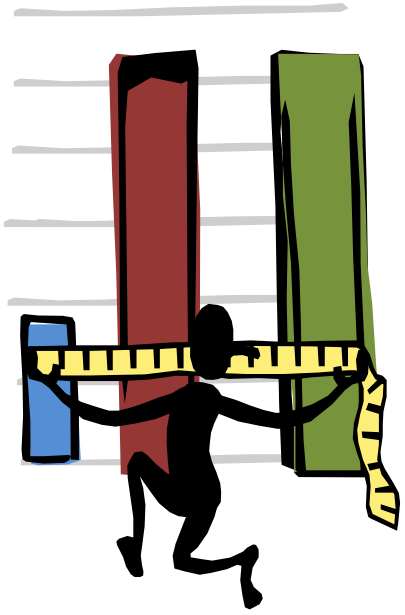
Developmental Disabilities Services
1915 (c) Waiver

Quarterly Performance Measure Report

QUARTER 2
FY 2014



PERFORMANCE MEASURES

INTRODUCTION

The DDS Quality Assurance Unit produces this document to report on progress according to the Performance Measures established to measure how the State complies with the Subassurances contained in the Alternative Community Services Home and Community Based Waiver. The report is presented to the DDS Quality Assurance Committee in order to determine areas of significance and whether any areas indicated a need for intervention at a systems level.

The Quarterly Performance Measure Report (QPMR) for the first quarter of State Fiscal Year (SFY) 2014, specifically July through September 2013, consists of four parts: Level of Care, Qualified Providers, Service Plans, and Health and Welfare.

DATA

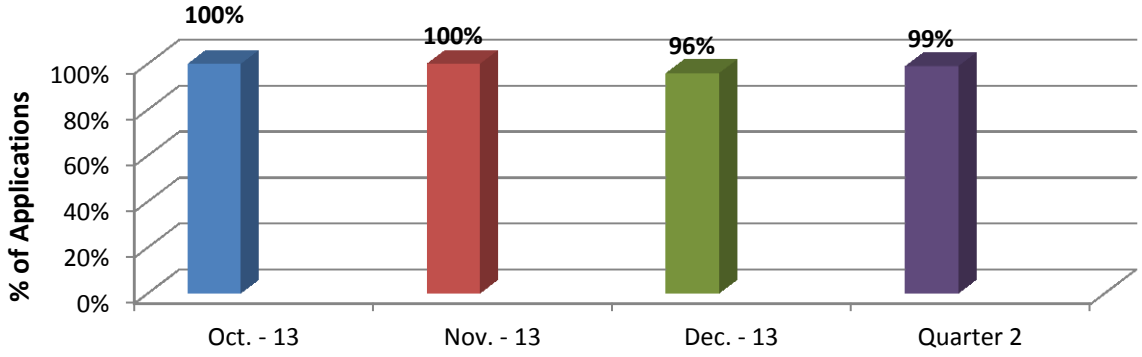
Level of Care

Subassurance A:
Waiver applicants for whom there is reasonable indication that services may be needed in the future are provided an individual level of care (LOC) evaluation.

The state developed the following to measure compliance with Subassurance A:

LOC A1: Number and percentage of applicants for whom an application packet is completed and submitted timely to the DDS psychology team for an LOC initial determination.

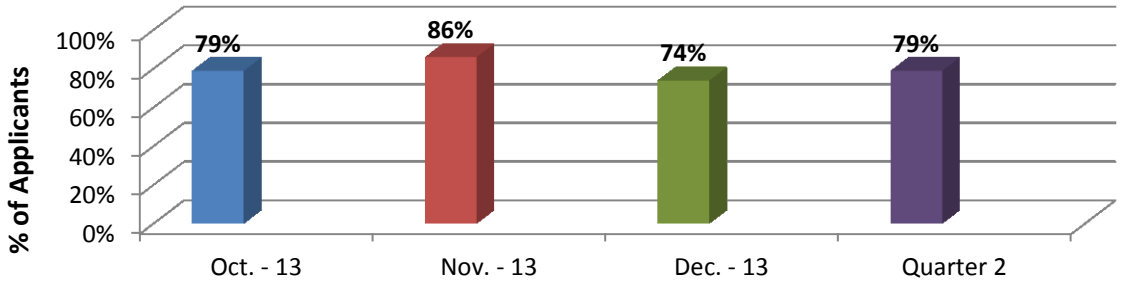
Chart 1: Timely Initial LOC



Of the 48 application packets due for completion in October 2013, 48 (100%) were completed within timeframes. Of the 37 application packets due for completion in November, 37 (100%) were completed timely. Of the 23 application packets due for completion in December, 22 (96%) were completed timely. This resulted in an overall percentage of 99% for the quarter.

LOC A2: Number and percentage of applicants who had an initial LOC determination completed before receipt of services.

Chart 2: LOC Before Receipt of Services



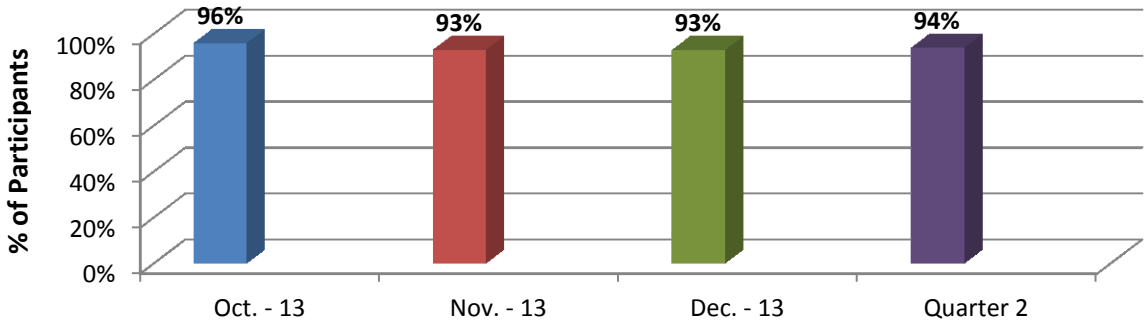
Of the 61 persons whose LOCs were due for completion in October 2013, 48 (79%) were completed within timeframes. Of the 63 persons whose LOCs were due for completion in November, 54 (86%) were completed timely. Of the 73 persons whose LOCs were due for completion in December, 54 (74%) were completed timely. This resulted in an overall percentage of 79% for the quarter.

Subassurance B:
The LOC of enrolled participants is reevaluated at least annually or as specified in the approved waiver.

