



The State of Tennessee

Department of Finance and Administration

Division of Mental Retardation Services

Annual Report July 1, 2005 – June 30, 2006



STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF MENTAL RETARDATION SERVICES
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Dear Reader:

During Fiscal Year 2005 – 2006, the Tennessee Division of Mental Retardation Services (DMRS) worked diligently toward the goal of improving the community-based delivery system in order to ensure sufficient and quality services. Tennessee’s Executive and Legislative Branches of government continued to show support for people with mental retardation by increasing financial appropriations to the Division’s work. Many stakeholders contributed to improving the nature and quality of services. These include the service recipients themselves, their families, advocacy groups, citizens serving on provider boards and on oversight committees, services provider organizations, the direct support staff organization, court monitors, and lawsuit parties. The ideas, proposals, and recommendations presented to DMRS from these sources all contributed to the improvements DMRS made during the past Fiscal Year.

This Annual Report is an attempt to summarize some of these improvements. In many cases, the data from Fiscal Year 2005-2006 is compared with the data from the previous year, a comparison which, if continued, will eventually lead to trending patterns. The trending patterns will be useful for making data-based systems improvements. In addition to the data presentations, the Annual Report also contains informative and explanatory narrative, where appropriate. The narrative and data, when taken together, should provide the reader with extensive overview of the DMRS program.

It is my hope, as the DMRS Deputy Commissioner, that you will find this Annual Report to be informative and useful.

Sincerely,

Stephen H. Norris, Deputy Commissioner
Division of Mental Retardation Services

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Annual Report Overview

FY 2005 - 2006

The Division of Mental Retardation Services (DMRS) is the state agency responsible for services for Tennesseans with mental retardation. The Division is led by Deputy Commissioner Stephen H. Norris under the direction of the Department of Finance and Administration. Programs designed by DMRS are provided with funding from state revenues as well as various grants and federal Medicaid Waiver monies. The state Medicaid Agency, the Bureau of TennCare, which is also under the direction of the Department of Finance and Administration, provides oversight through its Division of Developmental Disability Services for the DMRS Home and Community-Based Medicaid Waivers. The Medicaid Waiver programs are sanctioned and monitored by the federal Centers for Medicare and Medicaid Services (CMS).

The Division operates across the state with Regional Offices in the three grand divisions of West, Middle, and East Tennessee. The DMRS Central Office, based in Nashville, provides direction for programs as well as administrative support to the Regional Offices. DMRS provides services to Tennesseans of all ages with mental retardation and other disabilities. The programs DMRS oversees are Early Intervention Services for children 0-3, Family Support Services, and an array of community based services funded with state and federal resources. In addition to community based services, the Division operates three Intermediate Care Facilities for the Mentally Retarded (ICF/MR). These centers are located one per region: Arlington Developmental Center in Arlington (West), Clover Bottom Developmental Center in Nashville (Middle), and Greene Valley Developmental Center in Greeneville (East).

Fiscal Year 2005-2006: A Year of Expansion

During Fiscal Year 2004-2005, DMRS began the implementation of the new systems outlined in *The Blueprint for Improving the Service Delivery System for Individuals with Mental Retardation in Tennessee*. Collectively the new systems and products identified in the *Blueprint* are called the Tennessee Quality Management System, derived, in part, from the CMS Quality Framework for Home and Community-Based Waiver Services (HCBS) and the Interim Procedural Guidance. CMS has urged states to develop Quality Management Systems in order to provide CMS with evidence of effective state oversight of HCBS services. DMRS designed these systems in FY 03-04 and began implementing them in FY 04-05. In FY 05-06, these systems were refined and expanded.

In January 2005, CMS approved Tennessee's three Medicaid Waiver applications, which are the statewide HCBS Waiver, the Arlington HCBS Waiver, and the Self-Determination Waiver (designed for people who do not require residential services). Enrollment in these Waivers was granted by CMS effective April 14, 2005. Because of the limited number of Waiver enrollments during the two-year moratorium placed on Waiver enrollment by CMS, the lifting of the moratorium led to an impressive surge of new Waiver enrollments as well as conversions to the Waivers from 100 percent state-funded services. From January 2005 through June 30, 2006 (which includes the entirety of FY 05-06 along with six months of FY 04-05), 886 people were enrolled in the SD Waiver, 1,136 in the statewide HCBS Waiver, and 17 in the Arlington HCBS Waiver for a total of 2,039 Waiver enrollments. In addition, 406 totally state-funded people were converted to the SD Waiver and 644 were converted to the HCBS Waivers. This rapid growth rate in the Waivers forced the expansion and refinement of the DMRS oversight systems. The following are some of the highlights:

- **Budget**
 - The Governor’s Budget for FY 05-06 was \$26.3 Billion. Of this amount, \$746,292,700 was allocated for the DMRS’s operating budget. DMRS received an additional \$41,950,000 in supplemental appropriation for a total operating budget of \$788,242,700. Actual expenditures totaled \$775,153,500 or 1.6 percent under budget. The Governor’s budget also included \$520,000 in capital appropriation to fully plan the construction of 25 residential four-bedroom community-based waiver homes.

- **Quality Assurance**
 - The assessment of provider performance was on-going throughout the year utilizing the Quality Assurance tools with revised processes and introduction of Provider Manual references.
 - Inter-Rater Reliability studies were implemented, providing an opportunity to study the agreement between surveyors statewide and to identify checklist components needing further refinement. Utilization of data from the QA processes has continued to develop, providing managers valuable performance information to make data-driven decisions.

- **Clinical Services**
 - In the last few years, DMRS has developed a more focused approach to health. Reflective of this approach is a chapter exclusively addressing issues concerning health in the new Provider Manual and the formation of Clinical Units in the Central Office, which are mirrored in each Regional Office.

- **Employment Opportunities**
 - Since 2002, the number of adults in day services who are employed in competitive jobs in the community has increased by nearly 40 percent. DMRS believes in the power of work - it not only provides income, but more importantly it provides the opportunity to belong, contribute, and be a valued part of a team. A job must meet the needs, wants, and desires of the job seeker. By taking the time to explore ideas and to listen, employment specialists can develop job opportunities that fulfill the job seeker’s expectations.
 - Since 2001, representatives from Community Rehabilitation Providers, families, advocates, consumers, the Tennessee Council on Developmental Disabilities, and the Tennessee Division of Rehabilitation Services have comprised the Tennessee Employment Consortium (TEC). TEC has been instrumental in collaborating with DMRS to develop Tennessee’s capacity to create opportunities for integrated employment in the community. Simultaneously, DMRS also continues to partner with stakeholders to develop other options for other meaningful day activities.

- **Family Support**
 - During FY 05/06, the Family Support Program provided services to 4,267 individuals of all age groups with varying types of disabilities. This represents an increase of 237 persons supported from the previous year. Although most families receive a fairly modest amount of funding, it makes a tremendous difference. Family Support has a waiting list of 5,134 families. The Family Support Annual Satisfaction Survey was distributed to 3,514 families with a 46 percent return. The resounding majority of families report they are “very satisfied with the program.”
 - Family Support is a very cost effective service that is designed to help people remain with their families in their homes and in their local communities. The provision of this service

minimizes the risk that families may have to look to the Division to provide more costly services outside of the family setting. Every year that Family Support can provide services to these persons potentially prevents the need for more expensive services.

- **Communication**

- A new DMRS website, www.state.tn.us/dmrs, debuted in early spring. Thoroughly researched, the site was modeled after those of national mental retardation organizations and other state's departments and agencies. The site was constructed with an emphasis on easy navigation, and serving as a resource tool for service recipients, their families, providers and all other stakeholders. A news format applies as information and design features are in constant flux.
- The DMRS newsletter, *Personally Speaking*, continues to be a helpful tool for information dissemination and stakeholder feedback. The bimonthly publication can be found in full color on the DMRS website under Publications. *Personally Speaking* offers news and feature stories, columns from Deputy Commissioner Stephen H. Norris and Medical Director Dr. Adadot Hayes and a "Friends" section with contributions from the Vanderbilt Kennedy Center, The Arc of Tennessee, Tennessee Council on Developmental Disabilities, and the Tennessee Disability Coalition.

- **DSP Alliance**

- DMRS continued fostering a strong alliance with the Direct Support Professionals Association of Tennessee (DSPAT). Deputy Commissioner Stephen H. Norris stresses the importance of DSPs in the application of services and supports. The Division reallocated \$4 million in funds for an increase in DSP salaries. Recognition, mentoring and credentialing programs are in place and growing. The first TNCO (Tennessee Community Organizations)/DSPAT Playoffs, a huge success, drew DSPs from around the state, testing their knowledge and skills in tasks encountered in everyday care.

- **Outreach to Families**

- The Office of Consumer and Family Services (OCFS) was created in October 2003 and is a component of the Policy and Planning Unit within DMRS. One of the primary functions of OCFS is to provide outreach and training to special educators, consumers, and family members. In June 2005, OCFS began an outreach and public awareness campaign targeted to teachers in the Special Education Department. The purpose of the outreach was to provide special educators with information, materials, and training to ensure consumers and families know how to access DMRS services when exiting the school system.
- During the last year, OCFS has participated in many statewide special education conferences as presenters of DMRS information and exhibitors to distribute information. OCFS has also created a Parent Volunteer Committee to assist staff in developing training curricula for families. During fiscal year 2007, OCFS staff will begin conducting statewide family training sessions to educate persons with mental retardation and their families on various topics that include: how to access the DMRS service delivery system, what the consumer and family should expect from their assigned state case manager, and what it means to be on the DMRS Waiting List for services.

- **Efficiency**

- A paper billing system was replaced in April 2005 by a mechanism designed to enable providers to bill online.

Status of Federal Lawsuits

United States v. State of Tennessee (Arlington)

In January 2006, the US Department of Justice, People First, and the State agreed to a proposed Settlement Agreement designed to move the lawsuit forward toward resolution. The West Tennessee Parent and Guardian Association (PGA) did not sign on to the Agreement. The proposed Agreement must be approved by the Western District Court and a hearing has been set for the middle of January 2007. The Settlement Agreement does not take the place of the Remedial Order nor the Community Plan, but it does envision the closure of the Arlington Developmental Center and features the construction and state operation of 12 four-bed ICF/MR homes located in a residential neighborhood. The proposed Settlement Agreement contains requirements that strengthen the service delivery systems at Arlington Developmental Center and in the community. The proposed Agreement also mandates a Closure Plan, designed primarily to ensure safe transitions from the center to the community. The Closure Plan must be approved by the Court Monitor. Drafts of the plan have been submitted for discussion and a final plan is close to completion.

People First v. Clover Bottom

In March 2006, the Federal Middle District Court issued an Order granting the State's motion that Greene Valley Developmental Center in Greeneville, Tennessee, be found in substantial compliance with the institutional conditions and protection from harm sections of the Settlement Agreement. The motion effectively removes Greene Valley from the Lawsuit, although the current residents will remain as class members and the center will have to maintain services at a constitutional level. On the community side, the Quality Review Panel (QRP) completed its annual assessments of services in the three Regions and continued to find weaknesses in the service areas of mental health, communication, independence, relationships, work/school/day, support planning, and support coordination. The Division assesses these areas, and others, through its quality assurance monitoring and is in agreement with some of the QRP findings, but not all.

Brown et. al. v. Tennessee Department of Finance and Administration

The Waiting List Lawsuit is nearing the completion of its first two years during which the state is required to place 1,500 people from the Waiting List into services. While this mandate has already been exceeded, negotiations between the state and the parties are underway to reach an agreement on the requirements for years three, four, and five. Because of an aggressive outreach effort by DMRS, the Waiting List has actually grown since January 2005 even though 1,913 people have been placed into services since then. Waiting List issues challenging the Division include provider capacity, funding, and the expansion of oversight systems.

The People DMRS Serves

People in the Community

DMRS provides a wide range of services to more than 14,000 Tennessee citizens. Most of the people receiving services live in their home community and receive services from local community agencies. The funding to serve people comes from federal, state, and local resources. Through the federal Medicaid program, the state of Tennessee has three Home and Community Based Waiver programs that permit the state to use Medicaid funds to provide a variety of community services. DMRS, in partnership with the Bureau of TennCare and the Division of Developmental Disability Services, operates these Waivers. The federal government provides about 65 percent of this funding and the state government provides the remaining 35 percent.

