



The State of Tennessee

Department of Finance and Administration

Division of Mental Retardation Services

Annual Report July 1, 2006 – June 30, 2007



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

During Fiscal Year 2006 – 2007, 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. While this past Fiscal Year was mostly a year during which the new Quality Management Systems stabilized, significant progress was made in terms of fiscal clarification. This was especially the case in converting state-only funded people into the Waivers and in determining enrollment capacities. However, even with an emphasis on necessary fiscal management, program improvements were a result of data-based decisions.

This Annual Report is an attempt to summarize some of these improvements. In many cases, the data from Fiscal Year 2006-2007 is compared with the data from the previous two years, which allows for trending patterns. These trending patterns are 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 2006 - 2007

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 2006-2007: A Year of Stabilization

The new Quality Management Systems developed and implemented during the past three fiscal years were stabilized during Fiscal Year 2006-2007. Stabilization means that the glitches discovered during the implementation of the systems were worked out and that data has been collected for long enough time periods that in some cases, trends and patterns are being discerned. Stabilization also means that the chaos that the CMS moratorium made out of Waiver and funding demographics several years ago was almost completely resolved through conversions from State funding to Waiver funding.

Even though the focus of work centered on stabilizing the new Quality Management Systems, several new initiatives were implemented during Fiscal Year 2006-2007. Some examples follow:

- **ISP Quality Improvement Project**
 - A review of two years of Quality Assurance data revealed consistently low scores in the quality of ISPs and in the quality of their implementation. Realizing that the quality of ISPs and their implementation are at the core of an effective service delivery system, DMRS decided to initiate a special project designed to determine the causes of poor ISP quality and poor performance in the implementation of ISPs and to make recommendations for improvement. The Middle Regional Office of DMRS coordinated the project in which a sample of 244 people receiving services were interviewed, which involved 271 different providers, all of which yielded data from a total of 1,156 interviews. Data was collected using an enhanced QA instrument and entered into a specially created database designed to be responsive to a wide variety of information queries. Data analysis has only now just started, but ISP systems managers and Regional

and State-wide Quality Management Committees are expecting long term insight for systems improvements from this treasure trove of information.

- **Quality Improvement Resource Guide:**
 - The Division of Mental Retardation Services has developed a “How To” resource guide to help providers of services to develop effective quality improvement processes. It is recognized that no organization will be absolutely perfect in any given point in time; however, developing and implementing quality improvement planning processes can help ensure timely identification and resolution of issues. The manual has been designed as a practical nuts and bolts guide that can be used as a stand-alone resource, or in conjunction with hands on guidance. Workshops and technical assistance in the area of quality improvement planning are now available to providers from Regional and Central Office DMRS Staff. The resource manual is available on the Division’s web page.

- **ISC/ISP Planning and Implementation Manual:**
 - The Division of Mental Retardation Services, in partnership with a number of stakeholders, has developed a Planning and Implementation Resource Manual. The manual focuses on the planning process from enrollment through implementation. The manual is posted on the Division’s web page and Regional Office Staff are available to provide training and technical assistance in the area of planning and implementation.

- **Budget**
 - The Governor’s Budget for FY 06-07 was \$26.5 Billion. Of this amount, \$841,704,900 was allocated for the DMRS’s operating budget. Actual expenditures totaled \$840,705,700 or .12 percent under budget. The Governor’s budget also included \$19 million in capital appropriation for the construction of 25 residential four-bedroom community-based ICF-MR homes and \$310,000 to develop master plans for the Arlington and Clover Bottom Developmental Centers' campuses.

- **Quality Assurance**
 - Quality Assurance tools have continued to be utilized, now three years since initial implementation, to provide a measurement of systemic performance and to identify opportunities for improvement.
 - Processes for reduced Quality Assurance monitoring frequency, based upon a combination of quality indicators, have been implemented as an incentive and reward to those providers demonstrating a trend in providing quality services and supports.
 - Inter-rater reliability exercises have continued to assess agreement among surveyors in regard to Day-Residential providers. Resulting data has been utilized to identify areas needing attention in increasing reliability and consensus in utilizing Quality Assurance tools.

- **Employment Opportunities**
 - DMRS has a profound obligation to ensure that *every* individual has the opportunity to discover their potential. This obligation demands the very best of our perseverance and imagination.
 - This year, the Tennessee Employment Consortium developed *The Discovery Process as it Relates to Employment*. This process outlines how time is to be spent in community-based day services to help people discover if they want to work; and if so, what type of work they want to do.
 - Our challenge is to help people discover their talents. When people find something at which they are good, they also find a sense of belonging – a sense that many people with disabilities have seldom experienced in the community. People yearn to be “a part of” and not “apart from” life.

- **Family Support**
 - 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.
 - 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 continues to research funding options for these individuals.

- **Communication**
 - The DMRS Communications Office placed strong emphasis on image in 2007. Much of the Division’s general collateral material was updated and a new look was created for a more progressive image. Responsible for the Division’s website, www.state.tn.us/dmrs, much work was done in expansion and establishing the site as a strong resource for consumers and providers. The DMRS newsletter, “Personally Speaking” is recognized as one of the premier publications in the state system. It has welcomed contributions from outside sources, and enhanced its content appeals to all stakeholders. The office was again active in the Division’s annual town hall meetings, conducting pre-event publicity and media relations. Communication with the news media increased in the past year with the office maintaining a strong relationship with outlets, presenting the Division in the best possible light, and protecting the privacy of the persons the Division serves.

- **Information Technology**
 - Information Technology (IT) implemented a legacy system enhancement that enabled the Division to better manage the State's cash flow and capped a two-year effort to increase collection of federal waiver reimbursement dollars from

92% to 99.2% of funds paid to community providers. In addition, in conjunction with a third-party consultant, IT completed design work toward replacing part of that legacy system with a web-based, centralized data application that will support authorization for services (cost plans), billing, federal reimbursement and payment to providers for services.

- **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. Recognition, mentoring and credentialing programs are in place and growing.

- **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.
- During Fiscal Year 2006-07, OCFS participated in numerous statewide special education and advocacy forums as presenters of DMRS information. Furthermore, OCFS conducted seventy-eight (78) statewide family training sessions that were held in the evenings and on Saturdays with an overall attendance of 422 persons. The purpose of these trainings was to educate persons with mental retardation and their families on various topics that included: how to access the DMRS service delivery system, what consumers and families should expect from their assigned state case manager, and what it means to be on the DMRS Waiting List for services. OCFS staff co-presented many of the trainings with family members and/or staff from the ARC of Tennessee

- **CMS Review of the SD Waiver**

- In December 2006, CMS requested evidentiary-based information from the state of Tennessee concerning service provision in the Self-Determination Waiver. This methodology for monitoring waiver programs is relatively new for CMS and states that provide waiver services. It is built around the State's addressing several assurances related to the provision of quality services and supports and submitting information to CMS for their off-site review. Per the CMS request, Tennessee responded with information in February 2007, that addressed the areas specified.
- In June 2007, based upon its review of Tennessee's evidentiary package submission, CMS recommended and the State accepted technical assistance from Thompson (Medstat), regarding CMS expectations for waiver quality assurance. As a result of this technical assistance, Tennessee resubmitted its evidentiary-based information to CMS in October 2007, and at the time of finalization of this report, was awaiting response from CMS.
- In addition to the evidentiary request and response, Tennessee also developed a renewal request for the Self-Determination Waiver. This was submitted to CMS in late September 2007, with a projected date of implementation of January 2008.

Status of Federal Lawsuits

United States v. State of Tennessee (Arlington)

In February 2007, the Western District Federal Court approved a Settlement Agreement, which resolved several lingering legal issues and which paved the way for progress to be made in resolving the Arlington Lawsuit. Among other things, the Settlement Agreement set forth the conditions for new additions to the Class, established a closure plan for Arlington Developmental Center, and clarified expectations for certain community-based programmatic areas such as support coordination. Since the time of the approval of the Settlement Agreement by the Court, a Closure Plan has been written and conditionally approved by the Court Monitor, and implementation plans are being developed for the Settlement Agreement as a whole.

People First v. Clover Bottom

Following the Court's March 2006 decision that Greene Valley Developmental Center was in substantial compliance with the institutional conditions and protection from harm sections of the Settlement Agreement, DMRS turned its attention to bringing the Harold Jordan Center into compliance with the Settlement Agreement. During the past year, significant progress has been made toward that end. The motion to have the Harold Jordan Center case dismissed was filed with the Court on June 29, 2007. On the community side of the Lawsuit, DMRS continues to implement its Quality Management System and to measure provider performance using its Quality Assurance instruments. A process for matching up DMRS QA data with Lawsuit compliance expectations will need to be developed.

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

The Settlement Agreement for the Waiting List Lawsuit requires that, after the first two years of implementation, the parties are to work out the details of what needs to happen for years three, four, and five. During Fiscal Year 2006 – 2007, meetings between the parties, some of which were even mediated toward the end, were held but with no results. As a result, both plaintiffs and defendants have filed motions with the Court in an effort to bring clarity to what happens next since the implementation activities of years one and two have been completed. During Fiscal Year 2006 – 2007, the net effect in change to the Waiting List was an increase of 1226 people.

The People DMRS Serves

People in the Community

DMRS provides a wide range of services contracting with approximately 1300 service providers. Many of the people receiving services live in their home community and receive services from the local community. 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 to more than 7200 individuals. 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.

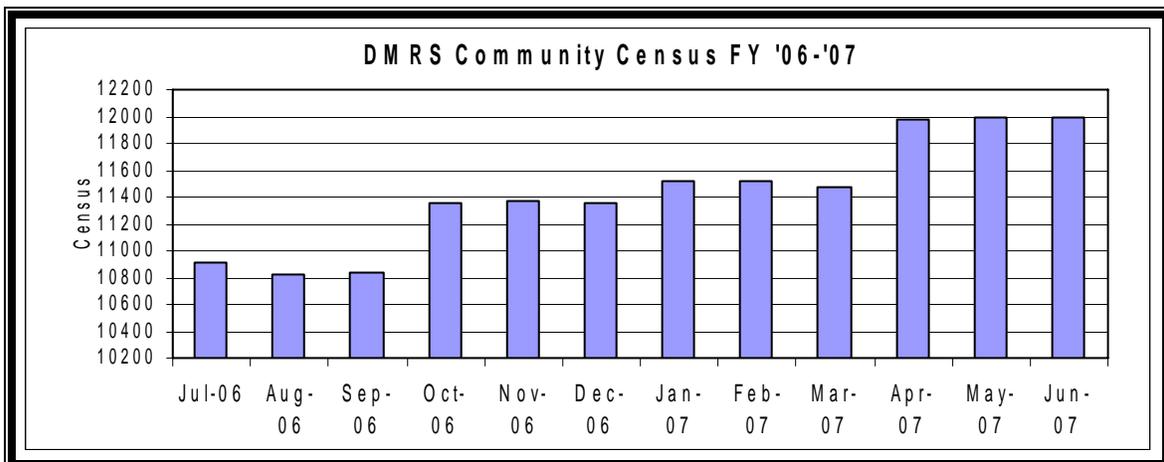
The state government also provides funding for more than 4100 people in the Family Support program. Local organizations, such as the United Way, and individual contributors provide additional support to local service providers. The Medicaid Waiver program, however, is by far the largest source for funding services.

