

DIDD

**DEPARTMENT OF INTELLECTUAL
AND DEVELOPMENTAL DISABILITIES**

The State of Tennessee

Annual Report

July 1, 2010 – June 30, 2011



**STATE OF TENNESSEE
DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
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December 29, 2011

The Honorable Bill Haslam, Governor
General Assembly, State of Tennessee
State Capitol Building
Nashville, Tennessee 37243

Governor Haslam and Members of the General Assembly:

Pursuant to Tennessee Code Annotated 4-4-114, The Department of Intellectual and Developmental Disabilities hereby submits its Annual Report to you for FY 2010-2011.

Fiscal year 2010-2011 was the inaugural year for the Department. Through the efforts of the General Assembly, the former Division of Intellectual Disabilities Services under the authority of the Department of Finance and Administration, was established as a full state department. This initiated the first steps needed to improve services for all Tennesseans with intellectual and developmental disabilities.

The Department is responsible for developing and maintaining a system of services for persons with intellectual and developmental disabilities as set out in applicable provisions of Tennessee Code Annotated Title 33, Chapter 5.

In submitting this report I would like to thank all the people who have helped shape this Department into the cornerstone of community services that it is. With the dedication of over 2,500 state employees and over 470 contracted providers and their Direct Support Professionals, Tennessee offers a system of services and support that will continue to grow and prosper as will the lives of Tennesseans with intellectual and developmental disabilities.

Respectfully,


James M. Henry
Commissioner

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FY 2010- 2011: ESTABLISHMENT OF THE DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

On January 15, 2011, the Tennessee Legislature through Tennessee Code Annotated § 4-3-2701 (a) formally created the Department of Intellectual and Developmental Disabilities (DIDD). The Department was previously known as the Division of Intellectual Disabilities Services, and was under the direction of the Department of Finance and Administration. The Department is directed to lead the state in developing and maintaining a system of supports and services for persons with intellectual and developmental disabilities which ensures its vision that those Tennesseans will have healthy, secure and meaningful lives with family and friends in their community. Services and supports are provided through the public and private sectors in Tennessee as set out in applicable provisions of Tennessee Code Annotated Title 33, Chapter 5.

The state further took steps to improve the lives of Tennesseans with disabilities by passing House Bill 1134/Senate Bill 818 on March 4, 2011. This bill replaced all references of the outdated terms "mental retardation" and "mentally retarded" in the Tennessee Code Annotated with the current language of "intellectual disability," "persons with intellectual disability", or "individuals with intellectual disability".

LEADERSHIP

Governor Bill Haslam appointed James M. Henry as the first Commissioner for the Department. Commissioner Henry mindfully assembled a strong leadership team for the Department to include: Debra K. Payne, Deputy Commissioner, Office of Program Operations; Dr. Scott Modell, Deputy Commissioner, Office of Policy and Innovation; Pat Nichols, Assistant Commissioner, Quality Management; Fred Hix, Assistant Commissioner, Fiscal and Administrative Services and Dr. Thomas Cheetham, Director, Office of Health Services.

Commissioner Henry is responsible for the oversight of a dynamic statewide system that serves over 8,000 Tennesseans with disabilities. The service system not only includes over 470 community providers that employ 27,000 Direct Support Professionals; there are also 2,500 state employees located in a Central Office, two Disabilities Developmental Centers, 17 state operated community homes, and three Regional Offices. Commissioner Henry also coordinates and administers an annual budget of approximately \$815 million dollars, utilizing federal and state funding systems along with various grant monies.

DEPARTMENT ORGANIZATION

The Department operates with a Central Office based in Nashville, that provides policy and program administration of the DIDD service delivery system. The Central Office serves as a liaison with the Bureau of TennCare, the state Medicaid agency and works collaboratively with other state agencies involved in the development and implementation of state services. The Central Office also works with the Federal Centers for Medicare and Medicaid Services in assuring quality service provision in Tennessee. The Department ensures quality services through its Quality Management (QM) Unit. The QM Unit is responsible for surveying contracted community-based providers to determine levels of performance related to the quality of services provided.

Each region of the state, East, Middle and West, contains a Regional Office and satellite offices that serve as direct access for contracted providers and community members receiving DIDD funded services. There are multiple avenues through which the Regional Office supports individuals with intellectual disabilities. Such supports include, enrollment into services, the direct provision of services such as assessments, training, and limited forms of interventions in a variety of clinical disciplines including physical therapy, occupational therapy, behavioral services, and nursing/medical services. The Regional Offices also offer specialty training and technical assistance programs.