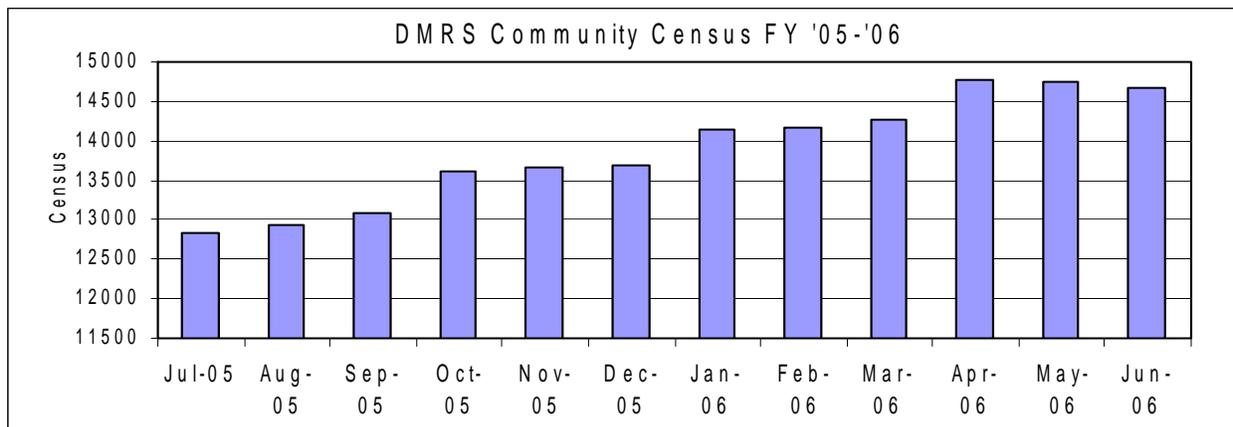
The state government also provides funding for the Family Support program and for a portion of the Early Intervention program. Local organizations, such as the United Way, and individual contributors provide additional support to local service providers. The Medicaid Waiver program, however, is by far the largest source for funding services.

During FY 05-06, the number of people served by DMRS increased dramatically. Much of this growth is a result of DMRS enrolling people into the Waiver program from the Waiting List for services. During this fiscal year, DMRS also implemented a massive conversion effort, enrolling people who were being served by pure state dollars into Waiver services whenever the person was eligible. The following table gives specific monthly census numbers of persons enrolled in each DMRS community program during FY 05-06. The chart on the following page shows the growth of the census for DMRS community programs.

Table 1: DMRS Census by Program per Month

	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06
Statewide Waiver	4895	5020	5166	5264	5377	5472	5573	5643	5702	5779	5899	5917
ADC Waiver	167	167	172	178	183	193	201	200	200	200	199	206
SD Waiver	148	199	252	352	393	435	526	559	692	786	864	886
SD Interim Services	58	46	38	32	25	19	13	12	11	10	8	7
State Funded	2041	1986	1953	1887	1784	1669	1557	1484	1379	1257	1019	911
Early Intervention	2480	2480	2480	2480	2480	2480	2480	2480	2480	2480	2480	2480
Family Support	3034	3034	3034	3412	3412	3412	3802	3802	3802	4267	4267	4267
Census Total	12823	12932	13095	13605	13654	13680	14152	14180	14266	14779	14736	14674

Chart 1: DMRS Census by Month for Community Waiver Services



The chart shows an increase in persons served over the year. This is attributed to several factors. First, the lifting of the moratorium on admissions allowed for new people to be enrolled. Second, the new Self-Determination Waiver program increased service rolls considerably.

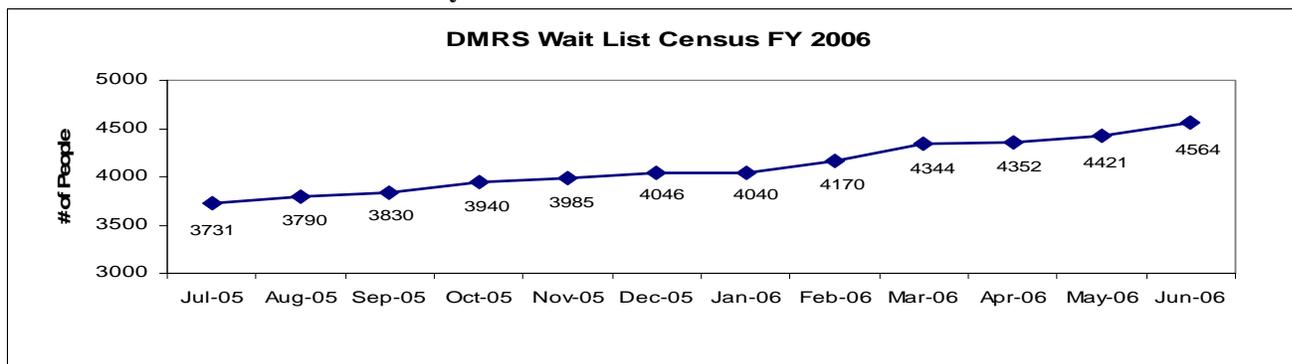
Waiting List

The Division manages a waiting list for individuals seeking Medicaid waiver services. DMRS has developed a comprehensive system to manage the cases of those waiting to be served. The Waiting List for Medicaid Waiver Services has been prioritized using several categories of need: crisis, urgent, active, and deferred. Each category has specific criteria that are applied to an individual’s unique situation. People in the category of crisis are given priority for services offered.

The Division continued a statewide public information campaign as an outreach effort to let citizens know how to begin the intake process for obtaining DMRS services. Through this effort, many people were added to the Waiting List. However, as people were enrolled in services the net effect on the list was an increase of 813 people for the fiscal year. The Division has been able to serve over 1,400 people who have been on the Waiting List for services. There were 742 people enrolled into the Self Determination Waiver program and 671 people enrolled into the Statewide Home and Community Based Services Waiver.

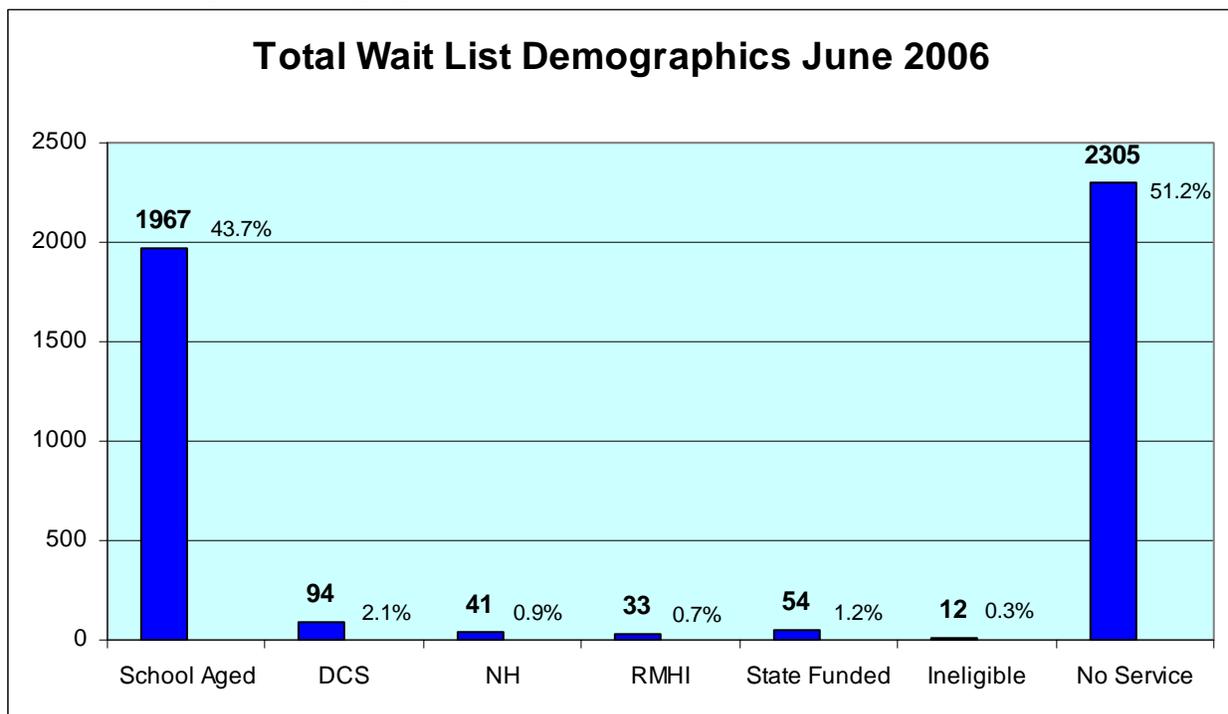
The following chart shows the census of the Waiting List over FY 05-06. Throughout the year, the Waiting List for Waiver services increased from 3,731 to 4,564 for a net total gain of 813 people.

Chart 2: DMRS Wait List Census by Month for Waiver Services



In this second year of implementing a new management system of the Waiting List, the Division has begun analysis of the populations of people who are seeking services. While the Division faces challenges of developing systems to serve more people, it has been important to understand the demographics of the citizens of Tennessee who are seeking services. Through analysis, it was highlighted that almost half of people on the list are between the ages of 0-22, or “school-aged.” The Waiting List was broken into populations of people who were receiving some type of service: Education, Children Services (DCS), Nursing Homes (NH), Regional Mental Health Institutes (RMHI), or DMRS State Funded Services. The remaining individuals were categorized as those who were ineligible for Medicaid Waiver services and those that were receiving no type of service. The chart below identifies the percentage of those populations on the DMRS Waiting List as of June 30, 2006.

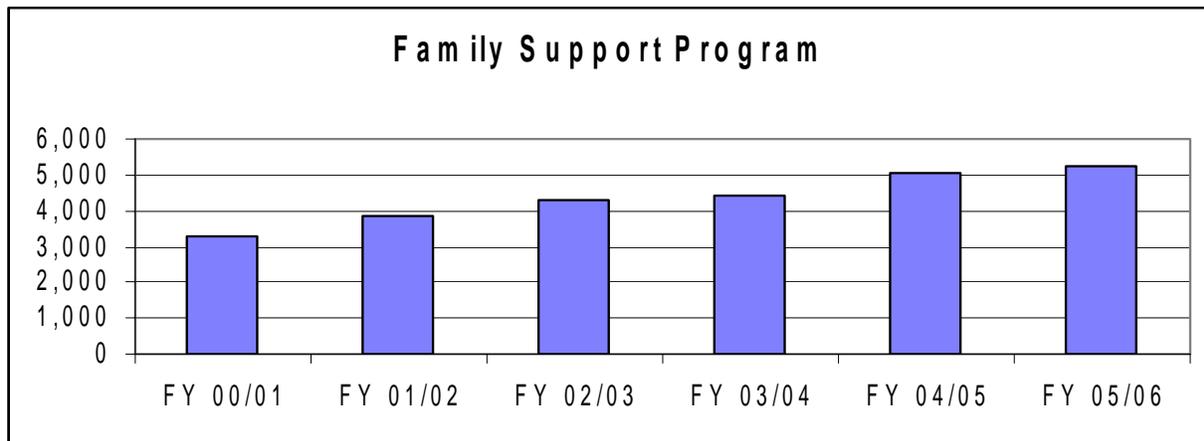
Chart 3: Waiting List Demographics for Waiver Services



When people are placed on the Waiting List, there are some options available. To provide some help, the Division continued its Consumer Directed Supports (CDS) program. This program provides financial assistance to those who qualify. The monies can be used for respite services as well as short-term, in-home support. A total of \$3,899,727 was provided to families during this past fiscal year.

DMRS strives to provide needed support to those who seek services. Each person on the Waiting List is assigned a case manager to coordinate the eligibility and intake process. The Division anticipates that future growth of the Waiting List will continue as public information campaigns are sustained and community outreach education programs are offered.

Chart 4: Waiting List Demographics for the Family Support Program

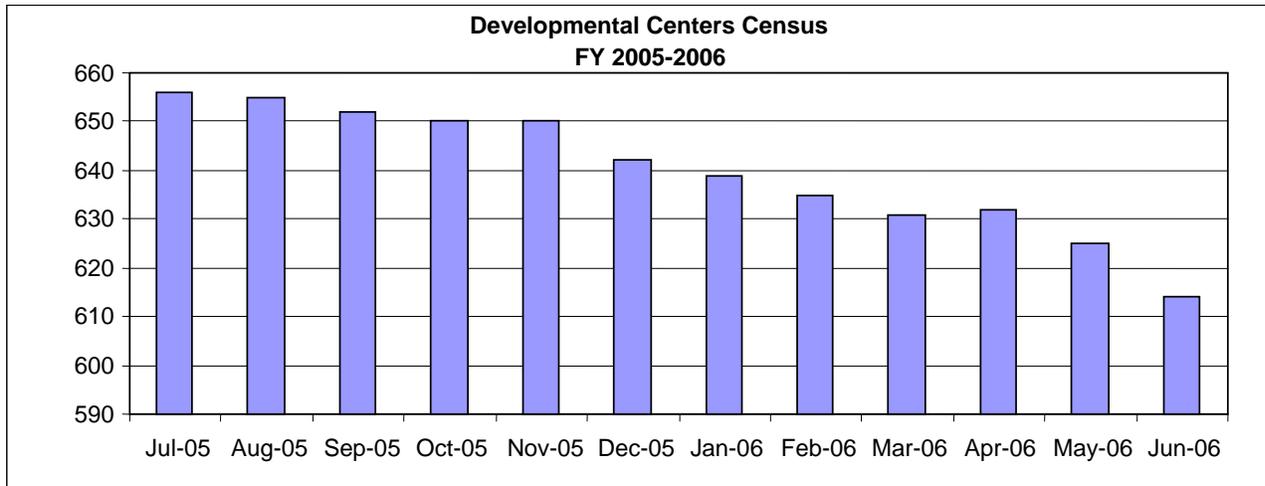


The Division also maintains a waiting list for families needing services through the Family Support program. These individuals have a wide range of disabilities (ex. autism, cerebral palsy, deaf and/or blind, developmental delay, neurological impairment, orthopedic impairment, spinal cord injuries, and traumatic brain injury). These families are referred to other resources for assistance, but there is limited funding available for these persons. Therefore, most of these individuals are unable to receive assistance until funding is available through the Family Support program. The Division is researching funding options for these individuals.