The following table gives specific monthly census numbers of persons enrolled in each DMRS community program during FY 06-07. 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-06	Aug-06	Sept-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07
Statewide Waiver	5934	5947	5953	5959	5959	5966	5970	5965	5974	6005	6032	6026
ADC Waiver	208	206	206	213	212	213	217	218	225	224	224	225
SD Waiver	896	904	907	914	917	925	932	937	954	973	1002	993
State Funded	803	793	786	775	760	759	736	698	649	614	564	547
Family Support	2988	2988	2988	3503	3503	3503	3657	3657	3657	4170	4170	4170
Census Total	10829	10838	10840	11364	11351	11366	11512	11475	11459	11986	11992	11961

Chart 1: DMRS Census by Month for Community Waiver Services



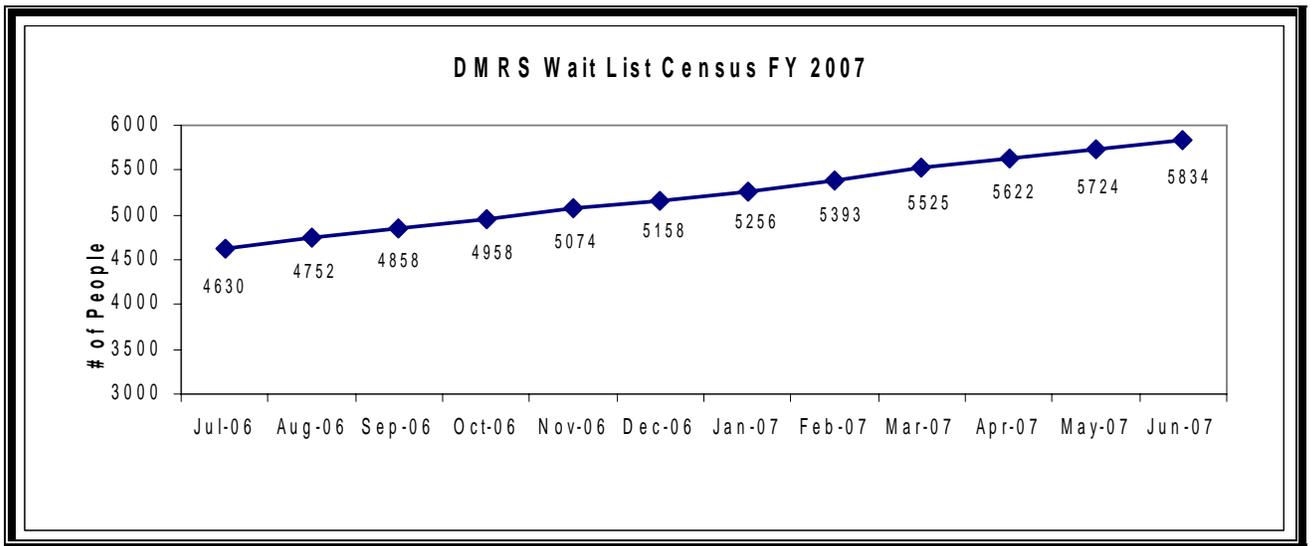
The chart shows an increase in persons served over the year. This is attributed to several factors. First, the lifting of the moratorium on admissions allowed for new people to be enrolled. Second, the new Self-Determination Waiver program increased service rolls considerably.

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.

During FY 2006-2007, the Division saw a net increase in the waiting list of 1226. The following chart shows the wait list census for the fiscal year.

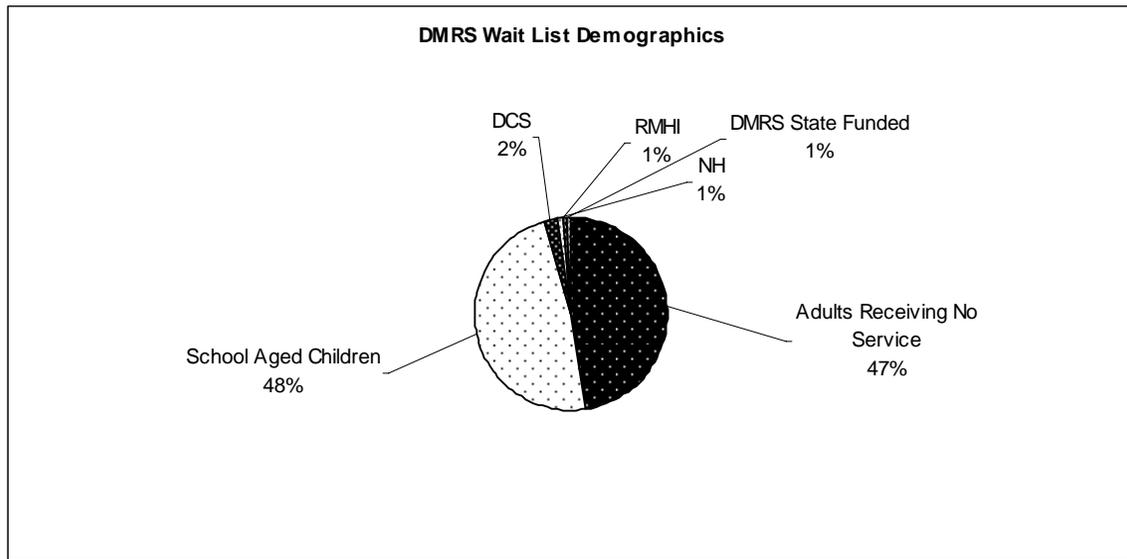
Chart 2: DMRS Wait List Census by Month for Waiver Services



Waiting List Demographics

The Division maintains demographic information 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 is broken into populations of Adults with No Services, School-Aged Children, children in custody in the Department of Children Services (DCS), people in Nursing Homes (NH), people in Regional Mental Health Institutes (RMHI), and consumers of DMRS State-Funded Services. The chart below identifies the percentage of those populations on the DMRS Waiting List as of June 30, 2007.

Chart 3: Waiting List Demographics for Waiver Services



Throughout the fiscal year, these same demographic statistics remained relatively the same. 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.

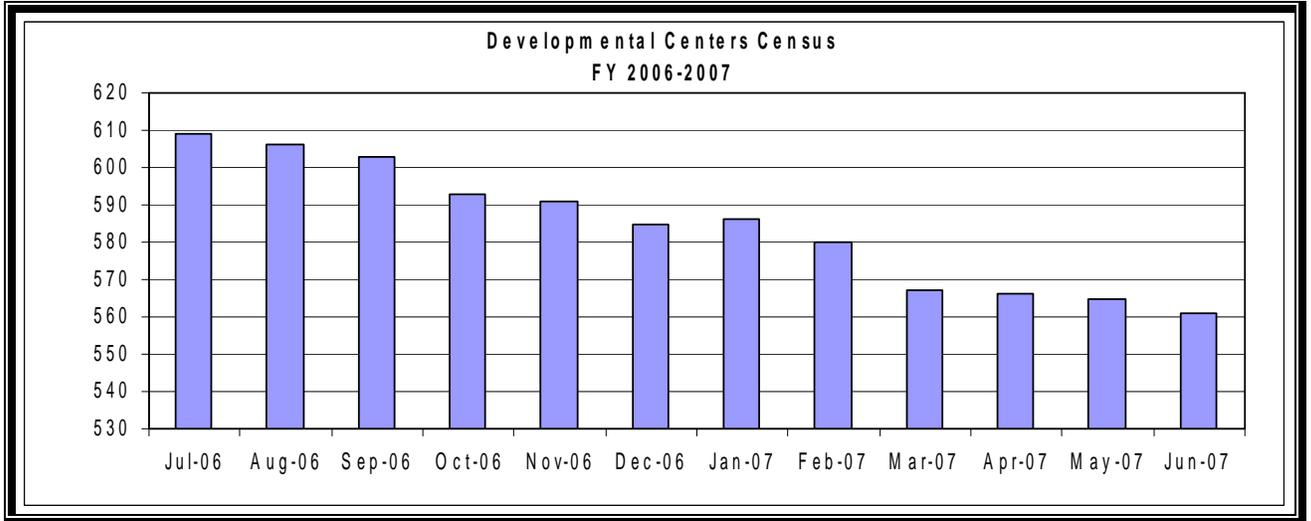
DMRS strives to provide needed support to those who seek services. Each person on the Waiting List is assigned a case manager to coordinate the eligibility and intake process. The Division anticipates that future growth of the Waiting List will continue as public information campaigns are sustained and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

The Division also maintains a waiting list for families needing services through the Family Support program.

People in the Developmental Centers

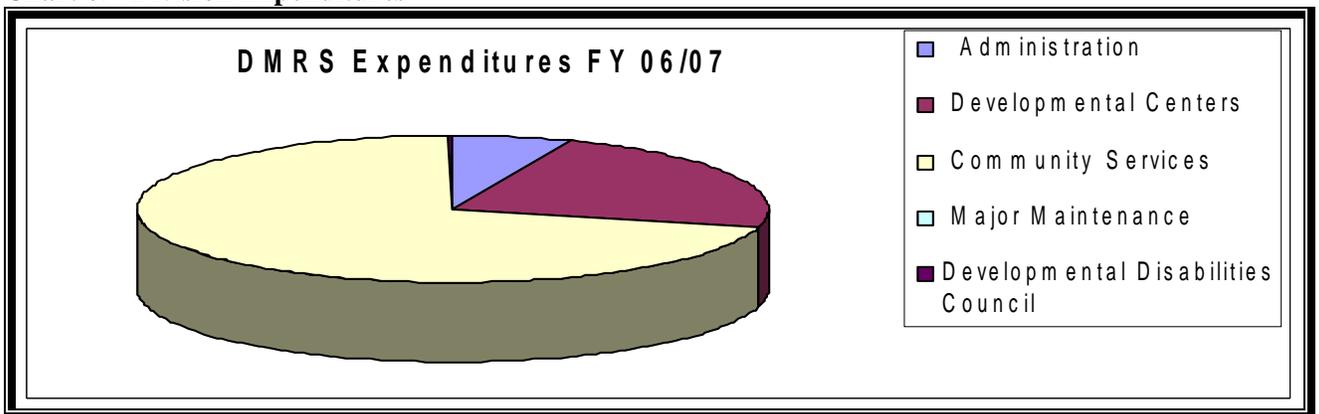
The three Developmental Centers are licensed Intermediate Care Facilities for the Mentally Retarded (ICF/MR) operated by DMRS. They are located in East Tennessee in Greeneville, in Middle Tennessee in Nashville, and in West Tennessee in Arlington. In addition to ICF/MR services, the Developmental Centers 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 06/07, the number of people living at the Developmental Centers declined by 48 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 \$840,705,700 in DMRS expenditures, 70 percent of the money went to Community Services and 23 percent of expenditures for FY 06/07, went to the State's three Developmental Centers.

Quality Management System Activities

The DMRS Advisory Council

The DMRS Advisory Council 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. The Council 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 the meetings and other DMRS staff attend on a regular basis.

The DMRS Advisory Council meets on the second Thursday of each month. During monthly meetings, the Council is provided information about the status of lawsuits affecting DMRS, updates on DMRS projects and initiatives, 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 systemic perspective.

DMRS Office of Consumer and Family Services

BACKGROUND

The DMRS Office of Consumer and Family Services (OCFS), with input from the Family Volunteer Committee, developed training for families on the following topics: What is a Waiver, Eligibility Requirements for the HCBS Waiver, The Application Process for DMRS Services, Benefits of the Waiting List, Rights and Responsibilities, Responsibilities of Case Managers and Finding Available Community Resources. In December of 2006, letters were sent to all persons on the Waiting List about the trainings, including the scheduled dates, times, locations and training topics. Notices were also sent to advocacy organizations and other appropriate State agencies. OCFS staff co-presented many of the trainings with family members and/or staff from the ARC of Tennessee. In total, 78 trainings were conducted statewide between January and September of 2007, with an overall attendance of 422 persons. Furthermore, the trainings were conducted both in the evenings and on Saturdays for the convenience of families.

It should be noted that OCFS conducted this same training in other forums across the State during this same time period (Transition Fairs, Special Education Conferences, etc) however, the data from those trainings will not be included in this report.

SUMMARY

Specific details regarding the family trainings that occurred in each region are outlined below.

In West Tennessee, 20 separate family training sessions were conducted. The trainings were held in Memphis, Germantown, Jackson, Martin, Paris and Union City.

<u>West Tennessee Total Attendance</u>	<u>Average Evaluation Rating</u>
112	4.8 on 5.0 scale

In East Tennessee, 23 separate family training sessions were conducted. The trainings were held in Chattanooga, Knoxville, Greeneville, Johnson City, Morristown and Newport.

<u>East Tennessee Total Attendance</u>	<u>Average Evaluation Rating</u>
86	4.7 on 5.0 scale

In Middle Tennessee, 35 separate family training sessions were conducted. The trainings were held in Clarksville, Nashville, Murfreesboro, Hermitage, Algood, Crossville, Columbia, Lawrenceburg and Tullahoma.

