Support Coordination Services Performance Report 2021

GEORGIA DEPARTMENT *of*

BEHAVIORAL HEALTH *and* DEVELOPMENTAL DISABILITIES

JUNE 2022

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EXECUTIVE SUMMARY

This is the sixth annual support coordination performance report. Analysis showed that most individuals were on caseloads within permitted limits of caseload size of individuals for support coordinators. Support coordinators delivered almost 17,000 coaching sessions and referrals (combined) to provide supports to benefit service recipients.

Necessary adjustments in services and data systems due to COVID resulted in some metrics not being reported. Despite that, DBHDD achieved performance expectations on all measures that could be calculated. The scrutinous review of the purpose and value of each performance measure yielded a set of measures and analyses that provide insight into the key operations and performance of support coordination, which is methodologically desirable, as is a streamlined report with metrics more closely aligned with the responsibilities and performance expectations for support coordination.

INTRODUCTION

To introduce support coordinator performance, consider performance from a process perspective: what processes, actions, or other operations made it possible for support coordination services to adapt, deliver services, and perform well? Consider this: regular, consistent, and pertinent updates were provided, which allowed a large state agency to make system-wide changes that otherwise would have taken much longer. One example of a benefit from making rapid adjustments is that a large state agency, expected to move slowly which had to think differently about many facets of the system that had been restricted by *a priori* conclusions such as "that's just the way it is," as if DBHDD would always deliver services in person. Another example of nimble data systems working well includes the enhancements to Developmental Disabilities Clinical Oversight (DDCO) database and Intellectual and Developmental Disabilities Connect (IDDC) system, along with Image, and several additional computer applications. DBHDD moved with intention and velocity and put in place information technology solutions that allowed DBHDD to identify and assess various sources of information expediently and make critical changes, such as to service guidelines, allowances made to deliver services with various media, and other adaptations to some parts of the system that experienced increased performance demand.

Adaptation, nimble responsiveness, and ongoing effective operations would not have been possible without Appendix K Operational Guidelines ("Appendix K"). As a result of these necessary adjustments in service delivery and documentation protocols, certain data elements

were no longer available. As a result, a small number of performance metrics were not conducted this year due to insufficient data which precluded drawing meaningful conclusions, or in some cases, producing analyses so constrained that the results explained and pertained only to "special situations." DBHDD's decision not to use some data due to lack of validity or usefulness for the current situation was similar to and validated by other state- and national-level organizations impacted by the COVID pandemic.

The above provides context for understanding the performance of support coordination during calendar year 2021, despite many challenges, and the stage is now set to contextualize performance analysis findings, to which this report now turns.

PURPOSE AND SCOPE OF THIS REPORT

The scope of this sixth annual report is performance analysis of support coordination services, which includes support coordination (SC) and intensive support coordination (ISC) funded by the New Options Waiver (NOW) or Comprehensive Supports Waiver (COMP) during January 1, 2021 through December 31, 2021 (CY2021).[1] The Division of Strategy, Technology, and Performance conducts and communicates analytical findings (including strengths, limitations, and potential implications of the findings) to other divisional leadership. Senior operations and programmatic leadership partner with quality improvement experts to apply study results to improve quality and enhance performance of DBHDD's programs and initiatives.

SUPPORT COORDINATION SERVICES

Support coordination services are a set of interrelated activities for identifying, coordinating, and overseeing the delivery of services to enhance the health, safety, and general wellbeing of waiver participants within the context of the person's goals toward maximum independence. Support coordination services cover two distinct waiver services known as support coordination (SC) and intensive support coordination (ISC).

During CY21, support coordination services were provided by seven agencies contracted by DBHDD and tasked with employing support coordinators to meet the support coordination service needs of individuals. Support coordinators are responsible for monitoring the implementation of the individual service plan (ISP), assisting in the coordination of ISP revisions,

[1]The data comes from the first and last calendar days of 2021, except health care level data comes from December 31, 2020.

assisting the individual or representative in locating a service provider, direct observation of individuals in service, review of documents, and follow-up to ensure that service plans have the intended effect. Support coordinators are also responsible for the ongoing evaluation of the satisfaction of individuals and their families with the ISP and delivery of waiver services utilizing a person-centered philosophy. ISC includes all the activities of SC, with additional activities that reflect specialized coordination of waiver, medical, and behavioral support services on behalf of individuals with complex medical and behavioral needs.

This report analyzed performance data from the perspective of the entire system of support coordination services as well as from the perspective of individual support coordination provider agencies. Since this is a support coordination services performance report, the content of this report is from the perspective of analyzing and reporting performance findings about the support coordination services "system" and "provider." DBHDD acknowledges that it may be more accurate to indicate that the performance of support coordination services and agencies, as well as the outcomes individuals experience, are dependent upon an entire system of DBHDD programs, administration, and providers of supports and services.