People in the Developmental Centers

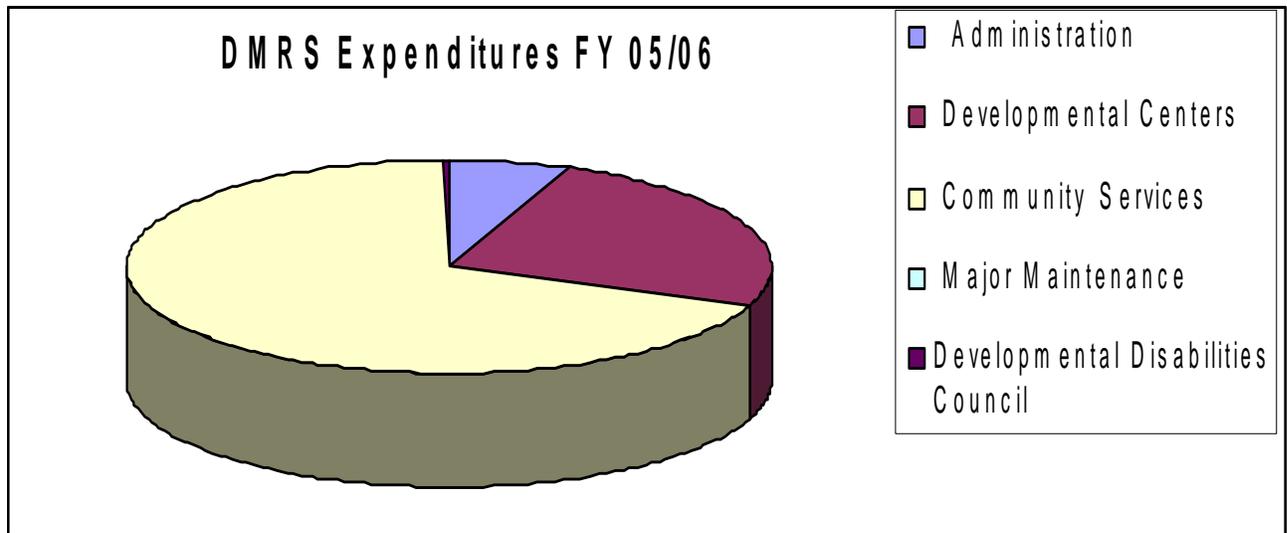
The three Developmental Centers are licensed Intermediate Care Facilities for the Mentally Retarded (ICF/MR) operated by DMRS. They are located in East Tennessee in Greeneville, in Middle Tennessee in Nashville, and in West Tennessee in Arlington. In addition to ICF/MR services, the Developmental Centers house state-of-the-art Assistive Technology Clinics, provide respite care, and perform comprehensive medical evaluations. These clinic services are available to both people living in the ICF/MR facilities and in the community. During FY 05-06, the number of people living at the Developmental Centers declined by 42 people. This decline in census is a result of the Division's compliance with the terms of the Settlement Agreement and the Remedial Order Federal Lawsuits.

Chart 5: Statewide DMRS Developmental Center Census



Where the Money Goes

Chart 6: Division Expenditures



As shown in chart 5 above, of the \$775,153,500 in DMRS expenditures, 69 percent of the money went to Community Services and 25 percent of expenditures for FY 05/06 went to the State’s three Developmental Centers.

Quality Management System Activities

The DMRS Advisory Council

The DMRS Advisory Council (DAC) was formed to provide stakeholder input to the Deputy Commissioner regarding the management of the DMRS service system, including the overall vision, mission, and philosophy guiding the management of the system. Members were initially appointed by the Deputy Commissioner to serve a one to three year term. As existing members' terms expire, new members will be appointed for three years. The DAC is composed of representatives from the DMRS provider community, service recipients and service recipients' family members, and representatives from advocacy organizations. The Deputy Commissioner chairs DAC meetings and other DMRS staff attend on a regular basis.

The DAC meets on the second Thursday of each month. During monthly meetings, the DAC is given information about the status of lawsuits affecting the DMRS service system, updates on DMRS projects and initiatives, and reports describing existing service recipients, people on the waiting list for services, quality assurance survey results, and other relevant information about the DMRS service system. As available, national information allowing comparison of the Tennessee service system to those operating in other states is provided and reviewed. In the past year, council members have reviewed and provided valuable input regarding proposed DMRS internal operating policies, proposed changes to waiver programs, and proposed revisions to the provider manual. In addition, DAC members have provided feedback following the implementation of policies and initiatives and have offered suggestions for achieving resolution of a variety of operational issues, both from an individual and systematic perspective.

Also in the past year, DAC task forces have been formed to study and provide recommendations relative to specific system components. The DAC Housing Task Force, formed to make recommendations for increasing housing access and options for people with intellectual disabilities, has made recommendations to the Deputy Commissioner. A meeting is scheduled for early fall to respond to these recommendations. The DAC Service Planning and Authorization Task Force, composed of members of the Tennessee Arc, the Tennessee Network of Community Organizations (TNCO), and the Tennessee Association of Support Coordinators (TASC), has completed a review of DMRS service planning and authorization processes and has submitted recommendations aimed at simplifying and streamlining these processes to the Deputy Commissioner. A written response to these recommendations is being compiled by DMRS staff. The recommendations of both of these task forces, as well as the DMRS response to individual recommendations will be discussed at upcoming DAC meetings.

Real Choice Systems Change Grant

The DMRS was awarded a Real Choice Systems Change Grant through the Centers for Medicare and Medicaid Services. This grant was contracted to the Arc of TN to create a Satisfaction Survey for service recipients throughout Tennessee. The Arc of TN developed a program called *People Talking to People: Building Quality and Making Change Happen* that took the consumer satisfaction survey concept and built a dynamic process that would involve face-to-face interviews with persons served. Survey interviews are conducted using the CMS approved Participant Experience Survey. The process includes a group of 20 service recipients and people familiar with disabilities to work as interviewers. The first phase of surveys (75) was conducted and completed in October 2004. The second set of surveys (747) was completed in November 1, 2005. The final set of surveys (1,474) is due to be completed by the end of the three year grant (September 2006).

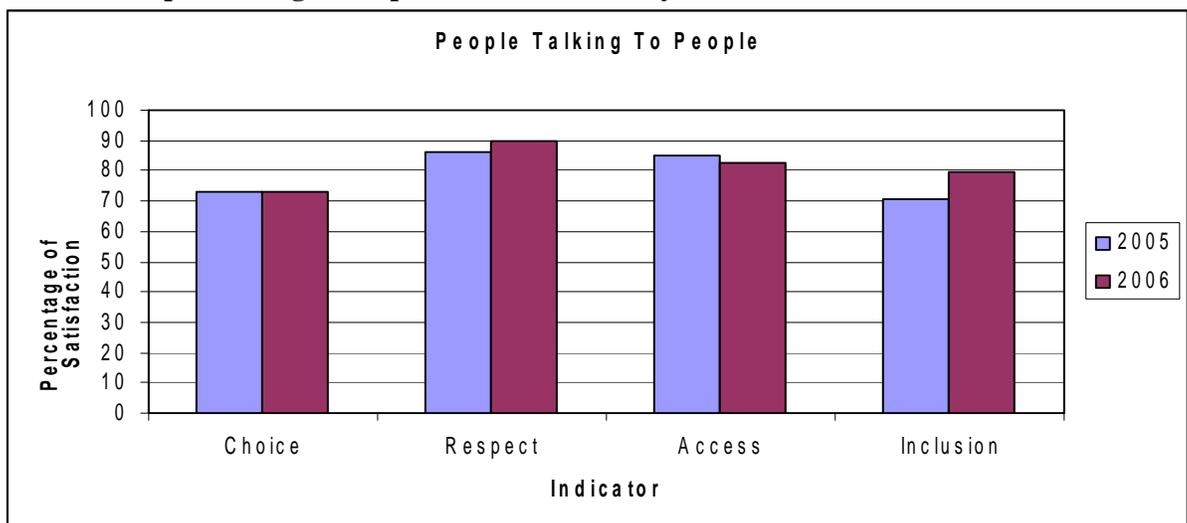
The survey provides indicators in four primary areas:

- **Choice and Control**
 - Do participants have input into the services they receive? Can they make choices about their living situations and day-to-day activities?
- **Respect/Dignity**
 - Are participants being treated with respect by providers?
- **Access to Care**
 - Are needs such as personal assistance, equipment, and access to help being met?
- **Community Integration/Inclusion**
 - Can participants participate in activities and events outside their homes when and where they want?

Results

There are some areas that are better, some stayed the same, and some declined. *Choice* dropped slightly but stayed relatively stable (73.28 percent vs. 73 percent). *Access* showed the most decline (85.12 percent vs. 82.88 percent). *Respect* climbed a few points (86.11 percent vs. 90.06 percent) and *Inclusion* improved the most (70.75 percent vs. 79.60 percent).

Chart 7: People Talking to People Satisfaction Survey Results



Future Plans

People Talking to People has recently been approved for an additional two years. The interview and the interviewer take on an even more important role. Many changes are in the planning stages, including a better survey instrument and a simpler way of managing data. In addition, a larger sample (20 percent of total) of those individuals with disabilities living in institutions will be added to the interview process. PTP also plans on continuing to work closely with the DMRS Protection From Harm Unit. In addition, the PTP program will be taking a look at individual agencies as well as “the big picture”, allowing agencies to see where improvement is needed in their own programs. PTP also plans on researching state comparisons to see where Tennessee stands regarding individual and family satisfaction.

Training Initiatives

DMRS is restructuring the training delivery system to include a multi-media, interactive, computer-assisted, web-based training system for Direct Support Professionals. The training system will include:

- Content based on a comprehensive job analysis of Direct Support Professional Roles
- Accessibility 24/7 to provide flexibility in completing training for direct support staff
- Database with a learner management system that allows for portable records for staff persons who move from one provider agency to another and ability to tailor individualized lesson plans to the learner
- On-the-job training skills checklist to ensure transfer of knowledge into the worksite
- Adaptability to families at no cost to them

The content will address court ordered training requirements as well as supplemental information to address management/supervisory skills of frontline supervisors and offers organizational tools to address retention and recruitment issues. Also, the courses and lessons will support each focus area and desired outcomes identified in the Centers for Medicare and Medicaid Quality Framework.

The training will be delivered in a two-part process:

- Online courses to be assigned based on position
- On-the-job skills assessment will be completed by the supervisor to ensure understanding of key concepts prior to working with individuals receiving services.

Health Supports

In the last few years, DMRS has developed a more focused approach to health. Reflective of this approach is a chapter exclusively addressing issues concerning health in the new Provider Manual and the formation of Clinical Units in the Central Office, which are mirrored in each Region.

The Provider Manual facilitates DMRS monitoring and oversight of the health-care system by requiring that documentation be recorded in three separate forms. The first is the Health Passport which was developed for use in emergencies. The goal of the Health Passport would be to have concise, identifying information as to who the person is, where they live, who could be contacted and what their general diagnosis and medications are to “get them started” in an emergency should such a situation arise.

The second required document is the PSR or Physical Status Review. This is a look at health needs and changes in both health and health needs over time. This is addressed elsewhere, but it has been used by the Division to project overall and individual needs. It also assists in understanding changing health needs, which aids in determining the clinical supports needed in our population

The last required form by the Provider Manual is the Health Care Oversight Form. This was developed as a concise form to help people project health needs based on experiences of the previous year. This allows an individual agency or clinician to have a concise overview of an individual’s basic health issues, basic interaction with the healthcare system, and basic projected needs. Properly used, it can be helpful in both directing health care and monitoring compliance.

Clinical units have been formally assembled in the Division to help with supporting the health of the individuals served by DMRS. There is a unit in the Central Office and a unit in each of the three Regions, all with the same structure. The structure consists of a physician, nursing services, therapeutic services, and behavior professionals.