<u>Middle Tennessee Total Attendance</u>	<u>Average Evaluation Rating</u>
224	4.6 on 5.0 scale

ATTENDEE COMMENTS ABOUT THE TRAININGS

The family training evaluation sheet provided a section for attendees to provide comments to the following items:

1. What is one thing that you learned during the training?
2. I really liked this about the training.
3. This could have been done differently during the training.
4. Other topics of interest on which you would like DMRS to provide families training.

Listed below are the overall responses from persons who completed this section:

What is one thing you learned during the training?

The overall comments from attendees who completed this section were that they learned about Consumer-Directed Supports, the Family Support Program, the HCBS Waiver Program, the differences between the category of needs on the waiting list, how to apply for DMRS services, available community/generic resources, DMRS contacts, what DMRS is and what services DMRS provides.

I really liked this about the training.

The overall comments from attendees who completed this section indicated they liked the pace of the training; the information presented; the presentation handouts; the presenters' professionalism, knowledge, and friendliness; that they learned so many different things; that the presenters spent time with each attendee; the presentation was easy to understand; the amount of time and ability to ask questions; the small group setting; snacks and audience input.

This could have been done differently during the training.

There were very few comments given about what could have been done differently during the training. Attendees in Knoxville requested the trainings be conducted at a location other than downtown due to parking costs and the overall problem with downtown parking. One person requested the trainings be completed in one session rather than two (the Saturday trainings were completed in one session), and one person requested that DMRS check the accessibility of the meeting rooms and location.

Other topics of interest on which you would like DMRS to provide families training on.

Attendees who completed this section indicated their interest in having future family trainings on the following topics: community resources including support groups, Legal Matters (i.e., conservatorship, special needs trusts, estate planning), current training held in additional areas across the State and also conducted in the school systems, responsibilities of the school system, supported employment, vocational rehabilitation, job training, Employment First Initiative, developing and implementing ISPs, circles of support, supported living, DMRS services and providers, TennCare Program, DMRS complaint process, DMRS Waiting List, respite care, Self-Determination Waiver and available housing for persons with disabilities.

The DMRS Office of Consumer and Family Services will develop additional family trainings on the topics requested by family members and other stakeholders, including the Family Volunteer Committee, for calendar year 2008.

Real Choice Systems Change Grant

In October 2003, the Tennessee Department of Finance and Administration, Division of Mental Retardation Services (DMRS) was awarded a Real Choice Systems Change Grant through the Centers for Medicare and Medicaid Services (CMS). This grant was contracted to The Arc of Tennessee 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 18 service recipients and people familiar with disabilities to work as interviewers.

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?

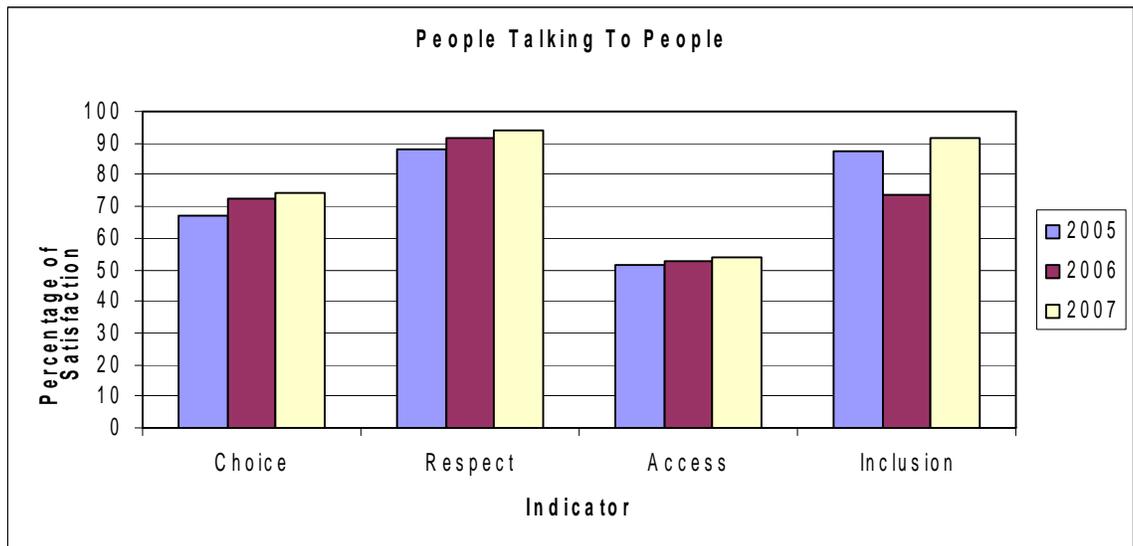
- **Access to Care**
 - Are needs such as personal assistance, equipment, and access to help being met?
- **Community Integration**
 - Can participants participate in activities and events outside their homes when and where they want?

Results

The following chart represents the percentage of “yes – satisfied” answers for the three years displayed. In order to compare data across three fiscal years, answers to survey questions which were “unsure”, gave “no response” or were “not applicable” were not included, and thus reflects a variance in the figures reported in last year’s Annual Report.

Over the past three years, survey data indicates a general rise in the level of satisfaction with services received through Tennessee’s service providers.

Chart 7: People Talking to People Satisfaction Survey Results



Future Plans

The PTP project creates the core of a system of quality assurance and quality improvement measures based on consumers providing pertinent and valuable feedback that result in timely remediation and system-wide quality improvement. PTP hopes to expand and better the lives of all of the individuals served and their families. Beginning FY07-08, the PTP project will track survey results by waiver services. PTP is additionally implementing a survey instrument to administer to persons receiving funding through the Self-Directed Waiver. The project will continue to conduct approximately 1,000 interviews on an annual basis.

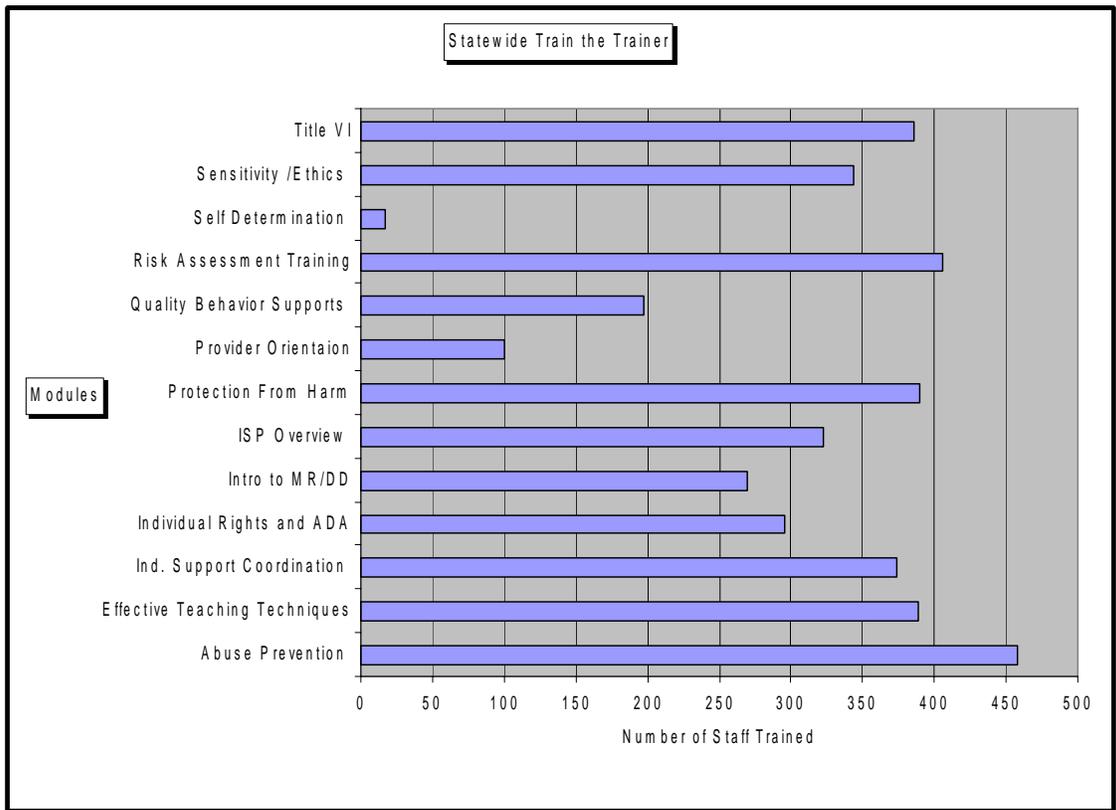
Statewide Annual Training Report

DMRS Implemented Nationally Recognized Web-Based Training Program

- DMRS awarded a contract to College of Direct Support (CDS) to implement and maintain a web-based training program for direct support professionals which includes:
 - Interactive Training Modules reviewed by nationally recognized experts
 - Emphasis on core values, person-centered practices, protection of health and well-being
 - Competency-Based Pre and Post Tests
 - Accessibility 24 hours a day, seven days a week
 - Training Management and other Human Resource Tools, which allow DMRS and organizations to:
 - ✓ Assign required and optional courses and lessons on an individual, organizational and departmental basis
 - ✓ Record and retain transcripts of the progress and accomplishments of each learner, organization and department
 - ✓ Simplify the portability of training records of the individual learner
- DMRS and College of Direct Support representatives conducted regional seminars to introduce the web-based training program to interested stakeholders
- DMRS initiated a pilot program and invited organizations to participate
- DMRS facilitated a workgroup of interested stakeholders to develop a Mentor Guide and Skills Standards Tool for implementing an on-the-job mentoring and assessment process to compliment the web-based training

DMRS Facilitated Train-the-Trainer Sessions

During the 2006/2007 Fiscal Year, DMRS Regional Training Staff facilitated five hundred train-the-trainer sessions for provider organization training staff throughout the state. The chart below represents the total number of provider organizations' training staff who participated categorized by the train-the-trainer session title.



Health Supports

Nursing Services

The activities of Regional Nursing are summarized under three core functions of assessment, technical assistance/training/education and assurance. The associated essential functions are:

Core Function – Assessment

Essential Service

- Review and identify health service needs through surveillance, consultation and data collection
- Monitor and review health status to identify health problems

Core Function – Technical Assistance/Training/Education

Essential Service

- Inform, educate and empower about the basic elements of health needs assessments, a process for setting priorities and options for interventions

Core Function - Assurance

Essential Service

- Link to needed medical and mental health services, and assure the provision of health care through scheduled visits to assigned agencies
- Provide oversight/monitoring of the Medication Administration Training Program for Unlicensed Personnel

Mortality

DMRS Death Review and Death Reporting Key Activities

- Ensure accurate identification and uniform consistent reporting of the cause and manner of *all* reportable deaths.
- Conduct retrospective reviews
Retrospective reviews are meetings that take place after a clinical death summary and investigation is completed, and case information is made available.
- Conduct immediate response reviews
Immediate Response reviews occur shortly after a death, usually of those that are unexpected/unexplained and or suspicious.

Immediate response review will also receive a retrospective review.

This process acts as an instrument for coordinating clinical death summaries and death investigations by the Regional Death Review Registered Nurse and State Investigator.

- Identify and advocate for needed changes in policy and practices and expanded efforts in health oversight and supervision.
- Review findings on the risk involved in the deaths, and advocate for the issues that affect health and safety.

Between July 1, 2006 and July 1, 2007, there were total number 125 deaths, or 0.1% for both centers and the community.

- The mortality death rate for all deaths is 1.4 per 100.

Of the total number of deaths, 12 or 0.02% 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, 113 or 0.01% were individuals who resided in the community

- The mortality death rate for the community is 1.4 per 100.

Table 2: Number of Deaths in Community Services

COMMUNITY

Region	06 Jul.	Aug.	Sept.	Oct.	Nov.	Dec.	07 Jan.	Feb.	Mar.	Apr.	May.	Jun.	Totals
East	2	1	6	2	2	3	3	5	4	4	3	3	38
Middle	8	3	3	5	8	4	2	2	3	2	3	2	45
West	1	2	2	2	2	3	1	3	2	6	3	3	30

The Mortality death rate for community is 1.4 per 100.