The Department operates three Developmental Centers, two are licensed Intermediate Care Facilities for persons with Intellectual Disabilities (ICF/ID). In addition, the Department manages community ICF/ID homes located in integrated residential community settings. The Developmental Centers are located each in the Middle and East Regions. Clover Bottom Developmental Center is located in Nashville, and Greene Valley Developmental Center is located in Greeneville. The third Developmental Center, the Harold Jordan Center (HJC) located in Nashville, provides specialized services for individuals with intellectual disabilities who have been court ordered for care, treatment, and training by court systems across the state.

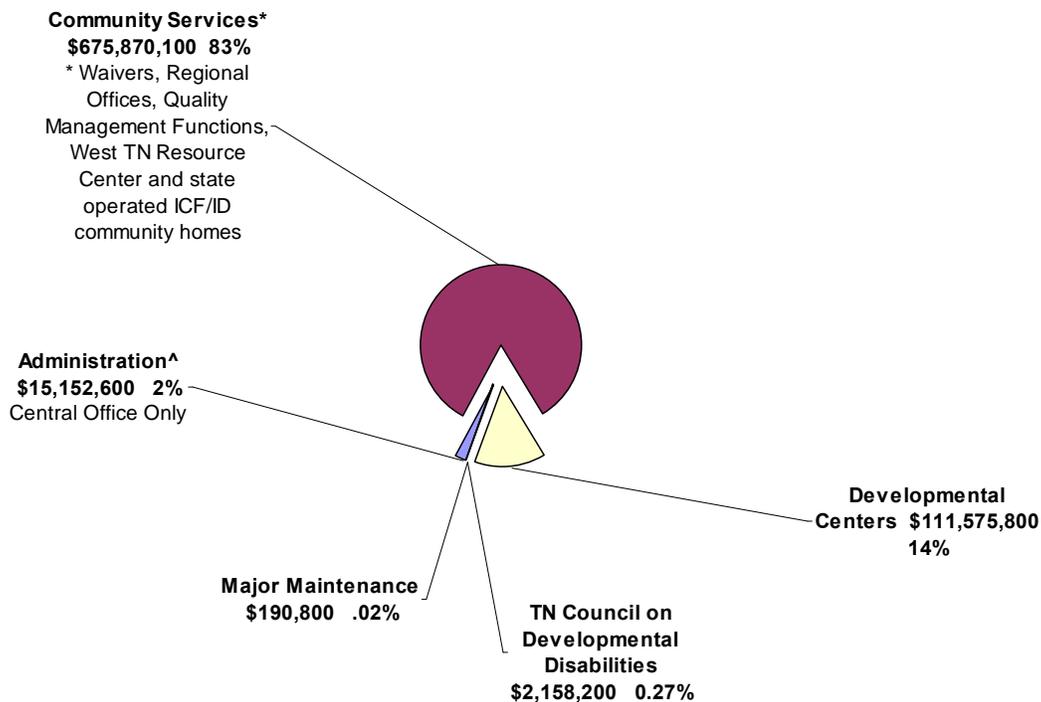
October 27, 2010 was a remarkable date for the Department when the last person supported transitioned from the Arlington Developmental Center in West Tennessee. The event was commemorated with a ceremony held on November 9, 2010 titled "Reflections and New Beginnings", showcasing the history of the Arlington Developmental Center and highlighted the new beginnings for persons with intellectual disabilities who have transitioned from the institution to homes in the surrounding Arlington community.

EXPENDITURES

Programs coordinated by the Department are financed from state appropriations, grants and federal Medicaid monies. The state Medicaid agency, the Bureau of TennCare, provides oversight for the DIDD Home and Community Based Services (HCBS) Medicaid waiver programs. The Medicaid waiver programs are sanctioned and monitored by the Federal Centers for Medicare and Medicaid Services (CMS).