GENERAL IMPACT OF COVID

It is critical that one recalls the events of the first years of the pandemic that spanned most of 2020 and 2021, from which most of these data come. Many factors challenged DBHDD and providers during this time that may not be discernible in the data, and performance changes in the data are difficult to compare not only between agencies but also within an agency at any point in time or across time. Moreover, COVID forced changes in how healthcare services are organized, delivered, and what and how data were collected due to changes in data systems that support them. In other words, CY21 and pre-COVID data are not similar in terms of the context and reality within which they were produced.

The forthcoming *Risk Event and Resolution of Events for Complex Needs CY20* discusses impacts due to COVID and the compounded impacts including impacts on DBHDD programs and services, and support coordination was affected like many other DBHDD services. Moreover, the Centers for Medicare and Medicaid Services approved Georgia's amendment (Appendix K) to both the NOW and COMP waivers.[2] Appendix K enables DBHDD to implement necessary flexibilities in services and supports during COVID. These flexibilities were implemented to support uninterrupted service delivery while also reducing risk of transmission of and maximizing the containment of COVID.

Most often, DBHDD's formal analytical reports are delimited to performance information and insights from the previous year, such as with this report. Formal, analytical reports involve very complex analyses about even more complex systems of care for a single year. Adding in a year of comparison information between the current and previous year almost doubles the size of the report, and the reader often expends tremendous effort to navigate an even more complex

[2] Appendix K: https://gadbhdd.policystat.com/policy/9560065/latest/

report, as well as keeping in mind information from the current performance year or comparison of this and the previous year.

The following metrics and analysis will occur in sequence:

- Support coordination agencies and counts of SC and ISC recipients
- Caseload size compliance
- Regional Mapping
- Coaching and referral activities

SUPPORT COORDINATION AND INTENSIVE SUPPORT COORDINATION

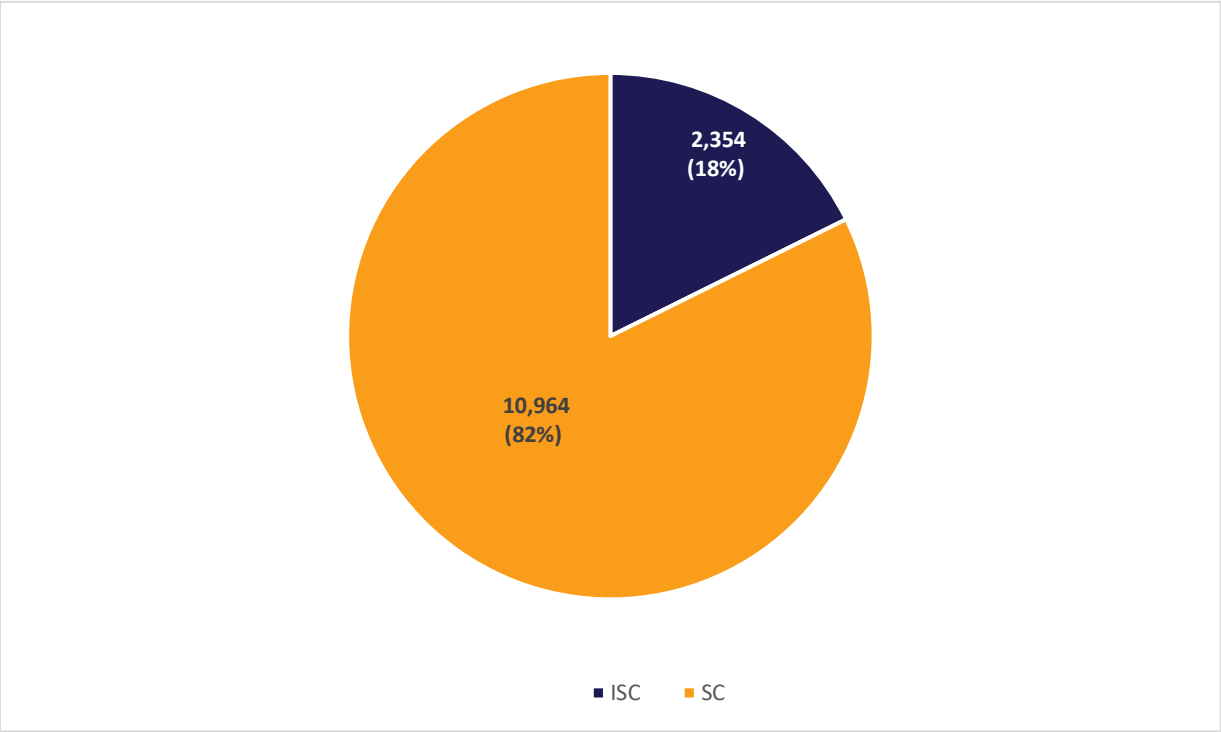
SUPPORT COORDINATION AGENCIES AND COUNTS OF SC AND ISC RECIPIENTS

This report focuses on system- and provider levels of performance. Seven support coordination agencies served 13,318 individuals receiving SC (10,964) and ISC (2,354) as of December 2021.