Table 3: Number of Deaths in the Developmental Centers

DEVELOPMENTAL CENTERS

Centers	06 Jul.	Aug.	Sept.	Oct.	Nov.	Dec.	07 Jan.	Feb.	Mar.	Apr.	May.	Jun.	Totals
ADC	0	1	1	0	0	0	0	1	1	0	0	0	4
CBDC	0	0	0	0	0	1	0	1	1	0	1	0	4
GVDC	0	1	0	0	1	0	0	0	1	0	1	0	4

The Mortality death rate for developmental centers is 2 per 100

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.

Three Year Death Rate FY 2004-2007

	FY 2004	FY 2005	FY 2006
Developmental Center and Community Death Rate	1.2 per 100	1.1 per 100	1.4per 100
Developmental Center Death Rate	2.3 per 100	2 per 100	2 per 100
Community Death Rate	1.1. per 100	1 per 100	1.4 per 100

- The average death rate for developmental center and community is 1.2 per 100.
- The average death rate for developmental centers is 2.1 per 100.
- The average death rate for the community is 1.1 per 100.

At first glance, the three year death rate average appears steady in years 2004 and 2005. 2006 data demonstrates a slight upward trend, of which DMRS is closely monitoring.

Individuals who died in the developmental centers had an average Physical Status Review Level (PSR) of six (6) as compared to the average PSR Level of four (4) 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. Moderate Risk (Level 4) is a category of risk whose health conditions have been difficult to stabilize and may require attention to antecedents to prevent acute events. High Risk (Level 6) is a category of risk that requires professional nursing intervention more than every two hours in a 24-hour day. Therefore, it is reasonable to expect a higher Mortality death rate due to higher medically fragile population, for those residing in the Developmental Centers Intermediate Care Facilities/Mental Retardation Centers (ICF?MR).

Reference Census Community Wavier 7104, State Funded 726, as of December 31, 2006

Reference Census Community, Waivers, State funded, 7830, as of December 31, 2006

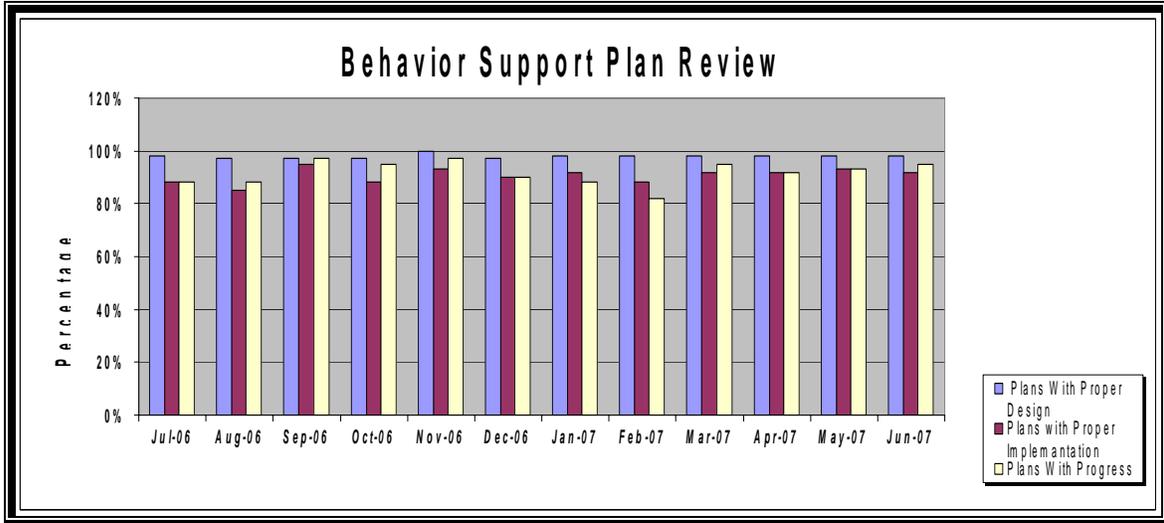
Reference Census Developmental Center 585 as of December 31, 2006

Behavior Supports

A statewide system to review the quality of behavior support plans written 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 on a standard checklist. The average ratings across the 12 month period were 98 percent for proper design (range over months, 97 percent to 100 percent), 91 percent for proper implementation (range: 85 percent to 93 percent), and 92 percent reporting progress in the month reviewed (range: 82 percent to 97 percent). Thus, the benchmark of 80 percent or higher was achieved for this 12 month period.

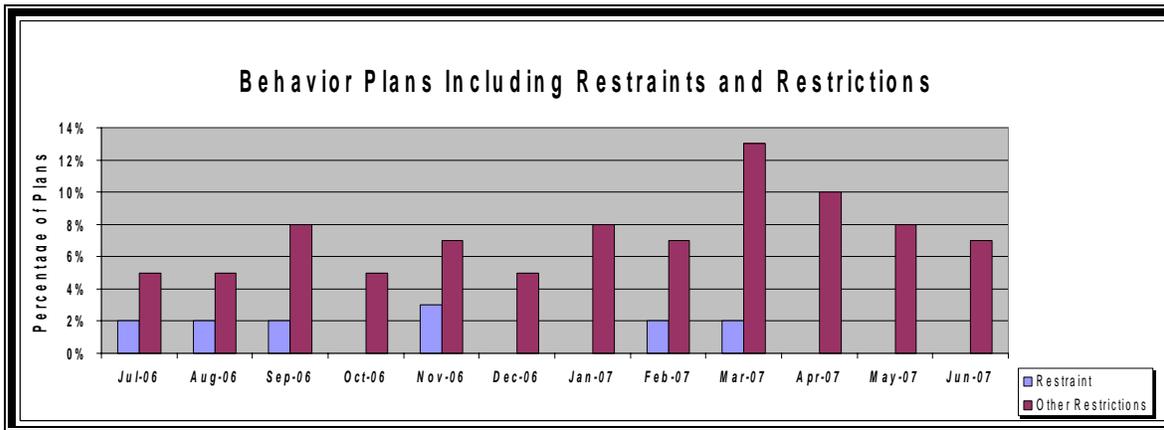
The Regional and State Behavior Analyst Directors are currently piloting an on-site assessment instrument that shall be used to collect information about the quality of the behavior support plan and the delivery of the behavior interventions in the natural settings where behavior services are provided. The expectation is that each month on-site evaluations of a sample of the 60 plans shall be completed.

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. The applications of restraints or interventions involving restrictions of rights remained low and stable. On average, 1 percent of the plans each month reported an application of restraint (range over the 12 months, 0 percent to 3 percent). The average monthly percentage of plans reporting interventions with restrictions was 7 percent (range over 12 months, 5-13%).

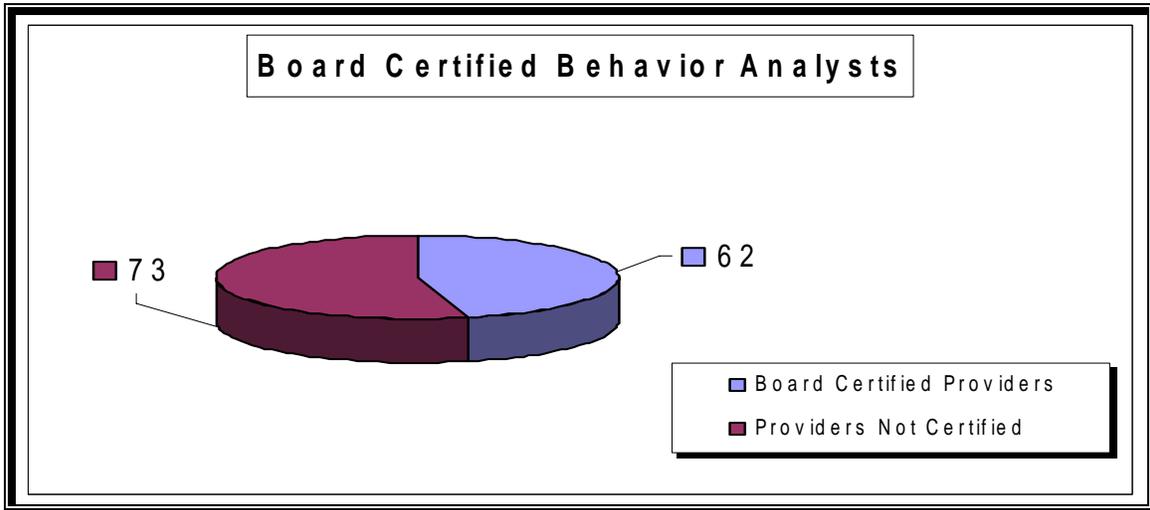
Chart 9: Behavior Plans Including Restraints and Restrictions



Activities continue that are directed toward building and maintaining the professional quality of behavior providers. The number of behavior analyst providers with certification from the Behavior Analyst Certification Board® has increased. Effective June 30, 2007, there were 117 DMRS Approved Behavior Analysts and 18 DMRS Provisionally Approved Behavior Analysts providing behavior services. Of these 135 providers, 62 individuals are currently Board Certified through the Behavior Analyst Certification Board®. The Regional Behavior Staff continues to provide formal orientation and technical assistance to behavior providers, and the State Director

of Behavior Services continues to provide monthly Behavior Seminars for continuing education in each Region.

Chart 10: Number of Board Certified Behavior Analysts Providers



Service System Performance and Analysis

Quality Assurance Reviews

The 2006/2007, fiscal year marks the third year for utilization of the revised Quality Assurance process that was implemented in July 2004. The system has continued to be a critical component of the Quality Management System (QMS) by providing the Division useful performance data by which to make management decisions and facilitate further technical assistance with providers. The fiscal year concluded with cumulative Quality Assurance data from three fiscal years that is available for analysis and utilization in planning.

Utilization of the DMRS Quality Assurance system continued in fiscal year 2006/2007, following relatively minor revision to the review tools' interpretive guidance aimed at enhancing surveyor reliability and consistency. One major tool adjustment in the current fiscal year, similar to the distinction of the three clinical provider types in FY 05/06, was the creation of a separate Quality Assurance tool for assessing compliance of Personal Assistance providers. Survey scoring instructions were also modified to include provisions for achieving a Proficient rating of performance and specific Domain 2 (Individual Planning and Implementation) scoring requirements for providers of Individual Support Coordination were established to reinforce the importance of that Domain.

The most significant revision to the Quality Assurance system during the past fiscal year was the development and implementation of criteria for reduced monitoring frequency, referred to as Three Star and Four Star achievement. This system allows providers to skip one annual Quality Assurance review if established criteria for performance are met. To achieve reduced monitoring, providers must have a history of achieving Exceptional or Proficient on Quality Assurance surveys, achieve compliance on Domains 2 and / or 3 for certain types of providers, pass

established indicators of quality relating to protecting service recipients from harm, and must have achieved Quality Tier status if the provider serves Remedial Order class members.

As with the revised process implemented in 2004, up to ten QA Domains continued to be assessed in FY 06/07, 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 ten Domains, QA tools include a series of Outcomes applicable to the various provider types: 27 Outcomes for Day-Residential providers, 20 for Personal Assistance providers, 13 for ISC providers, 13 for Behavioral Clinical, 16 for Nursing Clinical, and 13 for providers of Therapy services.

While providing an overview of the DMRS service delivery system, Quality Assurance findings have continued to be utilized to facilitate discussion and change. Special reporting has been provided to identify strengths, as well as areas needing improvement.

Review of Data Resulting from QA Review in Fiscal Year 2006/2007

The data that follows is representative of the variety of surveys conducted in FY 06/07, for the following provider types:

- 121 Day-Residential providers
- 15 Personal Assistance
- 22 ISC providers
- 25 Behavioral providers
- 6 Nursing providers
- 47 Therapy providers

The following charts represent the distribution of performance rating categories regionally and by provider type in FY 06/07.