For Tennessee, the fiscal year budget was \$32 billion. The Department operating budget was \$815.7 million. Actual expenditures totaled \$804.9 million or 1.3% under budget. The chart below shows total expenditures:

DIDD FY 2010-11 Expenditures



STATUS OF FEDERAL LAWSUITS

United States v. State of Tennessee (Arlington)

Arlington Developmental Center (ADC) closed its doors as a residential institution on October 27, 2010. This closure was a three year process as the state sought appropriate placements outside the institution to meet the needs of each person whose transition was approved by the Federal Court Monitor, a requirement for the Arlington Remedial Court Order. Part of this endeavor involved the construction of 12 state operated four-person homes located in and around the Arlington area that are licensed as Intermediate Care Facilities for persons with Intellectual Disabilities (ICF/ID) to meet the needs of persons who have medically complex issues. These homes are known as the West Tennessee DIDD ICF/ID Homes and are owned and operated by DIDD.

The closure of ADC also brought to completion the process of admitting new class members to the federal lawsuit through the "at-risk" category of the class definition. DIDD staff received referrals for 2,307 people to consider if they met the eligibility criteria to be classified as an "at-risk" class member. A total of 741 people were found to meet the criteria and were officially admitted to the class, pursuant to the 2006 Arlington Settlement Agreement.

Pursuant to the closure of ADC, the state has filed a *Motion to Vacate All Outstanding Orders and to Dismiss the Case* with the federal court. It is anticipated that a hearing will be scheduled in the coming year concerning the state's motion and the Parties' opposition to the dismissal.

People First, et.al. v. Clover Bottom

United States of America v. State of Tennessee

In November 2009 the state announced its intent to close Clover Bottom Developmental Center (CBDC). Following the transition, people would be provided appropriate services and supports in alternative settings such as small privately operated ICF/ID facilities, HCBS waiver programs, state operated ICF/ID homes, or other appropriate placements.

As people have transitioned out of CBDC into either HCBS waiver programs or private Intermediate Care Facilities, the census at CBDC has declined over the past year from 101 persons to 47 persons. DIDD has also begun purchasing property for nine four-person ICF/ID licensed homes in and around Davidson county for 36 persons at CBDC who have medically complex needs. An additional two homes will serve people who require specialized behavioral support. Transition to these homes is expected to begin in 2012.

The Quality Review Panel (QRP), which was established by the lawsuit, completed a review of CBDC in November 2010 and rated the facility to be in compliance or partial compliance with 90% of the requirements set out in the Settlement Agreement. The QRP is expected to conduct their next review of CBDC at the end of 2011.

An agreement was made with the QRP and the parties to this lawsuit on the methodology for the QRP to use in their annual review of community residential and day service providers in November 2010. They began their 2011 review of services provided to class members in the community and should provide a report of their findings around the first of December 2011 in regards to the state's compliance with the community system requirements outlined in the 1999 court-ordered part of the Settlement Agreement.

DEPARTMENTAL VISION STATEMENT

The DIDD vision is that Tennesseans with intellectual disabilities will have the opportunity and needed support to be part of the community in which they live. People with intellectual disabilities have a right to healthy, secure and meaningful lives surrounded by family and friends.

The DIDD mission has been provide leadership in the development and maintenance of a system that offers a continuum of services and support for persons with intellectual disabilities. Services and supports will contribute to those persons having healthy, secure and meaningful lives, living in a residence of their choosing.

The DIDD will work to accomplish its mission by recognizing that its values and principles are the cornerstones of the service delivery system. DIDD staff will act with professionalism, integrity and honesty to achieve and maintain the credibility that is required to fulfill the organization's mission.