Georgia's Support Coordination Service Agencies

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

Figure 1: **SC and ISC Population, December 2021**
(n = 13,318)



CASELOAD SIZE COMPLIANCE

This section provides caseload size compliance information.[3] DBHDD policy regarding the caseload size of SC and ISC support coordinators specifies upper limits for each type of support coordination service. The policy also specifies how caseload ratios may be adjusted to accommodate having both SC and ISC recipients on an individual support coordinator's caseload.

DBHDD's compliance standard is 86 percent. Annual caseload size compliance is computed by adding the count of support coordinators across four quarters who met caseload size compliance standards (1,530) divided by the total count of support coordinators at the same points in time

[3] At the time of the writing of this document, DBHDD policy regarding the caseload size of support coordinators (Support Coordination Caseloads, Participant Admission, and Discharge Standards, 02-432) states that support coordinators providing intensive support coordination must have no more than 20 individuals in their caseload, and those providing standard support coordination must have no more than 40. If a support coordinator has a mixed caseload with both support coordination and intensive support coordination individuals, the 1:3 rule applies, counting each intensive support coordination individual as being equal to three support coordination individuals. If a mixed caseload has more than 10 individuals receiving intensive support coordination, then they may have no more than 20 individuals, and the 1:3 rule no longer applies. The 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.

(1,751). DBHDD's caseload size compliance was 87.4 percent, which satisfied the caseload size standard for CY21.

Several factors may affect caseload compliance which are not measured in this report such as workforce shortages, as one example. The report does, however, highlights challenges of caseload size compliance given the differences in population density across Georgia, which is presented next.

REGIONAL MAPPING

Georgia is made up of mostly low-density population areas which challenges support coordinators in achieving caseload size and mix compliance. In densely populated areas, support coordinators can more easily achieve caseload compliance. Sometimes, ISC individuals reside 100+ miles from metropolitan areas, and in one county, no one receives SC services; in more than 20 counties, no one receives ISC services. In areas with less dense SC and ISC recipients, then caseload compliance is more likely to vary from precise caseload compliance ratios specified in policy.