The goals of the clinical unit are:

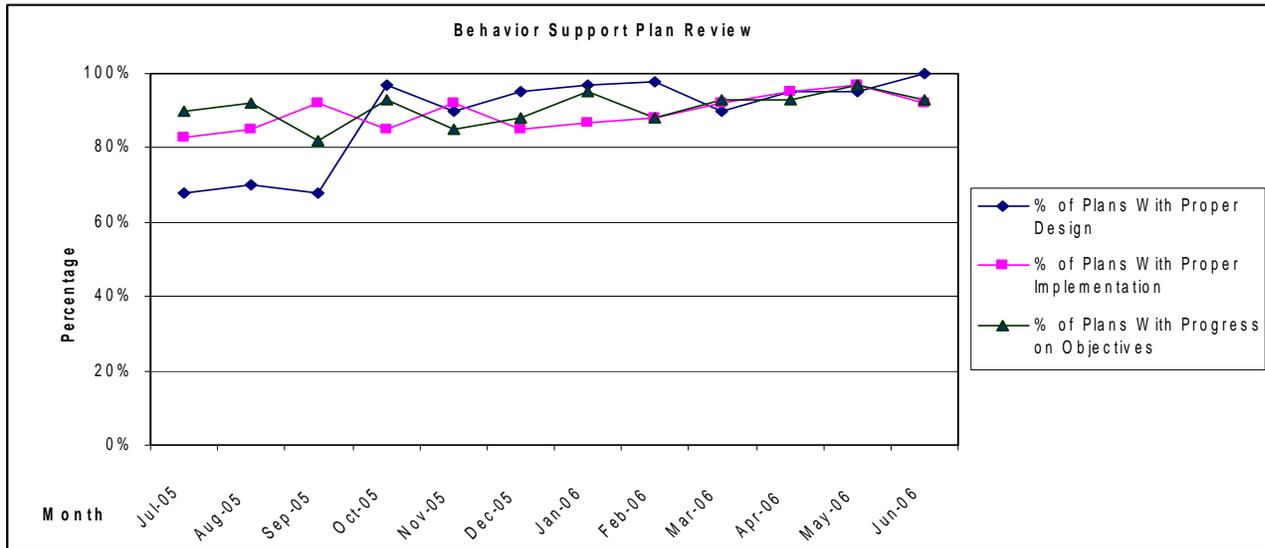
- Supporting/monitoring of health care
- Education
- Consultation

Supporting and monitoring of health consists of a number of projects, technical assistance, consultation, and oversight. A physician is available in each Region for consultation, as is the Medical Director in the Central Office. Nurses are available for technical assistance and with medication administration training and other requirements, in addition to special projects. Therapeutic services have a variety of services including education and training, as well as oversight of services. Behavior services, mainly in the area of behavior analysis, also has clinical training and oversight of various requirements in the system as referred to in the Provider Manual, such as behavior support committees, human rights committees, and monitoring of many issues such as restraints.

Behavior Supports

A statewide system to review the quality of behavior support plans by community providers was carried out during this annual report period. Each month, 20 plans from each of the three regions were reviewed by Regional Behavior Analysts for proper design, proper implementation, and progress on objectives. Regional Behavior Analysts provided feedback to the author of any plan that fell below the 80 percent correct checklist for proper design or implementation. The average ratings across the 12 month period were 89 percent for proper design (range over months, 68 percent to 100 percent), 89 percent for proper implementation (range: 83 percent to 97 percent), and 91 percent reporting progress in the month reviewed (range: 82 percent to 97 percent). Thus, the benchmark of 80 percent proper design and correct implementation was achieved, on average, for the year.

Chart 8: Behavior Support Plan Review



Each month the 60 plans were also reviewed for applications of restraint or other interventions involving restrictions of rights. These reviews indicated that each month, the applications of restraints or actions involving restrictions of rights remained low and fairly stable. The percent of the 60 plans with restraint applications over this 12-month period ranged from zero to three percent. The percent of the plans with applications of interventions with restrictions ranged from three percent to 15 percent.

Chart 9: Behavior Plans Including Restraints and Restrictions



Activities continue to build and maintain the professional quality of behavior providers. The number of behavior analyst providers with certification from the Behavior Analyst Certification Board® has increased. The Regional Behavior Staff has established formal orientation for new behavior providers, and the State Director of Behavior Services continues to provide monthly Behavior Seminars for continuing education in each Region.

Mortality Reviews

In 2005 the Division formed a centralized Death Review Committee that reviews and oversees *all* deaths and death reviews in collaboration with the Protection from Harm Team. The committee focuses on reviewing the following:

- Specific causes of deaths
- What records should be reviewed
- What risk factors were involved in the death
- What changes in behaviors, technologies, or agency systems could minimize these risk factors and prevent other deaths
- Types of services that may be provided to family members and/or agencies as a result of the death, e.g., training, education, consultation

Regions conduct formal death reviews on all suspicious or unexpected deaths and others as required. Agencies/stake holders participate in the death reviews. As a result, trends are identified to include effective prevention, direct training needs, and recommended development or modification of policies/procedures to address systemic issues.

Between July 1, 2005 and July 1, 2006, there were a total number of 108 deaths, or .01percent for both centers and the community.

- The mortality death rate for all deaths is 1 per 100.

Of the total number of deaths, 13 or .02 percent were individuals who resided in the developmental centers.

- The mortality death rate for developmental centers is 2 per 100

Of the total number of deaths, 95 or .01 percent were individuals who resided in the community

- The mortality death rate for the community is 1 per 100.

Table 2: Number of Deaths in Community Services

COMMUNITY

Region	05						06						Totals
	Jul.	Aug...	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May.	Jun.	
East	3	2	2	4	3	6	2	1	2	3	1	3	32
Middle	3	2	1	4	2	1	11	3	5	3	2	0	37
West	1	2	1	2	1	2	0	5	5	1	4	2	26

Table 3: Number of Deaths in the Developmental Centers

DEVELOPMENTAL CENTERS

Centers	05						06						Totals
	Jul.	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May.	Jun.	
ADC	0	2	0	0	0	0	0	1	1	0	0	0	4
CBDC	0	0	0	0	0	1	0	0	0	1	2	0	4
GVDC	1	0	0	0	0	1	1	1	0	1	0	0	5

The mortality death rates in the developmental centers were higher than in the community: 2 per 100 people in the developmental centers compared to 1 per 100 in the community.

Individuals who died in the developmental centers had an average Physical Status Review Level (PSR) of 6, as compared to the average PSR Level of 3 for those who resided in the community. The PSR is a health risk tool that describes the need for identifying potential and often predictable health risks in individuals with developmental disabilities. Therefore, it is reasonable to expect a higher mortality death rate in the developmental centers than in the community due to a more medically fragile population.

Service System Performance and Analysis

Quality Assurance Reviews

FY 05/06 began with continuation of a revised Quality Assurance (QA) system that was implemented on July 1, 2004. The QA system utilized by DMRS continues to be a foundational component of the Quality Management System (QMS), providing for review the variety of programs supporting individuals receiving DMRS services. As in FY 04/05, a series of QA tools were utilized to assess compliance of Day-Residential, Independent Support Coordination, and Clinical providers. FY 05/06 revisions were made based upon recommendations received from providers, QA surveyors, other users of the tools, and resulting data for the first year of this process.

Revision of QA tools resulted in division of the original clinical tools into three separate tools for Behavior, Nursing, and Therapy providers so as to assess performance based upon specific service requirements of the clinical types. Significant changes made in survey guidance and QA Indicators were cross-referenced with the DMRS Provider Manual where applicable. Changes were also made in scoring of the various QA tools, with the addition of Minimal Compliance as an option for Domains and Outcomes and the revision of overall performance ratings. The performance ratings utilized in FY 05/06 were revised to five categories (Exceptional Performance, Proficient, Fair, Significant Concerns, and Serious Deficiencies) to allow for greater specificity and accuracy in describing overall performance with QA requirements.

Management of data resulting from QA surveys has continued to develop, providing opportunity for comparison to FY 04/05 results and allowing for distribution of custom reports to users of data with resulting data useful to management and planning. As with the revised process implemented in 2004, up to ten QA Domains continue to be assessed, depending upon applicability to provider type:

- Access and Eligibility
- Individual Planning and Implementation
- Safety and Security
- Rights, Respect, and Dignity
- Health
- Choice and Decision-Making
- Relationships and Community Membership
- Opportunities for Work
- Provider Capabilities and Qualifications
- Administrative Authority and Financial Accountability

In addition to these 10 Domains, QA tools include a series of Outcomes applicable to the various provider types: 27 Outcomes for Day-Residential providers, 13 for ISC providers, 13 for Behavioral Clinical, 16 for Nursing Clinical, and 13 for providers of Therapy services.

QA surveys were conducted using a representative sample of the number of people a provider served; the services provided were measured against a series of Quality Indicators within each QA Outcome. Quality Indicators were based on best practice principles regarding provider performance and person-centered services as well as systemic measures of quality.

As in FY 04/05, survey teams continued with a conciliation process to arrive at survey final scores and performance ratings. Providers have continued to receive summaries of survey performance with the expectation that they incorporate corrective measures into their Quality Improvement Plans. Survey findings have continued to be utilized by Agency Teams and the Quality Management Committees (regional and statewide) to guide follow-up or technical assistance.

Review of Data Resulting from QA Reviews in FY 05/06

The implementation of QA tools in FY 05/06 allowed for DMRS to begin utilizing QA data to compare findings and assess progress between fiscal years. The data that follows is representative of the variety of surveys conducted in FY 05/06 for the following provider types:

- 136 Day-Residential providers
- 16 ISC providers
- 26 Behavioral providers
- 8 Nursing providers
- 48 Therapy providers

The following charts represent the distribution of performance rating categories regionally and by provider type in FY 05/06.

Chart 10: Performance Ratings by Region

Performance Ratings by Region, Cumulative, FY 05/06

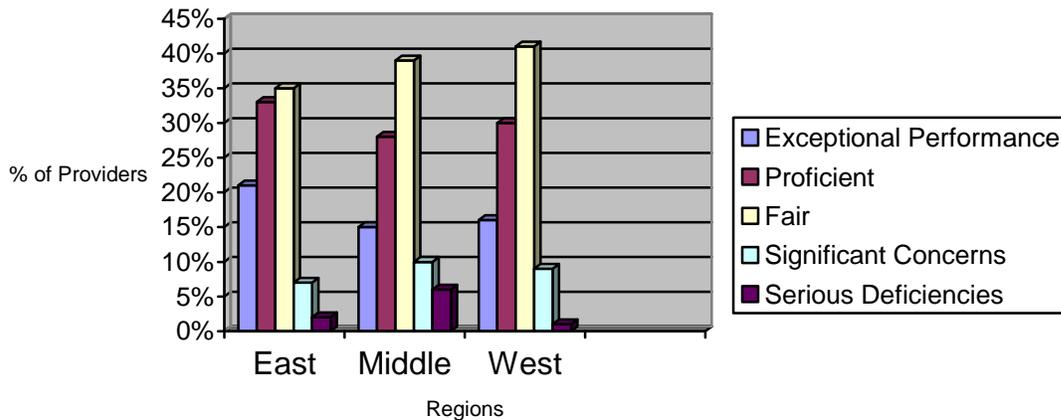
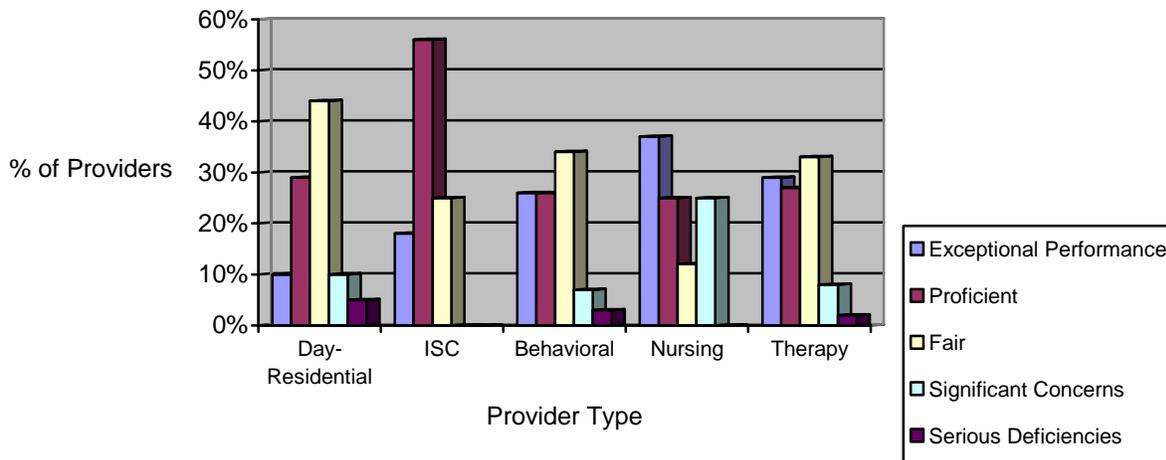


Chart 11: Performance Ratings by Provider Type

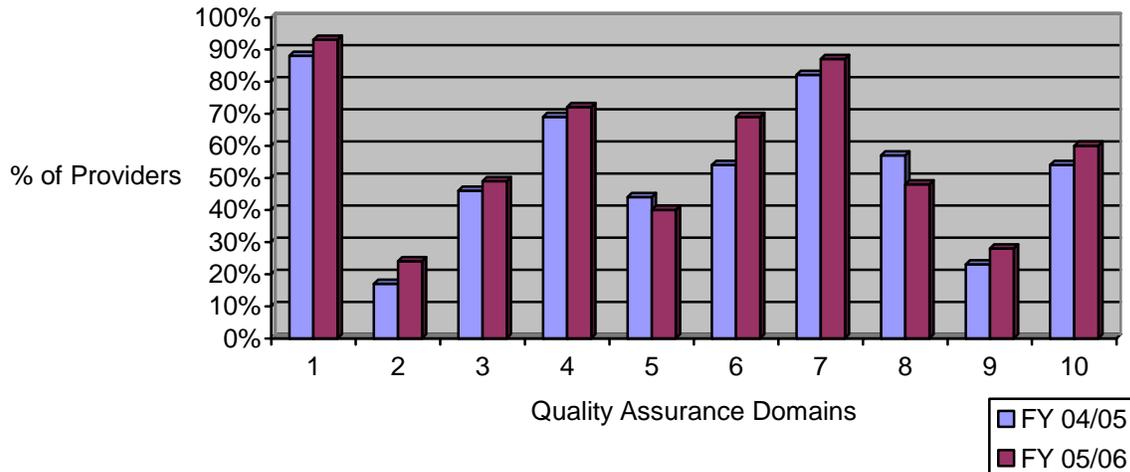
Performance Ratings by Provider Type, Statewide, Cumulative, FY 05/06



Improvement is noted during the past fiscal year among 80 percent of the Domains reviewed cumulatively statewide when comparing performance of providers in achieving Substantial Compliance. The chart that follows provides a comparison of performance between FY 04/05 and FY 05/06.