Chart 10: Performance Ratings by Region

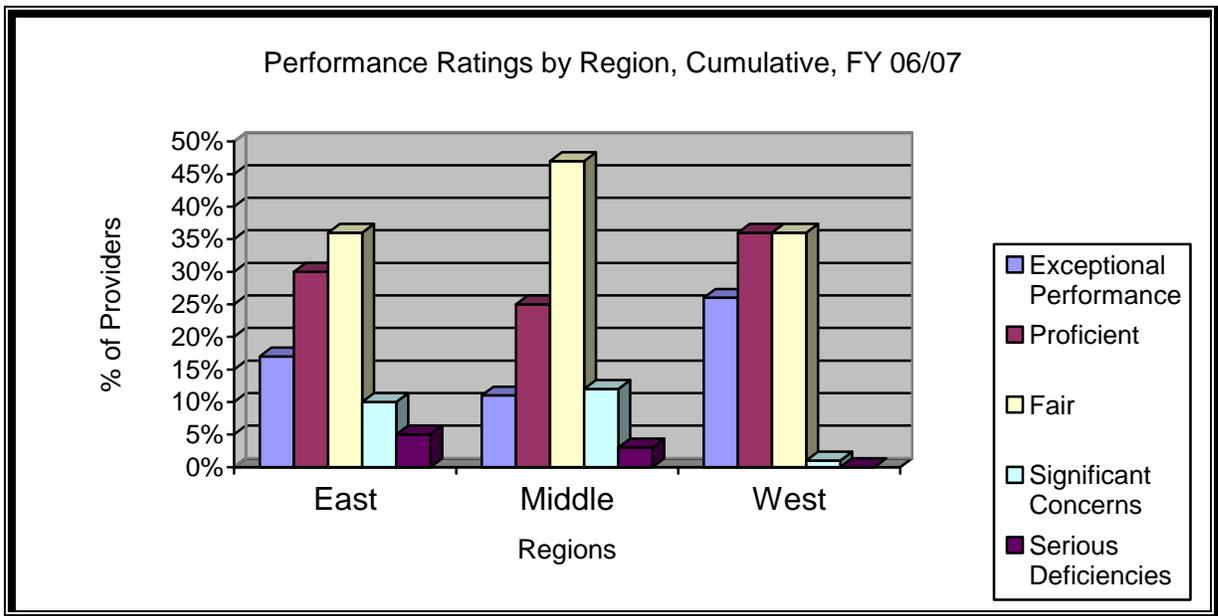
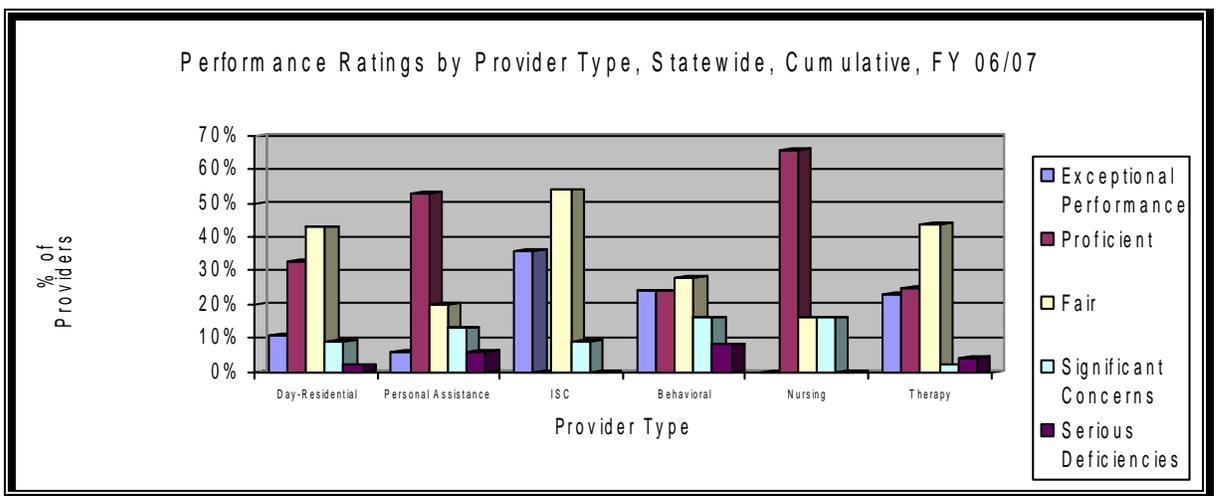
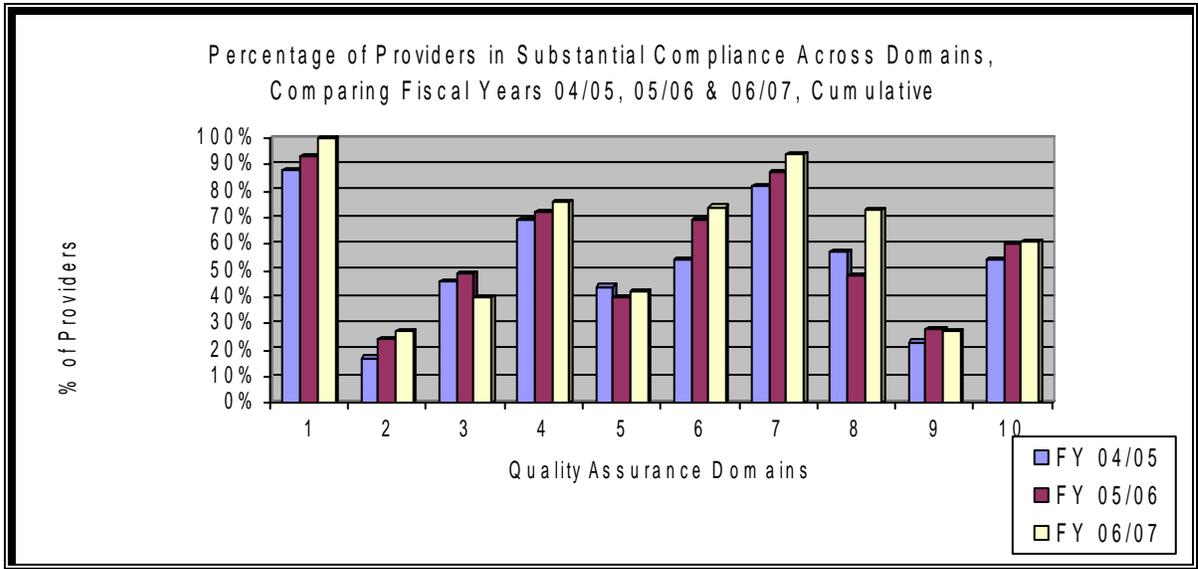


Chart 11: Performance Ratings by Provider Type



Improvement is noted during the past fiscal year among 80% of the Domains reviewed cumulatively statewide, when comparing performance of providers in achieving Substantial Compliance between fiscal years '05/06 and '06/07. The chart that follows provides a comparison of performance between fiscal years '04/05 and '06/07.

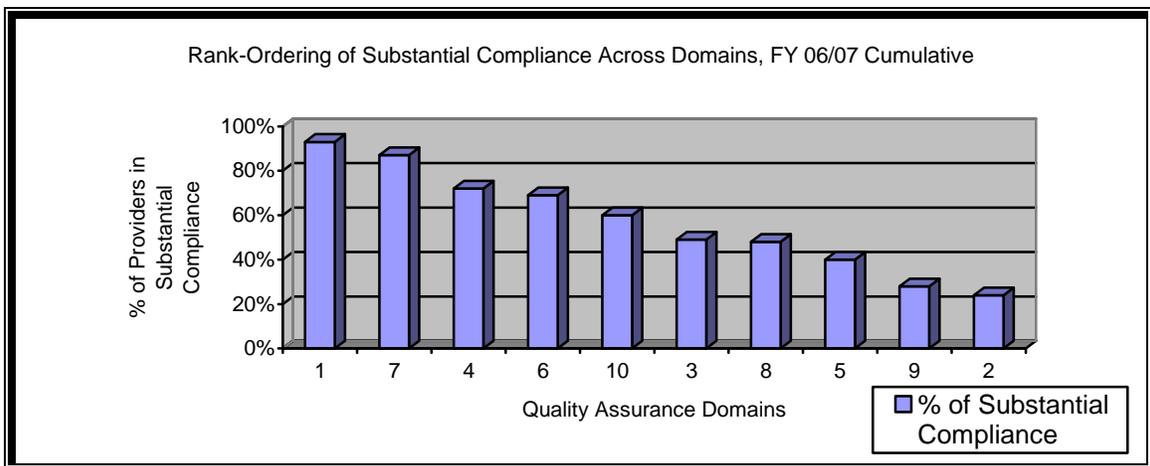
Chart 12: Percentage of Providers in Substantial Compliance



The most significant progress noted during the past year has been in Domain 8 (Opportunities for Work), from 48% of providers in Substantial Compliance in FY 05/06 to 73% in FY 06/07. Domains 2 and 9 continue to be the focus of attention by the statewide Quality Management Committee, as they are typically low performers across a variety of provider types. Of note in the graphic above is that six Domains show continued progress across the three years represented: Domains 1, 2, 4, 6, 7 and 10.

The following chart displays the rank-order of Substantial Compliance performance on QA Domains across all provider types and regions in FY 06/07.

Chart 13: Rank-Ordering of Substantial Compliance Across Domains



Throughout the past fiscal year, numerous Outcomes and Indicators have continued to be reviewed by special interest groups, as well as by the statewide Quality Management Committee. The Quality Assurance system continues to be an integral component of the DMRS Quality Management System, providing the department with valuable information on provider performance and systemic trends.

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 06-07. 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 Fiscal Year 2006-07, the Complaint Resolution System continued to make significant progress in establishing complaint resolution systems in each agency across the State. A statewide analysis indicates that over 98% of service providers have established complaint resolution systems and have complaint resolution coordinators and systems that are fully operational. This illustrates commitment to the DMRS overall philosophy of assisting service recipients, their families, legal representatives, paid advocates and other concerned citizens to resolve complaint issues at the most direct level possible. Providers are now addressing complaint issues, keeping records and working to resolve complaint issues at the provider level. During the period of 2006-07, many significant new aspects have been incorporated into the Complaint Resolution System:

- The Complaint Resolution System continues to operate a web-based tracking system, which encompasses all three geographic regions and allows for timely monitoring of complaint issues.
- On May 1, 2007, the Complaint Resolution System published its first Operations Manual, which has been distributed to each DMRS Regional Office. All Complaint Resolution staff have been completely trained on the use of the manual, and it has become a valuable tool for the Complaint Resolution System.
- Client satisfaction surveys are completed each month on ten percent of all complaints filed with DMRS statewide. During 2006-2007, 45 satisfaction surveys were completed; only one complainant expressed dissatisfaction on the manner in which his complaint was handled. The Complaint Resolution Director met face-to-face with that complainant and resolved the issue to his satisfaction.
- The Complaint Resolution Director conducts a face-to-face interview with each service recipient who files a complaint in order to complete a satisfaction survey. During 2006-07, ten service recipients filed complaints; all ten indicated that they were satisfied with the resolution of their complaints.
- The Complaint Resolution System coordinated compliance efforts with the Quality Assurance survey teams to monitor the progress of all statewide providers in establishing Complaint Resolution Systems. Data indicates that 98% of all statewide providers have operational Complaint Resolution Systems, which includes identifying a coordinator, data collection materials, utilization logs and proof of letters sent out to their service recipients and family members making them aware of and inviting them to use the provider's Complaint Resolution System.
- The statewide Director of Complaint Resolution meets each month with the Regional Complaint Resolution Coordinators and Regional Deputy Directors to discuss issues, provide training and review ideas, which will continue 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 whose issues have already been resolved.