Figure 2: **Total Waiver Population, December 2021**

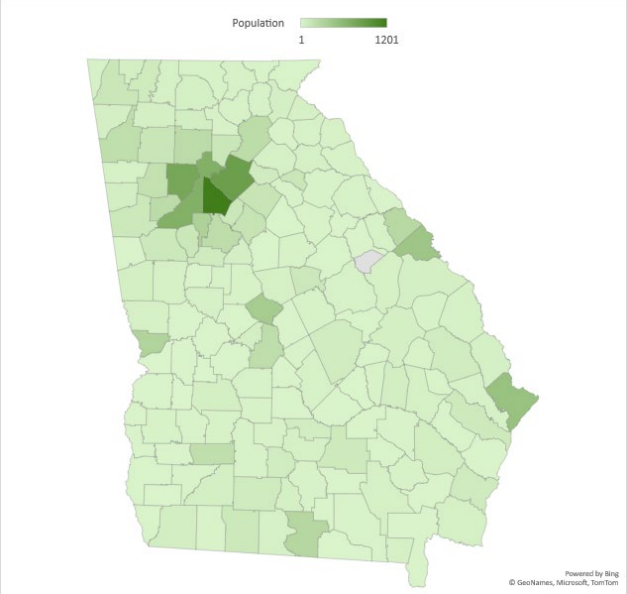


Figure 3: **ISC Waiver Population, December 2021**

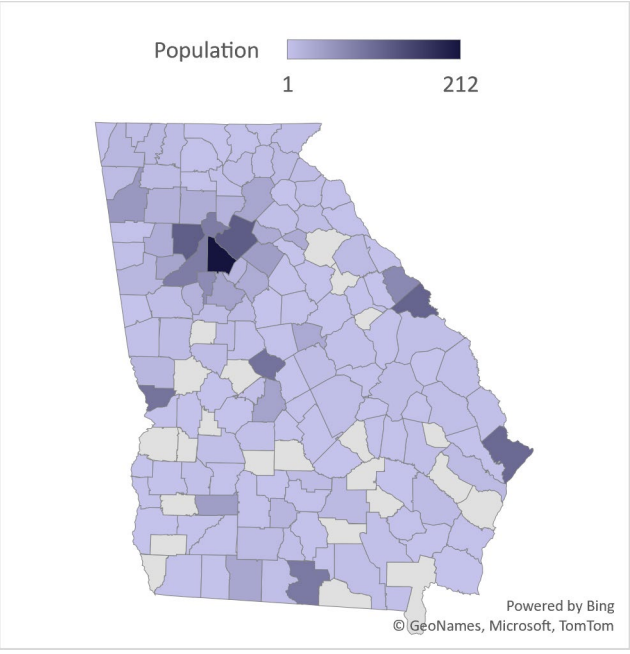
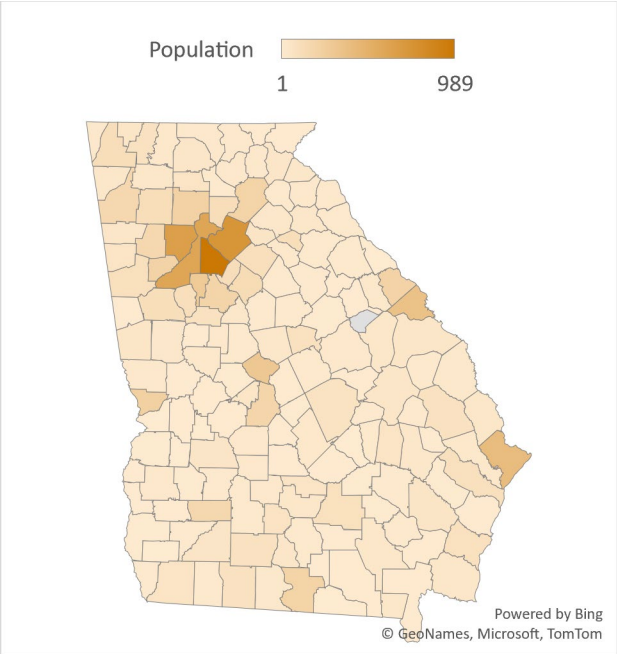


Figure 4: **SC Waiver Population, December 2021**



COACHING AND REFERRAL ACTIVITIES

After conducting a multi-domain assessment of the individual, home, and environment, along with many other factors, another aspect of support coordination performance is engaging in resolution activities and documenting related coaching and referral actions. The coaching and referral activities indicate productivity and performance of support coordination agencies.

Coaching

Required when a concern/issue/deficit is discovered in an element of a focus area question, and, in the support coordinator's professional judgment, (s)he 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.

Referrals

Required for more serious risks than those addressed by coaching. Referrals are first addressed by the Support Coordinator/Intensive Support Coordinator along with the provider/natural supports attempting to resolve the concern. Unresolved referrals are made to the Division of DD or to clinical staff to address serious concerns in the areas of the IQOMR. Referrals can also be used to escalate the urgency of a coaching due to slow response or worsening circumstances.

Table 1 highlights providing supports to the individual, provider, family network, internal referrals, and so on. Support coordination agencies managed 11,111 coaching sessions. For each coaching session, at least one concern/issue/deficit was detected, and the individual benefitted immediately because staff, natural supports, and the support coordinator collaborated to resolve the issue without involving others. Support coordination also made 5,671 referrals for more serious risks and situations. Referrals benefitted individuals when their issues require additional resources to address or resolve and support coordination's referrals actuate additional staff (especially clinical staff) were included to assure the individuals' healthcare and other service needs are met. Combined, SCs and ISCs initiated and followed up on 16,782 coachings and referrals to improve the services, supports, and outcomes of individuals they serve.

These coachings and referrals are important because their primary goal is to encourage a collaborative relationship between the Support Coordinator, provider agency staff, natural supports and the DBHDD staff. This collaboration serves as a pathway to effectively identify any

unmet needs for the individual, working together to reduce or eliminate any associated risks, and ultimately achieve the best outcomes for the individual.