The state developed the following to measure compliance with Subassurance B:

LOC B1: Number and percentage of participants who received an annual redetermination of LOC eligibility within 12 months of their initial or last LOC evaluation.

Chart 3: LOC Annual Reevaluation



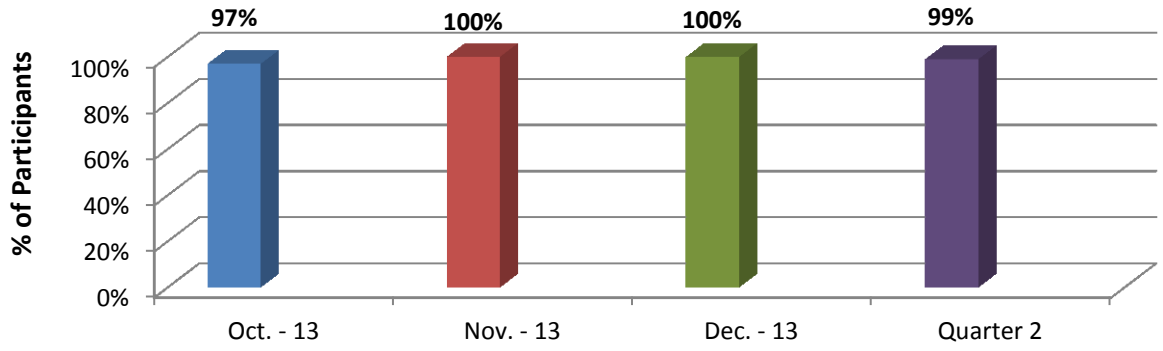
Of the 292 persons whose LOCs were due for annual reevaluation in October 2013, 281 (96%) were completed within timeframes. Of the 305 persons whose LOCs were due for annual reevaluation in November, 283 (93%) were completed timely. Of the 254 persons whose annual reevaluations were due for completion in December, 237 (93%) were completed timely. This resulted in an overall percentage of 94% for the quarter.

Subassurance C:
The processes and instruments described in the approved waiver are applied to LOC determinations.

The state developed the following to measure compliance with Subassurance C:

LOC C1: Number and percentage of participants for whom the appropriate process and instruments were used to determine eligibility.

Chart 4: Appropriate Process and Instruments



Of the 37 files reviewed for compliance with this requirement in October 2013, 36 (97%) were in compliance. Of the 34 files reviewed in November, 34 (100%) were in compliance. Of the 32 files reviewed in December, 32 (100%) were in compliance. This resulted in an overall percentage of 99% for the quarter.

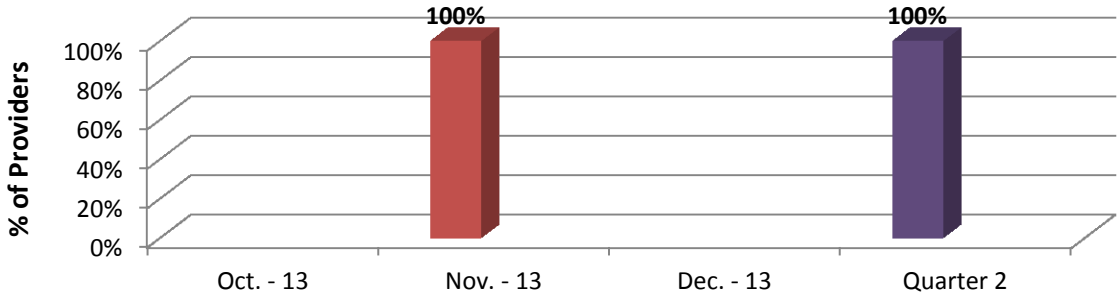
Qualified Providers

Subassurance A:
The state verifies that providers initially and continually meet required licensure and certification standards and adhere to other standards prior to their furnishing waiver services.

The state developed the following to measure compliance with Subassurance A:

QP A1: Number and percentage of providers who obtained initial certification in accordance with promulgated state Standards.

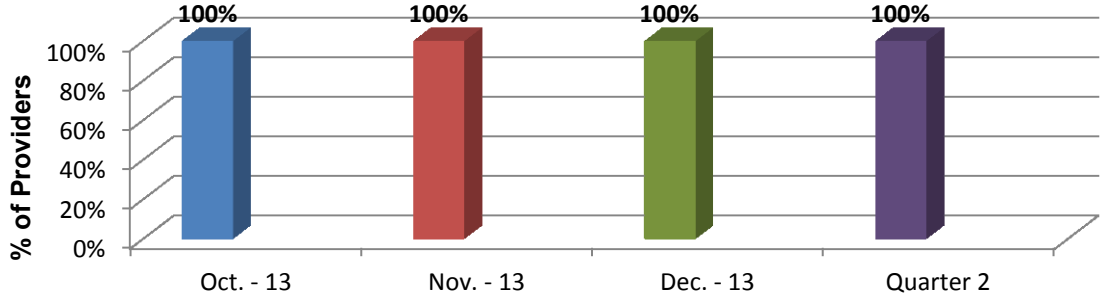
Chart 5: Timely Certification



No providers applied for an initial certification in October or November. One provider applied for initial certification in November 2013 and was certified timely (100%).

QP A2: Number and percentage of providers who met promulgated state Standards and obtained annual re-certification.

Chart 6: Timely Recertification



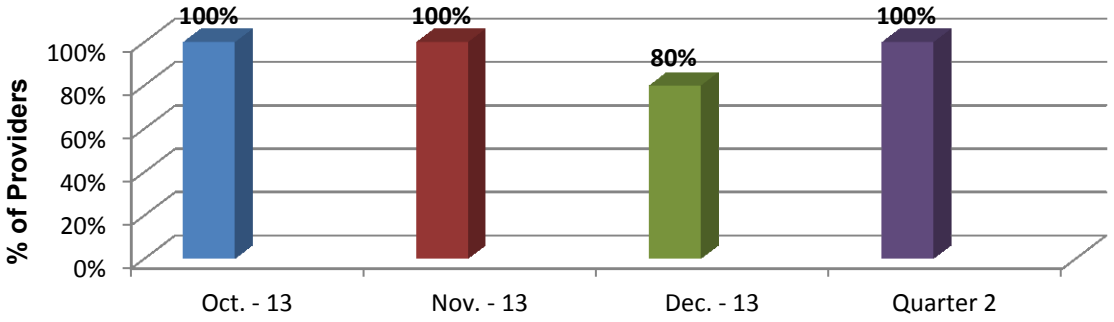
Of the four providers due for recertification in October 2013, DDS recertified four (100%) within timeframes. Of the six providers due in November, six (100%) were recertified timely. Of the five providers due in December, five (100%) were recertified timely. This resulted in an overall percentage of 100% for the quarter.