Values

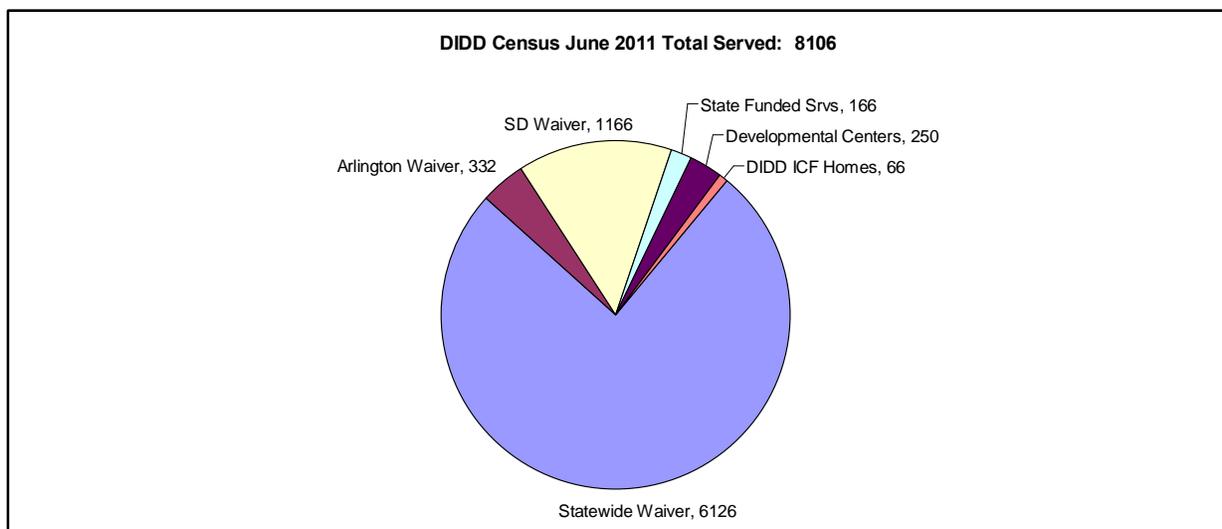
Person centered focus	Person friendly information
Individual choices	Opportunities
Respect	Safety and security
Professionalism	Innovation
Effective service planning	Quality Improvement
Risk identification and planning	Staff training
Access to reliable information	Stakeholder input

Future

Along with becoming a new Department, revisions to the service system and Vision Statement will continue throughout the upcoming year. The inclusion of people with developmental disabilities in existing and future service systems is in the beginning planning stages.

TENNESSEANS SERVED BY THE DEPARTMENT

By the end FY 2010-2011, the Department had a census of 8,106 persons being served in its traditional program settings as shown in the chart below.



The Department offers three HCBS Medicaid waiver programs throughout the state. These programs are funded with 63% federal monies and a state match of 37%. The Bureau of TennCare provides oversight while the Department operates the programs through contracted community providers. The HCBS programs allow individuals to receive Medicaid services in the community rather than an institutional setting. Persons either live with their family or in various supported living environments with roommates and/or group settings.

The largest of the three waiver programs is referred to as the Statewide HCBS waiver program. By the end of the fiscal year, 6,126 persons were being served in this program, receiving supports ranging from residential, employment services, day supports, personal assistant services, independent support coordination, clinical services, behavioral supports, environmental modifications, specialized medical equipment, respite, and transportation services. Persons receive services based on individual needs. Each person has a Circle of Support that meets annually and as needed with the person to help develop the supports needed.

The Arlington waiver program serves only a defined protected class of individuals. This waiver program had a census of 332 persons by the end of the fiscal year.

The third waiver program, the Self Determination waiver, is a self directed program that allows for persons to become more pivotal in the development and purchase of their own services. This program had a census of 1,166 by the end of the fiscal year.

The total Developmental Center census was at 250 people. This number steadily declined from 370 at the beginning of the fiscal year. In part, the decline was due to the closure of Arlington Developmental Center in West Tennessee and due to the planned closure of Clover Bottom Developmental Center in Middle Tennessee. The final census was: Greene Valley Developmental Center had 197 people in June 2011, Clover Bottom Developmental Center had 47 people and the Harold Jordan Center had six people.

The Department expanded residential options by adding small ICF/ID four-person homes. These ICF/ID homes are in operation in the West and East Regions. People who lived at Arlington Developmental Center moved into the West homes and people at Greene Valley Developmental Center now have the

option of moving into similar state operated ICF/ID homes. The West Region had 12 community homes with a census of 47 persons and East Tennessee had five community homes with 19 persons in residence by the end of the fiscal year. The East Tennessee program will be expanding with a goal to serve a total of 64 people. The Middle Region is in the process of developing this program and will serve a total of 36 people.