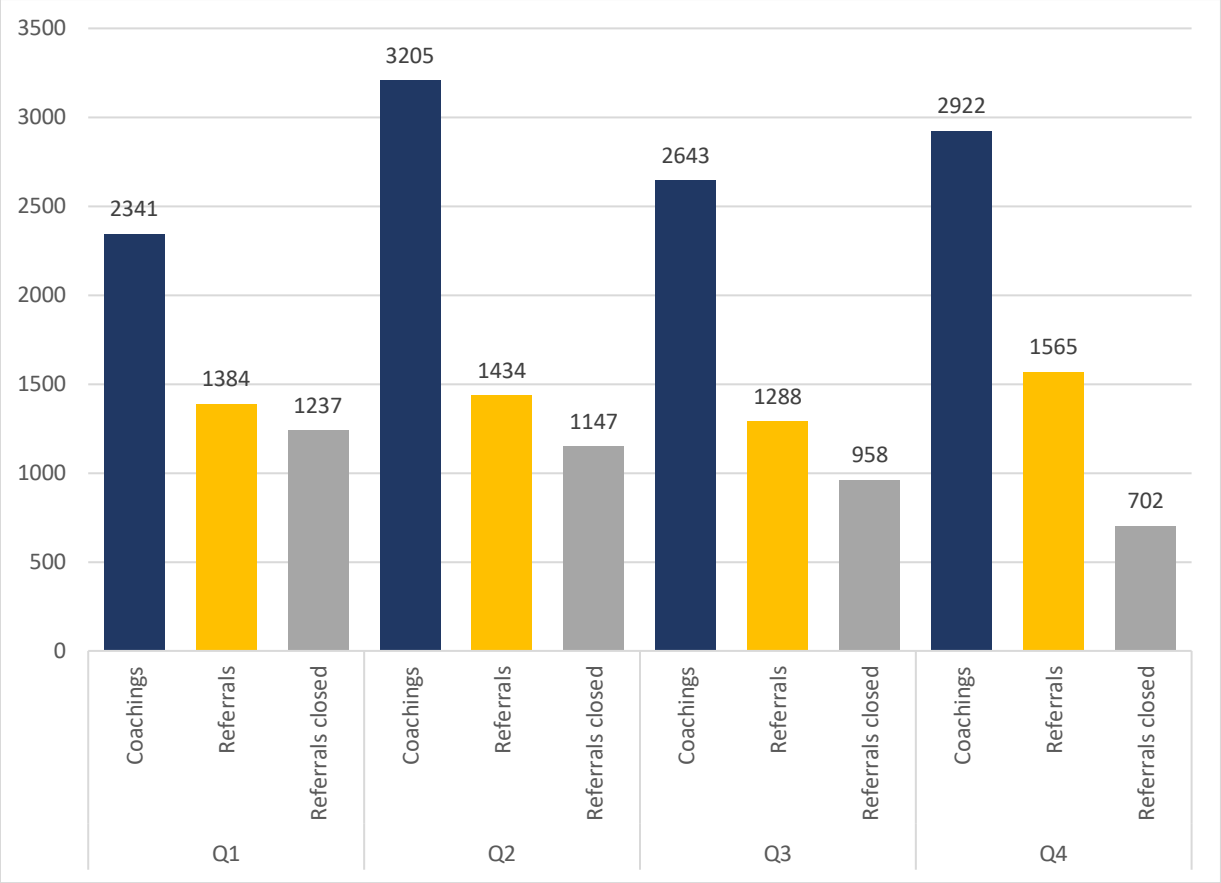
Table 1: Coaching and Referrals Activity, CY21

Coaching and Referrals Activity	Number of Coachings	Number of Referrals	Number of Referrals Closed by Intended Close Date	Percent of Referrals Closed by Intended Close Date
Appearance/Health	7,587	4,564	3,393	74.3%
Behavioral and Emotional	682	301	190	63.1%
Environment	665	233	110	47.2%
Financial	301	101	66	65.3%
Home/Community Opportunities	147	30	17	56.7%
Satisfaction	128	20	8	40.0%
Supports and Services	1,601	422	260	61.6%
Total	**11,111**	**5,671**	**4,044**[4]	**71.3%**

This coaching and referral analysis details the service or support deficits, whereas the IQOMR data would allow for positive outcome evaluation support coordination services. In later sections of this report, the limitations of IQOMR data during the reporting period will be discussed.

[4] The numbers reflected in Table 1 reflect coachings and referrals that had an open date (identified date) in CY21. Not all referrals opened in CY21 would have a scheduled close date that also fell within CY21, resulting in closed percentages that will never reach 100%.

Figure 5: **Support Coordination Services, Coaching and Referrals, CY21**



LIMITED REPORTING ON SOME PERFORMANCE ANALYSES: EFFECTS OF COVID RESPONSES

Some responses to COVID introduced new ways of collecting data or had no substantial impact on performance data collection. In some cases, new data systems were put in place or existing ones were modified to collect or measure data in these dynamic systems. In the first part of this report, DBHDD communicated performance information for some aspects of support coordination regional mapping, caseload size compliance, and coachings and referral actions.

However, the response to COVID affected services in such a way that did not allow for some performance data to be gathered or analyzed in a way that is meaningful. Ultimately, DBHDD and other organizations have attempted to balance the needs of continued service delivery through nimble adjustments and collecting and analyzing data with methodological and scientific rigor, though sometimes also making the difficult decision not to present data that are not

actionable due to several methodological and validity challenges that could not be overcome. The response to COVID limited support coordination performance analysis, which included the following metrics and analyses:

- Caseload compliance and adverse outcomes
- Face-to-face visits
- Face-to-face visits and increasing health risks
- IQOMR analysis

The remainder of this section describes the limitations of the data that were produced or collected and the factors for each data source that resulted in it not being usable or reported.

