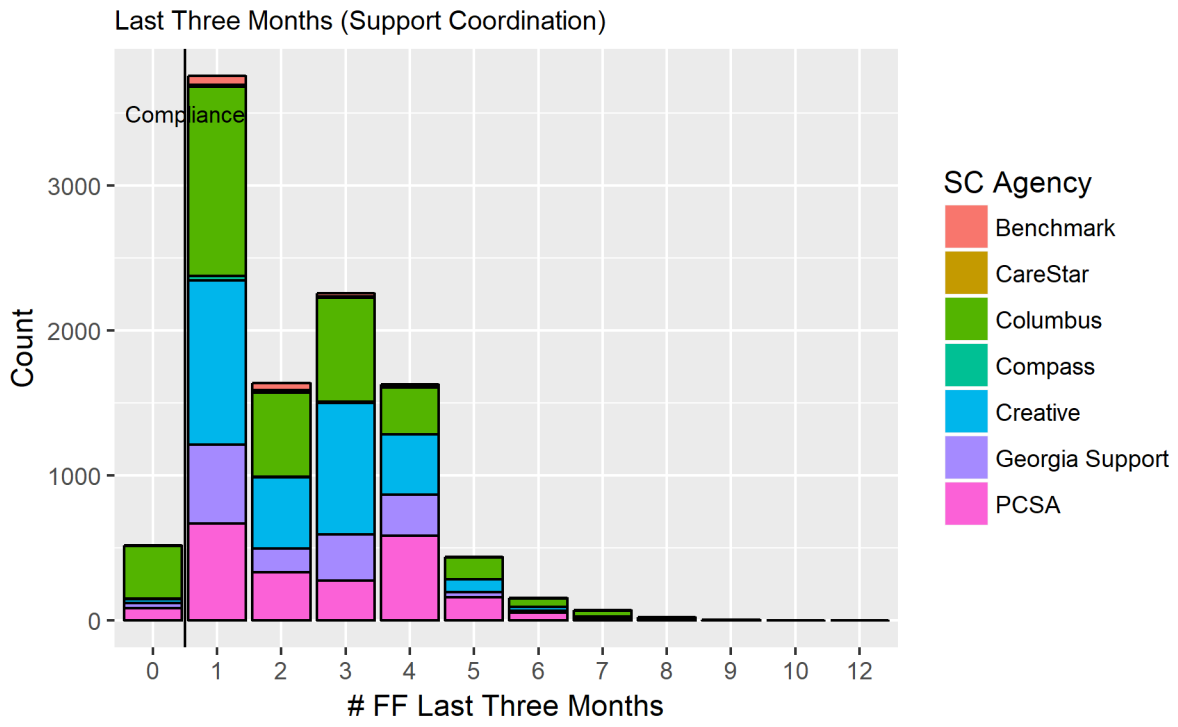


Table 4 buttresses this result in its "Percent Compliance" column. Each unique SC agency has greater than 89 percent compliance with the deliverable item; this implies the vast majority of individuals are seen at the proper frequency according to policy.

[7] DBHDD Policy: Support Coordination Contact Frequency Requirements, 02-433

Table 4: Number of Face-to-Face Visits January through March 2018 (SC)

SC/ISC Agency	Mean Visits per quarter	In Compliance	Total Individuals	Percent Compliance
Benchmark	2.15	159	166	96
CareStar	1.84	37	37	100
Columbus	2.09	3,202	3,566	90
Compass	1.57	44	47	94
Creative	2.33	3,088	3,112	99
GA Support	2.29	1,355	1,391	97
PCSA	2.64	2,079	2,164	96

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 Intensive Support Coordination Face-to-Face Visits January through March 2018 for Monthly Visit Requirements

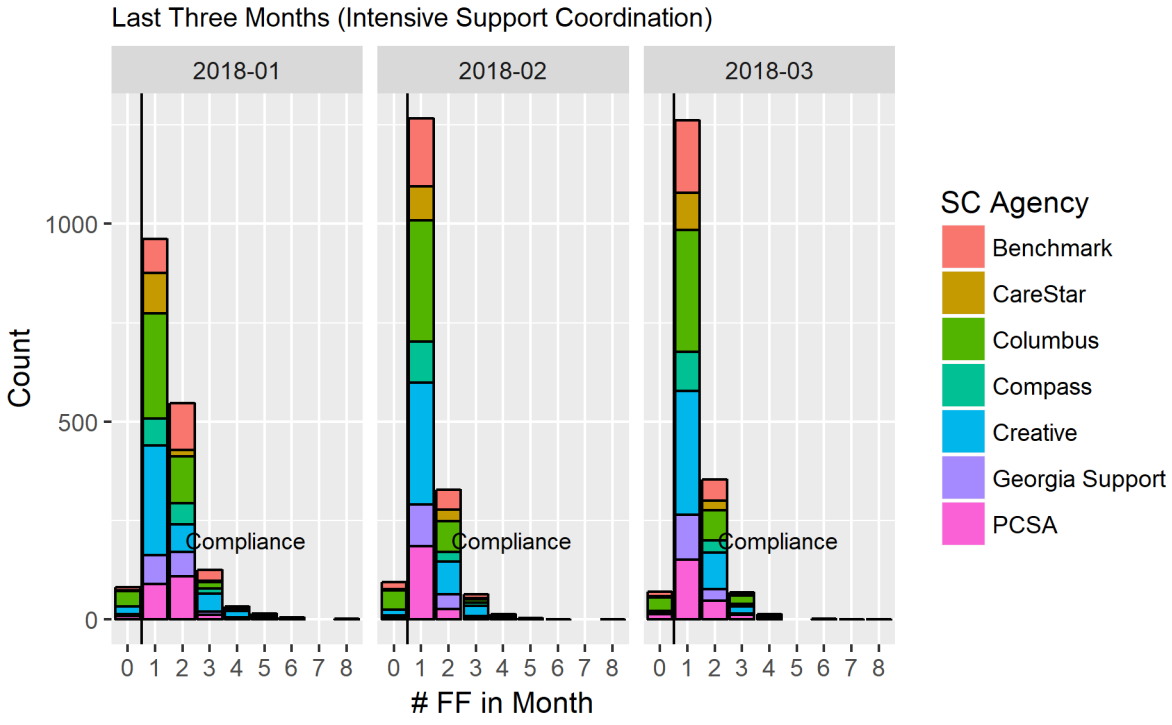


Table 5: Number of Monthly Face-to-Face Visits January to March 2018 (ISC)

SC/ISC Agency	Month	Mean Visits per month	In Compliance	Total Individuals	Percent Compliance
Benchmark	2018-01	1.89	248	256	97
	2018-02	1.32	238	256	93
	2018-03	1.27	245	256	96
CareStar	2018-01	1.18	122	125	98
	2018-02	1.29	121	125	97
	2018-03	1.27	122	125	98
Columbus	2018-01	1.29	405	444	91
	2018-02	1.13	396	444	89
	2018-03	1.23	410	444	92
Compass	2018-01	1.67	138	138	100
	2018-02	1.36	138	138	100
	2018-03	1.34	138	138	100
Creative	2018-01	1.49	415	434	96
	2018-02	1.29	419	434	97
	2018-03	1.31	428	434	99
GA Support	2018-01	1.54	144	149	97
	2018-02	1.25	145	149	97
	2018-03	1.23	146	149	98
PCSA	2018-01	1.66	216	224	96
	2018-02	1.15	218	224	97
	2018-03	1.28	211	224	94

Both Figure 3 and Table 5 (above) display statistics on the number of face-to-face visits intensive support coordination recipients received each month. These results were displayed by month to demonstrate compliance with monthly as opposed to quarterly visits. Intensive support coordination recipients are receiving the required minimum number of visits as evidenced by the percent compliance. These findings are equally positive in the March and February 2018 report.