- The Complaint Resolution System has a benchmark goal to resolve 90% all complaints within 30 days, to the satisfaction to the complainant. For Fiscal Year 2006-07, the complaint resolution average was 98% resolution of all complaints within 30 days. The average for Fiscal Year 2005-06 was 90% resolution of all complaint issues within 30 days. The complaint resolution system continues to strive for long-term resolution of complaint issues to reduce recidivism and increase satisfactory results for recipients and their families. The Regional Complaint Resolution Coordinators enhanced their efforts to work more closely with providers and increased face-to-face contacts with complainants, which ultimately increased the effectiveness of resolving complaints within 30 days.
- In 2006-07, there were a total of 342 complaints resulting in 391 issues that were addressed by the Complaint Resolution Coordinators. 75 additional issues were referred to other agencies to resolve via investigations by DMRS, APS or other DMRS regional office units. The overall goal is to make sure that each complainant is correctly referred immediately to the proper area responsible for assisting the complainant with his/her issues.
- The Complaint Resolution System implemented a new strategy for 2006-07, called Intervention. The analysis of staffing issues indicated that there were some long-standing negative relationships that had developed between providers and consumers that arose over staffing problems. The end result was that providers and consumers were indiscriminately stopping services with each over the disagreements. The Complaint Resolution Coordinators have been involved in resolving 50 of these situations in this fiscal year. All of the Complaint Resolution staff have completed Mediation, as well as Investigations training. It is the goal for 2007-08, to increase interventions and to also work to resolve chronic issues in the areas of environmental modifications and community-based transitions.
- Staffing, ISC and Environmental concerns comprised over 50% of all complaint issues in 2006-07. New strategies and policies are being developed statewide to improve the delivery of services in these areas. Specifically, the areas of Personal Assistance and the process of making environmental modifications were highlighted as problematic, and management teams are developing new strategies to improve these areas.
- Complaint Resolution staff continue to resolve any complaints referred by TennCare, and there were eight complaints resolved this year with TennCare. There have been no open complaints with TennCare for the last six months of 2006-07. Complaint Resolution staff continue to meet with TennCare staff once monthly as part of the DMRS/TennCare Partners system.
- Annual meetings between Complaint Resolution Coordinators and providers have been scheduled for the beginning of 2007-08.

Chart 14: Statewide Rate of Complaint Issues per 100 People

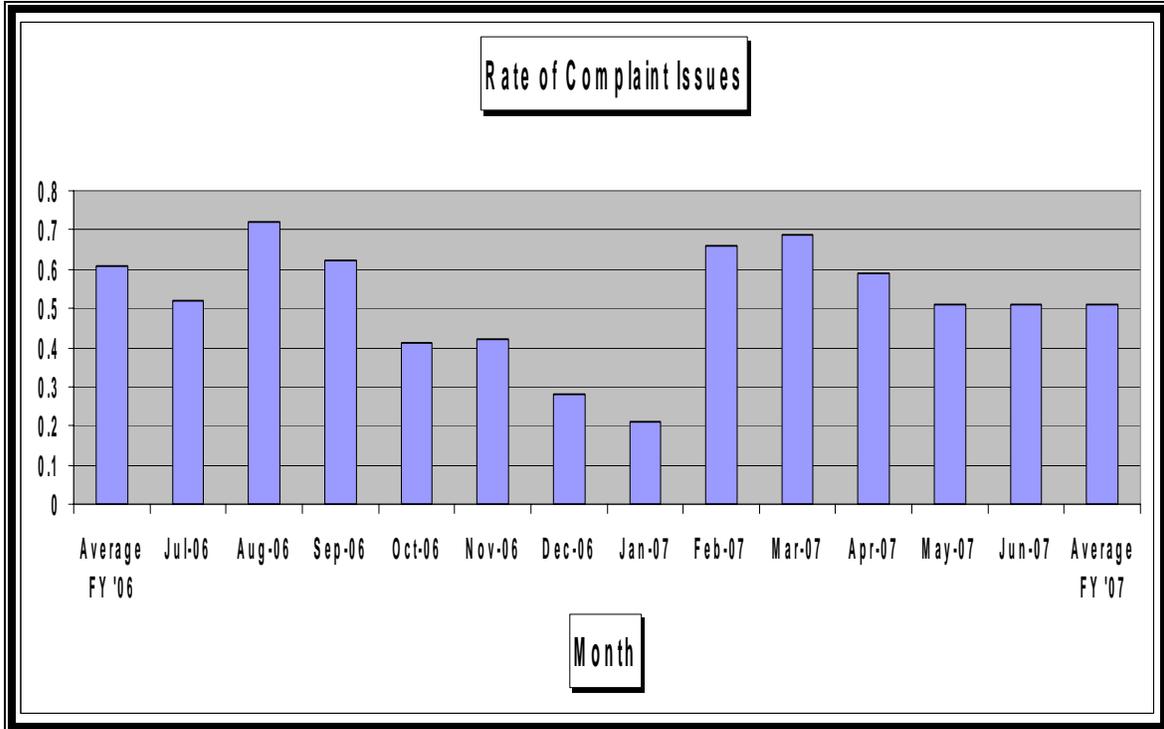


Chart 15: Complaint Issues by Category 06/07

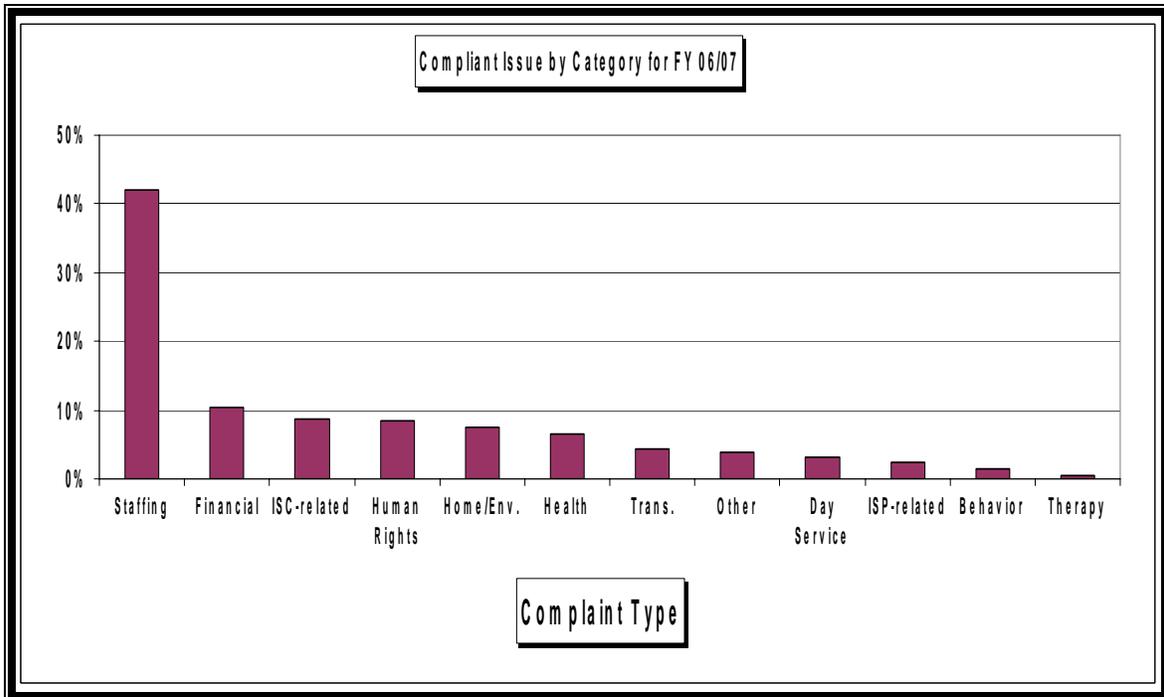
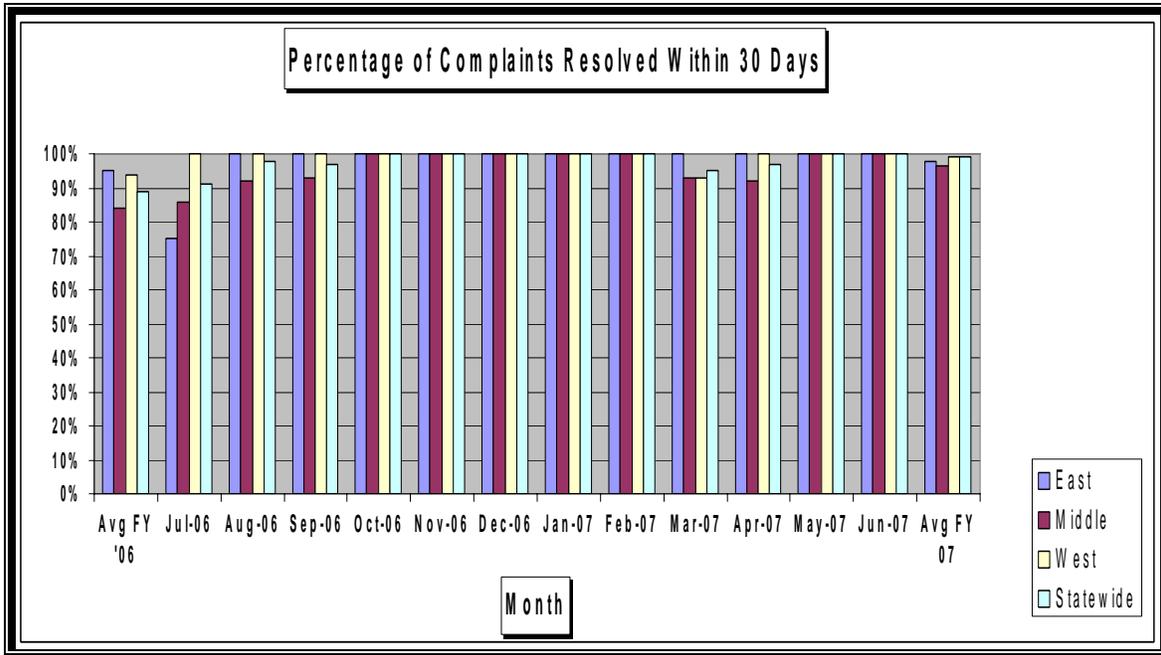


Chart 16: Percentage of Complaint Issues Resolved within 30 Days



The Incident Management System

Incident Management is an integral part of the overall DMRS Protection From Harm system. Since May 1997, service providers have had specific requirements pursuant to all of the types of incidents DMRS defines as “Reportable”, which are essentially all allegations of abuse, neglect, exploitation, and staff misconduct, as well as all medical, behavioral, and psychiatric incidents, and all accidents that require an “external” intervention such as an emergency room visit or a call to the police. (Investigations of allegations of abuse, neglect, exploitation and other staff misconduct are covered in the separate Investigations section.)

The most recent revision of incident reporting and management requirements became effective in April 2005, when the DMRS Provider Manual was promulgated. Most pertinent to this report, the scope of medical and misconduct incidents reportable to DMRS was expanded. There was no revision to the definition and classification of injury severity.

For service providers, DMRS requires that the staff person witnessing or discovering the incident ensure that a written incident report form is forwarded to both the responsible service provider and to DMRS. The service provider is also required by DMRS to implement incident management processes and to maintain personnel sufficient to review and respond to all Reportable incidents. The service provider is required to ensure that the incident and the initial response to the incident are documented on the incident report form, to review all provider incidents weekly (to identify possible additional management actions to address the incident and prevent similar future incidents), and to organize all incident information sufficient to identify at-risk service recipients, as well as other trends and patterns that could be used in provider-level incident prevention planning.

All incidents received by DMRS are reviewed for completeness of information (with follow-up as needed) and classified according to written criteria and definitions before they are entered into an electronic database.

During FY 06-07, 10,659 incidents were entered into the DMRS Incident & Investigation database. DMRS also continued to develop the incident reporting process by implementing an electronic system that converts faxed report forms to e-mails that can be efficiently forwarded to all of the DMRS Protection From Harm staff who need the information.