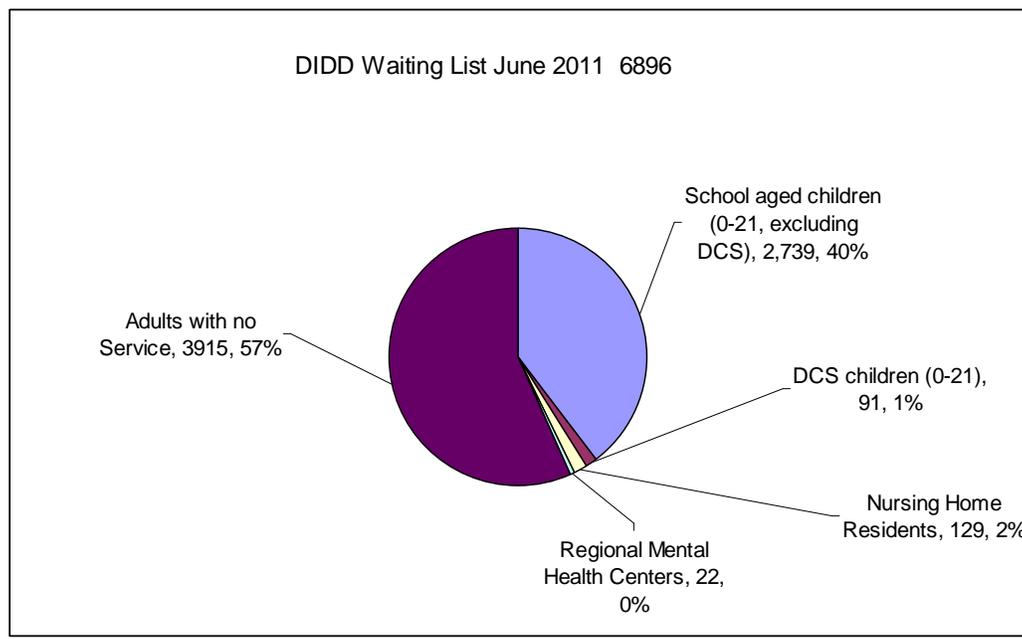
Finally, there were 166 people identified as receiving a state funded service. This did not include persons in the Family Support grant funded program. The Department does not routinely fund services and programs with pure state dollars.

WAITING LIST

The Department manages a waiting list for individuals seeking Medicaid waiver services. Individuals are assessed and prioritized to receive services based on the most critical of needs (crisis, urgent, active and deferred). Each of the four categories of need have specific criteria applied to an individual's unique situation. People in the crisis category are given priority for waiver program enrollment. Enrollment is contingent on approved funds available for the program.

FY 2010-2011 began with a statewide waiting list of 6,439 and ended with 6,896 on the list. This was a net increase of 457 people. At the Regional level, the East Region possessed the largest portion of the list with 2,427 people by years end, Middle Region had 2,169, and West Region had 2,300 persons on their list.

The demographics show that the largest percent of persons on the list are adults with no service (see chart below). The second largest group was school aged children, excluding children in the custody of the Department of Children Services (DCS). The smallest groups identified were those people residing in Nursing Homes, children in DCS custody and finally, persons in long term residency of mental health centers.



OFFICE OF PUBLIC AFFAIRS AND CONSTITUENT SERVICES

The Office of Public Affairs and Constituent Services provides outreach and training to special educators, consumers and family members. Each year, formal family training sessions are held primarily in the spring, and some in the fall for the convenience of families. The forums are used to discuss topics such as conservatorship, community resources, support groups, the DIDD wait list and case management services while on the wait list. This outreach opportunity also proves valuable for families to ask questions, voice concerns and receive information on available resources.

In addition to the training sessions held in FY 2010-2011, Public Affairs and Constituent Services represented the Department in 29 conferences, summit fairs, and resource fairs as both a guest speaker and as vendor across the state. Informational materials were distributed to inform attendees about the service delivery system and to provide them with resources concerning disability services in Tennessee.

An introductory training session was also developed and presented to members of the legislature and their support staff. This session provided a vital connection for the Department and established a relationship enabling information to be shared quickly with constituents in legislative offices seeking assistance pertaining to DIDD services.

FAMILY SUPPORT PROGRAM

The Department coordinates the Family Support Program designed to support persons with severe physical and developmental disabilities to remain with families in their home and local communities. The Program is legislated in Tennessee Code Annotated, Sections 33; 33-1-101 and 33-5-201 through 33-5-211.

The FY 2010-2011 budget was \$7.3 million in state appropriations of which \$7.1 million was non-recurring funds. The Program is available in all 95 counties of the state with each county having a population-based monetary allocation. A minimum allocation is set for those counties with small populations. The majority of the agencies underwent a DIDD fiscal audit with good results.