CASELOAD COMPLIANCE AND ADVERSE OUTCOMES

For several years DBHDD produced analyses to address the question: "Is being out of compliance with caseload size associated with negative outcomes?" Poisson regression analysis consistently indicated caseload size non-compliance is not significantly related to increased negative outcomes such as critical incidents, increased hospitalizations, and emergency department visits. DBHDD has decided to discontinue annual re-analysis of this measure due to limitations mentioned in prior reports and ongoing compliance with caseload size requirements. Should case load size compliance fall below acceptable ranges, DBHDD will resume analysis to understand the impact of non-compliance.

SC AND ISC FACE-TO-FACE VISITS

DBHDD sought and received approval from the Centers for Medicare and Medicaid Services to design and implement new services and supports, or adjustments to extant services and supports. Telehealth was a major mechanism to allow people to receive services that once were delivered face-to-face. With the implementation of telehealth protocols via Appendix K, CY21 data related to visits also include ancillary visits such as telephone conversations and video conferencing via various platforms as allowed by federal authorities, but which do not meet the definition of face-to-face visits. DBHDD considered using ancillary data and treating it as if were face-to-face visit data for analytical purposes, and DBHDD determined this would not provide valid analysis. Finally, in the past, analysis has demonstrated that increasing counts of face-to-face visits are associated with increasing HCLs; however, lack of face-to-face visits this year precludes conducting these analyses.

INDIVIDUALIZED QUALITY OUTCOMES MONITORING REVIEW (IQOMR)

Appendix K Operational Guidelines identify the IQOMR questions that may require in-person observation of the target behavior. However, Appendix K and constraints on personal protective equipment precluded that face-to-face observation from occurring. Most IQOMR questions were affected, including the following: 11, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 27, 28,

29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 41, 42, 43, 44, 46, 47, 48, 49, and 50. (The IQOMR items are in Appendix C.)

METRICS BELONGING WITH OTHER PROGRAMS

In the past, DBHDD investigated other metrics to determine how support coordination activities and performance can be monitored and initiated as needed. To offer additional context, DBHDD analyzed metrics that were process outcomes and more directly indicative of other DBHDD systems but not directly related to support coordination performance or outcomes.

CHANGES IN HCL SCORES

Previously, DBHDD analyzed changes in health risk level for support coordination performance. Measured health risk level is not a direct measure of either performance or outcomes. Health status (e.g., symptoms, functioning, physiological outcomes, diagnosis, etc.) 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. DBDHDD has decided to analyze and report health risk data within datasets and projects directly addressing measured health risk (e.g., *Risk, Event, and Resolution of Adverse Events for Individuals with Complex Needs*) or where health risk is a major factor (e.g., *Annual IDD Mortality Report*).

INCIDENT DATA

IDD providers are required to report certain types of incident reports and support coordinators may also submit them if necessary.[5] Support coordinators oftentimes play an integral role in the *process* of incident resolution. In this manner, incident data for support coordinators is one that (indirectly) indicates their activity to support incident resolution, a functional responsibility of Office of Incident Management which is responsible for conducting incident event analysis and reporting.

Though support coordination is involved with some processes such as HCL review and processing incident reports, these are not central, key functions or performance areas for support coordination. DBHDD has decided to focus on performance metrics that are key indicators of support coordination. Health risk level scores and incident resolution activity will continue to be analyzed and reported as part of services or programs more closely aligned with the metric.

[5] DBHDD Policy: Reporting Deaths and Incidents in Community Services, 04-106

SUMMARY & KEY FINDINGS

Despite not being able to calculate or collect some support coordination performance metrics this year, support coordination achieved performance expectations in CY21 on all performance metrics that could be calculated directly.

- Despite sometimes having to travel hundreds of miles to get to individuals (when face-to-face contact occurred), annual caseload size compliance was 87.4 percent.
- Support coordinators initiated and followed up on 16,782 combined coachings and referrals to improve the services, supports, and outcomes of individuals they serve, including the following:
    - Support coordinators delivered 11,111 coaching sessions
    - Support coordinators provided 5,671 referrals.

The effects of responses to COVID interfered with calculating, analyzing, and reporting some metrics. Face-to-face visits did not occur for part of the year, and performance measures that used visit data could not be computed. Without face-to-face visits, missing direct observation necessary to rate many individualized outcomes monitoring review (IQOMR) tool precluded IQOMR analyses. Understand that *the absence of a performance metric being calculated does not mean performance did not occur; instead, the responses to COVID affected data systems and processes that capture the data to calculate a few performance metrics.*

Thoughtful review and scrutiny of the purpose(s), value, and quality of information provided by previously calculated metrics and analyses resulted in multiple metrics and statistical analyses being removed for no longer providing meaningful information or being placed in other, more relevant report areas. The support coordination performance report now contains a more parsimonious and relevant set of performance indicators more closely aligned with the responsibilities and performance expectations for support coordination. Moving forward, DBHDD will continuously consider how to further improve and draw upon available information and data to measure the performance and impact of this important service.