Chart 12: Percentage of Providers in Substantial Compliance

Percentage of Providers in Substantial Compliance, Comparison FY 04/05 with FY 05/06, Cumulative

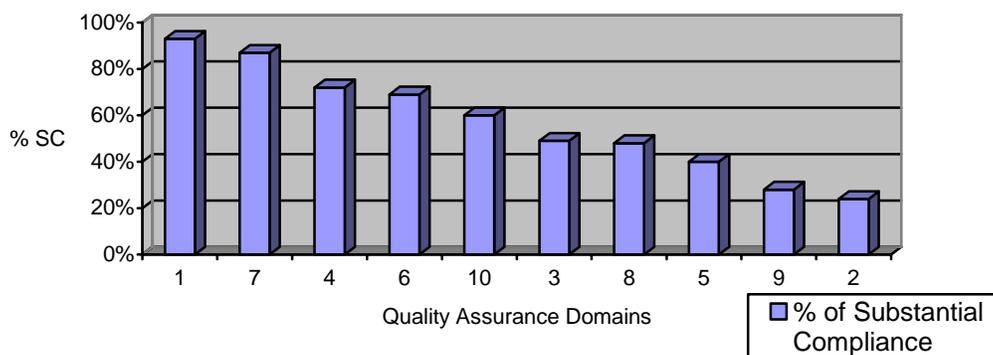


Most notable are improvements in Domain 2- Individual Planning and Implementation (from 17 percent to 24 percent Substantial Compliance), Domain 6- Choice and Decision Making (from 53 percent to 70 percent Substantial Compliance), and Domain 9- Provider Capabilities and Qualifications (from 23 percent to 28 percent Substantial Compliance). Furthermore, the DMRS Quality Management Committee has focused on Domains 2 and 9 during the past year through reviews of data and factors contributing to low performance. While performance in Domains 2 and 9 continue to present opportunities for improvement, continued progress is expected as the Division’s commitment to improvement continues.

The following chart displays the rank-order of Substantial Compliance performance on QA Domains across all provider types and regions in FY 05/06.

Chart 13: Rank-Ordering of Substantial Compliance Across Domains

Rank-Ordering of Substantial Compliance Across Domains, FY 05/06 Cumulative



As seen with data resulting from review of QA Domains, improvements are noted among a majority of QA Outcomes in comparing FY 04/05 to FY 05/06, with 64 percent of Outcomes demonstrating an increase in performance as shown in data cumulatively statewide. Among the Outcomes with the greatest improvement are:

- 2. B. Services and supports are provided according to the person's plan.
 - FY 04/05- 32 percent Substantial Compliance; FY 05/06- 43 percent Substantial Compliance
- 2. D. The person's plan and services are monitored for continued appropriateness and revised as needed.
 - FY 04/05- 20 percent Substantial Compliance; FY 05/06- 33 percent Substantial Compliance
- 6. A. The person and family members are involved in decision-making at all levels of the system.
 - FY 04/05- 53 percent Substantial Compliance; FY 05/06- 68 percent Substantial Compliance
- 9. A. The provider meets and maintains compliance with applicable licensure and Provider agreement requirements.
 - FY 04/05- 33 percent Substantial Compliance; FY 05/06- 42 percent Substantial Compliance
- 10. A. Providers are accountable for DMRS requirements related to the services and supports that they provide.
 - FY 04/05- 55 percent Substantial Compliance; FY 05/06- 77 percent Substantial Compliance

In addition to reviews of overall Domain and Outcome performance, various QA Indicators are reviewed either through the Quality Management Committee or data is compiled upon special request. Survey information is utilized by Agency Teams, the Compliance Units, and department managers in identifying regions or particular provider types that would benefit from technical assistance for corrective action or by intervening prior to surveys so as to improve future performance. Quality Assurance continues to be a key component of the Quality Management System with improvements in its systems and processes to meet the needs of the provider population.

Protection from Harm

The DMRS Protection from Harm (PFH) system is organized into three areas that include Complaint Resolution, Incident Management, and Investigations. The information below addresses each of these areas and provides a current update for FY 05-06. Monthly trends for each of the three areas are monitored via review of data and management decisions are made by the Regional and Statewide Quality Management Committees.

The Complaint Resolution System

During FY 05-06, DMRS made significant progress in establishing complaint resolution systems in each agency across the state. A statewide analysis indicates that over 91 percent of service providers have established complaint resolution systems and have complaint resolution coordinators and systems that are fully operational. This adheres to the overall philosophy of assisting service recipients, their families, legal representatives, paid advocates, or other concerned citizens to resolve complaint issues at the most direct level possible. Providers are addressing complaint issues, keeping records, and working to resolve complaint issues at the provider level. During the period of 2005-2006, many significant new aspects have been incorporated into the Complaint Resolution System:

- The DMRS Complaint Resolution process includes a Web-based tracking system, which became fully operational March 2006 and encompasses all three geographic regions and allows for timely monitoring of complaint issues.
- In September 2005, DMRS Protection from Harm staff began its partnership with TennCare representatives in an effort to improve complaint resolution. Monthly meetings are held to review and discuss any complaint issues.
- A letter was sent from the DMRS Central office to all providers of Day, Residential, Personal Assistance, Independent Support Coordination, Behavioral Services, and other Clinical services providers. The letters addressed the providers' need to establish Complaint Resolution systems at their agencies, including naming one of their staff as the Complaint Resolution Contact person and keeping formal records of complaint issues.
- In December 2005, DMRS mailed over 20,000 letters to service recipients, their families, legal representatives, and advocates. These letters announced the establishment of the Complaint Resolution System and invited the addressees to use the CRS if needed.
- The DMRS Director of Complaint Resolution facilitates monthly meetings with the Regional Complaint Resolution Coordinators and Deputy Regional Directors to discuss complaint issues, share ideas, and participate in ongoing training designed to enhance the delivery of service in the complaint resolution system. The meetings focus on Quality Assurance reviews of pending cases and client satisfaction of complainants already resolved.
- The Complaint resolution system has a benchmark goal of 90 percent resolution of all complaints within 30 days, to the satisfaction of the complainant. For FY 05-06 the complaint resolution average was 90 percent resolution of all complaints within 30 days. The average for FY 04-05 was 92.4 percent resolution of all complaint issues within 30 days. The complaint resolution system is striving for long-term resolution of complaint issues to reduce recidivism and increase satisfactory results for recipients and their families.
- There were a total of 335 complaints accounting for 424 issues that were addressed by the Regional Complaint Resolution Coordinators. Of these, 32 issues were referred to other agencies to resolve via investigations by DMRS or Adult Protective Services. The ETRO addressed 100 complaints with 133 complaint issues; MTRO addressed 115 complaints with

123 complaint issues; and the WTRO addressed 120 complaints with 168 complaint issues. The rate of complaint issues per 100 people was 7 which is an increase of 4 from the previous year.

- The Complaint Resolution System has continued to work on categorizing complaint issues and since the category, “Other” has been redefined, the issues have increased in the remaining complaint issue categories. Staffing related issues remains the major complaint issue: however, most of the staffing related issue was concerned with Personal Assistance Services rather than staffing plans. Because staffing plans were changed and requirements for staffing ratios eliminated last year, this area was closely monitored and measured. There were no negative patterns detected in the analysis of staffing related issues for 2005-2006. The second highest complaint issue was Financial followed by Health and ISC related concerns.