Health Care Level Scores

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 HCL values are the most recent ones taken as of January 1, 2018. The model estimates are presented in Table 6 and Table 7. 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 1.38. That value implies that individuals with HCL 3 have a 1.38-times (38 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 6: 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)	0.41	1.51	0.02	19.68	<.001
HCL 1	-	-	-	-	-
HCL 2	0.19	1.21	0.02	11.82	<.001
HCL 3	0.32	1.38	0.02	17.44	<.001
HCL 4	0.36	1.44	0.02	15.47	<.001
HCL 5	0.66	1.94	0.02	27.56	<.001
HCL 6	0.66	1.93	0.02	28.90	<.001
Age	0.01	1.08	0.00	17.98	<.001

Table 7: 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)	0.53	1.69	0.02	27.26	<.001
Age	0.01	1.08	0.01	18.73	<.001
SC	-	-	-	-	-
ISC	0.53	1.70	0.01	36.72	<.001

The results in Table 6 and Table 7 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 from this and the February 2018 report substantiate 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.

Very positive findings from this and the February 2018 report substantiate that as health risk 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, the number of support coordination and intensive support coordination visits a person would be expected to have based on their risk level and age were calculated and compared with the actual number of visits individuals 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, 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 8: Mean Difference between Expected and Observed Numbers of Face-to-Face Visits for January through March 2018

SC/ISC Agency	Difference between "Expected" & "Observed"
Benchmark	-0.81
CareStar	-0.02
Columbus	0.22
Compass	-0.64
Creative	-0.04
Georgia Support	0.13
PCSA	-0.24

The section above, along with very similar findings in the February 2018 report, show 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: coaching and referrals.

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 age and increasing health risk levels.

According to DBHDD policy[8], support coordinators can report and record concerns using Coaching and Referrals (*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.

The Individual Quality Outcomes Monitoring Review (IQOMR) is the services and support evaluation tool used for support coordination and intensive support coordination documentation. At a minimum, all participants receive one IQOMR per quarter; additional IQOMR administration may occur during this time, except for intensive support coordination recipients. Intensive support coordination participants have at least one IQOMR monthly[9].

The IQOMR is divided into seven focus areas: Environment; Appearance/Health; Supports and Services; Behavioral and Emotional; Home/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 coordinator's 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.

[8] DBHDD Policy: Outcome Evaluation "Recognize, Refer, and Act" Model, 02-435
[9] DBHDD Policy: Support Coordination Contact Frequency Requirements

Table 9 highlights the amount of effort and productivity of support coordinators in working with providers to assist individuals. When taken together, support coordination agencies provided 14,227 coaching sessions aimed at addressing issues to provide improved outcomes for individuals from July 2017 through March 2018. Support coordinators also provided 4,486 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 18,713 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.

Support coordinators initiated and followed up on 18,713 actions to improve the outcomes of individuals they serve.

Table 9: Coachings and Referrals Statistics for the System July 2017 through March 2018

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	483	849	1.76	295	0.61	107	27	0.06
CareStar	168	125	0.74	36	0.21	10	4	0.02
Columbus	4,006	1,958	0.49	483	0.12	140	52	0.01
Compass	185	596	3.22	182	0.98	25	11	0.06
Creative	3,543	4,690	1.32	2,179	0.62	141	27	0.01
Georgia Support	1,540	1,972	1.28	766	0.50	122	43	0.03
PCSA	2,408	4,037	1.68	545	0.23	77	39	0.02
Grand Total	12,333	14,227	1.15	4,486	0.36	622	203	0.02

Table 9 shows that support coordinators are also working productively toward positive outcomes, as evidenced by the number and rates of coaching sessions and referrals which the show productivity of support coordinators' work. Support coordinators resolved (number of referrals minus number of open referrals) 3,864 referrals during this period. As of March 31, 2018, support coordinators were actively working to resolution towards positive outcomes on 622 open referrals; 419 open referrals are within the expected period of resolution. On the other hand, 203 referrals remain open beyond the expected date. Though the number of coaching sessions and referrals indicate productivity towards positive outcomes, the 203 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.

Coaching and referral activities (combined), ordered from highest activity to lowest activity are listed below. The following provider tables also follow this order.

1. Appearance/Health
2. Supports and Services
3. Environment
4. Home/Community Opportunities
5. Financial
6. Behavioral and Emotional
7. Satisfaction
8. Critical Incident Follow-Up

Table 10: Coachings and Referrals: Appearance/Health, July 2017 through March 2018

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	483	286	0.59	109	0.23	41	9	0.02
CareStar	168	68	0.40	12	0.07	3	1	0.01
Columbus	4,006	898	0.22	246	0.06	71	22	0.01
Compass	185	243	1.31	72	0.39	9	6	0.03
Creative	3,543	2,486	0.70	1,286	0.36	42	1	0.00
Georgia Support	1,540	880	0.57	360	0.23	71	23	0.01
PCSA	2,408	2,279	0.95	315	0.13	50	27	0.01
Grand Total	12,333	7,140	0.58	2,400	0.19	287	89	0.01

Table 11: Coachings and Referrals: Supports and Services, July 2017 through March 2018

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	483	198	0.41	40	0.08	10	2	0.00
CareStar	168	25	0.15	11	0.07	3	2	0.01
Columbus	4,006	489	0.12	91	0.02	19	10	0.00
Compass	185	71	0.38	22	0.12	3	1	0.01
Creative	3,543	1,193	0.34	295	0.08	4	1	0.00
Georgia Support	1,540	552	0.36	145	0.09	15	5	0.00
PCSA	2,408	616	0.26	61	0.03	6	4	0.00
Grand Total	12,333	3,144	0.25	665	0.05	60	25	0.00

Table 12: Coachings and Referrals: Environment, July 2017 through March 2018

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	483	112	0.23	22	0.05	7	3	0.01
CareStar	168	16	0.10	1	0.01	0	0	0.00
Columbus	4,006	237	0.06	56	0.01	26	10	0.00
Compass	185	52	0.28	6	0.03	1	0	0.00
Creative	3,543	346	0.10	111	0.03	8	0	0.00
Georgia Support	1,540	151	0.10	138	0.09	8	4	0.00
PCSA	2,408	375	0.16	40	0.02	4	0	0.00
Grand Total	12,333	1,289	0.10	374	0.03	54	17	0.00

Table 13: Coachings and Referrals: Home/Community Opportunities, July 2017 through March 2018

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	483	87	0.18	21	0.04	8	4	0.01
CareStar	168	6	0.04	4	0.02	1	0	0.00
Columbus	4,006	62	0.02	19	0.00	3	0	0.00
Compass	185	103	0.56	19	0.10	4	2	0.01
Creative	3,543	266	0.08	47	0.01	3	0	0.00
Georgia Support	1,540	128	0.08	15	0.01	10	3	0.00
PCSA	2,408	239	0.10	19	0.01	4	4	0.00
Grand Total	12,333	891	0.07	144	0.01	33	13	0.00