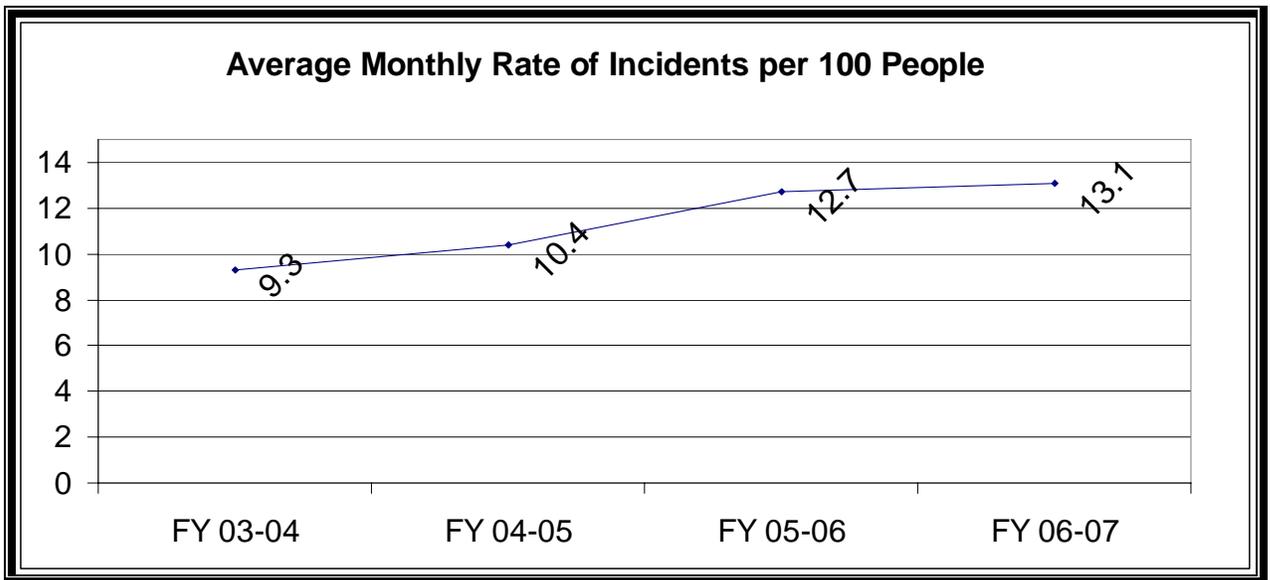
The DMRS Incident & Investigations database:

- Generates “alerts” about specific incidents that are e-mailed to designated DMRS management and specialists for follow-up as needed.
- Generates regular summary reports to designated DMRS management and specialists, and to the DMRS Regional and Statewide Quality Management Committees.
- Generates incident information for regular reports to external entities, such as TennCare and CMS.
- Generates incident information for other internal DMRS trend identification, such as individual service recipient risk, service provider risk, and identification of high risk types of incidents (e.g., data on injuries from falls for the annual fall trend study).

Other incident prevention activities completed during FY 06-07:

- DMRS Prevention From Harm staff attended a three-day training session with presentations by national experts on forensic analysis of injuries and approaches to interviewing persons with disabilities.
- Quarterly provider Incident Management Coordinator training & information sharing sessions were continued in each of the three DMRS regions.
- In coordination with other DMRS and service provider staff, DMRS Protection From Harm staff organized and ensured completion of a focused risk assessment of an at-risk service recipient in each region. This activity identified ways to improve the integration between case management and other service provision during the risk assessment process, as well as ways to best train staff on this process.
- Ensured that service provider follow-up was implemented for all at-risk service recipients who were identified by DMRS through the “Vulnerable Persons” project and the annual trend study of falls.
- Completed the report: **Compilation and Analysis of Data on Falls for the Period: July 2005 through June 2006**. This trend analysis of falls included specific recommended actions intended to prevent falls and serious injuries from falls among DMRS service recipients.
- Fall prevention training, which identifies individual and environmental risks for falls, was conducted for 527 service provider staff (management, as well as direct support staff).

Chart 15: Average Monthly Rate of Incidents per 100 People

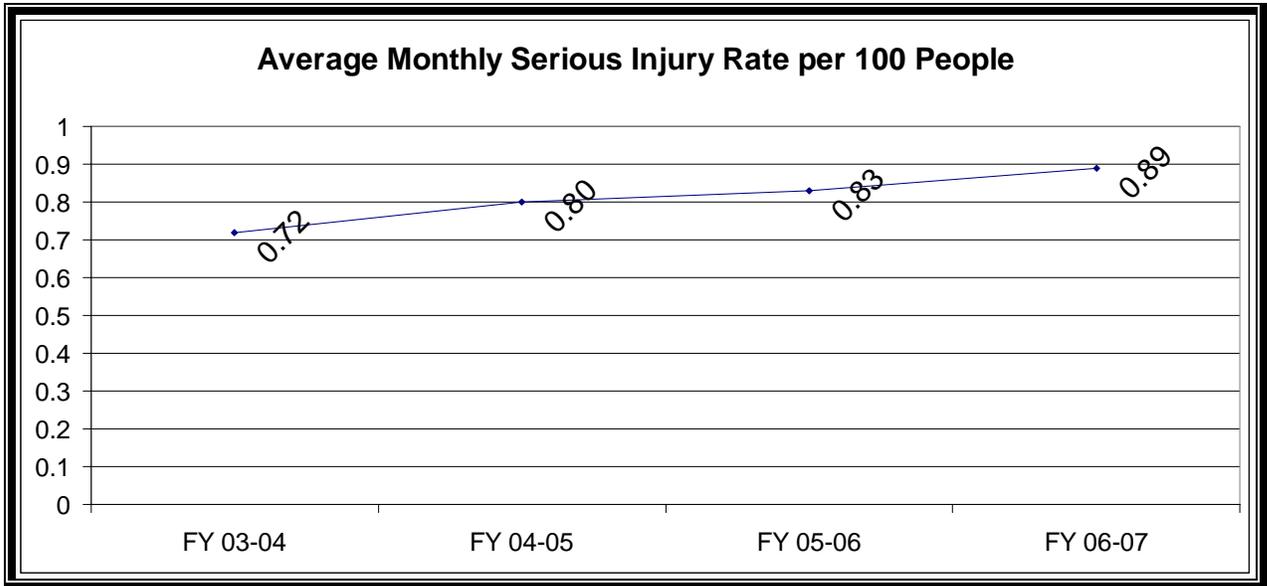


From Chart 15 above, the rate of incidents increased approximately 22 percent between FY 04-05 and FY 05-06, but the increase was only approximately three percent between FY 05-06 and FY 06-07. The incident reporting rate has essentially continued at this higher “plateau” during FY 06-07.

Most of the increase in the monthly rate of Reportable Incidents over the past four Fiscal Years is attributed to FY05-06. This large change in rate during FY 05-06 is believed to be associated with the greater scope of incidents that became reportable to DMRS effective April 1, 2005. (These new requirements were in place only the last three months of FY 04-05, but for the full twelve months of the two succeeding Fiscal Years.) Other factors considered to more generally contribute to the overall increase in incident reporting are 1) tighter controls over incident reporting (including audits of suspected under-reporting where indicated), 2) greater emphasis on provider incident management systems, and 3) increased training and dialogue with providers about incident management systems.

DMRS will continue to monitor incident reporting each year for trending purposes.

Chart 16: Average Monthly Serious Injury Rate per 100 People



From Chart 16 above, it is apparent that the rate of serious injuries (0.89 per 100 service recipients per month for FY 06-07) is much lower than the rate of incidents in general (13.1 per 100 service recipients per month). Only 6.8 percent of incidents resulted in a serious injury in FY 06-07.

Also, the average monthly rate of serious injuries per 100 people rose slightly in FY 06-07, after having remained relatively steady the previous year. The average increase of 7.4% per year over the past four years in the rate of serious injuries is lower than the comparable rate of increase for incidents in general (which show an increase of 12.4% per year). It has been the experience of DMRS that serious injuries have been consistently reported to DMRS over the past four years (and more) and have not been affected significantly by marginal changes in incident classifications and general reporting issues. Serious injuries are almost always well-documented and known to DMRS. Also, as mentioned previously, there was essentially no change in the DMRS definition of “serious injury” in April 2005, which was not the case with incidents overall.

The injury rate per 100 people in the population at large, as reported by the CDC 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. Comparison of this rate with the DMRS rate in FY 06-07 finds the DMRS system to have a significantly lower rate per year (10.6 per 100 people).

DMRS expects an eventual decline in the serious injury rate, so monitoring will continue and further prevention efforts will be explored.

*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

- In FY 06-07, DMRS continued to improve its Investigations system with several enhancements within its operations. The process to record, track and monitor follow-up to the investigations was standardized across all regions. DMRS employees responsible for following each substantiated investigation, monitoring plans of correction and tracking the changes, began meeting on a monthly basis to develop tracking logs, timeframes for response letters and other communication back to the agencies so that each investigation promotes positive changes for all individuals served by the agency. Follow up teams also included provider agencies in some of the meetings to provide input as to how to make the plan of correction more user friendly.
- In FY 2006-07, DMRS Investigations conducted 2752 investigations alleging abuse, neglect or exploitation.
- PFH continued to monitor and standardize the Reportable Staff Misconduct category. A letter was sent to all providers informing them that any allegations of abuse, neglect or exploitation would be investigated, regardless of the credibility of the reporter. All potential initial staff misconduct reports go through a multi-step screening to ensure that reportable staff misconduct is identified and investigated timely and effectively by the agency investigators.
- In FY 2006-07, DMRS approved the completion of 908 RSM investigations.
- In December of 2006, DMRS launched the Substantiated Investigation Search (SIS) Function, which is a web-based listing of all current or former agency employees who have been substantiated in a DMRS investigation since 2000. DMRS initially began a pilot project that included seven agencies from across the three regions. Agency directors involved in this pilot reported that the application was easy to use, and the information received was proving very useful in completing background checks for employees. Based on initial success, DMRS began to open the system to other agencies on a volunteer basis and added additional staff to handle the volume of requests. By June of 2007, twenty-eight provider agencies have begun utilizing the system and the information on current employees or applicants gained from this data base. DMRS eventually plans to require that agencies use this function as part of the new hire background check, although from all reports, there will be no resistance. The most positive result for agencies contracting with DMRS is that substantiated staff are less able to drift from agency to agency when they are terminated from one or more places for abuse of a service recipient. While some substantiated employees continue to work in this field, agencies have enough information to provide additional oversight and monitoring when they have a better understanding of an employee's past work history.
- DMRS continues to be aggressive by making referrals to the Abuse Registry; although the SIS seems to be offering a better option of keeping those staff most risky out of the employment system immediately. The time that elapses between a referral and a placement on the Abuse Registry can be lengthy, while the SIS function gives an agency immediate feedback. In FY 2006-07, DMRS referred a total of 114 persons to the Abuse registry for consideration. Also, in FY06-07, DMRS placed 45 individuals on the Abuse Registry. Due to the variable time between recommendation and placement, those placed in FY2006-07 are not necessarily the same recommended for placement in FY 2006-07.
- In Fiscal Year 2006-07, all the DMRS investigators attended two full trainings designed to increase their understanding of physical and mealtime challenges that agency staff

experience each and every day. These trainings helped DMRS investigators experience a broader perspective when investigating abuse reports.

- In May, 2007, all PFH staff, including facility PFH employees attended a training retreat at a nearby state park. This year, two nationally recognized trainers were brought in to further build on the knowledge and skills necessary to protect and investigate allegations among the persons DMRS supports. One trainer was an expert on interview techniques for persons with disabilities, and the other was an expert on wound and injury identification.
- In late spring, the Director of Investigations became involved with a coalition seeking to identify and collaborate with agencies that provide safety information and education to and about vulnerable adults. This organization, named Tennessee Vulnerable Adult Coalition (TVAC) seeks to establish a clearing house for information on how to prevent abuse, how to report abuse and how abuse reports are handled among the various agencies. While the group is in the early stages of organization, there is a clear need for this since so many agencies; both public and private are unaware of the resources and services that other agencies provide. State agencies involved include: DMRS, TBI, APS, DCI and DMHDD, and other agencies include Legal Aid Society, Regional Agencies on Aging and Disability, East Tennessee Elder Watch, and the Social Services departments of area universities. This group continues to recruit other possible members including other law enforcement agencies, as well as medical and ministerial groups.
- DMRS participated with TBI in supporting legislation to increase penalties for persons charged with knowingly abusing, neglecting or exploiting a vulnerable adult, from a misdemeanor to a felony. Additionally, any physical abuse or gross neglect of an impaired adult, knowingly committed, which results in physical or mental harm has now become a Class C felony. These changes in the state statutes were needed to increase chances for law enforcement agencies and district attorneys to become more proactive in prosecuting offenders.
- The DMRS Investigation Review Process continued to be an effective resource for agencies and family members when final investigation reports are seriously questioned. In FY 06-07 DMRS reviewed twenty five cases.
- A new position has been established within the Investigations for a clinical investigator. DMRS will seek a qualified nurse to assist in reviewing and investigating abuse allegations of a medical nature.