Subassurance C:
The State implements its policies and procedures for verifying that training is provided in accordance with State requirements and the approved waiver.

The state developed the following to measure compliance with Subassurance C:

QP C1: Number and percentage of provider agencies that meet DDS requirements for abuse and neglect report training for staff. (Standard 301.1.E.h & i)

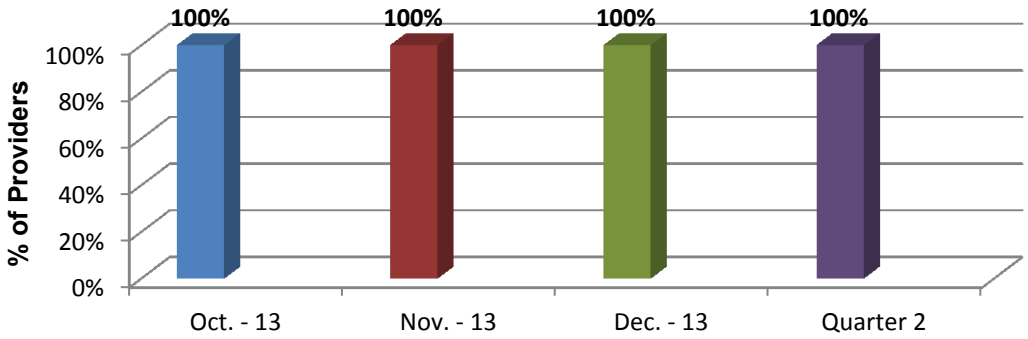
Chart 7: Abuse & Neglect Report Training for Staff



Of the four providers reviewed for compliance with or investigated due to a complaint regarding this Standard in October 2013, four (100%) were found to be in compliance. Of the six providers reviewed or investigated in November, six (100%) were in compliance. Four of five (80%) of those reviewed or investigated in December were in compliance with the Standard. This resulted in an overall percentage of 93% for the quarter.

QP C2: Number and percentage of provider agencies that meet requirements for training staff on the specific needs of the persons they serve. (Standard 301.5.4)

Chart 8: Training on Specific Needs



Of the four providers reviewed for compliance with or investigated due to a complaint regarding this Standard in October 2013, four (100%) were found to be in compliance. Of the six providers reviewed or investigated in November, six (100%) were in compliance. Five of five (100%) of those reviewed or investigated in December were in compliance with the Standard. This resulted in an overall percentage of 100% for the quarter.

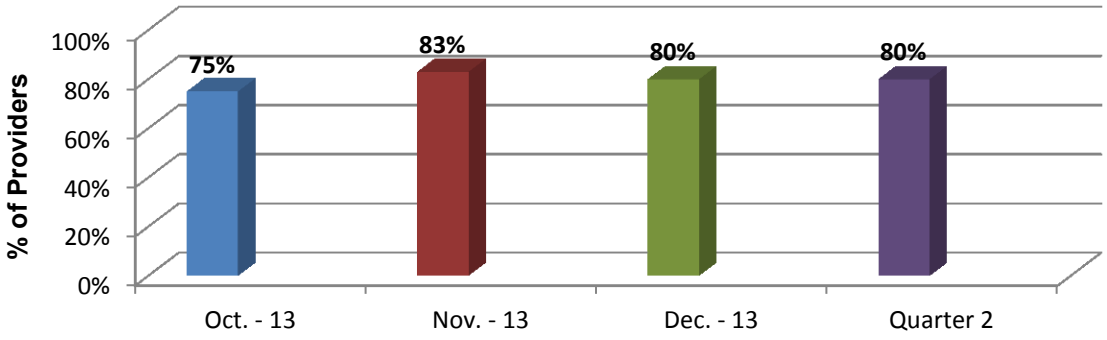
Service Plan

***Subassurance A*:**
Service plans address all participant's assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

The state developed the following to measure compliance with Subassurance A:

SP A1: Number and percentage of providers who developed service plans that were adequate and appropriate to the needs of individuals as indicated by their assessments. (Standard 507)

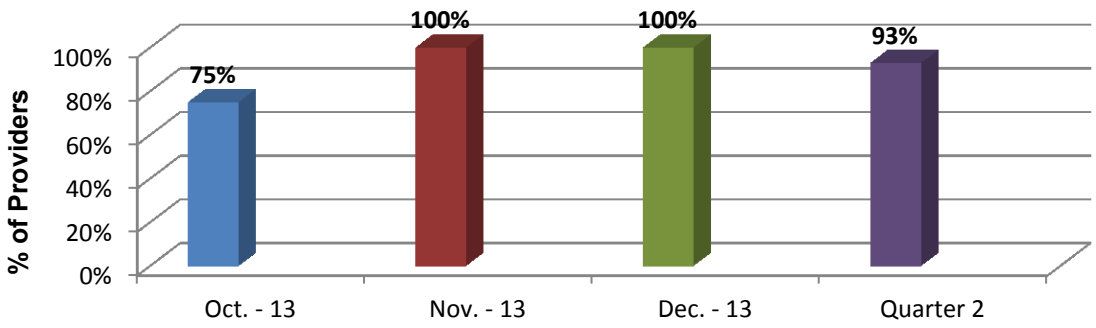
Chart 9: Appropriate to Needs



Of the four providers reviewed for compliance with or investigated due to a complaint regarding this Standard in October 2013, three (75%) were found to be in compliance. Of the six providers reviewed or investigated in November, five (83%) were in compliance. Four of five (80%) of those reviewed or investigated in December were in compliance with the Standard. This resulted in an overall percentage of 80% for the quarter.

