



Florida Agency for Persons with Disabilities Group Home Medical Review Program

**Training for Group Home Providers
2024**

Agenda

- Introductions
- Scheduling Process and Resident Census
- Medical Review Questionnaire
- Documentation Requirements
- Review Procedures
- Findings, including Suspected Abuse, Neglect, and Exploitation Reports
- Medical Review Report
- Notifications and Recommendations
- Questions and Answers

Introductions

Kristin J. Korinko, PhD, BCBA, LMHC, NCC
Agency Senior Behavior Analyst
Agency for Persons with Disabilities
850-414-8695
Kristin.Korinko@apdcares.org

Ellen Olsen, LCSW, MBA
Vice President of Operations
Acentra
888-305-6377
ellen.olsen@acentra.com

Shaquala Campbell, RN, BHA
Program Manager
Acentra
888-305-6377 Ext 4069
Shaquala.campbell@acentra.com

Jennifer McKnight, RN, BSN
Executive Director
Acentra
888-305-6377
Jennifer.mcknight@acentra.com

Medical Reviews

April 17, 2024, Acentra launched Group Home Medical Review (GHMR) services on behalf of the Agency for Persons with Disabilities (APD) to individuals residing in APD licensed group homes in the state of Florida. Documentation and reporting will be completely electronic.



- **GHMR Defined**

Medical review includes a comprehensive chart review and onsite observation completed by a Clinical Reviewer for each APD client residing in an APD Licensed Group Home.



- **GHMR Goal**

Acentra will conduct the medical review annually to verify the resident's well-being and safety needs are being met and that appropriate healthcare follow-up is occurring timely.



2021 Florida Statutes

CHAPTER 393 DEVELOPMENTAL DISABILITIES

393.062 Legislative findings and declaration of intent.—

Priority shall be given to the development and implementation of community-based services that will enable individuals with developmental disabilities to achieve their greatest potential for independent and productive living, enable them to live in their own homes or in residences located in their own communities, and permit them to be diverted or removed from unnecessary institutional placements. This goal cannot be met without ensuring the availability of community residential opportunities in the residential areas of this state. The Legislature, therefore, declares that all persons with developmental disabilities who live in licensed community homes shall have a family living environment comparable to other Floridians and that such residences shall be considered and treated as a functional equivalent of a family unit and not as an institution, business, or boarding home. Finally, it is the intent of the Legislature that all caretakers unrelated to individuals with developmental disabilities receiving care shall be of good moral character.

[Chapter 393 - 2021 Florida Statutes - The Florida Senate \(flsenate.gov\)](https://flsenate.gov)



2021 Florida Statutes

393.13 Treatment of persons with developmental disabilities

- LEGISLATIVE INTENT:

(a) The Legislature finds and declares that the system of care provided to individuals with developmental disabilities must be designed to meet the needs of the clients as well as protect the integrity of their legal and human rights.

(b) The Legislature further finds and declares that the design and delivery of treatment and services to persons with developmental disabilities should be directed by the principles of self-determination and therefore should:

- To provide programs for the proper habilitation and treatment of persons with developmental disabilities which shall include, but not be limited to, comprehensive medical/dental care, education, recreation, specialized therapies, training, social services, transportation, guardianship, family care programs, day habilitation services, and habilitative and rehabilitative services suited to the needs of the individual regardless of age, degree of disability, or handicapping condition.



2021 Florida Statutes

393.13 Treatment of persons with developmental disabilities (cont.)

- Each client shall receive prompt and appropriate medical treatment and care for physical and mental ailments and for the prevention of any illness or disability. Medical treatment shall be consistent with the accepted standards of medical practice in the community.
- Medication shall be administered only at the written order of a physician. Medication shall not be used as punishment, for the convenience of staff, as a substitute for implementation of an individual or family support plan or behavior analysis services, or in unnecessary or excessive quantities.
- Daily notation of medication received by each client in a residential facility shall be kept in the client's record.