Table 14: Coachings and Referrals: Financial, July 2017 through March 2018

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	483	63	0.13	19	0.04	5	2	0.00
CareStar	168	1	0.01	0	0.00	0	0	0.00
Columbus	4,006	89	0.02	24	0.01	5	0	0.00
Compass	185	59	0.32	12	0.06	0	0	0.00
Creative	3,543	116	0.03	28	0.01	4	0	0.00
Georgia Support	1,540	103	0.07	38	0.02	4	3	0.00
PCSA	2,408	332	0.14	27	0.01	4	3	0.00
Grand Total	12,333	763	0.06	148	0.01	22	8	0.00

Table 15: Coachings and Referrals: Behavioral and Emotional, July 2017 through March 2018

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	483	72	0.15	9	0.02	4	1	0.00
CareStar	168	6	0.04	1	0.01	1	0	0.00
Columbus	4,006	88	0.02	32	0.01	11	8	0.00
Compass	185	45	0.24	26	0.14	6	1	0.01
Creative	3,543	140	0.04	59	0.02	3	0	0.00
Georgia Support	1,540	91	0.06	24	0.02	8	3	0.00
PCSA	2,408	147	0.06	23	0.01	1	1	0.00
Grand Total	12,333	589	0.05	174	0.01	34	14	0.00

Table 16: Coachings and Referrals: Satisfaction, July 2017 through March 2018

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	483	20	0.04	0	0.00	0	0	0.00
CareStar	168	2	0.01	0	0.00	0	0	0.00
Columbus	4,006	94	0.02	11	0.00	3	2	0.00
Compass	185	20	0.11	5	0.03	1	1	0.01
Creative	3,543	143	0.04	18	0.01	1	0	0.00
Georgia Support	1,540	53	0.03	17	0.01	1	0	0.00
PCSA	2,408	36	0.01	2	0.00	0	0	0.00
Grand Total	12,333	368	0.03	53	0.00	6	3	0.00

Table 17: Coachings and Referrals: Critical Incident Follow-Up, July 2017 through March 2018

Critical Incident Follow-Up								
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	483	11	0.02	75	0.16	32	6	0.01
CareStar	168	1	0.01	7	0.04	2	1	0.01
Columbus	4,006	1	0.00	4	0.00	2	0	0.00
Compass	185	3	0.02	20	0.11	1	0	0.00
Creative	3,543	0	0.00	335	0.09	76	25	0.01
Georgia Support	1,540	14	0.01	29	0.02	5	2	0.00
PCSA	2,408	13	0.01	58	0.02	8	0	0.00
Grand Total	12,333	43	0.003	528	0.043	126	34	0.003

Coaching and Referral Summary

- As with the overall system performance perspective, and as substantiated by the findings in the February 2018 report, Compass most frequently delivered the largest number of coaching and referral activities per individual across most areas; 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 and Services areas by delivering coaching and referral activities second most frequently in this area. Almost 12.5 percent of all open referrals beyond the expected close date are in this area, which suggests that support coordinators may need additional support to facilitate improved Supports and Services outcomes. In February's report, this figure was 25 percent; so, support coordination has improved in this area.

- One should exercise great caution before proceeding to draw conclusions on number and frequency comparisons for several reasons; this is still a new performance metric for DBHDD. 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. Therefore, people are achieving positive outcomes, regardless of the variation in these metrics.

- DBHDD is still investigating ways to determine how support coordination activities (e.g., face-to-face visits, coaching sessions, referrals, ancillary activities, etc.) as well as the combination of other services and supports are related to outcomes.

Outcomes of Support Coordination and Intensive Support Coordination

This report examines outcomes by looking at change in health risk levels, IQOMR outcomes, quality assurance of ISPs, and a comparison of support coordination performance on National Core Indicator (NCI) Survey sections.

Health Care Level Scores

While measured health care level (HCL) is not a direct measure of outcomes, it is useful to consider HCL changes over time as an indirect indicator. 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 have shown that the average heath care level for the intellectual and developmental disability population has increased over time. 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.

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.

Table 18: Difference in HCL between 2017 and 2018

SC Type in 2018	Mean Difference (Increase) in HCL	SD	Median
Support Coordination*	0.08	0.62	0
Intensive Support Coordination*	0.24	1.32	0
***Indicates statistical significance of $\alpha = .01$**			

Table 19: Increase/Decrease in HCL between 2017 and 2018

SC Type in 2018	HRST Decreased	Same	HRST Increased
Support Coordination*	668 (7.4%)	7,155 (79.1%)	1,225 (13.5%)
Intensive Support Coordination*	243 (16.1%)	843 (55.7%)	427 (28.2%)
**Indicates statistical significance of χ^2, $\alpha = .01$*			

Table 20: HCL Summary Statistics 2017 and 2018

SC Type in 2018	Average HCL Before Jan 17	Average HCL After Jan 17	SD HCL Before Jan 17	SD HCL After Jan 17	Median HCL Before Jan 17	Median HCL After Jan 17
Support Coordination	1.80	1.88	0.91	0.96	2	2
Intensive Support Coordination	4.63	4.87	1.40	1.29	5	5

Table 21: Difference in HCL between 2017 and 2018 by Agency

SC/ISC agency	Mean Increase in HCL	SD	Median	N
Benchmark	0.07	1.27	0	241
CareStar	0.13	0.83	0	111
Columbus	0.08	0.77	0	3,465
Compass	0.11	1.01	0	127
Creative	0.13	0.74	0	3,130
Georgia Support	0.14	0.77	0	1,376
PCSA	0.11	0.68	0	2,112

Table 22: HCL Summary Statistics 2017 and 2018 by Agency

SC/ISC agency	Average HCL Jan 16-Jan 17	Average HCL Jan 17-Jan 18	SD HCL Jan 16-Jan 17	SD HCL Jan 17-Jan 18	Median HCL Jan 16-Jan 17	Median HCL Jan 17-Jan 18
Benchmark	3.93	4.00	1.73	1.76	4	4
CareStar	4.39	4.51	1.53	1.49	5	5
Columbus	2.13	2.20	1.33	1.38	2	2
Compass	4.04	4.15	1.64	1.60	4	4
Creative	2.14	2.27	1.36	1.43	2	2
Georgia Support	2.15	2.28	1.28	1.35	2	2
PCSA	2.05	2.16	1.30	1.37	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. Health status (e.g., symptoms, functioning, physiological outcomes) are more likely to vary over time. Health risk is a critical factor for managing service provision to these populations, and health risk will remain prominent in DBHDD analyses and planning.

IQOMR Outcomes

After the initial deployment of the IQOMR, the Division of Developmental Disabilities recognized a need to improve the capture of discrete variables elicited from the IQOMR. In January 2018, a revised IQOMR was deployed, which expanded the 25-item tool to a 55-item tool. The increase in the number of items resulted from separating multi-question items into single question items, improving the specificity of the data collected, such that targeted response could be initiated for items demonstrating negative outcomes and better highlight specific areas of positive outcomes.

Since this is a new tool, the analysis of the data from January 2018 through March 2018 will act as a baseline of performance. Caution should be used if one attempts to compare earlier IQOMR performance to the new tool. This section will look at current scores as an indicator of current outcomes. Future reports will look at changes in outcomes over time.