SP A2: Number and percentage of providers who developed service plans that addressed the individual's personal goals. (Standard 508.1B.3.a.1-6)

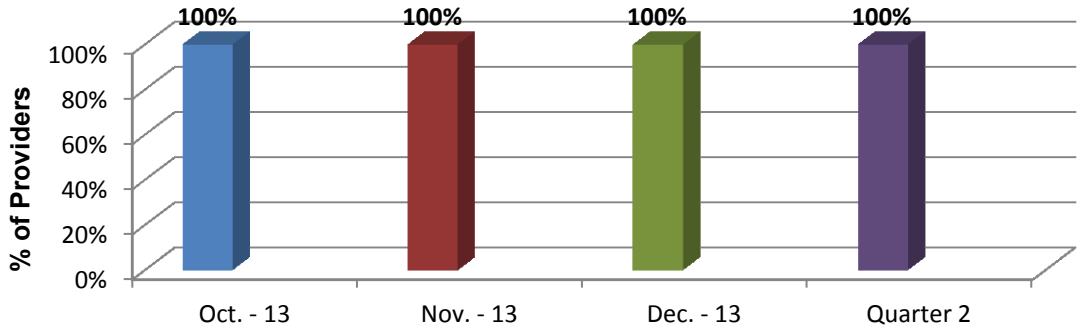
Chart 10: Personal Goals



Of the four providers reviewed for compliance with or investigated due to a complaint regarding this Standard in October 2013, three (75%) were found to be in compliance. Of the six providers reviewed or investigated in November, six (100%) were in compliance. Five of five (100%) of those reviewed or investigated in December were in compliance with the Standard. This resulted in an overall percentage of 93% for the quarter.

SP A3: Number and percentage of providers who developed service plans that address the individuals' risk factors. (Standard 507.A)

Chart 11: Risk Factors



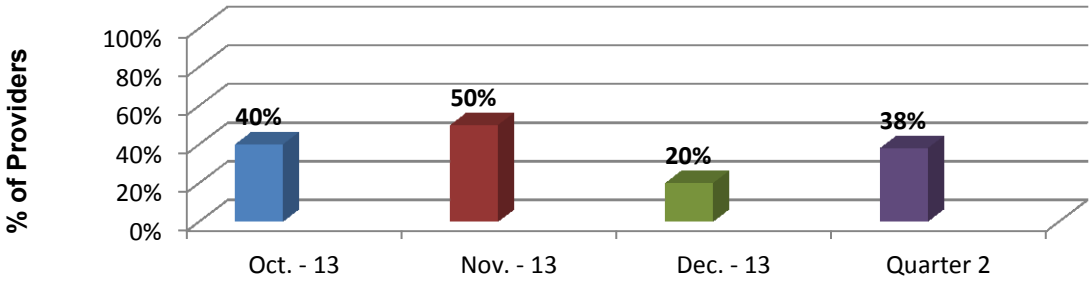
Of the four providers reviewed for compliance with or investigated due to a complaint regarding this Standard in October 2013, four (100%) were found to be in compliance. Of the six providers reviewed or investigated in November, six (100%) were in compliance. Five of five (100%) of those reviewed or investigated in December were in compliance with the Standard. This resulted in an overall percentage of 100% for the quarter.

Subassurance B:
The state monitors service plan development in accordance with its policies and procedures.

The State developed the following to measure compliance with Subassurance B:

SP B1: Number and percentage of providers who developed service plans in accordance with Standard 508-508.2.D (excluding 508.1.B.3-5).

Chart 12: Proper Procedures



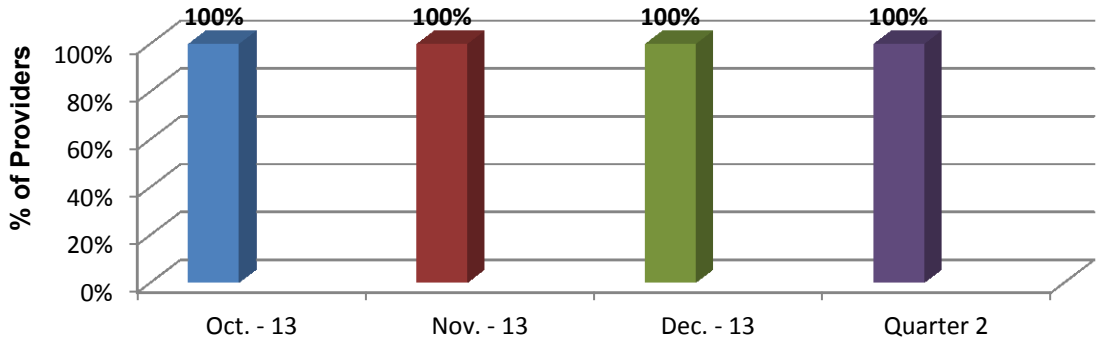
Of the five providers reviewed for compliance with or investigated due to a complaint regarding this Standard in October 2013, two (40%) were found to be in compliance. Of the six providers reviewed or investigated in November, three (50%) were in compliance. One of five (20%) of those reviewed or investigated in December were in compliance with the Standard. This resulted in an overall percentage of 38% for the quarter.

Subassurance C:
Service plans are updated or revised at least annually or when warranted by changes in the individuals' needs.

The State developed the following to measure compliance with Subassurance C:

SP C1: Number and percentage of providers who updated service plans at least annually. (Standard 509.B)

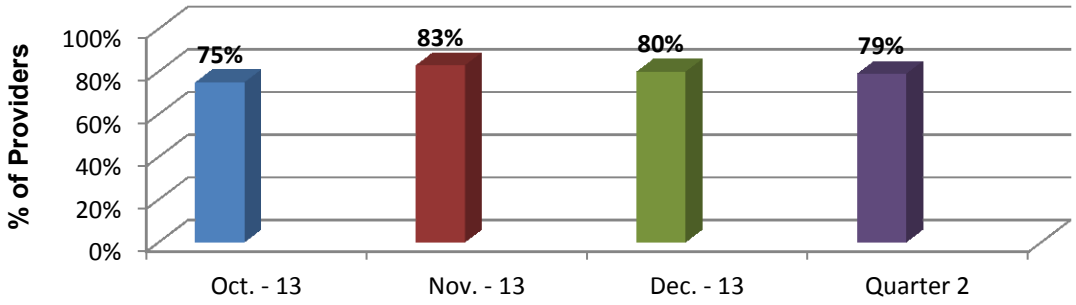
Chart 13: Updated Service Plans



Of the four providers reviewed for compliance with or investigated due to a complaint regarding this Standard in October 2013, four (100%) were found to be in compliance. Of the six providers reviewed or investigated in November, six (100%) were in compliance. Five of five (100%) of those reviewed or investigated in December were in compliance with the Standard. This resulted in an overall percentage of 100% for the quarter.