Appendix A: Core Scientific, Theoretical, and Statistical Methods and Techniques to Understand and Improve Performance

DBHDD's analytic studies are reports of the results of the practical application of scientific theories, research methods, and analytical techniques to understand and improve performance. The appendix details for the interested reader the philosophical, scientific, theoretical, methodological, statistical, and interdisciplinary foundation for the empirical analysis. Several scientific, theoretical, methodological, and analytical principles and techniques common to many studies are presented here as the "core" of how and why DBHDD conducts most of its studies. Less common principles, theories, techniques, etc. not part of the core, if utilized during the study, are presented separately. The information provided here informs the readers about process and procedures (and best practice for research); it is also instructive for those interested in a basic working knowledge of how scientific theory, methods, and statistical analysis is used to drive change and improvement.

General guidelines for interpreting statistical research findings:

The reader is cautioned to be mindful of restrictions and limitations of internal and external validity when comparing data across times when the exogenous contributing and confounding variables vary and may have undeterminable and nonzero value.

DBHDD SAMPLING PROCEDURE

DBHDD carefully considers information and data to answer analytical questions. High quality, valid information and data are the basis of useful, practical, and valid research findings and conclusions. Ideally, analysis occurs from data on an entire population, and DBHDD strives to accomplish this when feasible; this produces maximum validity. However, when data on the entire population are not available or feasible, then DBHDD carefully considers how the analytic data sample is built, as the sampling procedure has great impact on the quality, validity, and generalizability of research findings.

DBHDD's sampling procedure proceeds in the following manner:

- First, when available, DBHDD uses data on the full population under study (e.g., all individuals who received services within a given period such as calendar or fiscal year).
- Second, if some individuals within the full population have missing data for variables being used for analysis, DBHDD considers widely accepted procedures to address missing data. For example, individuals with missing data typically are excluded from analysis using listwise deletion,[6] resulting in a subset of the full population. DBHDD may

[6] Listwise deletion is a method for handling missing data, whereby an entire record is excluded from analysis if any single value is missing.

consider other theoretically sound methods and procedures to understand or address missing data.[7]

- Third, in some cases, DBHDD utilizes some form of random sampling[8] (e.g., a random subset of providers or events that occurred). For this approach to be valid, one must be able to define the entire population from which it is being drawn, and each unit (e.g., individual, situation, etc.) must have an equal chance of being included in the sample. This method is unbiased, and the resulting sample is representative of the full population under study.
- Fourth, DBHDD also occasionally makes use of purposive sampling, a non-probability sampling method. This method is typically reserved for specific instances (e.g., identifying when a situation occurred, selecting specific cases, identifying specific errors, etc.). Purposive sampling is a selective, non-probabilistic method, and purposive sampling is not representative of the full population under study; therefore, findings or results based on purposive sampling are not generalizable to the full population, rather only to the cases from which data were sampled.

[7] Sensitivity analyses are conducted to evaluate the pattern of missing data, wherein missing data are determined to be either missing completely at random (MCAR) or missing at random (MAR). Data are determined to be MCAR when the probability of missing data on a variable is unrelated to any other measured variable and is unrelated to the variable with missing values itself. Data are determined to be MAR when the missingness can be explained by variables that do not contain missing values.

[8] The leading component of simple random sampling is that every case (e.g., individuals or providers) has the same probability of being selected for inclusion in analysis.

Appendix B: Support Coordination Services, Agency Data, CY21

Agency	ISC	SC	Proportion ISC
Benchmark	412	393	51%
CareStar	155	243	39%
Columbus	579	3,763	13%
Compass	169	314	35%
Creative	588	3,171	16%
Georgia Support	194	1,310	13%
PCSA	257	1,770	13%
Totals	2,354	10,964	18%

Appendix C: IQOMR Questions

Individual Quality Outcome Measures Review

Individual Information

Individual's Name

Physical Address Location of Visit Date & Time of Visit

ADA Population Funding Source

	Focus Area: Environment	Select:	Comments/Actions Needed: Concerns, Barriers, Successes
1	The home/site is accessible to the individual.	Select	
2	The individual has access to privacy for personal care.	Select	
3	The individual has a private place in the home to visit with friends or family.	Select	
4	The individual has access to privacy for phone discussions with friends or family.	Select	
5	The individual has access to receive and view their mail/email privately.	Select	
6	The individual is able to have private communications with family and friends through other means.	Select	
7	The home setting allows the individual the option to have a private bedroom.	Select	
8	All assistive technologies are being utilized as planned.	Select	
9	All assistive technologies are in good working order.	Select	
10	The individual has adequate clothing to accommodate the individual's needs or preferences/choices.	Select	