Currently, support coordination recipients are scoring above 90 percent positive in four IQOMR areas: Appearance/Health, Environmental, Home/Community Opportunities, Supports and Services. Intensive support coordination recipients are scoring above 90 percent positive in three IQOMR areas: Appearance/Health, Environmental, Support and Services.

Table 23: IQOMR Area Proportion Positive Answer March 2018

Baseline March 2018		
	SC	**ISC**
Environmental	92.8%	97.3%
Appearance/Health	93.3%	90.9%
Supports and Services	95.6%	91.5%
Behavioral and Emotional	73.5%	58.1%
Home/Community Opportunities	91.0%	85.5%

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 Environmental, Appearance/Health, and Supports and Services options. In other words, individuals are enjoying safe and healthy environments, improved health, and experiencing positive rewards in their homes and communities. These are very positive outcomes.

Conversely, both support coordination and intensive support coordination recipients are currently scoring below 90 percent positive in the area of Behavioral and Emotional outcomes; intensive support coordination recipients are also scoring below 90 percent positive for in the area of Home/Community Opportunities. Individuals receiving support coordination and intensive support coordination are not achieving as positive behavioral and emotional outcomes as they are experiencing in other areas. Individuals receiving intensive support coordination are not experiencing as positive outcomes in their homes and communities as they are in most other areas.

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

- Creative, Georgia Support, and PCSA each had outcomes over 90% in almost every area save for Behavioral and Emotional.
- Benchmark had outcomes below 90 percent in all but Appearance/Health.
- Each agency produced outcome percentages lower than 90 percent for Behavioral and Emotional; this finding should prompt evaluation of the coachings and referrals surrounding this area.

Table 24: SC IQOMR Area Proportion Positive Answer as of March 2018

Support Coordination	**Current: <90%**	**Current: At least 90%**
Benchmark	Supports and Services (86%) Environmental (85%) Behavioral and Emotional (73%) Home/Community Opportunities (81%)	Appearance/Health (95%)
CareStar	Environmental (70%) Behavioral and Emotional (77%) Home/Community Opportunities (77%)	Appearance/Health (90%) Supports and Services (93%)
Columbus	Environmental (83%) Behavioral and Emotional (83%) Home/Community Opportunities (89%)	Appearance/Health (94%) Supports and Services (97%)
Compass	Behavioral and Emotional (79%) Home/Community Opportunities (71%)	Appearance/Health (90%) Supports and Services (91%) Environmental (93%)
Creative	Behavioral and Emotional (70%)	Appearance/Health (93%) Supports and Services (93%) Environmental (98%) Home/Community Opportunities (90%)
Georgia Support	Behavioral and Emotional (85%)	Appearance/Health (93%) Support and Services (97%) Environmental (97%) Home/Community Opportunities (93%)
PCSA	Behavioral and Emotional (57%)	Appearance/Health (94%) Supports and Services (96%) Environmental (94%) Home/Community Opportunities (96%)

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

- All but two of the providers had three areas in the at least 90 percent column. This may imply that the quality of service outcomes is generally positive for this population.
- All intensive support coordination providers had at least one outcome area below 90 percent.
- Behavioral and Emotional remained the most commonly found to be below 90 percent, followed by Home/Community Opportunities.

Table 25: Intensive Support Coordination IQOMR Area Proportion Positive Answer as of March 2018

Intensive Support Coordination	**Current: <90%**	**Current: At least 90%**
Benchmark	Appearance/Health (89%) Behavioral and Emotional (63%) Home/Community Opportunities (86%)	Supports and Services (92%) Environmental (97%)
CareStar	Behavioral and Emotional (78%) Home/Community Opportunities (89%)	Appearance/Health (95%) Supports and Services (95%) Environmental (99%)
Columbus	Behavioral and Emotional (65%) Home/Community Opportunities (89%)	Appearance/Health (90%) Supports and Services (94%) Environmental (97%)
Compass	Behavioral and Emotional (45%) Home/Community Opportunities (81%)	Appearance/Health (93%) Supports and Services (91%) Environmental (99%)
Creative	Appearance/Health (86%) Supports and Services (83%) Behavioral and Emotional (46%)	Environmental (95%) Home/Community Opportunities (90%)
Georgia Support	Supports and Services (87%) Behavioral and Emotional (66%) Home/Community Opportunities (84%)	Appearance/Health (98%) Environmental (99%)
PCSA	Behavioral and Emotional (54%)	Appearance/Health (96%) Supports and Services (94%) Environmental (99%) Home/Community Opportunities (92%)

Individual Support Plan Quality Assurance by Support Coordination Agency

DBHDD is committed to providing high level care to individuals receiving IDD services. Support Coordination agencies are required to verify that each person who has been determined eligible to receive IDD services has an active Individualized Service Plan (ISP) as described in policy.[10] An approved ISP authorizes the provision of safe, secure, and dependable support and assistance in areas that are necessary for the individual to achieve full social inclusion, independence, and personal and economic well-being. The ISP identifies the individual's personally-defined outcomes and planning goals and describes the services and supports needed to assist the individual in attaining those goals and outcomes. This plan is developed based on assessed needs identified through the HRST, SIS, clinical assessments, and additional documentation as needed.

Support coordinators are responsible for the development of ISPs with input from the individual and the individual's support team, monitoring of the implementation of the plans, recognizing the individual's needs and risks (if any), promoting community integration, and responding by referring, directly linking, or advocating for resources to assist the individual in gaining access to needed services and supports.

The Georgia Collaborative Administrative Service Organization (ASO), as part of the DBHDD quality management system, carries out specific quality review processes. The quality review processes for IDD services determine whether the current service delivery systems are promoting outcomes and independence through person centered practices.

ASO reviewers complete the Individual Support Plan Quality Assurance (ISP QA) checklist. The ISP QA checklist was developed by the Division of Developmental Disabilities to assess the support plan. The ISP QA checklist helps to determine an overall rating of the ISP, monitor certain specific requirements, and determine the extent to which the ISP addresses different aspects of the person's life.

A new ISP template was developed in a strategic manner to resolve many of the challenges experienced with the ISP in the current system. The new ISP template is much more condensed, has information that populates directly from assessments and screenings, and is easily editable as changes occur. Consequently, changes made to the ISP resulted in the changes needed to the ISP QA checklist.

The new ISP QA checklist was implemented January 1, 2018. The ASO collects information from a stratified, randomly-selected sample of individuals across the DBHDD delivery system to be representative of the population served by DBHDD. Data presented in this section are indicators from ISP QA checklist that were selected as approximate indicators of support coordination quality assurance when creating ISPs. The current tool does not allow for delineation between support coordination and intensive support coordination. From January 1, 2018 through March 31, 2018, 236 ISP QA checklists were completed. Only 35 of the new ISP QA checklists, however, were completed using the new ISP QA checklist; these data are not included in the report but will be added to the next report after more ISPs have been reviewed using the new checklist.

[10] DBHDD Policy: The Service Planning Process and Individual Service Plan Development, 02-438

Category Ratings

The ISP QA checklist assesses different categories of the ISP, rating each on a five-point scale from zero (0) to four (4). Zero, the lowest score, means it is important to and for the individual, but the section is blank or inadequately addresses the objective. Four, the highest score, means the section is adequately addressed in the ISP. This can be considered as a scale indicating the degree to which each objective is addressed by the ISP.