Chart 14: Statewide Rate of Complaint Issues per 100 People

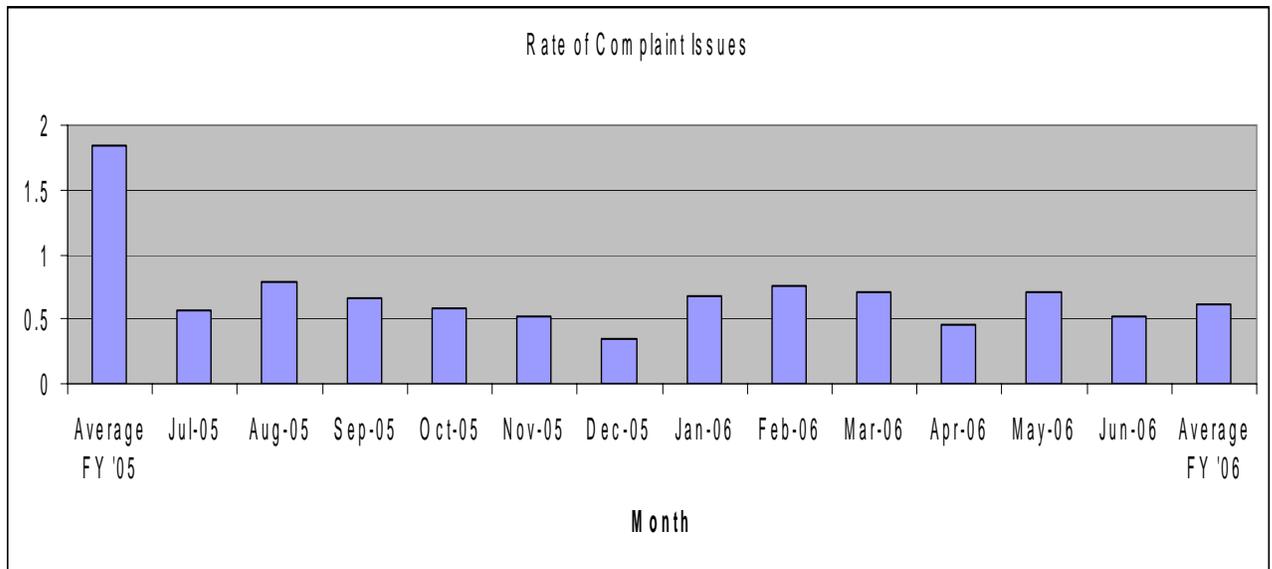


Chart 15: Complaint Issues by Category 05/06

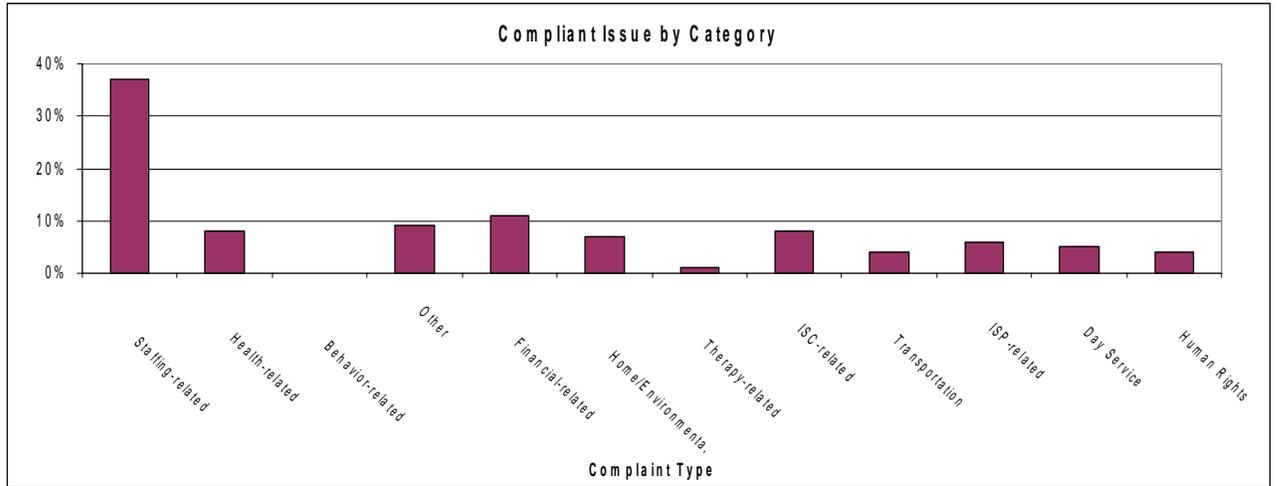
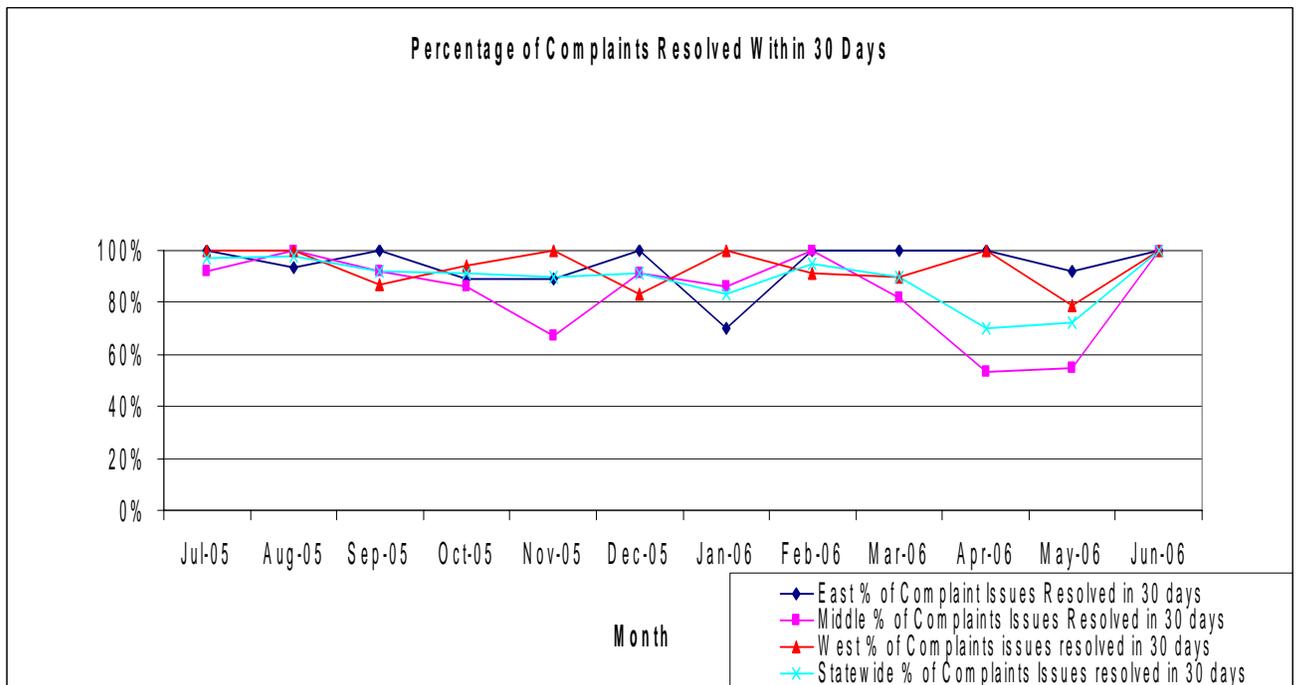


Chart 16: Percentage of Complaint Issues Resolved within 30 Days



The Incident Management System

During FY 05-06, DMRS maintained an emphasis on incident prevention by continuing to work with providers to strengthen their incident management systems. In the Provider Manual that became effective April 1, 2005, day and residential providers are required to continue Incident Review Committees, whose primary responsibilities include ensuring appropriate reporting of incidents, developing and monitoring the implementation of corrective actions in regard to incidents and investigations, and organizing systemic approaches to incident prevention by using trend analyses.

At the regional level, the Regional Quality Management Committees review summarized incident information at the individual provider agency level. The information provided to the Regional committees has been enhanced over the past year through the development of "Agency Profiles." The DMRS Quality Management Committee reviews incident data monthly at both regional and statewide levels. DMRS Protection From Harm also continues to mail detailed reports of incidents and investigations to providers each quarter.

Below is a list of actions completed during FY 05-06:

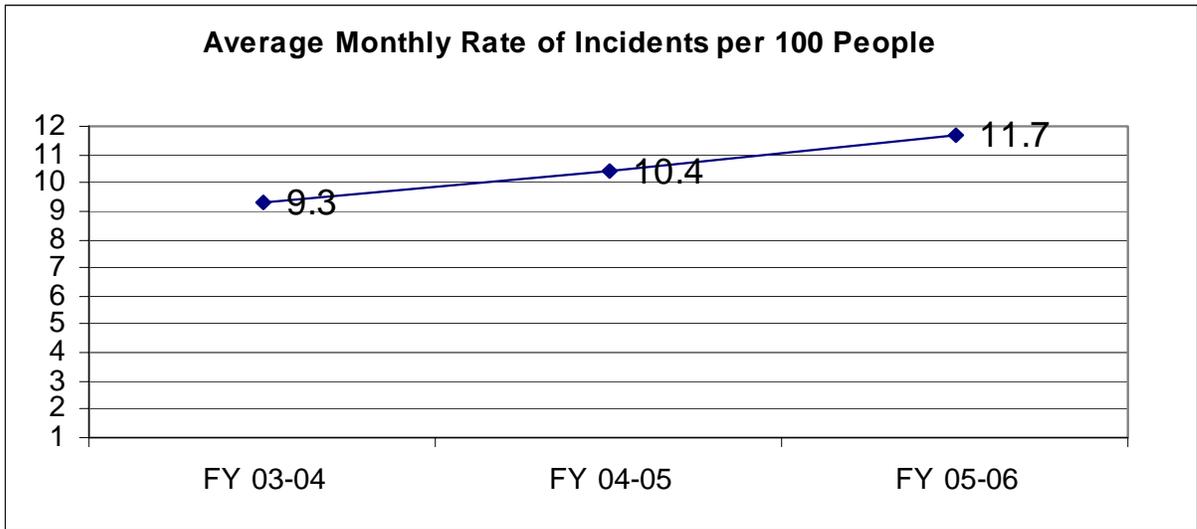
- Fall Prevention Training was continued to address the concerns and issues surrounding individuals who are vulnerable to falls.
- A three-day training session was conducted for DMRS Protection from Harm staff that addressed the following topics:
 - Protection from Harm overview
 - Quality Assurance overview
 - Protection from Harm training (Incident Management)
 - Complaint Resolution overview
 - Staff Misconduct Investigations
 - Investigations Follow Up processes
- Labor Relations Alternatives provided training on Abuse, Neglect, and Exploitation investigations: Weighing Evidence

Quarterly Provider Incident Management meetings were continued, to allow an ongoing dialogue regarding Protection from Harm issues.

Consultations on systemic approaches to fall prevention, involving Regional and Central Office incident management and therapies staff, were conducted with six of the larger residential and day service providers.

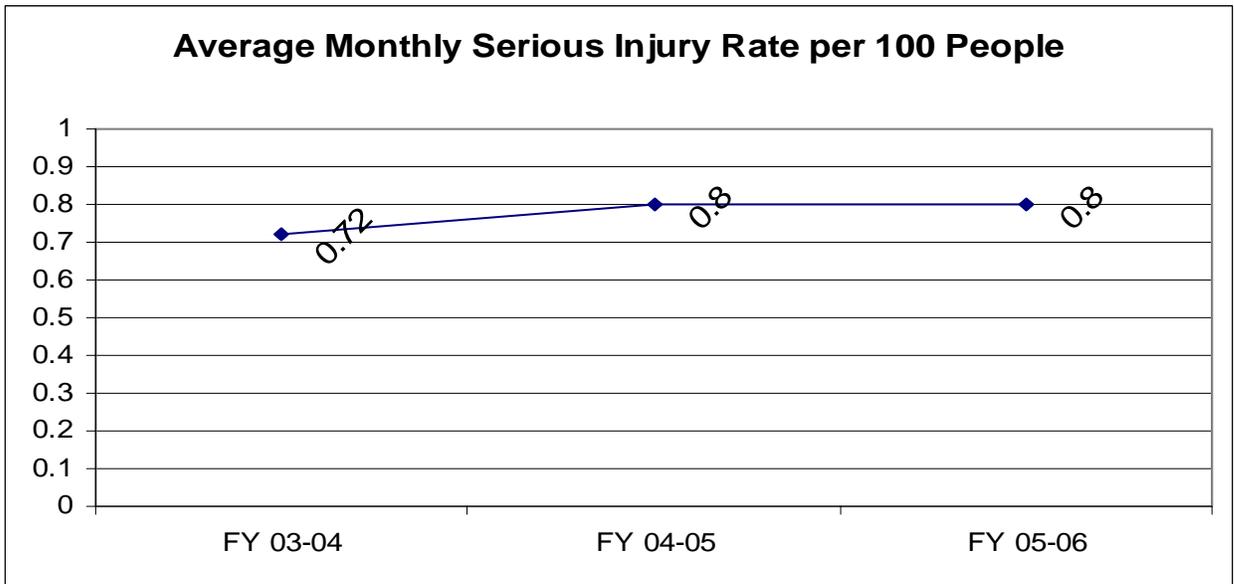
Issued the report: *Compilation and Analysis of Data on Falls for the Period: July 2004 through June 2005*. This trend analysis of falls included specific recommended actions intended to prevent falls and serious injuries among DMRS service recipients.

Chart 17: Average Monthly Rate of Incidents per 100 People



As illustrated in the chart above, the average monthly rate of incidents per 100 people increased slightly over the three successive Fiscal Years included in this report. It is believed that a wider scope of incidents reportable to DMRS in the revised provider requirements effective April 1, 2005, as well as tighter controls over incident reporting, greater emphasis on provider management systems for incident management, and increased training and dialogue with providers about incident management systems has led to improved and more accurate reporting and thus, an increase in the incident rate. DMRS will continue to monitor incident reporting each year for trending purposes.

Chart 18: Average Monthly Serious Injury Rate per 100 People



In Chart 18, the average rate of serious injury per 100 people remained steady this past fiscal year, after having risen slightly the previous year. It is important to note that this serious injury rate did not increase while the overall rate of incidents reported to DMRS, as shown in the previous graph, did increase slightly. It is believed that incidents involving serious injuries are fairly consistently reported to DMRS and will not be affected much by marginal changes in incident definitions and general reporting issues. At the same time, DMRS expects an eventual decline in the serious injury rate as a result of prevention efforts. DMRS will continue to monitor the serious injury rate.

The injury rate per 100 people in the population at large, as reported by the Centers for Disease Control in a survey in 1994*, is 23.8 per year. The definition of injury used by the CDC appears to be comparable to the DMRS definition of serious injury.

The rate of serious injuries per 100 DMRS waiver recipients for FY 04-05 was 9.7. The comparable rate was 9.2 for FY 05-06. Thus the occurrence of serious injuries among DMRS waiver recipients in Tennessee is significantly lower than that for the population at large.

*National Center for Health Statistics. (1995). Current estimates from the National Health Interview Survey, 1994. (DHHS Publication No. [PHS] 96-1521). Hyattsville, MD: Centers for Disease Control and Prevention. Episode of injury defined as each time a person was involved in an accident causing injury that resulted in medical attention or at least a half day of restricted activity, which is comparable to the DMRS definition of serious injury.