SP C2: Number and percentage of providers who reviewed and revised service plans as warranted by changes in individual needs. (Standard 509.A or 510)

Chart 14: Individual Needs



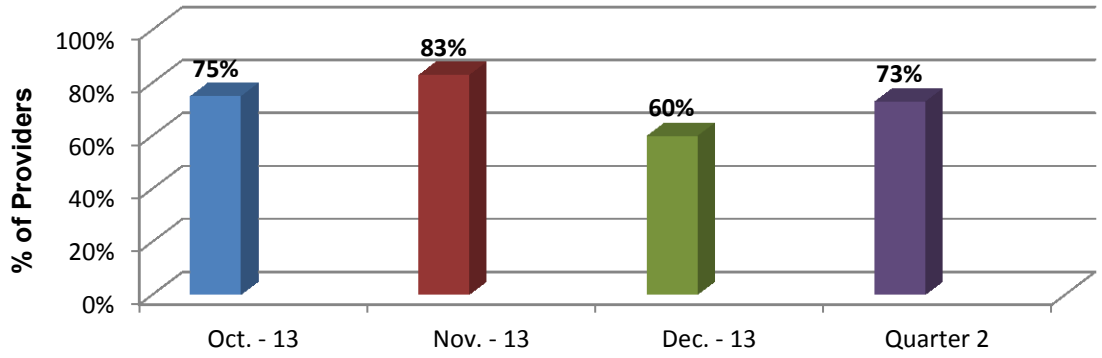
Of the four providers reviewed for compliance with or investigated due to a complaint regarding this Standard in October 2013, three (75%) were found to be in compliance. Of the six providers reviewed or investigated in November, five (83%) were in compliance. Four of five (80%) of those reviewed or investigated in December were in compliance with the Standard. This resulted in an overall percentage of 79% for the quarter.

Subassurance D:
Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

The State developed the following to measure compliance with Subassurance D:

SP D1: Number and percentage of providers who delivered services in in the type, scope, amount, duration and frequency specified in the service plan. (Standard 508.1.B. 4 & 5 and 508.2.E.1-3)

Chart 15: Type, Frequency & Duration



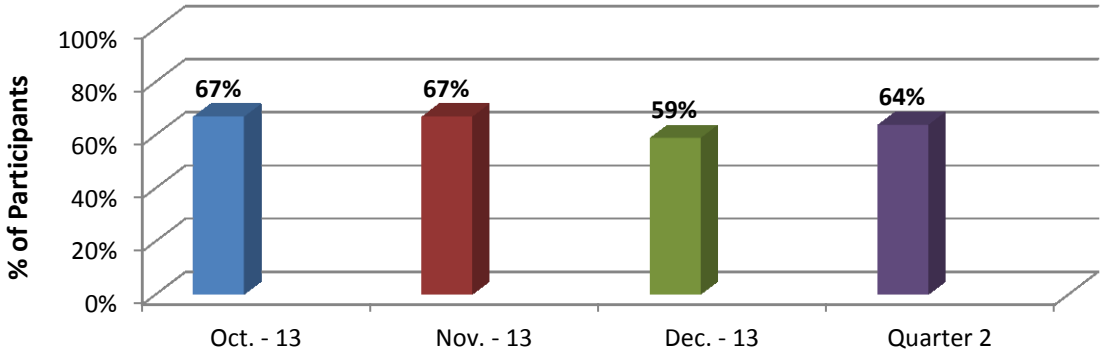
Of the four providers reviewed for compliance with or investigated due to a complaint regarding this Standard in October 2013, three (75%) were found to be in compliance. Of the six providers reviewed or investigated in November, five (83%) were in compliance. Three of five (60%) of those reviewed or investigated in December were in compliance with the Standard. This resulted in an overall percentage of 73% for the quarter.

Subassurance E:
Participants are afforded choice between waiver services and institutional care and between or among waiver services and providers.

The State developed the following to measure compliance with Subassurance E:

SP E1: Number and percentage of participants who were offered choice as indicated by an appropriately completed and signed freedom of choice form that specified choice of institutional care or waiver services.

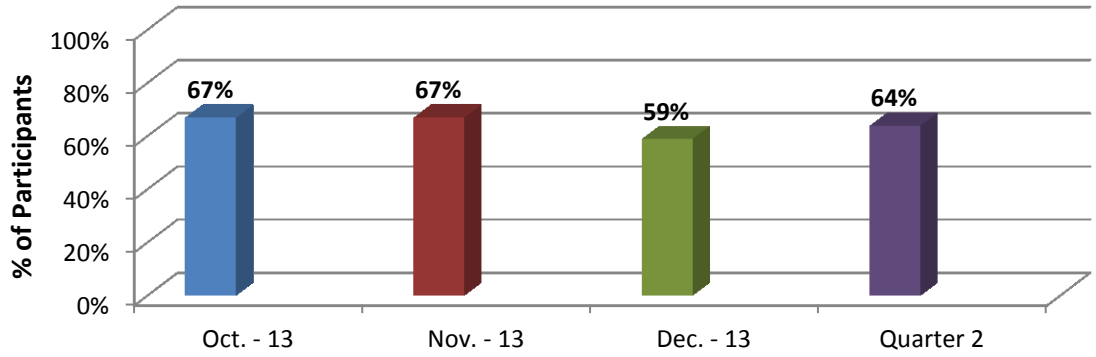
Chart 16: Choice of Waiver or Institution



Of the 230 files reviewed for compliance with this requirement in October 2013, 155 (67%) were found to be in compliance. Of the 242 files reviewed for compliance in November, 163 (67%) were in compliance. One hundred thirty of 220 (59%) of those reviewed in December were in compliance. This resulted in an overall percentage of 64% for the quarter.

SP E2: Number and percentage of participants who were offered choice as indicated by an appropriately completed and signed freedom of choice form that specified choice of providers.

Chart 17: Choice of Provider



Of the 230 files reviewed for compliance with this requirement in October 2013, 155 (67%) were found to be in compliance. Of the 242 files reviewed for compliance in November, 163 (67%) were in compliance. One hundred thirty of 220 (59%) of those reviewed in December were in compliance. This resulted in an overall percentage of 64% for the quarter.

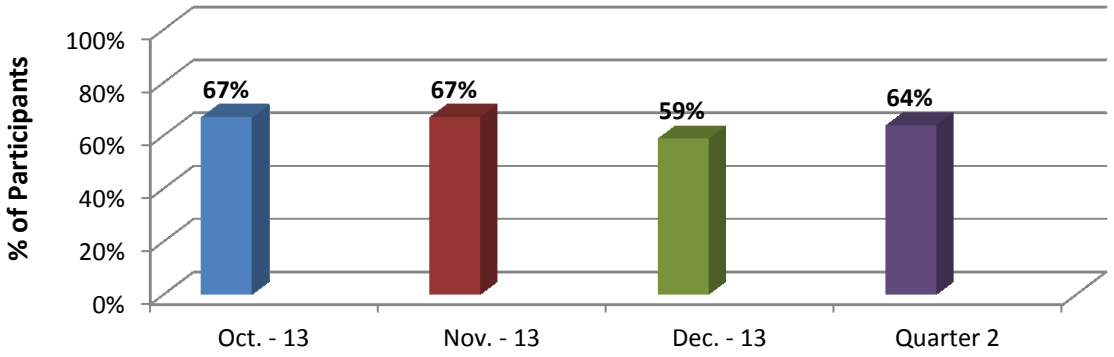
Health and Welfare

Health and Welfare Subassurance:
On an ongoing basis the State identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.

The State developed the following to measure compliance with the Health and Welfare Subassurance.

HW 1: Number and percentage of participants or legal guardians who received information about how to report abuse, neglect and exploitation as documented on the applicable form.

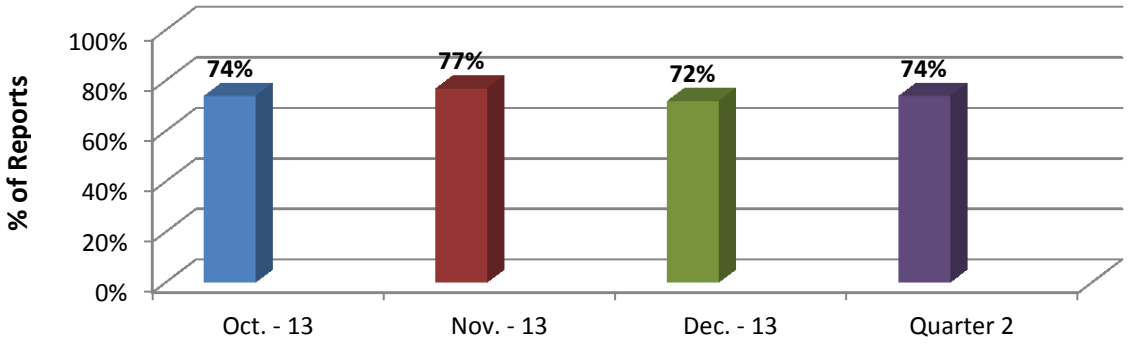
Chart 18: Information on Reporting



Of the 230 files reviewed for compliance with this requirement in October 2013, 155 (67%) were found to be in compliance. Of the 242 files reviewed for compliance in November, 163 (67%) were in compliance. One hundred thirty of 220 (59%) of those reviewed in December were in compliance. This resulted in an overall percentage of 64% for the quarter.

HW 2: Number and percentage of critical incidents that were reported by the provider to DDS within required time frames.

Chart 19: Reporting Critical Incidents to DDS



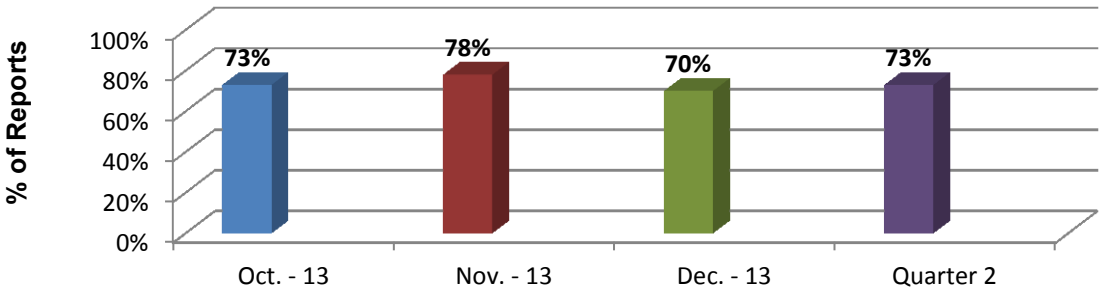
To be considered timely, the provider must report an incident within 2 business days of the incident. A critical incident is defined as death, suicidal behavior, suspected abuse and neglect by a staff person, a consumer whose location is unknown for 2 hours, use of a restrictive intervention and arrest of a consumer.

Of the 42 reports of critical incidents submitted in October 2013, 31 (74%) were submitted timely. Of the 26 reports submitted in November, 20 (77%) were timely. Twenty of 29 (72%) of those submitted in December were submitted timely. This resulted in an overall percentage of 74% for the quarter.

HW 3: Number and percentage of critical incidents that were reported to Adult Protective Services (APS) or Child Protective Services (CPS).

A critical incident is defined for this measure as suicidal behavior, suspected abuse and neglect by a staff person, a consumer whose location is unknown for 2 hours, use of a restrictive intervention and arrest of a consumer.

Chart 20: Reporting Critical Incidents to APS to CPS

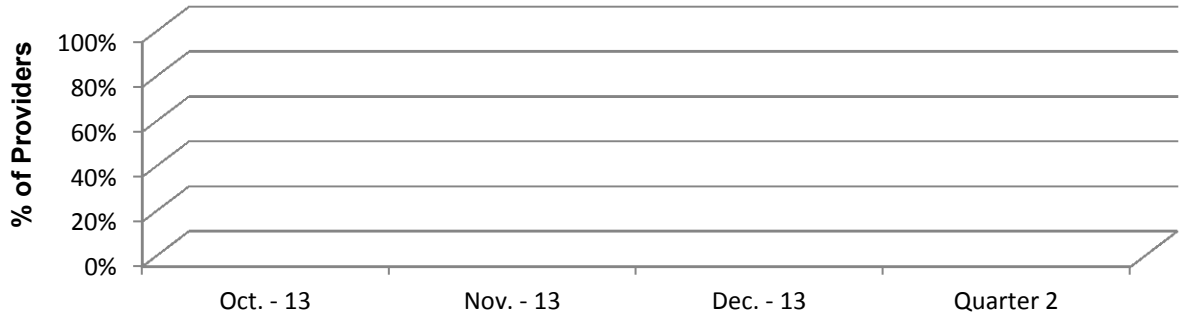


Of the 22 reports of critical incidents submitted in October 2013, 16 (73%) were submitted timely. Of the nine reports submitted in November, seven (78%) were timely. Ten of seven (70%) submitted December were submitted timely. This resulted in an overall percentage of 73% for the quarter.

HW 4: Number and percentage of critical incidents where the provider took corrective actions to protect the health and welfare of the individual.

A critical incident is defined for this measure as suicidal behavior, suspected abuse and neglect by a staff person, a consumer whose location is unknown for 2 hours, use of a restrictive intervention and arrest of a consumer.

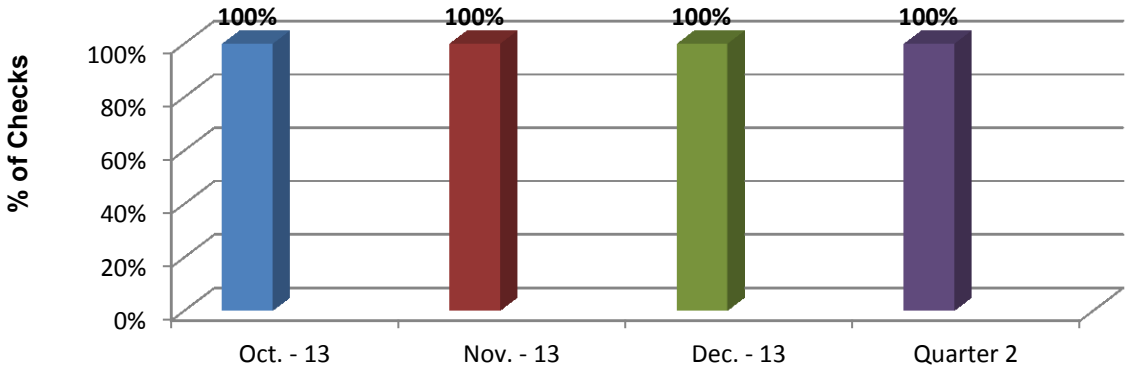
Chart 21: Corrective Actions



There is no data available for this quarter.

HW 5: Number and percentage of criminal background checks completed by DDS on a timely basis.

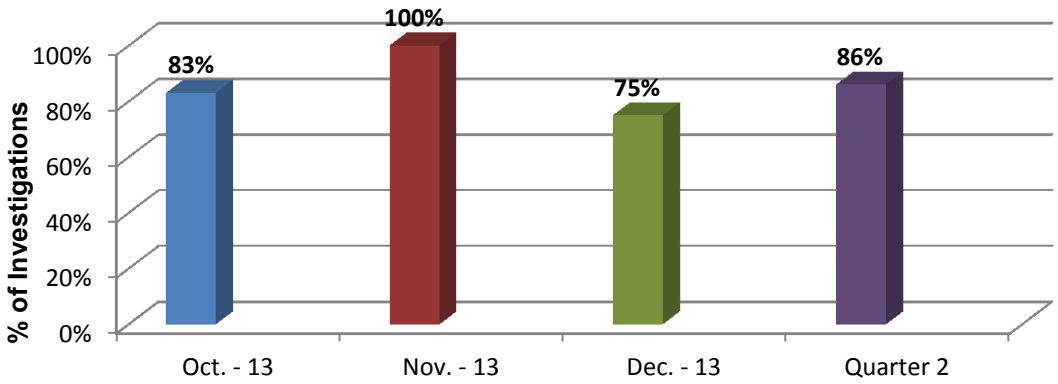
Chart 22: Timely Background Checks



To be considered timely, the Background Check Unit must complete the check within 14 days of the date they receive the request. Of the 311 received in October 2013, 311 (100%) were completed timely. Of the 88 received in November, 88 (100%) were completed timely. Two hundred one (100%) received in December were completed timely. This resulted in an overall percentage of 100% for the quarter.

HW 6: Number and percentage of complaint investigations that were completed on a timely basis.

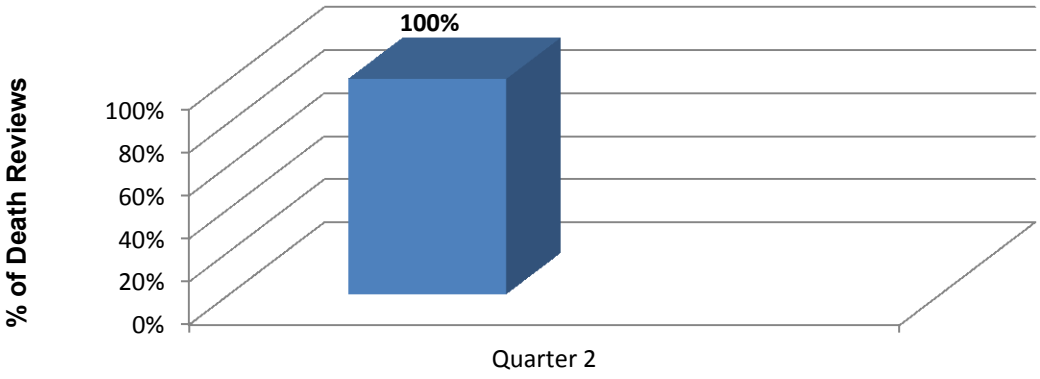
Chart 23: Timely Investigations



To be considered timely, the Investigation Unit must complete an investigation within 30 calendar days. Of the six complaints received in October 2013, five (83%) were completed timely. Of the four received in November, four (100%) were completed timely. Three of four (75%) of those received in December were completed timely. This resulted in an overall percentage of 86% for the quarter.

HW 7: Number and percentage of reported deaths that were reviewed by the Pre-Mortality Review Committee on a timely basis.

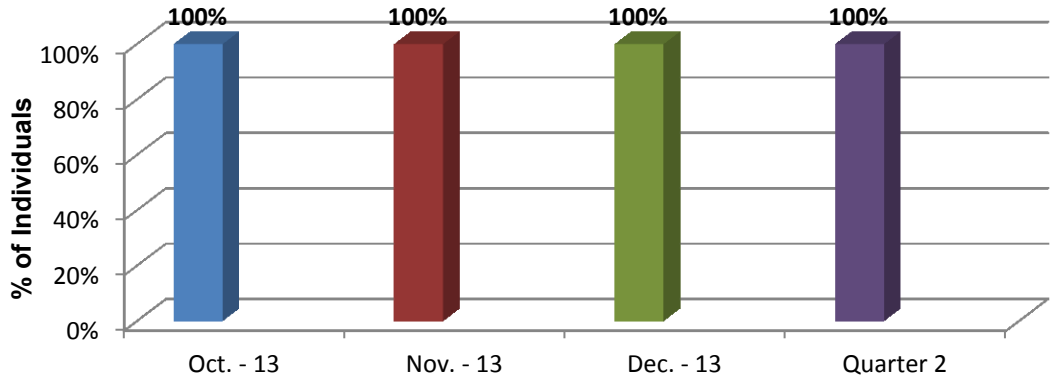
Chart 24: Death Reviews



To be considered timely, the Committee must review the circumstances of a death within 9 months of the date the death occurred. Of the ten deaths reviewed in this quarter, ten (100%) were completed timely.

HW 8: Number and percentage of individuals for whom the provider adhered to DDS requirements for the use of restrictive interventions.

Chart 25: Restrictive Interventions



Of the six Incident Reports describing the use of a restrictive intervention reviewed for compliance with requirements in October 2013, six (100%) were found to be in compliance. Of the seven Incident Reports reviewed in November, seven (100%) were in compliance. Four of four (100%) of those reviewed in December were in compliance with the requirement. This resulted in an overall percentage of 100% for the quarter.

Standards

Standard 301.1.E. h & i (QP C1)

301.1 All personnel shall receive initial and annual competency-based training to include, but not limited to:

E. Legal

h. Ark. Code Ann. §§5-28-101 – 5-28-109; --Abuse of Adults

i. Ark. Code Ann. §§12-12-501 – 12-12-515; --Arkansas Child Maltreatment Act

Standard 301.5.4 (QP C2)

301.5. Training Requirements for direct care staff

4. Prior to beginning service delivery, direct care staff must receive a minimum of six of the required 12 training hours in the individual's plan of care and specific health and safety needs (medication, positive behavior programming, etc.). Documentation of the training shall be maintained in the staff's personnel file and shall be evidenced by the signatures of the trainer and the direct care staff, the date the training was provided and the specific information covered.

Standard 507 (SP A1)

507. A service needs assessment must be completed on every individual seeking services. A copy of the assessment must be maintained on file in the individual's file.

Standard 508.1B.3.a. 1-6 (SP A2)

508.1 The Individualized Plan of care:

B. Shall Identify:

3. Long-range goals (addressing a period of 3-5 years) and annual goals

a. Individuals shall have a person-centered plan of care. The planning process shall support the individual in decision making and choosing options by:

1. Actively involving the individual in the person-centered plan development and implementation
2. Reflect the individual's choice of services which are relevant to the individual's age, abilities, life goals/outcomes
3. Address areas such as the individual's health, safety and challenging behaviors which may put the individual at risk
4. Demonstrates the rights and dignity of individual/ family
5. Incorporates the culture and value system of the individual
6. Ensures the individual's orientation and integration to the community, its services and resources.

Standard 507.A (SP A3)

507. A service needs assessment must be completed on every individual seeking services. A copy of the assessment must be maintained on file in the individual's file.

A. A Health and Safety Assurances Assessment shall be included as a component of the needs assessment in order to safeguard the individual against physical, mental and behavioral risks.

Standard 508-508.2.D (excluding 1.B.3-5) (SP B1)

508 Every individual shall have a written Individualized Plan of care

A. The organization shall include the person served and/or legal guardian as an active participant giving direction in all aspects of the planning and revision processes. The person may have other representatives present as desired.

B. Services shall be provided based on the choices of the individual/parent/guardian (as appropriate) and on the strengths and needs of the individuals to be served by the organization

C. Individual choice shall be determined by a comprehensive assessment which addresses:

1. Relevant medical history
2. Relevant psychological information
3. Relevant social information
4. Information on previous direct services and supports
5. Education
6. Strengths
7. Abilities
8. Needs
9. Preferences
10. Desired outcomes
11. Cultural background
12. Other issues, as identified

508.1 The Individualized Plan of care:

A. Shall be developed and implemented with the input of the person served and/or their legal guardian.

B. Shall Identify:

1. Most appropriate environment
    a. Documentation of discussion of most appropriate environment appropriate for individual strengths and needs
    b. In general, the concept of most appropriate environment means that whenever a service or a program is being provided to a person with a developmental disability, that program or service shall be provided to promote community integration, in least restrictive of the person's rights and provides a setting in which he/she can function effectively. It should be the setting that is most like normal and in which the individual can function with necessary supportive assistance. The program must document the justification for specialized

environments if they are to be used. Plans shall be made for return to normal environments as soon as possible.

1. Individuals shall be in contact as much as possible with those who do not have disabilities
2. Plans of care will be reviewed for provisions of program services in the least restrictive environment appropriate to the ability of the individual. Document this item with a summary of the discussion by the entire team about the most appropriate alternatives

2. Barriers

a. Describe the conditions or barriers that interfere with the achievement of the goal(s) or skills(s). Describe why a particular individual's needs cannot be met or what needs to be accomplished to meet the need.

b. Resources and/or environment changes, adaptations or modifications necessary to attain the goal or skill shall be listed. The person responsible for attempting to get the service must be identified.

1. Example of barriers are: lack of funds, lack of staff, individual absent due to illness, prosthetic devices, equipment space, etc. The responsible person may be staff member, individual, family, etc.

6. A Back up plan to ensure continuity of care and health and safety of the individual. The back-up plan should include contact information and identification of back-up resources for the individual as well as any informal support network as identified by the individual and legal representative.

508.2 Short-term objectives (3-6 months) may be either habilitative in nature or service related objectives. Short-term objectives shall be developed and implemented, as needed, for each annual goal. Objectives describe sequential steps and expected outcomes needed to reach the annual goal.

A. Each objective must have criteria for success that states what the individual must do to complete.

B. Short-term objectives will have methods/materials for implementation and describe the procedures to be used in individual training.

C. The person responsible for implementation of each objective shall be specified.

D. Short-term objectives shall have an initiation, target, and completion date.

<u>Standard 509 B (SP C1)</u>

509 Continued Stay Review Service Objectives

B. The organization shall develop and implement a new plan annually and submit to DDS for approval.

<u>Standard 509 A (SP C2)</u>

509 Continued Stay Review

Service Objectives

A. Shall be reviewed on a regular basis with respect to expected outcomes.

<u>Standard 510 (SP C2)</u>

510 Every 90 days of service delivery, the service provider shall complete a quarterly report on the goals/objectives of the plan of care. If needed, modifications may be made with meeting of entire team. Quarterly reports must be specific to reflect the individual's performance concerning goals and short-term objectives as specified in the plan of care and shall be based on the case notes for the reporting period.

Standard 508.1.B.4 & 5 (SP D1)

508.1 The Individualized Plan of care:
B. Shall Identify:
4. Specific measurable objectives.
5. Daily schedule of direct service hours

Standard 508.2.E.1-3 (SP D1)

508.2 E. Target dates (for habilitation goals):
1. The target date shall be individualized and noted at the same time of the initiation date and the projected date when the individual can realistically be expected to achieve an objective.
2. The target date shall be used as a prompt to see if expectations for the individual are realistic in relation to attainment and appropriateness of goals and objectives. If the starting or target dates need to be revised, mark through, initial and put in a new date.
3. The ending date shall be entered in as the person completes each objective.