A higher percentage for a score of 3 or 4 is considered an indicator of positive performance. All support coordination agencies had at least 80 percent overall for combined scores of three and four, as indicated below, which is a very positive indication that support coordination agencies are performing well as they engage to create ISPs:

Table 26: ISP QA Combined Scores

ISP QA Combined Score of 3 or 4	Average
Benchmark	95%
CareStar	80%
Columbus	88%
Compass	100%
Creative	89%
Georgia Support	95%
PCSA	92%
State Overall Average	**89%**

Analysis compared each support coordination agency percentage for each level of score with the corresponding state average for each level of score. All agencies performed equally well compared to the state averages, and there were not statistically significant differences between individual agency performance on the ISP QA checklist and overall state performance.

Average results for the state can be found in Table 28. Individual support coordination agencies are reported separately in Tables 29 through 35.

Table 27: ISP QA Checklist State Average, January through March 2018

ISP QA Checklist Description (N = 201)	0	1	2	3	4
Communication chart	1%	1%	7%	43%	49%
Person-centered important to/for	1%	0%	4%	25%	71%
Rights, psychotropic medications, behavior supports section	1%	0%	0%	6%	93%
Health and safety review section completed accurately and thoroughly	1%	0%	1%	10%	90%
Goals are Person-centered	5%	14%	18%	28%	34%
State Average	**1%**	**3%**	**6%**	**22%**	**67%**

Table 28: ISP QA Checklist Ratings: Benchmark, January through March 2018

Benchmark ISP QA Checklist Ratings by Expectation					
ISP QA Checklist Description (N=4)	**0**	**1**	**2**	**3**	**4**
Communication chart	0%	0%	0%	25%	75%
Person-centered important to/for	0%	0%	0%	50%	50%
Rights, psychotropic medications, behavior supports section	0%	0%	0%	%	100%
Health and safety review section completed accurately and thoroughly	0%	0%	0%	25%	75%
Goals are Person-centered	0%	25%	0%	25%	50%
SC Agency Average	**0%**	**5%**	**0%**	**25%**	**70%**
State Average	**1%**	**3%**	**6%**	**22%**	**67%**

Table 29: ISP QA Checklist Ratings: CareStar, January through March 2018

CareStar ISP QA Checklist Ratings by Expectation					
ISP QA Checklist Description (N = 5)	**0**	**1**	**2**	**3**	**4**
Communication chart	0%	0%	20%	20%	60%
Person-centered important to/for	0%	0%	40%	20%	40%
Rights, psychotropic medications, behavior supports section	0%	0%	0%	40%	60%
Health and safety review section completed accurately and thoroughly	0%	0%	0%	40%	60%
Goals are Person-centered	0%	0%	20%	20%	60%
SC Agency Average	**0%**	**0%**	**16%**	**28%**	**56%**
State Average	**1%**	**3%**	**6%**	**22%**	**67%**

Table 30: ISP QA Checklist Ratings: Columbus, January through March 2018

Columbus ISP QA Checklist Ratings by Expectation					
ISP QA Checklist Description (N=41)	**0**	**1**	**2**	**3**	**4**
Communication chart	0%	0%	12%	39%	49%
Person-centered important to/for	0%	0%	10%	17%	73%
Rights, psychotropic medications, behavior supports section	2%	0%	0%	12%	85%
Health and safety review section completed accurately and thoroughly	0%	0%	0%	22%	78%
Goals are Person-centered	5%	15%	20%	34%	27%
SC Agency Average	**1%**	**3%**	**8%**	**25%**	**62%**
State Average	**1%**	**3%**	**6%**	**22%**	**67%**

Table 31: ISP QA Checklist Ratings: Compass, January through March 2018

Compass ISP QA Checklist Ratings by Expectation					
ISP QA Checklist Description (N=8)	**0**	**1**	**2**	**3**	**4**
Communication chart	0%	0%	0%	75%	25%
Person-centered important to/for	0%	0%	0%	13%	88%
Rights, psychotropic medications, behavior supports section	0%	0%	0%	0%	100%
Health and safety review section completed accurately and thoroughly	0%	0%	0%	13%	88%
Goals are Person-centered	0%	13%	13%	38%	38%
SC Agency Average	**0%**	**3%**	**3%**	**28%**	**68%**
State Average	**1%**	**3%**	**6%**	**22%**	**67%**

Table 32: ISP QA Checklist Ratings: Creative Consulting, January through March 2018

Creative Consulting Services ISP QA Checklist Ratings by Expectation					
ISP QA Checklist Description (N=57)	**0**	**1**	**2**	**3**	**4**
Communication chart	0%	0%	7%	53%	40%
Person-centered important to/for	0%	0%	0%	14%	86%
Rights, psychotropic medications, behavior supports section	0%	0%	0%	0%	100%
Health and safety review section completed accurately and thoroughly	0%	0%	0%	5%	95%
Goals are Person-centered	7%	13%	26%	25%	30%
SC Agency Average	**1%**	**3%**	**7%**	**19%**	**70%**
State Average	**1%**	**3%**	**6%**	**22%**	**67%**

Table 33: ISP QA Checklist Ratings: Georgia Support Services, January through March 2018

Georgia Support Services ISP QA Checklist Ratings by Expectation					
ISP QA Checklist Description (N=24)	**0**	**1**	**2**	**3**	**4**
Communication chart	0%	0%	0%	38%	63%
Person-centered important to/for	0%	0%	0%	42%	58%
Rights, psychotropic medications, behavior supports section	0%	0%	0%	0%	100%
Health and safety review section completed accurately and thoroughly	0%	0%	0%	0%	100%
Goals are Person-centered	0%	13%	17%	33%	38%
SC Agency Average	**0%**	**3%**	**3%**	**23%**	**72%**
State Average	**1%**	**3%**	**6%**	**22%**	**67%**

Table 34: ISP QA Checklist Ratings: Professional Case Management, January through March 2018

Professional Case Management Services of America ISP QA Checklist Ratings by Expectation					
ISP QA Checklist Description (N=24)	**0**	**1**	**2**	**3**	**4**
Communication chart	0%	5%	5%	29%	62%
Person-centered important to/for	0%	0%	5%	29%	67%
Rights, psychotropic medications, behavior supports section	0%	0%	0%	12%	88%
Health and safety review section completed accurately and thoroughly	0%	0%	2%	5%	93%
Goals are Person-centered	2%	12%	12%	31%	43%
SC Agency Average	**1%**	**3%**	**5%**	**21%**	**71%**
State Average	**1%**	**3%**	**6%**	**22%**	**67%**

National Core Indicators 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 majority of 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, Centers for Medicare and Medicaid Services-approved survey. These findings are presented below.

DBHDD's Division of Developmental Disabilities participates in the National Core Indicators (NCI) survey.[11] 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 (ACS). The ACS was developed for the purpose of collecting information directly yet anonymously from individuals with intellectual/developmental disabilities and their families or advocates. Since ACS data is collected anonymously, the tool does not allow for comparison between support coordination and intensive support coordination. In Georgia, the ADS is administered by the ASO as part of the DBHDD quality management system.