The Investigation System

FY 05-06 has been a time of enhancing, refining, and clarifying processes started or improved in the previous year, such as Reportable Staff Misconduct, Abuse Registry referral, the Investigation Review Process and the Substantiated Investigation Search Function (originally called the Perpetrator Search Function). A new Director of Investigations was hired in October 2006 and a part time position has been established to develop and implement quality assurance measures for Protection from Harm initiatives. The Director of Investigations and the Protection from Harm Quality Assurance Director have worked in concert to improve the processes resulting in more timely and comprehensive investigations. Other initiatives and changes that were made during the last fiscal year include:

- Reportable Staff Misconduct investigations/reviews became a significant part of the DMRS Protection from Harm system. This category of reportable incidents is designed to identify problematic staff behavior before harm occurs. Providers have taken aggressive corrective personnel actions when Reportable Staff Misconduct is validated, e.g., training, reassignment, suspension or termination as deemed appropriate. (see chart)
- Protection from Harm has developed an internal tool to level the actions of each provider employee who is substantiated for abuse, neglect or exploitation based on the egregiousness of the event. This process has helped to clarify and standardize which substantiated individuals are referred to the Abuse Registry Committee for consideration for placement. Types of substantiated cases referred to the Abuse Registry Committee have been consistent over the past year. Once referred and recommended for placement, individuals begin a due process prior to placement on the Registry. (see chart).
- The *Substantiated Investigation Search* function development included a massive cleanup of names in the DMRS database, as well as a partnership with DMRS Information Systems. The intent of this function is for provider agencies to check current and potential staff to determine if an employee or potential employee has any substantiation/s for abuse, neglect or exploitation. Where a substantiation history is identified, DMRS will research and determine the level of egregiousness of the event and will then notify the provider of the results. This system (which is now in use internally) is being piloted and once fully operable, it is expected to quickly identify repeat offenders who move from agency to agency or who work at multiple agencies. Implementation of a statewide system will be pursued in FY 06-07, in conjunction with the further development of the Division's Integrated Services Information System (ISIS).
- The Investigation Review Committee process was refined and a protocol was updated to provide guidelines for agencies and other entities to make requests for full reviews of the final investigation report when the results are questioned. The committee has reviewed 42 cases over the past year and has upheld findings in 60 percent of these cases.
- A statewide benchmark of 95 percent for timeliness of Final Investigation Reports and Reportable Staff Misconduct reports has been established. This benchmark has been met consistently during the past fiscal year.
- DMRS Protection from Harm and TennCare staff began monthly meetings to address issues related to DMRS investigations, as well as other Protection from Harm challenges.

These meetings have been very successful in terms of resolving issues and developing a greater understanding of each agency's systems.

- Protection from Harm provided "Investigating Serious Incidents" (Labor Relations Alternatives) training to DMRS regional medical staff. Medical staff are frequently called upon by investigators to interpret complex medical reports when cases involving medical neglect are under investigation.
- A Family Contact Protocol was developed and implemented to ensure that all investigators make timely and appropriate contact with family members and/or legal representatives when an individual is alleged to be a victim of abuse, neglect, or exploitation. This contact is designed to apprise the family or legal representative of the investigative process and to glean any pertinent information regarding the individual in relation to the investigation.
- Rates of neglect continue to remain higher than any other investigated event. In efforts to further identify the cause of neglect, four categories were established: treatment, supervision, training, and communication. Establishing how people are neglected is essential in developing effective preventative measures.
- The Office of Investigations began meeting monthly with DMRS Regional Investigators Follow Up staff to revise protocols and provider requirements for plans of correction. This ensures that consistent and timely follow-up was occurring across the state. A self-assessment tool was developed for providers as a guideline for writing and implementing plans of correction.
- A Protection from Harm staff retreat was used as an opportunity to conduct investigator training on "Weighing of Evidence."
- DMRS is participating in bimonthly meetings with other public entities interested in the protection of vulnerable persons. These meetings, facilitated by Tennessee Bureau of Investigations, include individuals from Health Related Boards, Mental Health, and Adult Protective Services to address topics of concern such as criminal background checks, protection laws of Tennessee, and public relations issues with local law enforcement agencies.

Chart 19: Rate of Substantiated Investigations of Abuse, Neglect and Exploitation per 100 People

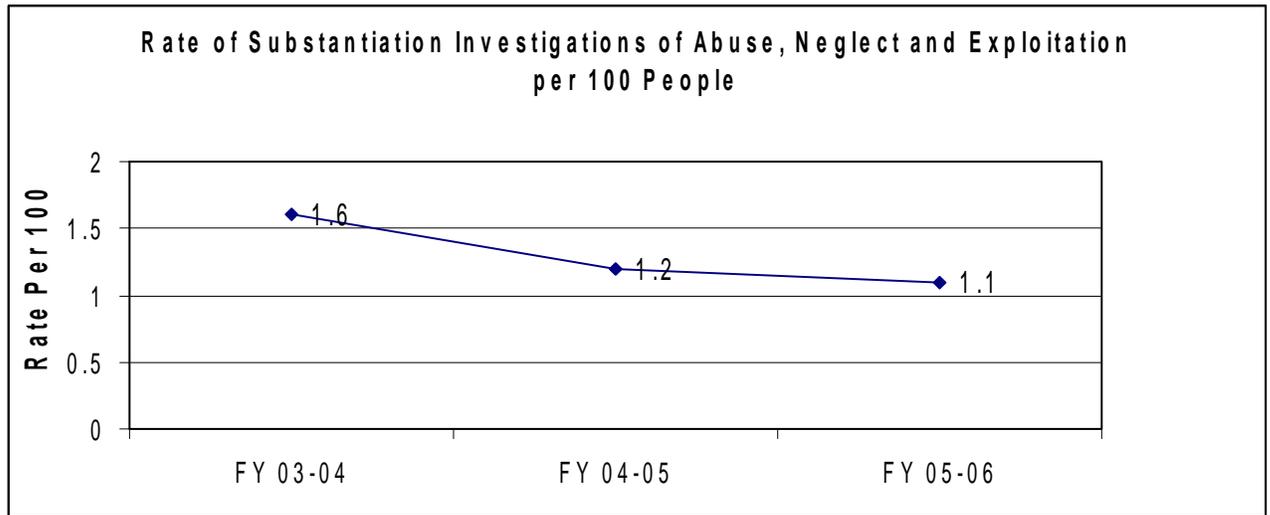
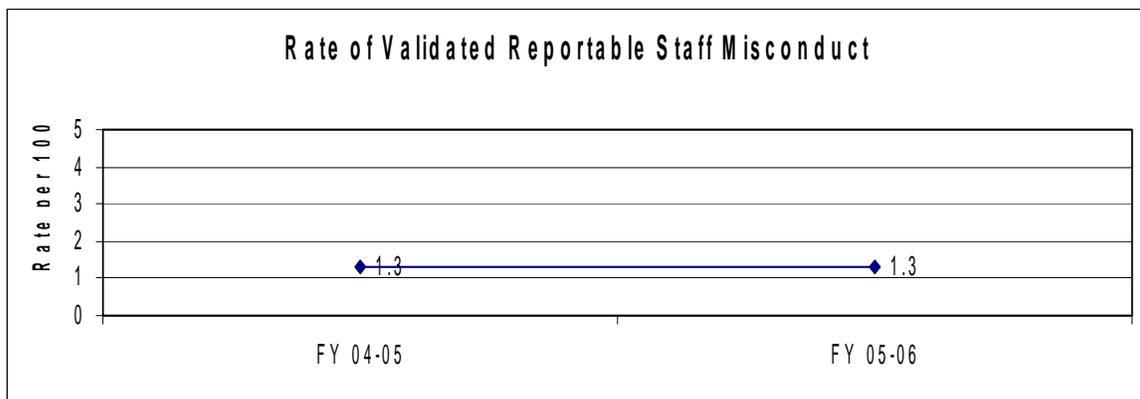


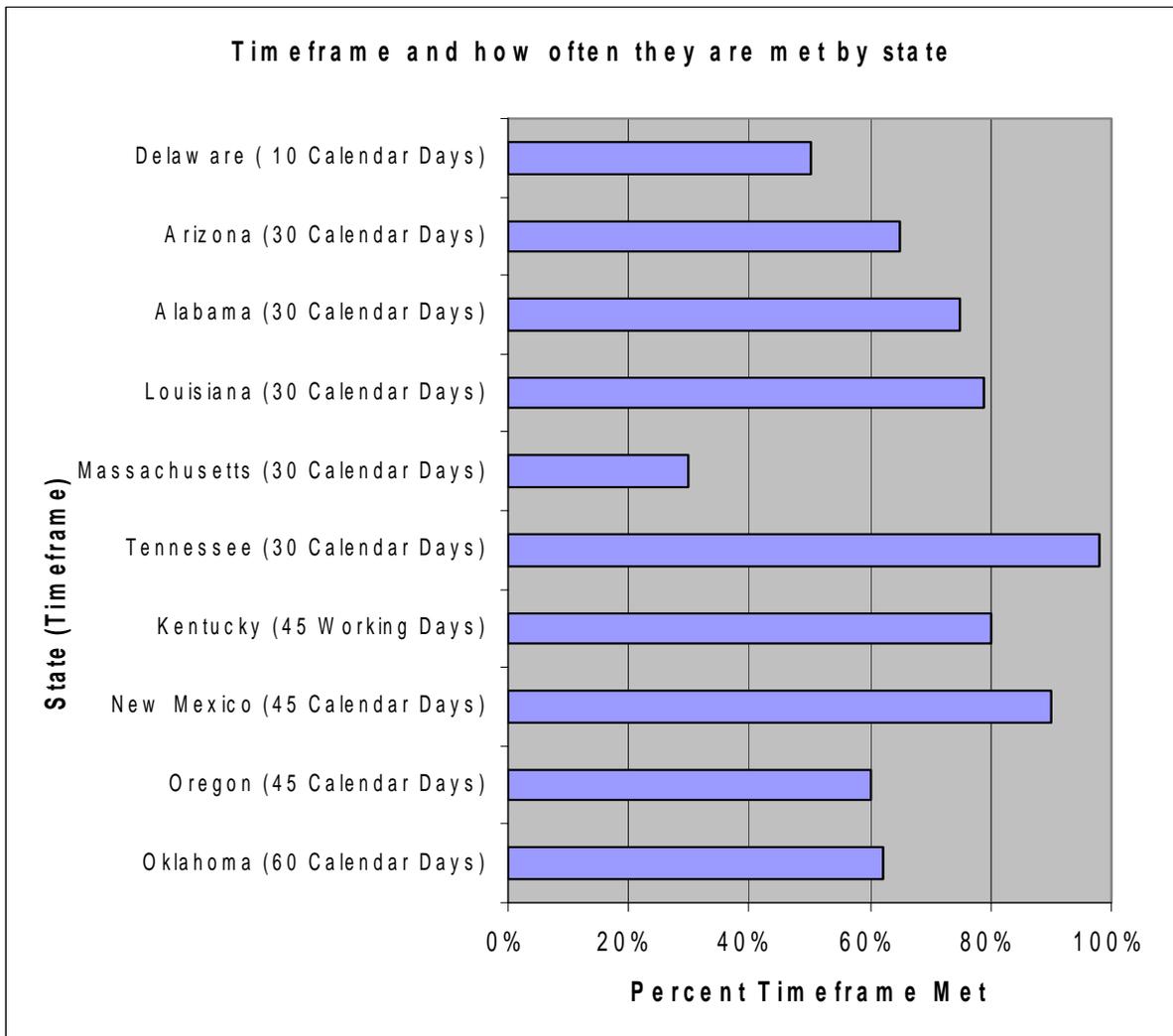
Chart 20: Rate of Validated Reportable Staff Misconduct Investigations per 100 People



DMRS is committed to ensuring that all service recipients receive basic protections and the systems established by Protection from Harm effectively demonstrate that commitment. Investigations ended the fiscal year by piloting an internal “screening” tool to further refine incident classification, again ensuring that true allegations of abuse, neglect, or exploitation were being addressed appropriately.

In early November, DMRS received a copy of the New Mexico Research Project, a tool designed to compare and contrast states’ incident and investigation systems for people with developmental disabilities. Twenty-six states participated in answering questions regarding protection from harm service systems. Results indicated that Tennessee is doing very well as timeliness of investigations surpassed all other states surveyed. Ways to report abuse and neglect were measured for all states and Tennessee scored sixth highest and tied with four other states for second highest number of incident reporting categories required. It is apparent that this study displays effective and concentrated efforts by DMRS to improve protection from harm initiatives for people with developmental disabilities in Tennessee.

Chart 21: Incident Management across the United States*



As indicated in chart 21, Tennessee ranks highest in timely completion of investigations despite one of the smallest amount of time allotted for completion. * Used with Permission from the New Mexico Incident Management Bureau. Taken from, "Incident Management Across the US," by Luke E. Calhoun. 2005.

Clearly DMRS is on the right track for putting systems in place to ensure that service recipients can enjoy a quality of life that includes a measure of safety and security. DMRS Protection from Harm staff will continue to refine and promote initiatives that dually serve to protect service recipients and to alert agencies about potential risks.

Providers

Service Needs Analysis and Provider Recruitment

DMRS recognizes the importance of developing and sustaining a network of qualified service providers. Each year the Division holds forums around the state to identify gaps in the provider network and to develop strategies to address identified needs.

During FY 05-06, DMRS met the challenge to develop new providers and to expand the existing provider network to serve an impressive number of people who have been waiting for services. The chart below summarizes the numbers of new providers who were enrolled and/or existing provider agencies that expanded the types of services provided.