Scheduling and Resident Census

- ❖ Florida Agency for Persons with Disabilities (APD) will provide Acentra a monthly report of group home residents.
- ❖ Acentra will contact the group home to coordinate the day and time of the visit.
- ❖ Acentra will provide a list of documentation that should be gathered by the group home prior to the visit.
- ❖ Each group home will receive a written notice for confirmation of the date/time via mail 30 days prior to the scheduled review which will include the date and time of the review along with census. The group home should contact Acentra with any questions regarding the scheduled date and/or census.



Scheduling and Resident Census (cont'd)

- ❖ Acentra will email a 2-week reminder to the group home contact provided by APD to confirm the census of the group home and remind them of the scheduled review date and time.
- ❖ If a Medical Review must be rescheduled for any reason, the group home must contact Acentra at 888.305.6377 as soon as possible.



Medical Review Subjects

- Identification and Initial History
- Healthcare Visits per review of medical records
- Behavior Analysis Services
- Functional Status
- Therapeutic and Wellness Support
- Health Conditions
- Medications
- Reviewer Information



Documentation Requirements for GHMR

Documentation within the past 12 months:

- Primary and/or specialty provider records/orders
 - *Include the following health records as applicable
 - Age-appropriate exams
 - Labs
 - Dietary and nutrition orders
 - Hospital/ER records
 - Therapy/treatment records and orders
 - Nursing orders



Documentation Requirements for GHMR (cont'd)

Documentation within the past 12 months:

- Person-Centered Support Plan.
- Information related to the individual's involvement and schedule of meaningful day activities provided outside of the residence.
- A copy of the behavioral plan and behavioral data (if applicable).



Documentation Requirements for GHMR (cont'd)

Documentation within the past 30 days:

- Medication administration record and medication error reports.

Behavior Analysis Services



Behavior Analysis

Behavior Analysis in Group Homes

Behavioral Services - Responsibilities of Group Home Staff



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Review Procedures

Onsite observation:

- Visual assessment of resident focusing on safety and well-being.

Review relevant records to assess the following:

- Scheduled appointments with the primary care physician and/or specialist are completed as scheduled and timely.
- Preventative screening (labs and age-appropriate exams) are completed timely.
- Nursing and therapy services are delivered per doctor's orders.
- Diet and nutritional needs are met.
- Condition of adaptive equipment and environmental accommodations are accessible.
- Unmet safety and well-being needs that require follow up (reportable findings).



Review Procedures (cont'd)

Medications:

- Review of all current prescription medications to confirm that medications are administered per doctor's orders.
- Verify group home staff administering medications are properly trained and validated per 65G-7, F.A.C.
- Confirm medication errors are being reported and documented in a timely manner.



Findings, including Suspected Abuse, Neglect, and Exploitation Reports



- ❖ Reportable incidents that may involve the abuse, sexual misconduct, neglect, threatened harm, or exploitation of a client, or impending impact on the health or safety of a client shall be reported immediately to the Florida Abuse Hotline.
- ❖ FL APD shall be notified immediately.

**Florida Abuse Hotline:
1.800.962.2873**



Medical Review Report

- ❖ Individual Annual Medical Review Report for each Resident review that includes all findings and any need for follow-up





Annual Group Home
Resident Medical Review

Name of Nurse Reviewer:	Case ID:	APD Region:
Date of Review:	Time of Review:	
Name of Group Home (GH):	Name of GH Primary Contact:	
GH Address:	GH Primary Contact Phone #:	
Name of Resident:	DOB:	Age:
iConnect #:	Admission Date (if known):	
Name of Waiver Support Coordinator:		
Number of staff on duty at time of review:		
Name of Guardian (s):		
Name of Primary Care Provider(PCP):	PCP Phone #:	
Diagnoses (List all):		
Describe onsite observation of resident (detail physical appearance, behavior and affect):		

1. Healthcare Visits

Visit Type	Documented Visit within Last Year?	Provider Name (if different from PCP)	Date (Most Recent)	Details (information regarding a missed visit, provider comments, or recommendations)
Wellness Visit				
Additional PCP				
Specialty Care				
Dental				
Vision				
Labs				
Were all healthcare visit recommendations followed (including any recommendations from any screenings)?				