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 35 presents national, state, and support coordination agency averages for the 481 stratified, randomly sampled, representative NCI reviews that were conducted in 2017. The indicators are grouped into 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.[12] Scores are also

[11] National Core Indicators

[12] 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 team, who are expert NCI assessors. DBHDD requested that the ASO quality management team identify NCI items that would be indicative of the IQOMR areas or items. The ASO quality management team was unaware that DBHDD would use the items selected by the ASO to compare IQOMR findings. The ASO also produced the identified NCI data.

included for seven survey questions directly related to the provision of support coordination services. Support 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 2017, only five support coordination agencies were included in the NCI survey. Benchmark's caseload was not sufficiently large to gather significant data through the NCI survey to report on all the FOA indicators. Sufficient data for Benchmark was gathered on 10 indicators. This data is included in Table 35 but are not included in the FOA specific analysis below. Also, due to low caseloads, neither CareStar nor Compass were included in the survey sample.

The majority of the NCI data is reported for the four agencies providing support coordination. Support coordination agency scores and state scores for 2017 were compared to the NCI national average for each indicator listed.

2017 NCI Results

In Table 35, Georgia's statewide and support coordination agency-specific scores indicators are color coded for performance comparisons against the national averages.

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 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 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 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 either within or significantly above the national average.

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 within or significantly above the national average 88 percent of the time in 2017. PSCA was performing significantly below the national average for the indicator of individuals having transportation when needed. Georgia Support Services and PSCA were performing significantly below the national average in individuals reporting that they have a paid job in the community.

Community Outings Focused Outcome Area

Community outings were assessed using four indicators related to types of outings. Support coordination agencies overall were performing within or significantly above average 88 percent of the time in 2017. All agencies were performing significantly above the national average for persons responding that they went out to eat or shopping more than once a month. Columbus Services and Georgia Support Services performed significantly below the national average concerning individuals going out to complete errands.

Rights Focused Outcome Area

Respect of a person's rights was assessed using seven indicators. Questions were related to people entering an individual's home or bedroom without prior notice, privacy, dating, and phone/internet use. (One indicator related to the amount of privacy a person has does not have a national average reported; therefore, it was not used in the comparison, but is reported.) Support coordination agencies were performing within or significantly above the national average 100 percent of the time in 2017. All the agencies were performing significantly above the national average for the indicator of individuals having the ability to be alone with guests.

Person-Centered Focused Outcome Area

This outcome area was assessed using two indicators related to individuals' satisfaction with employment and two indicators related to individuals' satisfaction with their living arrangements. For the entire FOA, all support coordination agencies performed within or significantly above the national average. Agencies performed significantly above average 100 percent of the time for the indicator 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. States are not evaluated to determine if they are significantly above, within, or significantly below the national average for these individual indicators; therefore, agencies cannot be ranked for the indicators used in the FOA. All support coordination agencies performed near or above the national average for all items; however, all agencies performed above the national average for the indicator of a person having someone to talk to when they were afraid.

Choice Focused Outcome Area

The level of choice a person has 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. States are not evaluated to determine if they are significantly above, within, or significantly below the national average for these indicators; therefore, agencies cannot be ranked for the indicators used in the FOA. All agencies performed below the national average for seven of the eight indicators in this FOA. All agencies scored above the national average for person's reporting that they chose their staff.

Support Coordination-Specific Questions

The NCI also captures support coordination-specific data. 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.) Support coordination agencies performed within or significantly above the national average 96 percent of the time on all NCI support coordination-specific items. All agencies performed significantly above the national averages for the indicators of individuals having the people they wanted at their service planning meeting; and for persons being able to choose the services they want in their service plan. Georgia Supports Services was the only agency scoring significantly below the national average for the indicator related to individuals being able to contact their support coordinator when they want to.