Table 4: Provider Increase by Type

Service	Number of Providers in FY 04/05	Number of Providers in FY 05/06	Percentage Increase in FY 05/06
Supported Living	138	154	10%
Residential Habilitation	58	69	16%
Family Model	41	50	18%
Day Service – Facility Based	142	130	-9%
Day Service – Community Based	141	151	7%
Day Service – Supported Employment and Follow Along	131	142	8%
Personal Assistance	173	181	4%
Respite	64	89	28%
Behavioral Respite	3	4	14%
Physical Therapy	79	78	-1%
Occupational Therapy	80	76	-5%
Speech, Language, Hearing	64	65	2%
Medical Equipment/AT	53	62	15%
Dietician	42	46	9%
Dentist	69	73	6%
Orientation and Mobility Therapy	4	5	20%
Nursing Services	108	119	9%
Vision	1	1	0%
Behavior Services	222	279	20%

Chart 22: Percentage Increase in Service Providers FY 05/06

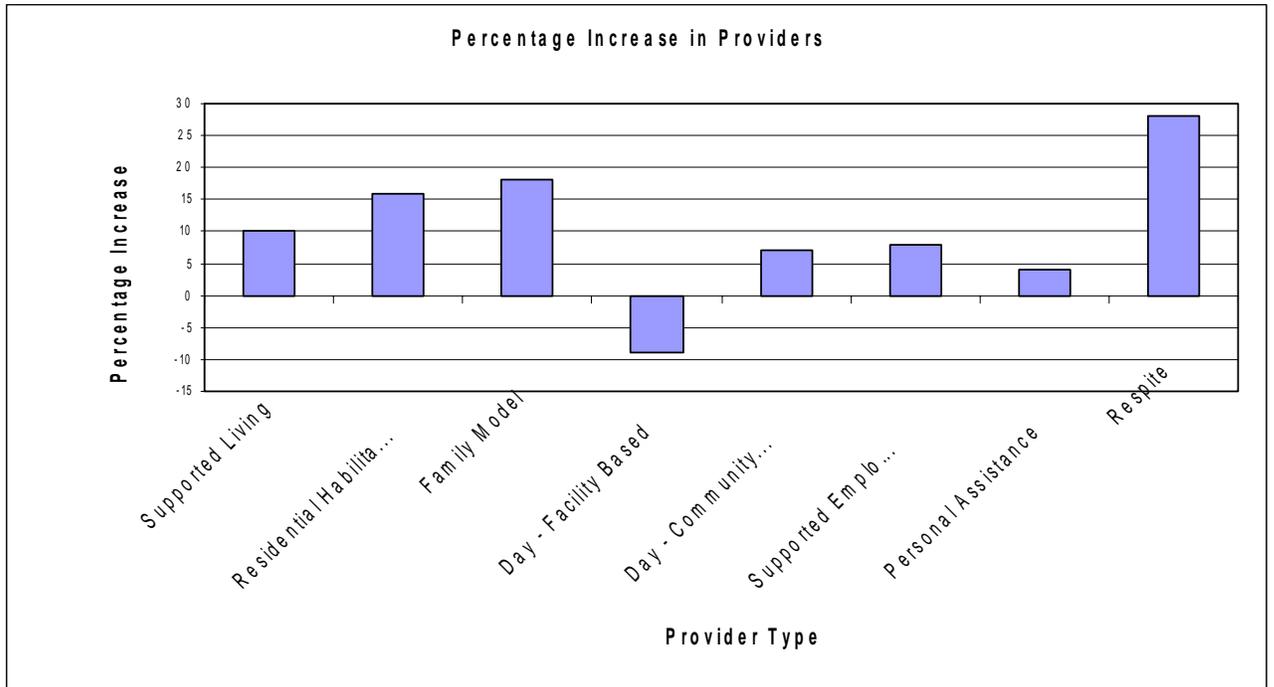
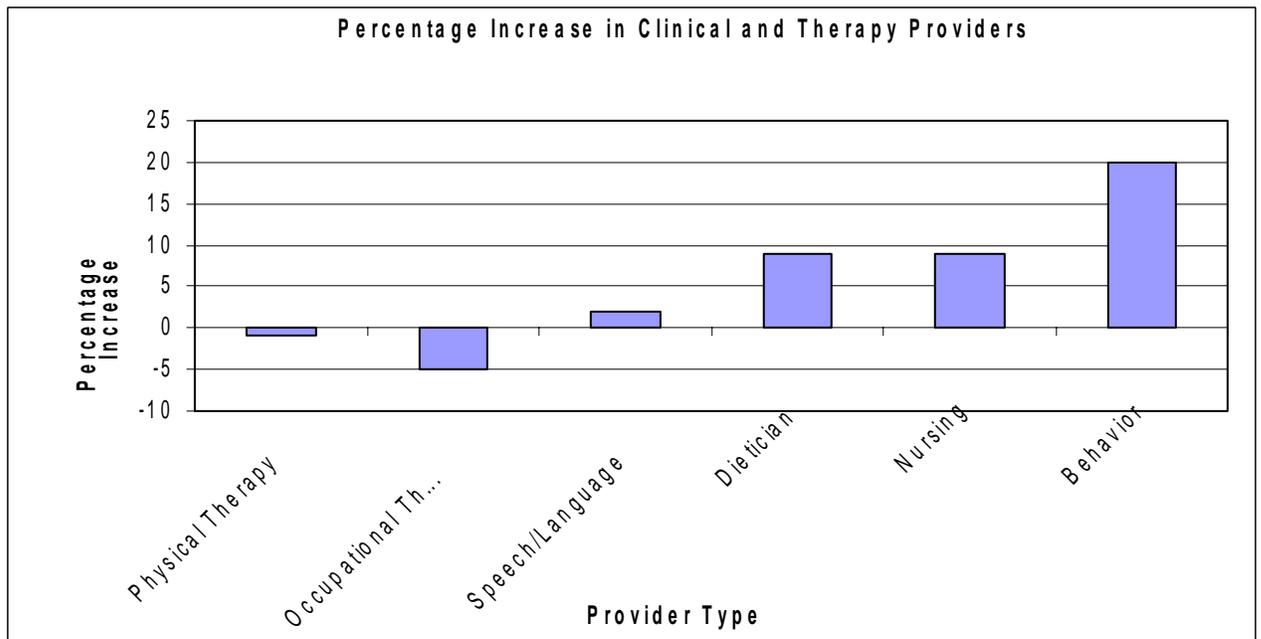


Chart 23: Percentage Increase in Clinical and Therapy Providers FY 05/06



Employment Opportunities for People with Developmental Disabilities

Since 2002, the number of adults in day services who are employed in competitive jobs in the community has increased by nearly 40 percent. DMRS believes in the power of work - it not only provides income, but more importantly it provides the opportunity to belong, contribute, and be a valued part of a team. A job must meet the needs, wants, and desires of the job seeker. By taking the time to explore ideas and to listen, employment specialists can develop job opportunities that fulfill the job seeker's expectations.

Since 2001, representatives from Community Rehabilitation Providers, families, advocates, consumers, the Tennessee Council on Developmental Disabilities, and the Tennessee Division of Rehabilitation Services have comprised the Tennessee Employment Consortium (TEC). TEC has been instrumental in collaborating with DMRS to develop Tennessee's capacity to create opportunities for integrated employment in the community. Simultaneously, DMRS also continues to partner with stakeholders to develop options for other meaningful day activities.

Tennessee's Early Intervention System

DMRS participates in the provision of early intervention services in the state of Tennessee under the rules and regulations formulated in Part C of the Individuals with Disabilities Act (IDEA). Part C of IDEA requires each state to ensure the implementation of a statewide, comprehensive, coordinated, multidisciplinary, interagency system of services for infants and toddlers with disabilities and their families. According to the federal legislation, the lead agency, Department of Education, is responsible for coordinating resources from all entities in the state to assure the appropriate provision of early intervention services.

An array of 37 service providers licensed through the TDMH/DD in cooperation with the Department of Education (DOE) make up Tennessee's Early Intervention System including TEIS district offices, the TN Department of Health, Tennessee Infant-Parent Service (TIPS), other DMRS providers, public/private providers, and various local advisory boards. DMRS agencies serve about half of the children eligible for Part C services.

During 2005-2006, a new, comprehensive self-assessment monitoring process, referred to as the Continuous Improvement Monitoring Process (CIMP), was implemented in conjunction with Office of Early Childhood, Division of Special Education, and Tennessee Department of Education. The new system measures compliance with the rules and regulations set forth in the Individuals with Disabilities Education Act (IDEA), Part C. Each agency assesses its performance based on a variety of data sources, analyzes the data collected, and based on the analysis, determines compliance with outcomes and indicators. A one-year Program Improvement Plan is developed when an agency determines that its compliance on a particular cluster is less than 100 percent. This continuous cycle of examining performance and making adjustments based on data is critical to service quality for the children and families receiving services. As of June 30, 2006, 22 of the 37 EI agencies had completed at least one cycle of examination.

The Governor's Office of Children's Care Coordination (GOCCC) began coordinating an analysis of Tennessee's Early Intervention services, in collaboration with the child serving departments including DMRS. The Children's Cabinet (DMRS is represented by Deputy Commissioner Stephen Norris) endorsed the analysis and dedicated resources to accomplish a comprehensive review which will lead to recommendations to strengthen the service system statewide.

The analysis focuses on:

- Services for children, birth to age three, in the context of services from birth to five years
- Administration at the state and local levels, and
- Financing of activities that fall within the coordination responsibilities of the Department of Education, the lead agency for the Federal IDEA, Part C program.

Recommendations will be presented to the Children's Cabinet in January 2007.

The early years of a child's life are crucial for cognitive, social, and emotional development. Therefore, it is important that we take every step necessary to ensure that children grow up in environments where their social, emotional, and educational needs are met. Costs to society of less than optimal development are enormous and far-reaching. Children who grow up in environments where their developmental needs are not met are at an increased risk for compromised health and safety, and learning and developmental delays. Failure to invest time and resources during children's early years many have long term effects on the foster care, health care and the education systems. Therefore, it is in the public's interest to ensure that children develop in safe, loving and secure environments. (Child Development Studies Team, 2005)

Conclusion

Fiscal Year 2005-2006 was a year of expansion of the service delivery system in order to address the requirements of the Waiting List lawsuit, the Clover Bottom and Arlington Developmental Center lawsuits and general refinement in the operations of the DMRS. The system continues to need even more refinement in order to meet the of an expanded service system. Already, DMRS has plans for FY 06-07 and beyond to continue to fine tune the work of the Division which include the following:

- **ISIS:** DMRS continues development of an Integrated Services Information System which will include: online, Web-based interface accessible 24/7 to authorized users, a centralized database with real-time updates that contains all consumers served by DMRS, utilization of online forms and document imaging to reduce paper, utilization of system alerts, timeframes, and management reports to monitor status of in-process transactions and maintain accountability across stakeholders and fiscal controls, and a compacted process to provide a more timely and comprehensive financial status of DMRS .
- DMRS is in the process of negotiating the terms of years 3-5 of the Waiting List Settlement Agreement. The terms of this agreement will dramatically impact enrollment into Waiver Services.
- DMRS is developing the Arlington Developmental Center Closure and Community Transition Plan. The plan is an implementation guidance document that describes in broad terms the commitment of the State of Tennessee to assure a safe and meaningful community transition for individuals that reside at the Arlington Developmental Center (ADC). It shall also serve as a long term plan for replacing the current services that ADC offers with resources in the community to meet the needs of individuals with mental retardation in West Tennessee.
- DMRS established a work group to clearly delineate the DMRS expectations of that which constitutes a quality ISP and the actions which comprise the successful implementation of an ISP. Additionally, this work group will develop a methodology for monitoring the quality of ISPs and their implementation along with a mechanism for technical assistance when performance does not meet expectations.
- Statewide workshops for training and technical assistance for implementing the concepts contained in the Quality Improvement Planning Resource Manual.
- Conducting extensive statewide training on the ISP/ISC Planning and Implementation Resource Manual.
- The Four/Three Star recognition program which offers providers public recognition for excellent performance as well as a reduced DMRS Quality Assurance monitoring frequency.
- Revision of the ICAP assessment process to ensure consistent, reliable administration and scoring.
- DMRS will implement an online training system which will improve the integrity of the training curricula by reducing the dependency on the “train-the trainer” process, will allow

staff to complete training requirements on a more convenient basis, and will provide an accurate tracking mechanism for training activity.

- On May 4, 2006, Governor Phil Bredesen signed Public Chapter 604 to amend Tennessee Code Annotated, Title 33, Chapter 5, Part 2, which related to services for persons with developmental disabilities other than mental retardation. Comprehensive home and community-based services do not exist for these persons. DMRS has established a Developmental Disabilities Task Force to conduct a statewide needs assessment, identify the capacity of the system to meet the needs, and develop a plan to provide cost-effective home and community-based services.

The above are but a few of the activities DMRS will be involved in during FY 2006-2007. The challenge of operating within the demands of three Federal lawsuits while complying with requirements of CMS and TennCare will likely place a tremendous amount of pressure once again upon this system. Look for further refinement of the DMRS Service Delivery System as the year progresses based on these pressures as well as from recommendations that develop through the Division's own Quality Management System.

It is hoped that this report has been informative. Questions about any portion of the Report or requests for more information about DMRS can be directed to the Compliance Unit in the DMRS Office in Nashville at:

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