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2. Diagnostic and Age-Appropriate Exams



Name of Screenings	Yes	No	Not Applicable	Unable to Verify
Falls Screening				
Prostate Cancer Screening				
Colorectal/Colonoscopy Screening				
Cervical Cancer Screening (PAP)				
Breast Cancer Screening (Mammogram)				
DEXA Scan				
Osteoporosis Screening				
Other:				

Details (include follow-up recommendations from screenings, provide reasons for unable to verify, missed screening, and/or not applicable outcomes):

3. Wellness and Therapeutic Supports

Therapy	Not Ordered	Daily	Every other day	Twice a week	Three times a week	Other
Physical Therapy						
Occupational Therapy						
Speech Therapy						
Respiratory Therapy						
Dialysis						
Nursing Services						
Name of nursing provider (if applicable):						
Nursing orders (if applicable):						
List of nursing duties/type of nursing provided (if applicable):						
Are there any other recommended therapeutic services or supports?						
Describe any discrepancy between what has been ordered and what the individual is receiving:						
Describe whether service recommendations/changes are updated in the medical record and provided for the individual:						

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4. Nutrition

Unexplained/concerning weight change: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain (weight/date/intervention):		Most recent documented weight: Date:
Food Allergies:		
Diet Status/interventions (check all that apply):		
Oral Feeding	Special Diet-Chopped	
Gastric Tube	Special Diet-Soft	
Jejunostomy Tube	Special Diet-Puree	
Gastrojejunostomy Tube	Special Diet-Thickened Liquids	
Enteral Medication Administration	Enteral Formula Administration	
Other type of Enteral Feeding	Enteral Water Flush	
Prescribed Enteral Formula Administration (PEFA) Validation		
If tube is used for feeding, list the name of validated PEFA staff on duty at time of review: PEFA Validation Date : _____ PEFA Expiration Date : _____		
Special Diet/Safety/Concerns		
Documented history of choking or swallowing issues (coughing, eating fast, etc.) Yes No If yes, describe issues and choking prevention strategies in place:		
Describe other special diets or feeding or any noncompliance (and any additional feeding preventions or interventions):		

5. Functional Status


Activity	Independent	Stand-by Assist	Stand-by and Cueing	Hands on Physical Assistance	Total Physical Assistance
Bathing					
Dressing					
Toileting					


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Medical Review Report (cont'd)

- ❖ Individual Annual Medical Review Report for each Resident review that includes all findings and any need for follow-up




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Grooming					
Eating					
Ambulation					
Positioning					
Transfers					

6. Adaptive Needs

Equipment/Adaptation Utilized by Resident	Operable	Inoperable
Bedside Commode		
Elevated toilet seat		
3 in 1 (bedside commode, raised toilet seat, and shower chair)		
Bedpan		
Urinal		
Shower bench/chair		
Handheld shower		
Grab bars		
Transfer board		
Hospital bed		
Mechanical lift		
Gait belt		
Walker		
Cane		
Braces		
Crutches		
Motorized wheelchair		
Transfer Board		
Trapeze bar		
Protective helmet		
Ramp		
Shower		
Appropriate clearance for wheelchair/walkers		
Describe any other adaptive equipment:		

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Equipment/Adaptation Utilized by Resident	Operable	Inoperable
Describe any medical or safety concerns (include details for all instances where "inoperable" was chosen):		

7. Meaningful Day Activity

Activity	Yes	No	Rating
Adult Day Training			
Employment			
Companion Services			
School			
Volunteer Activities			

Rating Scale for Estimating the Time Spent by the Person in an Activity
 1: Person performs or participates in the activity less than 1 day a month.
 2: Person performs or participates in the activity 1 to 3 days per month.
 3: Person performs or participates in the activity 1 to 2 days per week.
 4: Person performs or participates in the activity 3 to 7 days per week.

8. Behavior Analysis Services (BAS)


Does the resident require behavior analysis services?


Yes	No
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Only show below if yes to previous question

List maladaptive behaviors being addressed: Add drop down		
Behavioral Analysis Documentation	Yes	No
Is there an approved behavior plan?		
Is there documented tracking of behavior plan?		
Is there a safety plan (ALL individuals with a history of sexually inappropriate behavior should have a safety plan)		

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9. Health and Safety-Remove grid on tool, will need individual questions with child question if yes.