Table 35: NCI Results 2017

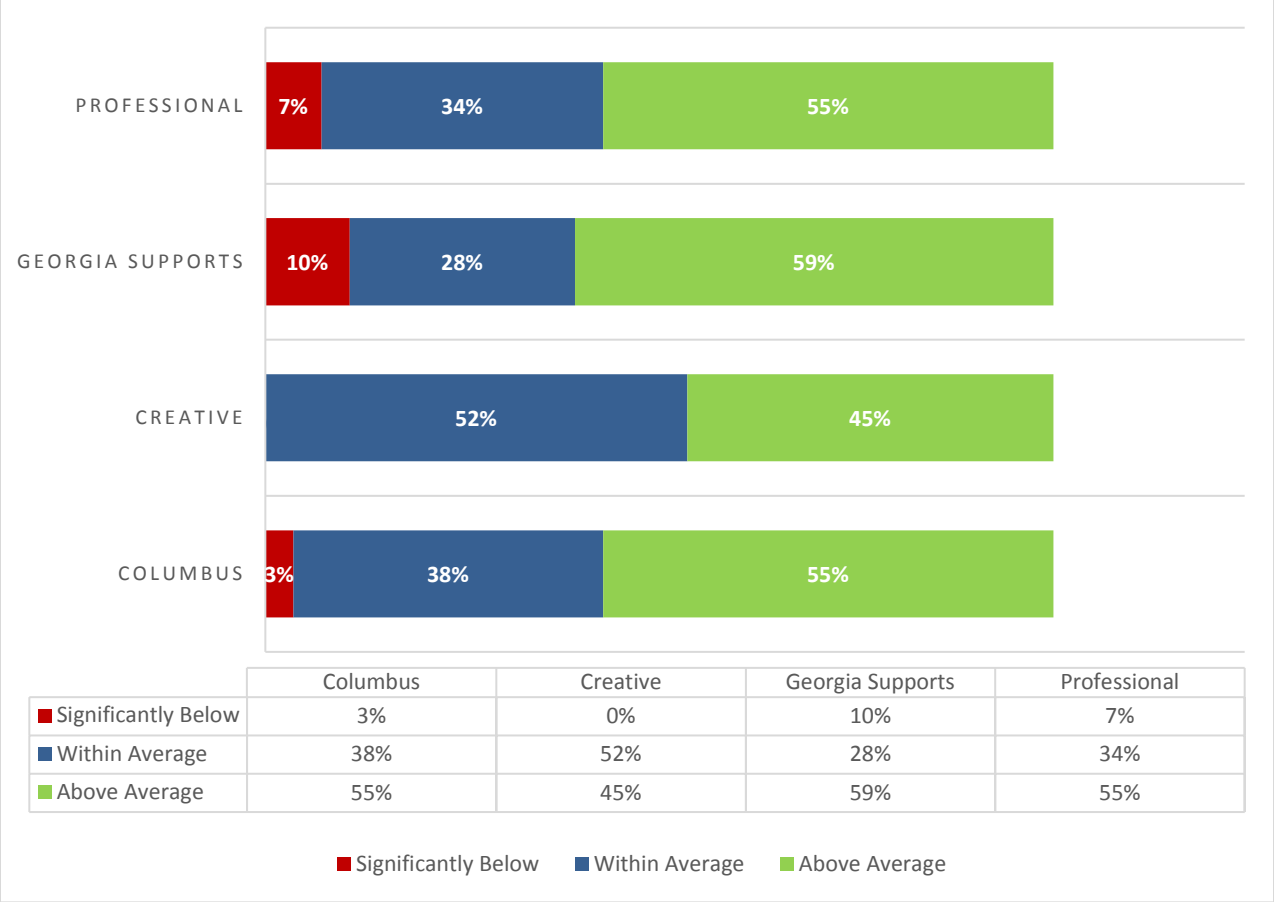
National Core Indicator	FY 2017						
	% Positive National	% Positive Georgia	% Positive Columbus Community Services	% Positive Creative Consulting Services	% Positive Georgia Support Services / MGBS	% Positive Professional Case Management Services of America	% Positive A.W. Holdings / Benchmark
Health							
Person reports being in poor health. (A lower percentage indicatoes a lower proportion of people reporting are in poor health.)	3%	1%	1%	3%	0%	1%	0%
Community Life							
Person has friends who are not paid staff or family members	77%	84%	82%	80%	85%	85%	NA
Person has transportation when needed.	93%	88%	89%	90%	88%	85%	NA
Do you participate in community groups?	34%	59%	50%	39%	74%	53%	80%
Do you have a paid job in the community?	19%	17%	22%	23%	11%	12%	NA
Do you volunteer?	34%	38%	44%	43%	30%	35%	NA
Do you go to a program or workshop, where other people with disabilities work?	59%	84%	84%	81%	96%	74%	NA
Community Outings							
Go out to eat?	86%	97%	94%	98%	96%	96%	100%
Go out for entertainment?	77%	86%	82%	89%	79%	92%	NA
Go out on errands?	88%	86%	82%	89%	79%	92%	NA
Go shopping?	90%	98%	97%	100%	98%	96%	100%
Rights							
Do people let you know before entering your home?	90%	87%	85%	91%	85%	85%	NA
Do people let you know before entering your bedroom?	87%	92%	91%	89%	96%	91%	NA
Can you go on a date if you want to?	70%	82%	84%	86%	75%	81%	NA
Do you have enough privacy at home?	NA*	100%	99%	100%	100%	100%	NA
People do not read mail or email without asking?	87%	89%	76%	91%	96%	94%	NA
Can you be alone with guests?	83%	95%	92%	94%	100%	96%	NA
Are you allowed to use the phone or internet?	89%	94%	90%	97%	96%	92%	NA
Support Coordination							
Have you met your case manager/service coordinator?	95%	97%	97%	92%	100%	98%	NA
Case Manager/Service Coordinator asks what you want?	88%	88%	88%	89%	86%	90%	NA
Are you able to contact your case manager/service coordinator when you want to?	87%	82%	82%	89%	77%	86%	NA
Do you have a service plan?	NA*	84%	82%	89%	77%	86%	NA
At the service planning meeting, did you know what was being talked about?	83%	90%	92%	88%	92%	88%	NA
Did the service planning meeting include people you wanted to be there?	92%	97%	96%	98%	96%	96%	NA
Were you able to choose the services that you get as part of your service plan?	75%	89%	92%	83%	87%	92%	NA
Person Centered							
Do you like your job in the community?	92%	94%	100%	83%	100%	86%	NA
Would you like to work somewhere else? (A lower percentage indicatoes a lower proportion of people reporting they want to work somewhere else.)	28%	20%	42%	24%	0%	14%	NA
Do you like where you live?	89%	92%	87%	94%	89%	96%	NA
Would like to live somewhere else? (A lower percentage indicatoes a lower proportion of people reporting they want to live somewhere else.)	27%	18%	26%	13%	19%	15%	NA
Safety							
Ever afraid at home? (A lower percentage indicatoes a lower proportion of people indicating they feel afraid in this particular setting.)	5%	3%	1%	2%	3%	3%	NA
Ever afraid in community? (A lower percentage indicatoes a lower proportion of people indicating they feel afraid in this particular setting.)	5%	1%	0%	0%	0%	3%	NA
Ever afraid at day program? (Positive answer indicates positive outcome.)	2%	1%	3%	1%	0%	0%	NA
Ever afraid while being transported? (A lower percentage indicatoes a lower proportion of people indicating they feel afraid in this particular setting. States are not ranked against NCI average for this indicator.)	2%	0%	1%	0%	0%	0%	NA
Ever afraid at work? (A lower percentage indicatoes a lower proportion of people indicating they feel afraid in this particular setting.)	1%	0%	0%	0%	0%	0%	NA
If you ever feel afraid, do you have someone to talk to?	94%	99%	99%	99%	100%	98%	NA
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 FY17, Georgia ranked first out of 36 NCI States.)	87%	62%	57%	59%	72%	58%	NA
Person chose job. (States are not ranked against the National average for this indicator; however states are ranked against other states. For FY 17, Georgia ranked second out of 31 NCI States.)	86%	64%	57%	59%	75%	54%	NA
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 FY17, Georgia ranked first out of 35 NCI states.)	92%	72%	67%	72%	70%	76%	60%
Person chooses daily schedule. (States are not ranked against the National average for this indicator; however states are ranked against other states. In FY17, Georgia ranked first out of 32 NCI states.)	83%	64%	57%	65%	69%	65%	80%
Person chose day activity. (States are not ranked against the National average for this indicator; however states are ranked against other states. In FY17 Georgia ranked second out of 35 NCI states.)	62%	41%	44%	24%	48%	51%	60%
Person chose home. (States are not ranked against the National average for this indicator; however states are ranked against other states. In FY17 Georgia ranked first out of 29 NCI states.)	53%	33%	35%	30%	28%	33%	60%
Person chose housemate. (States are not ranked against the National average for this indicator; however states are ranked against other states. In FY17, Georgia ranked fourth out of 30 NCI states.)	40%	28%	30%	23%	28%	30%	20%
Person chose staff. (States are not ranked against the National average for this indicator; however states are ranked against other states. In FY17, Georgia ranked eighth out of 38 NCI states.)	64%	9%	9%	10%	9%	9%	40%
*National percents were not calculated for the following indicators: "Do you have enough privacy at home?" and "Do you have a service plan?"							

ISP-Specific Questions

DBHDD also seeks to understand support coordinators' performance in the development of ISPs. Referencing the ISP-specific questions, support coordinator agencies scored as well as, or better, on 100 percent of comparisons with national averages; moreover, Georgia's support coordination agencies scored above national averages in ISP development 63 percent of the time.

Four support coordination agencies were compared to one another on 43 indicators in 2017, for a total of 172 evaluation points. In Figure 5, the four agencies' scores were compared to the national average on 29 indicators of the 43 indicators for a total of 116 evaluation points.[13] Though there were some areas for improvement in 2017, the support coordination system performed within or significantly above the national average 91 percent of the time which is similar to the finding reported in the February 2018 report. This is a very positive performance level for the support coordination agencies in Georgia.

Figure 4: Proportion of NCI Responses Significantly Higher or Lower than National Average



	Columbus	Creative	Georgia Supports	Professional
Significantly Below	3%	0%	10%	7%
Within Average	38%	52%	28%	34%
Above Average	55%	45%	59%	55%

Significantly Below Within Average Above Average

[13] States are not ranked against national averages for all the National Core Indicators.

DBHDD, ASO, 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 the Behavioral and Emotional outcomes area.

This report is the first support coordination performance report to include ISP quality assurance data. Analysis of scores on the ISP QA checklist indicate support coordination agencies are performing at a relatively high level in assuring that ISPs contain specific requirements and are addressing specific aspects of a person's life. What's more, support coordination agencies were performing as well as or better than national averages for ISP development questions from the NCI 100 percent of the time; support coordination agencies, furthermore, outperformed national averages 63 percent of the time. Future reports will continue to monitor agency performance concerning the ISP development.