Chart 17: Rate of Substantiated Investigations of Abuse, Neglect and Exploitation per 100 People

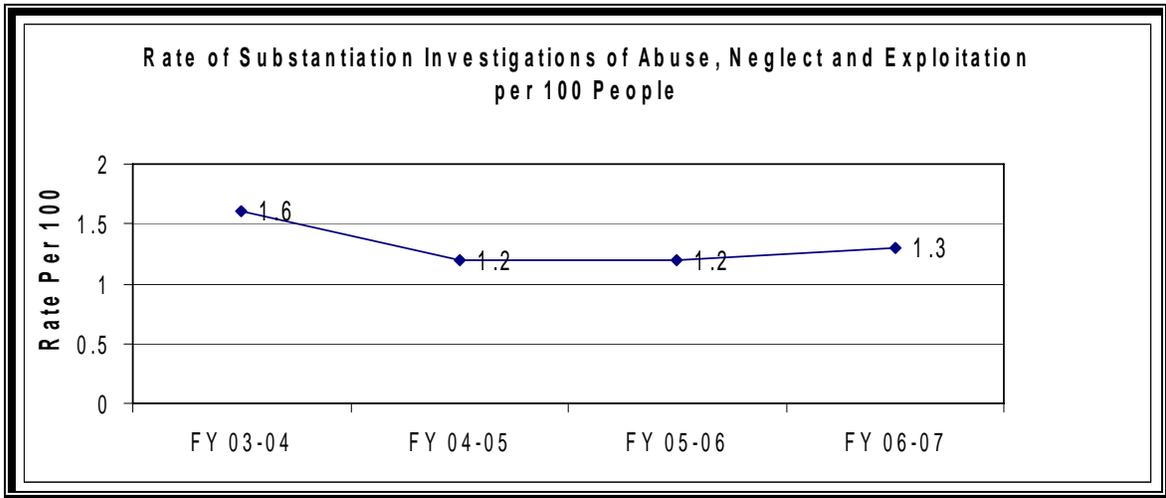
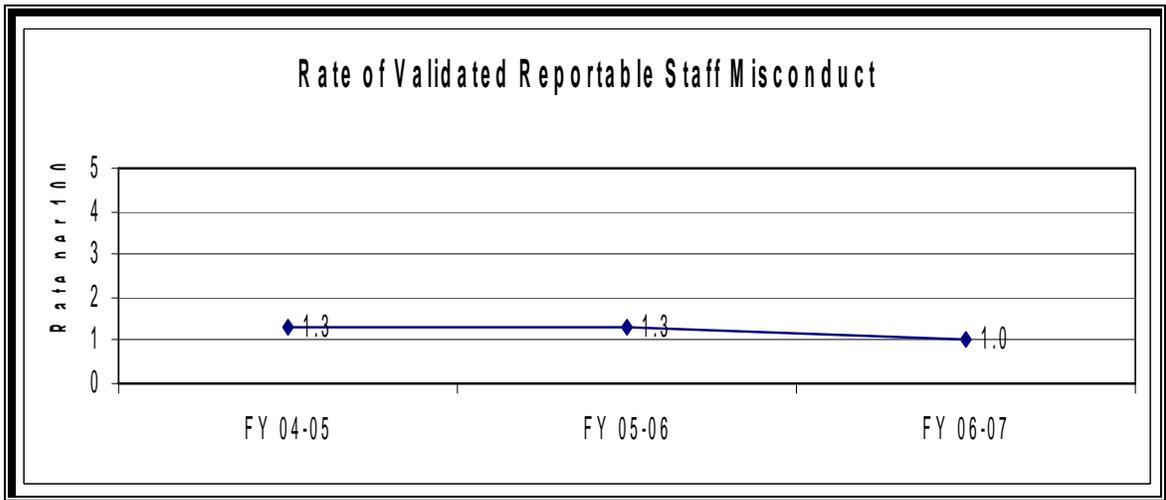


Chart 18: Rate of Validated Reportable Staff Misconduct Investigations per 100 People



Providers

Service Needs Analysis and Provider Recruitment

DMRS continues to support the needs of people in the waiver program through various types of DMRS community provider expansions:

- Recruiting new community providers and supporting existing providers to increase the number of people supported.
- Expand to other counties within their present DMRS region and to expand to other DMRS regions.
- DMRS continues to support community provider development by conducting regular orientation training for new providers and ongoing regional meetings for existing providers.
- Also, DMRS now has three provider recruiter staff positions to support provider expansion.
- DMRS has introduced a pre-application meeting for applicants interested in becoming DMRS providers. The purpose of these meetings is to give potential applicants an overview of the DMRS system, the requirements and information on how to become a DMRS community provider.

Provider Capacity and Development: Total Number of Active Providers by Service FY06/07 entails the number of active providers, number of provider exits and number of new providers. During this period, DMRS had a total of 188 Long-Term Providers per the provider agreement. The data above represents an array of approved services of any one provider. Hence, for example of the 188 providers: 150 are approved to provide Supported Living service, 79 are approved to provide Residential Habilitation service, 51 approved to provide Family Model service, etc. The present numbers represent real-time services collected mainly from DMRS provider agreements. Numbers reported from previous years were based on the number of providers who listed a particular service on their cost plan. This did not allow an accurate account of actual services approved per provider since it was connected to other variables, such as billing. Therefore, a provider who may have terminated service would still be listed as providing the service until the cost plan was resolved. The current record system is real-time numbers as a provider terminates or adds services to the system per the provider agreement. The present record system also allows for quick analysis of provider service development, for example there is potential to increase Family Model service, which is now at 51 to the remaining 137 providers.

**Behavior Respite and Medical Residential numbers were gathered from DMRS community tracking system. Precise record keeping and a clarified definition of which agencies actually provide a given service will allow for comparison in FY 07/08.*

Table 4: Provider Increase by Type

Type of Service Provided	Total Number of Active Providers by Service FY06/07	Number of New Providers by service FY 06/07	Number of Provider Exits 06/07
Supported Living	150	7	2
Residential Habilitation	79	2	2
Family Model	51	2	0
Day Service- Facility Based	133	4	4
Day Service- Community Based	155	7	4
Day Service- Employment Supports	139	7	3
Personal Assistance	167	9	5
Respite	80	1	2
Behavioral Respite*	5	2	1
Medical Residential*	22	4	0

Note: The data between FY 05/06 and FY06/07 defined differently. FY06/07 data is from DMRS provider agreement information and DMRS CST

Therapeutic, Dental, and Other Ancillary Providers

As a part of the continued commitment to developing and sustaining an adequate network of qualified clinical providers, DMRS created a new position titled, *Provider Network Manager for the Clinical Unit* in September 2006. One of the main responsibilities of this position is to recruit new providers to the DMRS system. In addition to recruitment, this position serves as a liaison to the clinical and ancillary providers to communicate their concerns to DMRS senior management, assist with resolving systemic issues, and to reassure them of their value to the DMRS, thereby maintaining the provider network.

Having secured this full-time position, DMRS has been better able to track the number of active providers of therapy and ancillary services. Numbers from previous years reporting were based on the number of providers who listed a particular service on their cost plan. This did not allow an accurate account of actual services provided, as many providers sought approval for services they hoped to be able to provide in the future. For example, records show five (5) Orientation and Mobility Specialists (O & M) in FY 05/06. This number was based on the number of provider agreements that included this service in their listing. In actuality, at no time has the DMRS had more than two (2) active O & M providers in the state.

A major focus of FY 06/07, was to expand the number of providers of Environmental Accessibility Modifications as family members and residential agencies all expressed difficulty finding DMRS-approved contractors for needed home modifications. Eight (8) new providers of Environmental Accessibility Modifications (EAM) completed their provider agreements in FY 06/07. Seventeen (17) providers of Specialized Medical Equipment and Supplies and Assistive Technology (SMES/AT) were also added, either as expansions of existing provider agreements or new agencies contracting with the DMRS for the first time. Amendments to the Provider Qualifications for the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Delayed resulted in six (6) agencies removing SMES/AT from their provider agreements and four (4) providers removing EAM.

In a similar vein, many residential and day providers erroneously listed Dental Services on their provider agreements in order to be reimbursed for dental expenses paid out-of-pocket. These services were recently removed from residential and non-dental provider agreements in keeping with the Centers for Medicaid and Medicare Services regulations. DMRS has increased its Dental network significantly across the state allowing payment directly to the dentist or oral physician performing the work.

Given the above situation, it is not possible to accurately reflect the gain or loss of clinical and ancillary providers in FY 06/07 compared with FY 05/06. Therefore, the table below represents the number of active providers without comparison to previous years. More accurate record-keeping and a better understanding of which agencies actually provide a given service will allow for this comparison in FY 07/08.

Clinical/Ancillary Providers FY 06/07

Service	Total Number of Active Providers*	Number of New Providers	Number of Provider Exits
Dental	40	8	0
Environmental Accessibility Modifications	58	14	-4
Nutrition	32	2	-4
Occupational Therapy	50	4	-7
Orientation and Mobility Specialists	2	1	0
Physical Therapy	45	4	-4
Specialized Medical Equipment and Supplies and Assistive Technology	73	18	-6
Speech-Language Hearing	48	5	-4
Vehicle Accessibility Modifications	13	6	0

** Often one provider agency will provide services across several regions. The numbers above reflect the total of all services available across the state. Therefore, for any given service, one provider agency may be counted as many as three times.*

Employment Opportunities for People with Developmental Disabilities

The goal of DMRS and of the Tennessee Employment Consortium (TEC) is to continually increase the number of people who are in meaningful, competitive employment. To this end, DMRS, the Division of Rehabilitation Services (DRS) and TEC collaborate to develop policy to promote employment.

- ***Stabilization Policy:*** Up until late December 2006, many providers were waiting until DRS closure to begin accessing DMRS employment-based funding. This often meant that providers did not access DMRS employment-based funding for as long as a year after a person went to work. Due to a DMRS policy clarification in December 2006, if a person works 11 hours or more a week, the provider can access DMRS funding as soon as 30 days after placement. If a person works 10 hours or fewer a week, the provider can access DMRS employment-based funding as soon as 60 days after placement. DMRS employment-based funding allows providers to develop and deliver the level of support each person needs. Some people require only moderate support while others require constant support.
 - ***The Discovery Process As It Pertains to Employment:*** It has been common practice for providers to refer people to DRS if they express even an initial interest in employment or if the provider is trying to fulfill the DMRS Provider Manual requirement that a person must have at least one vocational evaluation every three years. This can lead to a circumstance where people only have the opportunity to sporadically get an impression of:
 - If they want to work
 - What type of work they are interested in

Last fall, TEC established a Discovery Subcommittee to develop guidance to assist providers in using DMRS community-based services to facilitate a quality Discovery Process. This will allow providers to structure time during community-based activities to explore if a person wants to work, and if so, in what type of work they are interested.

Conclusion

Fiscal Year 2006-2007, was a year of stabilization. During the upcoming fiscal year, knowledge derived from refinements to the service delivery system will be utilized to better address the requirements of the Waiting List lawsuit, the Clover Bottom and Arlington Developmental Centers lawsuits. General refinements in the operations of the DMRS will enhance the lives of the Service Recipients. As continued growth is experienced, further enhancements will be necessary in order to meet the needs of an expanded service system. Already, DMRS has plans for FY 07-08, 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 includes: 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 seeking resolution of its obligations under the Wait List settlement agreement for years 3, 4 and 5.
- The Arlington Developmental Center Closure and Community Transition Plan was completed in August, 2007, and work is underway to meet the commitments of this Plan. It is available on the DMRS website at www.state.tn.us/dmrs/dev_centers/arlington.
- DMRS will continue to meet with the Parties to the lawsuit and the Court Monitor on a quarterly basis to report status and progress on all court-ordered requirements.
- The Four/Three Star recognition program offers providers public recognition for excellent performance. During the FY 06/07, DMRS recognized 5 providers obtaining Four Star status and 19 providers reaching the Three Star status.
- During the 2006-2007 fiscal year, there were substantial changes to the ICAP assessment process that will ensure consistent, reliable administration and scoring across the State.
- DMRS continues to hone the operational details of the web-based training initiative while simultaneously providing required DMRS Train-the-Trainer sessions and elective specialized training sessions during this transitional phase.
- DMRS will convert data systems to track Service Recipient data by wavier. This will allow DMRS to further analyze services provided, as well as complying with requirements of CMS and TennCare.

The above are examples of the activities DMRS will be involved in during FY 2007-2008. 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. Further refinement of the DMRS Service Delivery System is expected 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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