Hospitalizations within last 12 months if yes, list the date and reason for each admission	
ER visits within the last 12 months if yes, list the date and reason for each ER visit	
Falls within the last 12 months if yes, list date of each fall, injuries, and any intervention	
Skin condition issues documented within the last 12 months	
Skin condition issues documented within the last 12 months (ulcers, breakdowns, wounds). If yes:	
Date of initial onset:	
Location of skin breakdown:	
Treatment and interventions (orders):	
Name of wound care provider:	

10. Medication

Documented Medication Allergies:

Name of Pharmacy:

Name of validated Medication Assistance Provider (MAP) on duty at time of review:

Primary Route Validation Date: _____ Validation Expiration Date: _____


Medication Administration Summary	Met	Not Met	N/A	Unable to Verify
Consent - Authorization for medication administration (Must be signed MD/DO/PA/APRN)				
Consent - informed consent from individual for medication administration (not applicable for clients that self-administer without supervision)				
Resident's medication, including over-the-counter (OTC) medication, are maintained in their original containers, intact original label, with name of individual, name of medication, directions for administration, prescribing provider's name				
Current prescriptions, prescribing provider's orders, or pharmacy profile per rule (includes resident's name, name of medication, dosage, medication schedule, route, instructions, reason)				
Provisions for medication requiring refrigeration are present				
Medication Administration Record (MAR) is current & documented correctly for all medication including individual's name				

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Medical Review Report (cont'd)

- ❖ Individual Annual Medical Review Report for each Resident review that includes all findings and any need for follow-up



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Food or drug allergies				
Name of each medication				
Strength (i.e., 5mg/tsp, 20 mg)				
Name of prescribing physician for each medication				
Dosage (i.e., 1 tab)				
Scheduled time of administration for each medication				
Prescribed route of administration for each medication				
Instructions for mixing, diluting if applicable				
Date each medication was administered				
Initials & signature of MAP or licensed person who administered medication				
Refused or missed medication documented per Rule Chapter 85G-7, F.A.C.				
If a medication error is identified at time of review, in the current MAB, was a medication error report submitted				
MAB reconciled within 24 hours of discharge from any inpatient, FR, or urgent care facility				
Insulin Administration	Yes	No		
Does this resident receive insulin?				
If yes:				
Type of diabetes				
Name of insulin:				
Who administers:				
Additional Health Interventions	Yes	No		
Oxygen				
C-PAP				
Blood Glucose Monitoring				
Other (Please provide name of intervention)				
Medication Concerns				
Details of any medication administration concerns (including details for all instances where "not met" and/or "unable to verify" were chosen):				

11. Summary of Findings


Medical Review Outcome	No Findings	Findings – No Additional Reporting	Findings – Report to APD same day	Findings – Immediate Report to Abuse Hotline & APD
1. Onsite Observation				

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Medical Review Outcome	No Findings	Findings – No Additional Reporting	Findings – Report to APD same day	Findings – Immediate Report to Abuse Hotline & APD
Describe any findings:				
2. Healthcare Visits, Exams, and Screenings				
Describe any findings:				
3. Behavioral Analysis and Meaningful Day Activity				
Describe any findings:				
4. Functional Status				
Describe any findings:				
5. Therapeutic and Wellness Support				
Describe any findings:				
6. Health and Safety				
Describe any findings:				
7. Diet and Nutritional Status				
Describe any findings:				
8. Medications				
Describe any findings:				

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12. Summary of Recommendations

Recommendations for group home follow up regarding findings from onsite medical review:

Nurse Reviewer's Electronic Signature:

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Recommendations for Group Homes

- ❖ Acentra will provide a report to group home providers following the medical review.
- ❖ The report will also be provided to APD.
- ❖ The report will contain any findings along with these recommendations.

All recommendations will be developed in collaboration with APD, and will align with existing APD requirements.





Questions

Additional Resources & Support

CONTACT INFORMATION

Toll-free 888.305.6377

FLAPDGH@acentra.com

Fax: 844.209.4288