11	The individual has adequate food and supplies to accommodate the individual's needs or preferences/choices.	Select	
12	The Residential/Day setting is clean according to the individual's needs and preferences.	Select	
13	The Residential/Day setting is safe for the individual's needs.	Select	
14	The Residential/Day setting is appropriate for the individual's needs and preferences.	Select	
Focus Area: Appearance/Health		**Select:**	**Comments/Actions Needed: Concerns, Barriers, Successes**
15	The individual appears healthy. Describe any observations regarding health since the last review.	Select	
16	The individual appears safe. Describe any observed changes related to safety since the last review.	Select	
17	There have been no reported changes in health since the last review.	Select	
18	The HRST aligns with current health and safety needs.	Select	
19	The ISP is available to staff on site. If there have been ISP addendums, they are available to staff on site.	Select	
20	Staff are knowledgeable about all information contained within the individual's ISP.	Select	
21	Indicated healthcare plans are current and have been reviewed by a nurse within the past year.	Select	
22	Indicated healthcare plans are available to staff on site in all applicable settings.	Select	
23	All staff are knowledgeable about all of the individual's healthcare plans.		

24	Indicated healthcare plans are being implemented.	Select	
25	Skilled nursing hours are being provided, as ordered.	Select	
26	All medical/therapeutic appointments have been scheduled and attended.	Select	
27	All follow-up appointments have been scheduled and attended.	Select	
28	All physician/clinician recommendations are being followed.	Select	
29	All prescribed medications are being administered, as ordered, and documented accurately.	Select	
30	All required assessments/evaluations have been completed.	Select	
31	The individual has had no hospital admissions, emergency room, or urgent care visits since the last review.	Select	
32	If applicable, hospital/ED/urgent care discharge plan instructions have been followed.	Select	
Focus Area: Supports and Services		**Select:**	**Comments/Actions Needed: Concerns, Barriers, Successes**
33	The individual's paid staff appear to treat them with respect and dignity.	Select	
34	The individual's natural supports appear to treat them with respect and dignity.	Select	
35	Supports and services are being delivered to the individual, as identified in the current ISP.	Select	

36	The individual is 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	
37	There are no needs for additional services/supports at this time.	Select	
Focus Area: Behavioral & Emotional		**Select:**	**Comments/Actions Needed: Concerns, Barriers, Successes**
38	Since the last visit, there are no emerging or continuing behavioral/ emotional responses for the individual.	Select	
39	Current supports and behavioral interventions are adequate to prevent engaging external interventions.	Select	
40	The individual has no active Behavioral Support Plan, Crisis Plan, and/or Safety Plan relating to behavioral interventions.	Select	
41	If applicable, the plan(s) is/are available on site for staff review.	Select	
42	There is evidence of implementation of the Behavioral Support Plan, Crisis Plan, and/or Safety Plan. Staff are knowledgeable about the plan(s) and able to describe how they are implementing the plan.	Select	
43	Since the last visit, there have been no needs to access GCAL or the Mobile Crisis Response Team in response to a behavioral emergency If GCAL/MCT has been accessed, describe reason, frequency, duration of any admissions, and if discharge recommendations have been followed. If applicable, the BSP/ Safety Plan/ Crisis Plan has been adapted to reflect any new recommendations or	Select	

	interventions needed.		
44	Since the last visit, the individual has had no contact with law enforcement. If they have, describe reason and length of involvement. If applicable, the BSP/ Safety Plan/ Crisis Plan has been adapted to reflect any new recommendations or interventions needed.	Select	
Focus Area: Home/ Community Opportunities		**Select:**	**Comments/Actions Needed: Concerns, Barriers, Successes**
45	The individual has unpaid community connections. If not, describe steps being taken to further develop community connections.	Select	
46	The individual is 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	
47	The individual is being offered/provided documented opportunities to participate in activities of choice with non-paid community members.	Select	
48	The individual has 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	
49	If desired, the individual is actively supported to seek and/or maintain employment in competitive and integrated settings and/or offered customized opportunities. If applicable, note how he/she is supported to do so. If no, indicate how the issue is being addressed.	Select	
50	The individual has the necessary access to transportation for employment and community activities of his/her choice.	Select	
Focus Area: Financial		**Select:**	**Comments/Actions Needed: Concerns, Barriers, Successes**

51	There are no barriers in place that limit the individual's access to spend his/her money, as desired.	Select	
Focus Area: Satisfaction		**Select:**	**Comments/Actions Needed: Concerns, Barriers, Successes**
52	Overall, the individual is satisfied with their life activities since the last review.	Select	
53	Overall, the individual is satisfied with their service providers since the last review.	Select	
54	Overall, the individual is satisfied with the type of services received since the last review.	Select	
55	Overall, the individual is satisfied with their family relationships/natural supports since the last review.	Select	