For 2017, Georgia support coordination agencies performed as well as average or better than average on 91 percent of the 116 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 71 percent to 96 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 for the positive performance of support coordination.

Summary of Support Coordination Performance Findings

This section summarizes the findings from the support coordination performance report. The major findings are listed below. It is concluded that even though there are areas which require improvement, all support coordination agencies are performing well, 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:

- Six support coordination agencies have achieved positive performance with caseload size requirements. CareStar did not achieve performance compliance; however, CareStar does have a record of having near 100 percent 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 less visits than required, many more 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 (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 18,713 coaching and referral activities to facilitate positive outcomes. Where positive outcomes are noted in this report, it is reasonable that much of what has been reported has been supported by 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 and Services. These two areas also have the highest proportion of all referrals that are beyond their expected close date (Appearance/Health: 89/287 = 31%; Supports and Services: 25/60 = 42%). That Appearance/Health and Supports and Services comprise 50 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 a low number (763) of combined coaching and referral activities relative to Appearance/Health (9,540) and Supports and Services (3,809) (reviewed in next section). This finding is concerning given that Behavioral and Emotional outcomes was the area that most consistently demonstrated low performance 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. Columbus, in particular, had higher scores than its peers in IQOMR outcomes.

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 continuing to pursue developing other measures to provide information about health status and outcomes.
- Appearance/Health outcomes: Individuals receiving both types of support coordination have benefitted from high levels of positive health outcomes.
- Home/Community Opportunities outcomes: 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. Behavioral and emotional outcomes lowest area of performance concern found within this report and across time.
- Analysis of scores on the ISP QA checklist showed that all support coordination agencies performed equally well compared to the state averages, and there were not statistically significant differences between agency performance and overall state performance.

- 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 (91%).
    - 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-Center
        - Safety
        - Choice
        - ISP development

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.

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).
    - The ISP QA Checklist has been revised to align with the new ISP template.
    - 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)

	Focus Area	Yes/No: *Yes* *No*	Select: *Acceptable* *Coaching* *Non-Clinical Referral – Critical* *Clinical Referral - Critical* *Non-Clinical Referral – Immediate* *Clinical Referral - Immediate*	Comments/Actions Needed: Concerns, Barriers, Successes *Free Response*
Environment				
1	Is the home/site accessible to the individual?	Select	Select	
2	Does the individual have access to privacy for personal care?	Select	Select	
3	Does the individual have a private place in the home to visit with friends or family?	Select	Select	
4	Does the individual have access to privacy for phone discussions with friends or family?	Select	Select	
5	Does the individual have access to receive and view their mail/email privately?	Select	Select	
6	Is the individual able to have private communications with family and	Select	Select	

	friends through other means?			
7	The home setting allows the individual the option to have a private bedroom.	Select	Select	
8	Are all assistive technologies being utilized as planned?	Select	Select	
9	Are all assistive technologies in good working order?	Select	Select	
10	Does the individual have adequate clothing to accommodate the individual's needs or preferences/choices ?	Select	Select	
11	Does the individual have adequate food and supplies to accommodate the individual's needs or preferences/choices ?	Select	Select	
12	Is the Residential/Day setting clean according to the individual's needs and preferences?	Select	Select	
13	Is the Residential/Day setting safe for the individual's needs?	Select	Select	

14	Is the Residential/Day setting appropriate for the individual's needs and preferences?	Select	Select	
Appearance/Health				
15	Does the individual appear healthy? Describe any observations regarding health since the last review.	Select	Select	
16	Does the individual appear safe? Describe any observed changes related to safety since the last review.	Select	Select	
17	Have there been any reported changes in health since last review?	Select	Select	
18	Does the HRST align with current health and safety needs?	Select	Select	
19	Is the ISP available to staff on site? If there have been ISP addendums, are they available to staff on site?	Select	Select	
20	Are all staff knowledgeable about all information	Select	Select	

	contained within the individual's ISP?			
21	Are indicated healthcare plans current (i.e. not expired)?	Select	Select	
22	Are indicated healthcare plans available to staff on site?	Select	Select	
23	Are all staff knowledgeable about all of the individual's healthcare plans?			
24	Are indicated healthcare plans being implemented?	Select	Select	
25	Are skilled nursing hours being provided, as ordered?	Select	Select	
26	Are all medical/therapeutic appointments being scheduled and attended?	Select	Select	
27	Are all follow-up appointments being scheduled and attended?	Select	Select	
28	Are all physician/clinician recommendations being followed?	Select	Select	

29	Are all prescribed medications being administered, as ordered, and documented accurately?	Select	Select	
30	Are all required assessments/evaluations completed?	Select	Select	
31	Has the individual had any hospital admissions, emergency room, or urgent care visits since the last review?	Select	Select	
32	Have hospital/ED/urgent care discharge plan instructions been followed?	Select	Select	
Supports and Services				
33	Do the individual's paid staff appear to treat them with respect and dignity?	Select	Select	
34	Do the individual's natural supports appear to treat them with respect and dignity?	Select	Select	
35	Are Supports and Services being delivered to the individual, as identified in the current ISP?	Select	Select	

36	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.	Select	Select	
37	Are there any additional service/support needs not being met at this time? Describe.	Select	Select	
Behavioral and Emotional				
38	Since the last visit, are there any emerging or continuing behavioral/ emotional responses for the individual?	Select	Select	
39	Are current supports and behavioral interventions adequate to prevent engaging external interventions?	Select	Select	
40	Does the individual currently have a Behavioral Support Plan, Crisis Plan, and/or Safety Plan relating to	Select	Select	

	behavioral interventions?			
41	Is/Are the plan(s) available on site for staff review?	Select	Select	
42	Is there evidence of implementation of the Behavioral Support Plan, Crisis Plan, and/or Safety Plan? (Includes staff being knowledgeable about plan and ability to describe how they are implementing the plan.)	Select	Select	
43	Since the last visit, has the individual accessed GCAL or the Mobile Crisis Response Team? 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?	Select	Select	

44	Since the last visit, has the individual had contact with law enforcement? If yes, describe reason and length of involvement. As a result, has the BSP/Safety Plan/Crisis Plan been adapted to reflect any new recommendations or interventions needed?	Select	Select	
Home/Community Opportunities				
45	Does the individual have unpaid community connections? If no, describe steps being taken to further develop community connections.	Select	Select	
46	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)?	Select	Select	
47	Is the individual being offered/provided documented opportunities to participate in activities of choice with non-paid community members?	Select	Select	

48	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.	Select	Select	
49	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?	Select	Select	
50	Does the individual have the necessary access to transportation for employment and community activities of his/her choice?	Select	Select	
Financial				
51	Are there barriers in place that limit the individual's access	Select	Select	

	to spend his/her money, as desired?			
Satisfaction				
52	What is the individual's overall satisfaction with their life activities since the last review?	Select	Select	
53	What is the individual's overall satisfaction with their service providers since the last review?	Select	Select	
54	What is the individual's overall satisfaction with their type of services received since the last review?	Select	Select	
55	What is the individual's overall satisfaction with their family relationships/ natural supports since the last review?	Select	Select	

Section II: Additional

Observations / Comments: