

**Developmental Disabilities Services
1915 (c) Waiver
Quarterly Performance Measure Report**

**QUARTER 2
FY 2015**

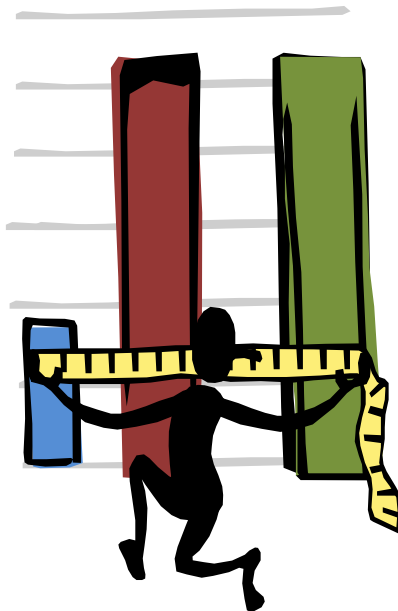


TABLE OF CONTENTS

LEVEL OF CARE

SUBASSURANCE A: INDIVIDUAL LOC EVALUATION	
LOC A1: TIMELY APPLICATION PACKETS	CHART 1
LOC A2: LOC COMPLETED BEFORE SERVICE RECEIPT	CHART 2
SUBASSURANCE B: DISCONTINUED APRIL 2014	
LOC B1: DISCONTINUED APRIL 2014	CHART 3
SUBASSURANCE C: APPROVED PROCESSES AND INSTRUMENTS	
LOC C1: APPROPRIATE PROCESS AND INSTRUMENTS	CHART 4

QUALIFIED PROVIDERS

SUBASSURANCE A: CERTIFICATIONS	
QP A1: INITIAL CERTIFICATIONS	CHART 5
QP A2: RECERTIFICATIONS	CHART 6
SUBASSURANCE C: APPROPRIATE TRAINING	
QP C1: ABUSE AND NEGLECT TRAINING	CHART 7
QP C2: TRAINING ON INDIVIDUAL NEEDS	CHART 8

SERVICE PLAN

SUBASSURANCE A: PLANS ADDRESS ALL ISSUES	
SP A1: PLANS ADDRESS ASSESSED NEEDS	CHART 9
SP A2: PLANS ADDRESS PERSONAL GOALS	CHART 10
SP A3: PLANS ADDRESS RISK FACTORS	CHART 11
SUBASSURANCE B: DISCONTINUED APRIL 2014	
SP B1: DISCONTINUED APRIL 2014	CHART 12
SUBASSURANCE C: PLANS UPDATED OR REVISED	
SP C1: PLAN ANNUAL UPDATES	CHART 13
SP C2: PLAN REVISED	CHART 14
SUBASSURANCE D: PLAN SERVICES IN TYPE, SCOPE, AMOUNT & FREQUENCY	
SP D1: SERVICE FREQUENCY AND DURATION	CHART 15
SUBASSURANCE E: CHOICE	
SP E1: DISCONTINUED APRIL 2014	CHART 16
SP E2: CHOICE OF PROVIDER	CHART 17

HEALTH AND WELFARE

SUBASSURANCE: ABUSE & NEGLECT PREVENTION	
HW 1: INFORMATION ON REPORTING	CHART 18
HW 2: TIMELY REPORTS TO DDS	CHART 19
HW 3: TIMELY REPORTS TO APS OR CPS	CHART 20
HW 4: PROVIDER CORRECTIVE ACTIONS	CHART 21
HW 5: TIMELY DDS BACKGROUND CHECKS	CHART 22
HW 6: TIMELY DDS INVESTIGATIONS	CHART 23
HW 7: DEATH REVIEWS	CHART 24
HW 8: RESTRICTIVE INTERVENTIONS	CHART 25
HW9: HEATH CARE STANDARDS ADDED APRIL 2014	CHART 26

STANDARDS

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 second quarter of State Fiscal Year (SFY) 2015, specifically October through December 2014, consists of four parts: Level of Care, Qualified Providers, Service Plans, and Health and Welfare.

DATA

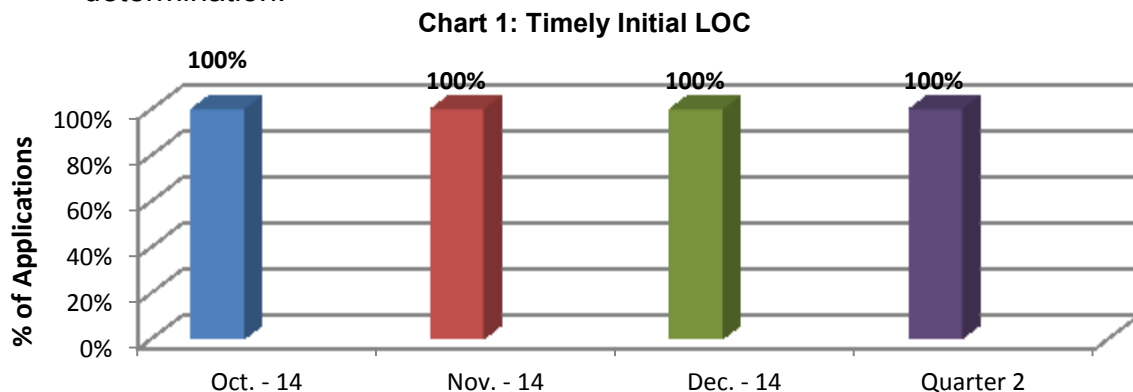
Level of Care

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:

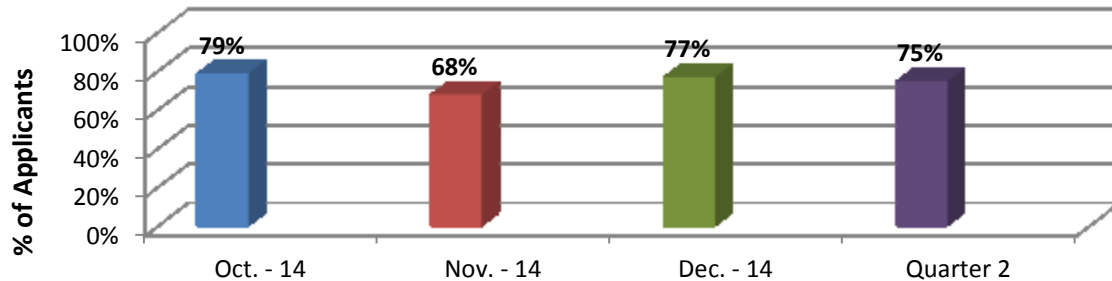
LOC A1: Number and percentage of applicants for whom an application packet is completed and submitted timely to the DDS psychology team for an LOC initial determination.



Of the 26 application packets due for completion in October, 26 (100%) were completed within timeframes. Of the 54 application packets due for completion in November, 54 (100%) were completed timely. Of the 20 application packets due for completion in December, 20 (100%) were completed timely. This resulted in an overall percentage of 100% 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 70 persons whose LOCs were due for completion in October, 55 (79%) were completed within timeframes. Of the 60 persons whose LOCs were due for completion in November, 41 (68%) were completed timely. Of the 71 persons whose LOCs were due for completion in December, 55 (77%) were completed timely. This resulted in an overall percentage of 75% for the quarter.

Subassurance B:

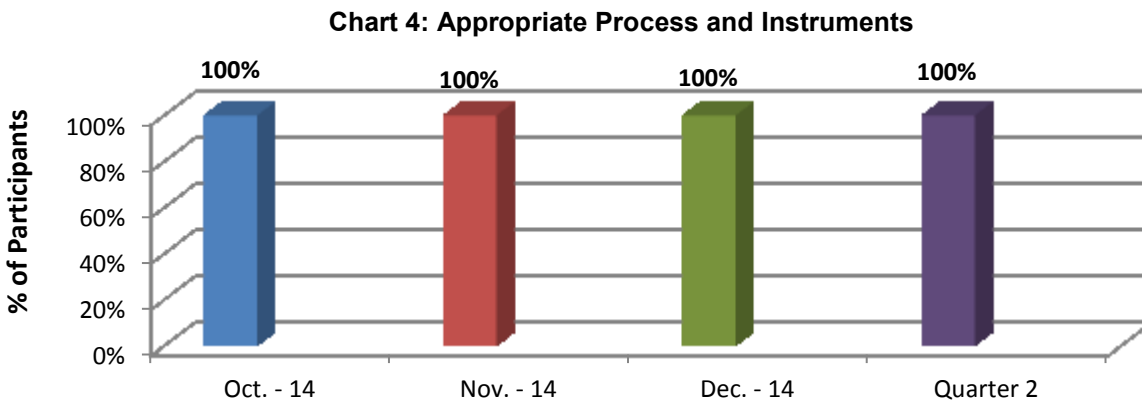
LOC B1: Number and percentage of participants who received an annual redetermination of LOC eligibility within 12 months of their initial or last LOC evaluation.
DISCONTINUED APRIL 2014

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 initial eligibility.



Of the 55 files reviewed for compliance with this requirement in October, 55 (100%) were in compliance. Of the 28 files reviewed in November, 28 (100%) were in compliance. Nineteen of the 19 (100%) files reviewed in December were in compliance. This resulted in an overall percentage of 100% for the quarter.

Qualified Providers

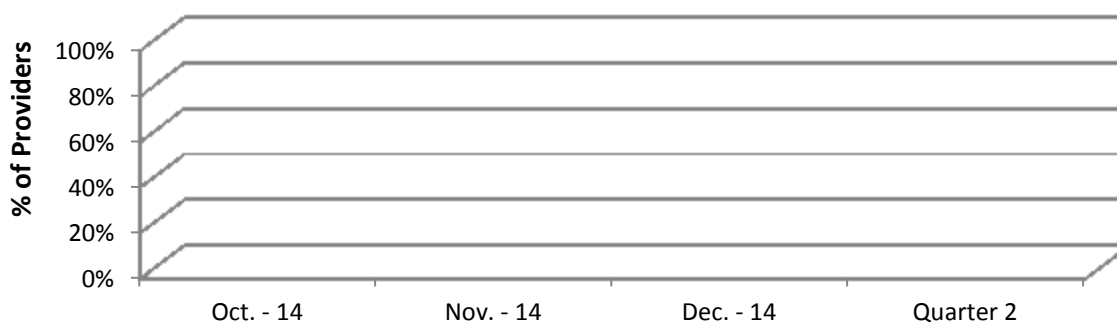
Subassurance A:

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.

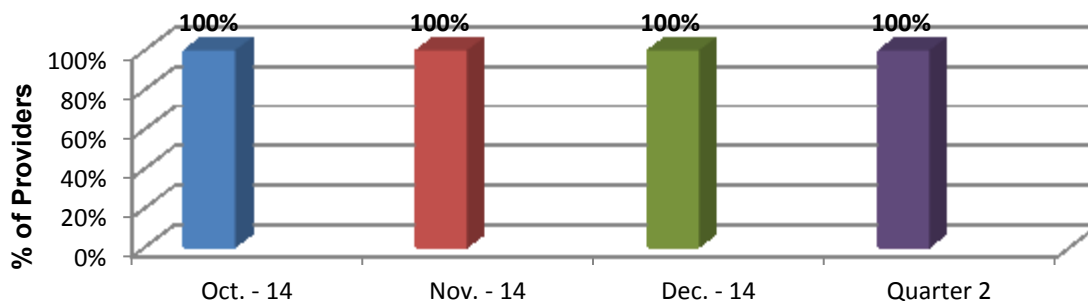
Chart 5: Timely Certification



No providers obtained initial certification in this quarter.

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

Chart 6: Timely Recertification



Of the five providers due for recertification in October, DDS recertified five (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.

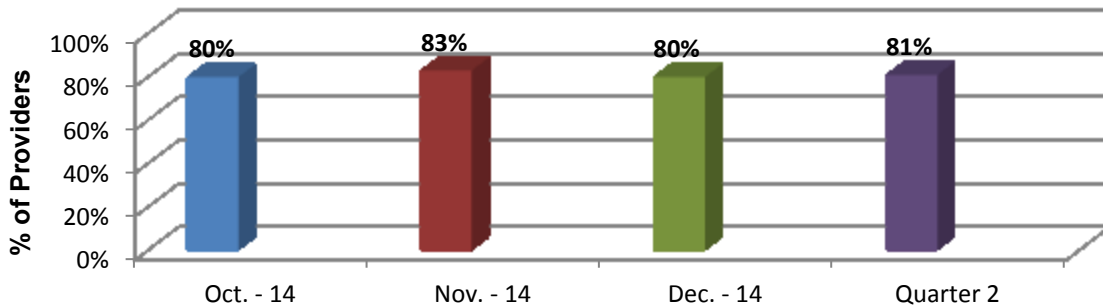
Subassurance C:

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)

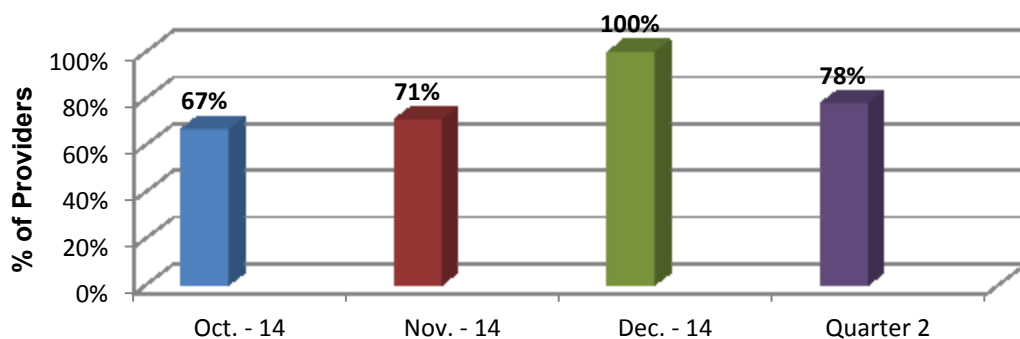
Chart 7: Abuse & Neglect Report Training for Staff



Of the five providers reviewed for compliance with or investigated due to a complaint regarding this Standard in October, four (80%) 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 81% 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 six providers reviewed for compliance with or investigated due to a complaint regarding this Standard in October, four (67%) were found to be in compliance. Of the seven providers reviewed or investigated in November, five (71%) 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 78% for the quarter.

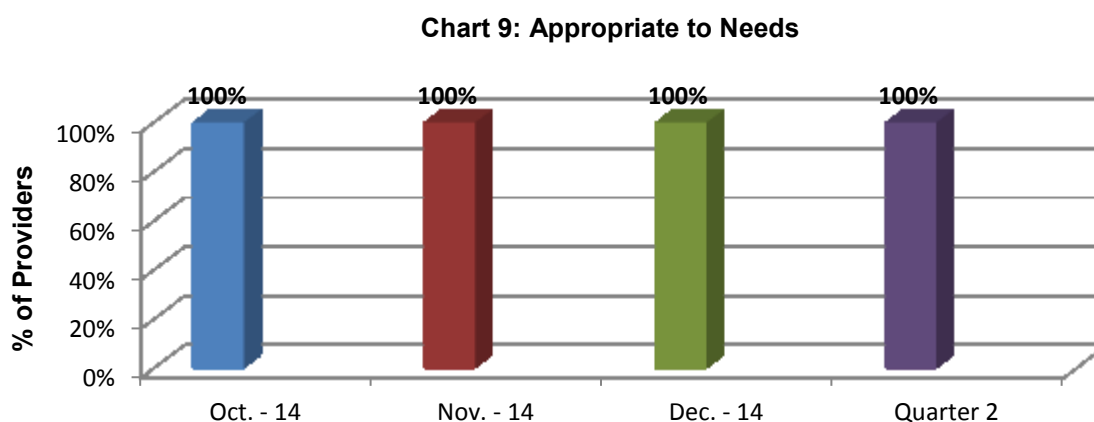
Service Plan

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:

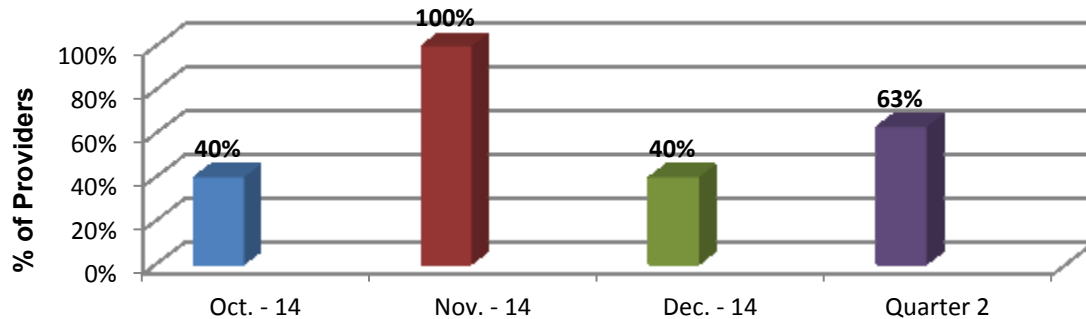
SP A1: Number and percentage of providers who developed service plans that were adequate and appropriate to the needs of individuals as indicated by their assessments. (Standard 507)



Of the five providers reviewed for compliance with or investigated due to a complaint regarding this Standard in October, five (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 A2: Number and percentage of providers who developed service plans that addressed the individual’s personal goals. (Standard 508.1B.3.a.1-6)

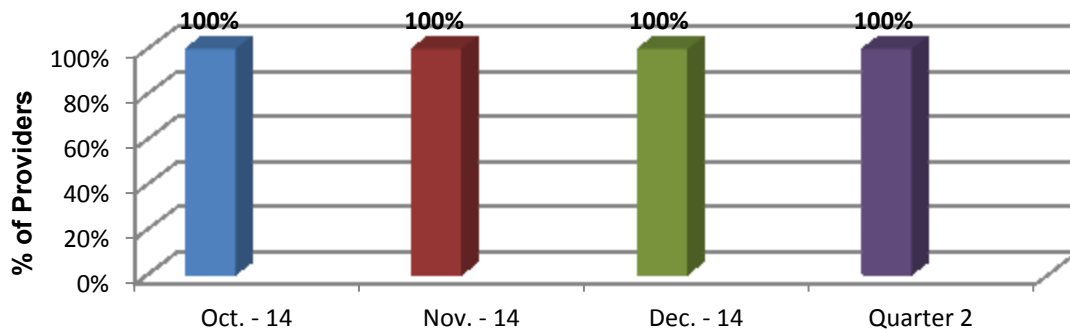
Chart 10: Personal Goals



Of the five providers reviewed for compliance with or investigated due to a complaint regarding this Standard in October, two (40%) were found to be in compliance. Of the six providers reviewed or investigated in November, six (100%) were in compliance. Two of five (40%) of those reviewed or investigated in December were in compliance with the Standard. This resulted in an overall percentage of 63% 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 five providers reviewed for compliance with or investigated due to a complaint regarding this Standard in October, five (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:

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).

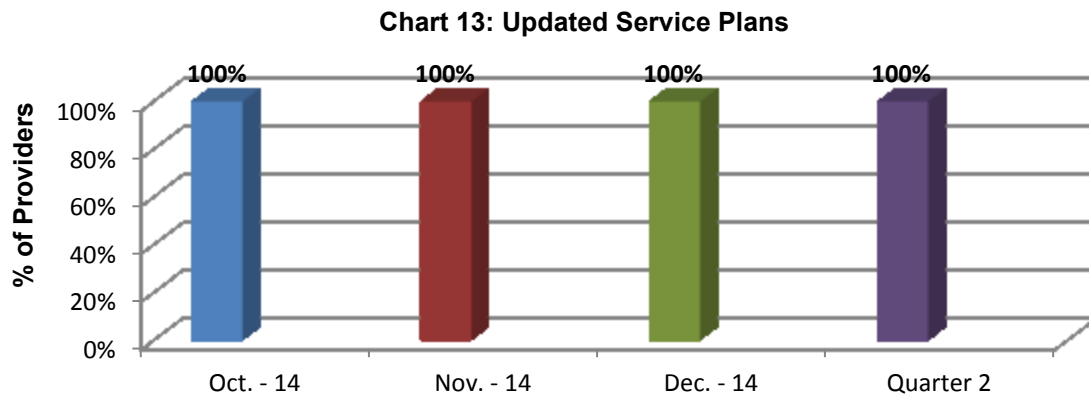
DISCONTINUED APRIL 2014

Subassurance C:

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

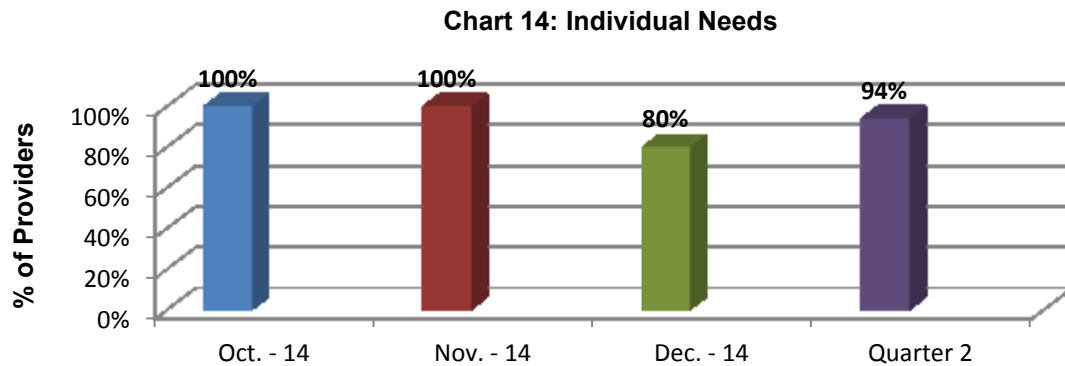
The State developed the following to measure compliance with Subassurance C:

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



Of the five providers reviewed for compliance with or investigated due to a complaint regarding this Standard in October, five (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)



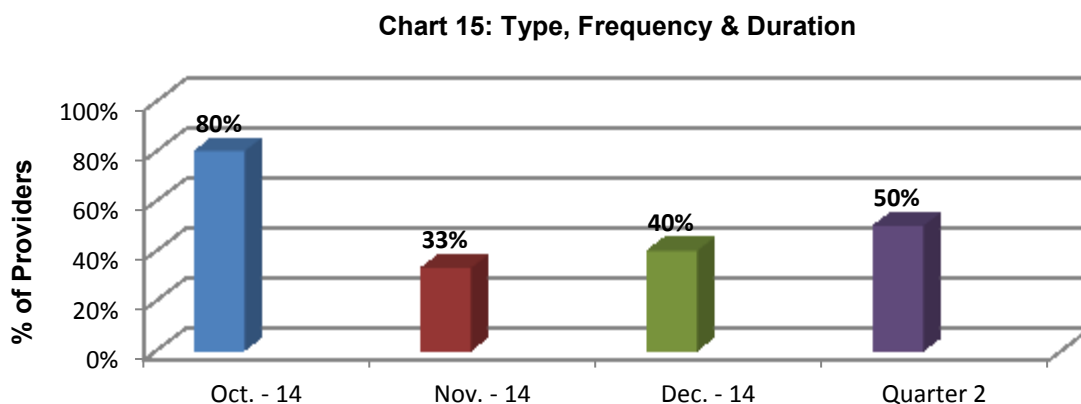
Of the five providers reviewed for compliance with or investigated due to a complaint regarding this Standard in October, five (100%) were found to be in compliance. Of the six providers reviewed or investigated in November, six (100%) were in compliance. Four of five (80%) of those reviewed or investigated in December were in compliance with the Standard. This resulted in an overall percentage of 94% 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.D&E.1-3)



Of the five providers reviewed for compliance with or investigated due to a complaint regarding this Standard in October, four (80%) were found to be in compliance. Of the six providers reviewed or investigated in November, two (33%) were in compliance. Two of five (40%) of those reviewed or investigated in December were in compliance with the Standard. This resulted in an overall percentage of 50% for the quarter.

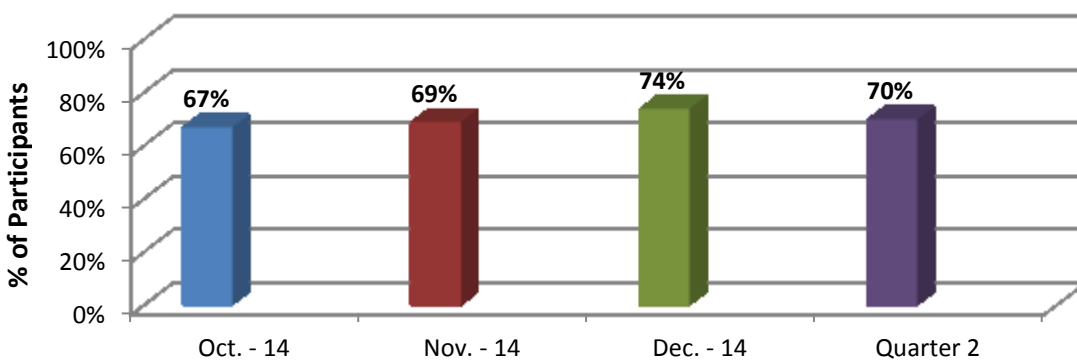
Subassurance E:

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.

DISCONTINUED APRIL 2014

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 286 files reviewed for compliance with this requirement in October, 191 (67%) were found to be in compliance. Of the 285 files reviewed for compliance in November, 197 (69%) were in compliance. One hundred and eighty two of 245 (74%) of those reviewed in December were in compliance. This resulted in an overall percentage of 70% for the quarter.

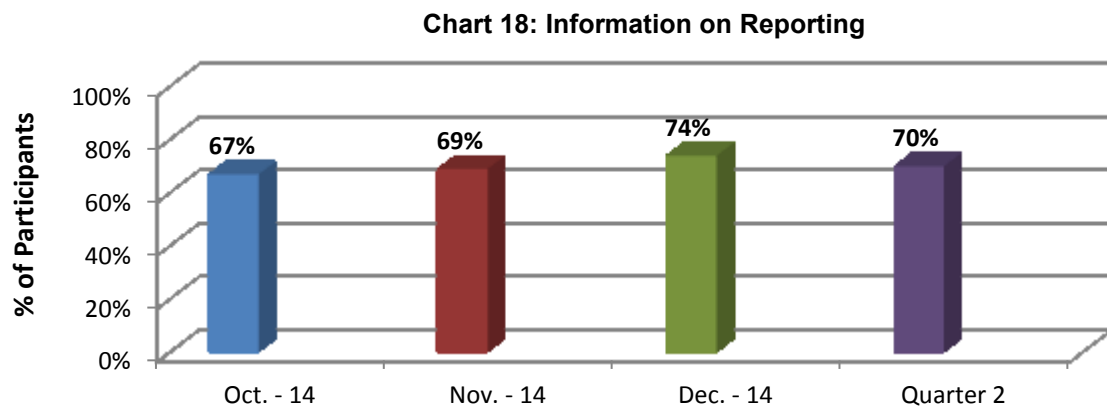
Health and Welfare

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.

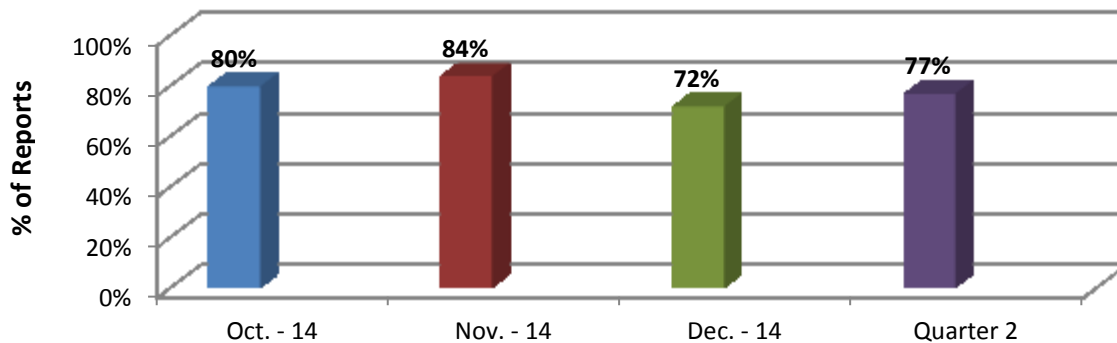
HW 1: Number and percentage of participants or legal guardians who received information about how to report abuse, neglect and exploitation as documented on the applicable form.



Of the 286 files reviewed for compliance with this requirement in October, 191 (67%) were found to be in compliance. Of the 285 files reviewed for compliance in November, 197 (69%) were in compliance. One hundred and eighty two of 245 (74%) of those reviewed in December were in compliance. This resulted in an overall percentage of 70% 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



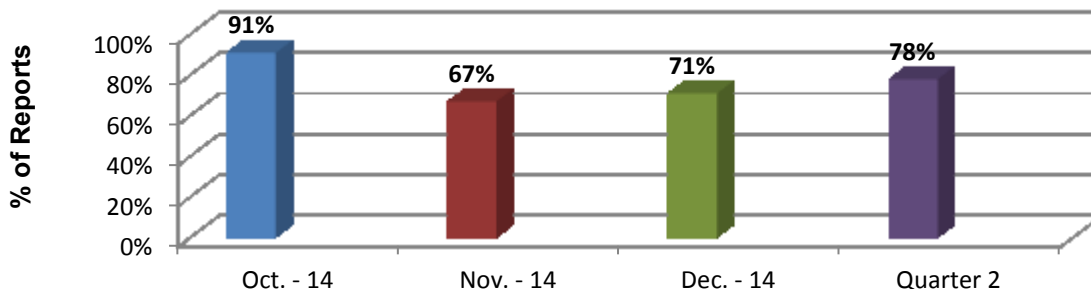
To be considered timely, the provider must report an incident within 2 business days of the incident. A critical incident is defined as death, suicidal behavior, suspected abuse and neglect by a staff person, a consumer whose location is unknown for 2 hours, use of a restrictive intervention and arrest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

Of the 50 reports of critical incidents submitted in October, 40 (80%) were submitted timely. Of the 37 reports submitted in November, 31 (84%) were timely. Fifty two of 72 (72%) of those submitted in December were submitted timely. This resulted in an overall percentage of 77% 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 or CPS

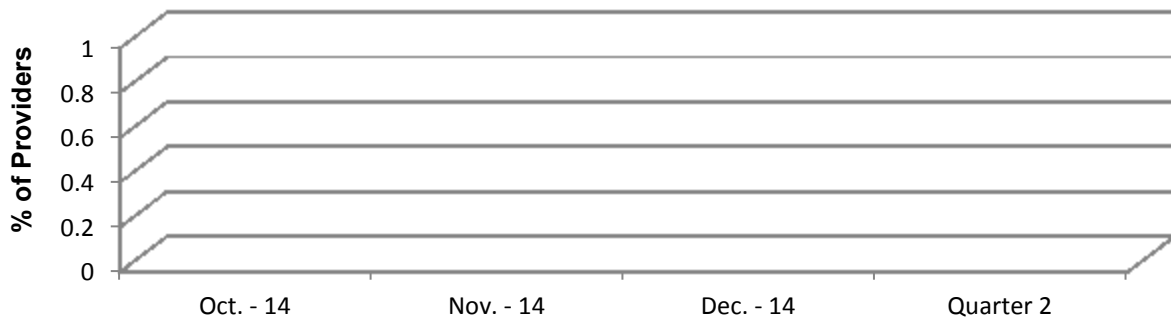


Of the 11 reports of critical incidents submitted in October, 10 (91%) were submitted to APS or CPS. Of the nine reports submitted in November, six (67%) were reported. Five of seven (71%) submitted December were submitted to APS or CPS. This resulted in an overall percentage of 78% for the quarter.

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.

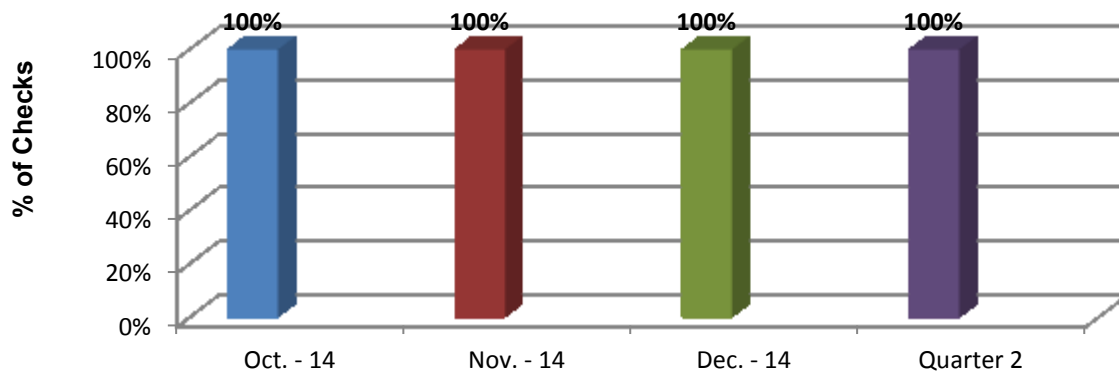
Chart 21: Corrective Actions



Data not available at the time of the meeting on February 10, 2015.

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

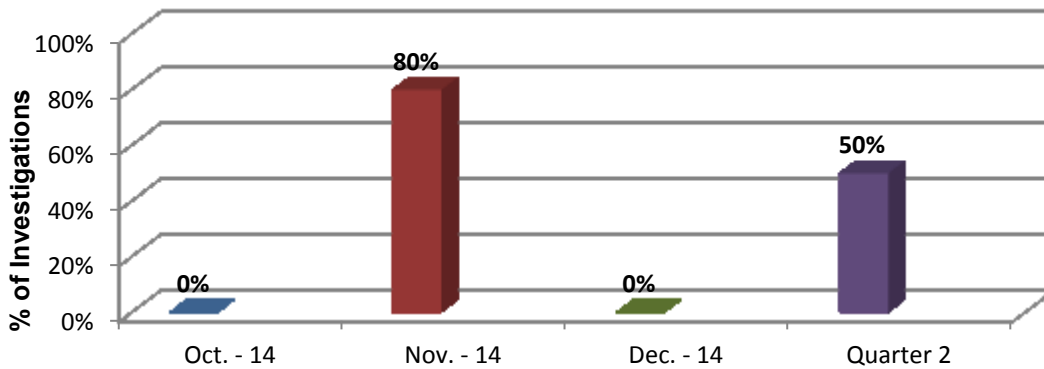
Chart 22: Timely Background Checks



To be considered timely, the Background Check Unit must complete the check within 14 days of the date they receive the request. Of the 184 received in October, 184 (100%) were completed timely. Of the 144 received in November, 144 (100%) were completed timely. One hundred twenty five of 125 (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.

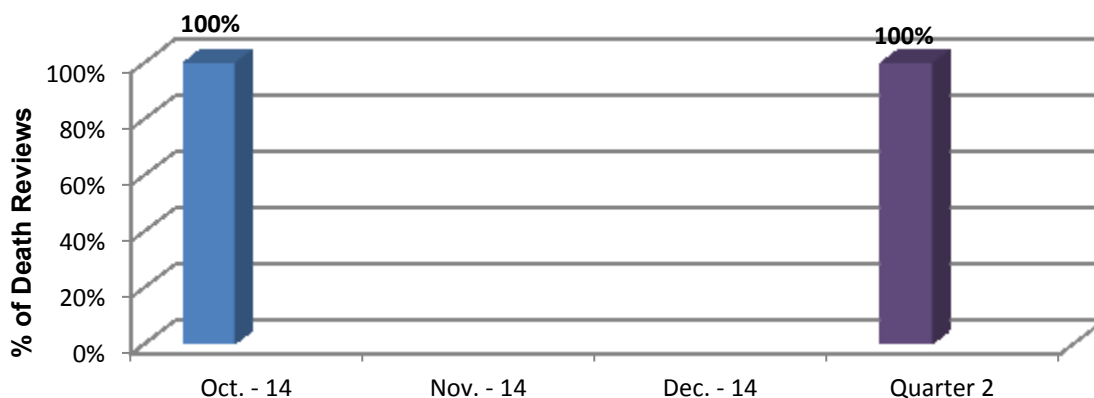
Chart 23: Timely Investigations



To be considered timely, the Investigation Unit must complete an investigation within 30 calendar days. Of the two complaints received in October, zero (0%) were completed timely. Of the five received in November, four (80%) were completed timely. Zero of one (0%) of those received in December were completed timely. This resulted in an overall percentage of 50% for the quarter.

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

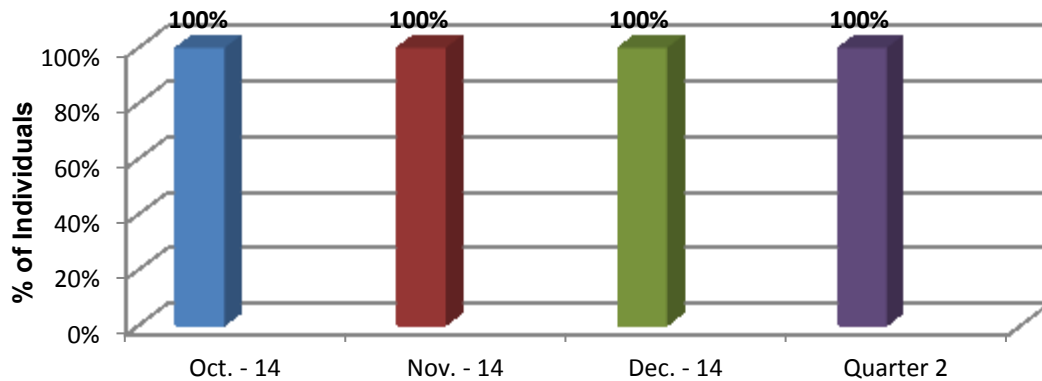
Chart 24: Death Reviews



To be considered timely, the Committee must review the circumstances of a death within 9 months of the date the death occurred. The Pre-Mortality Review Committee did not meet in November or December. Of the 10 deaths reviewed in October, 10 (100%) were completed timely. This resulted in an overall percentage of 100% for this quarter.

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

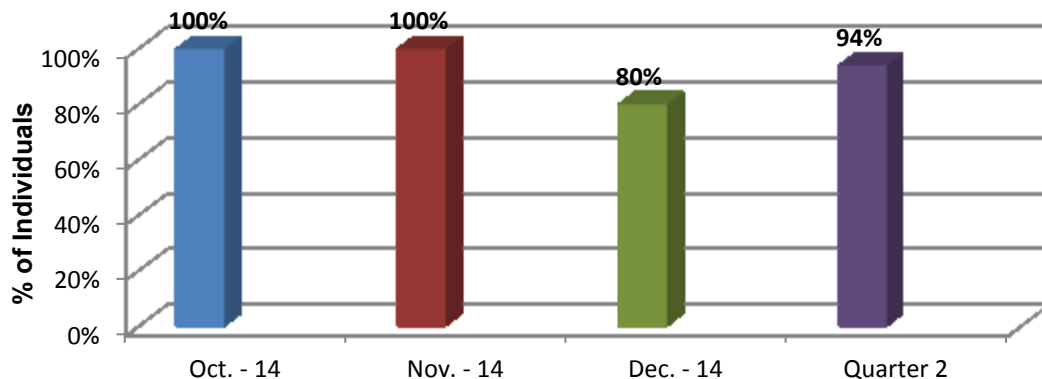
Chart 25: Restrictive Interventions



Of the 18 Incident Reports describing the use of a restrictive intervention reviewed for compliance with requirements in October, 18 (100%) were found to be in compliance. Of the 11 Incident Reports reviewed in November, 11 (100%) were in compliance. Thirty three of 33 (100%) of those reviewed in December were in compliance with the requirement. This resulted in an overall percentage of 100% for the quarter.

HW 9: Number and percentage of providers who demonstrate responsibility for maintaining overall health care standards. (Standard 704.B)

Chart 26: Health Care Standards



Of the five providers reviewed for compliance with or investigated due to a complaint regarding this Standard in October, five (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 94% 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 509 B (SP C1)

509 Continued Stay Review Service Objectives

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

Standard 509 A (SP C2)

509 Continued Stay Review
Service Objectives

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

Standard 510 (SP C2)

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.D&E.1-3 (SP D1)

508.2.D. Short-term objectives shall have an initiation date, a target date, and, when completed, a completion date

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.

Standard 704.B (HW 9)

704 The Case Manager (CM) is responsible for locating, coordinating and monitoring:
B. Needed medical, social, educational and other services