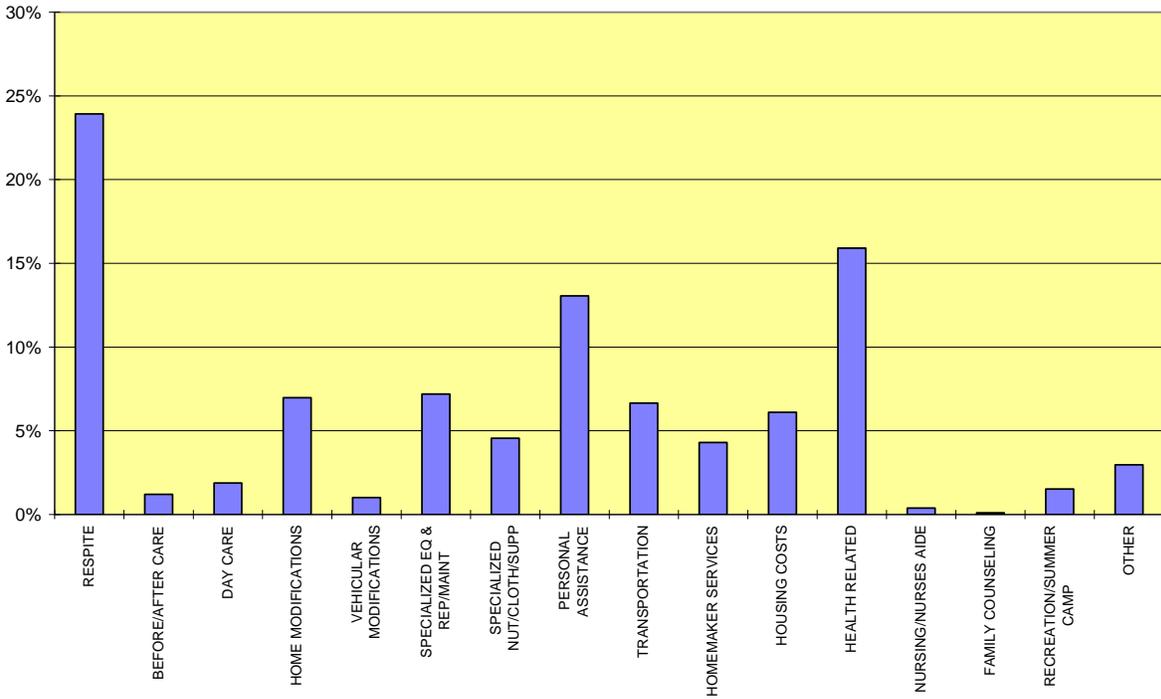
The Family Support Program is administered at the local level by more than 200 volunteers through contracts with private, non-profit agencies competitively bidding for the opportunity to participate. A state Family Support Council assists the Department in setting policy, providing oversight, and resolving program implementation issues.

The state Council is comprised of 15 members appointed by the Department, most of who are persons with severe or developmental disabilities or their parents or primary care givers. There are 22 Local and nine District Councils that provide program oversight. District and state Council volunteers conducted programmatic monitoring visits for five agencies, resulting in recommendations for two agencies. The state Council met four times to give guidance and oversight to the Tennessee Family Support Program.

In FY 2010-2011, a total of 4,508 persons received Family Support Funds. Individuals supported by the Program have disabilities such as autism, cerebral palsy, deafness and/or blindness, developmental delay, neurological impairment, orthopedic impairment, spinal cord injuries, and traumatic brain injury. The average amount received in service funding per individual for FY 2010-2011 was \$1,387.

Funds provided are used to purchase a variety of supports and services. The chart below shows expenditures by service type that were utilized from FY 2010-2011.

**TENNESSEE FAMILY SUPPORT PROGRAM
EXPENDITURES BY SERVICE TYPE - FY 2010/2011**



The Program's continuation per year is dependent on grassroots efforts to educate state legislators about program successes in order for state allocations to continue. The Family Support agencies, Council members, persons served and their families continue volunteer efforts to assure the program is funded for the next fiscal year. The Family Support Program itself has a waiting list of over 3,455 people.

The website for the agencies and people served by the Program and their families is:
<http://www.tnfamilysupport.org/>.

SUPPORT SYSTEMS IN THE DEPARTMENT

OFFICE OF CIVIL RIGHTS

The Department's Office of Civil Rights (OCR) monitors compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, sex, age, and disability in programs or activities that receive federal financial assistance. The following federal regulations are monitored by DIDD OCR:

Title VI of the Civil Rights Act of 1964, prohibits discrimination on the basis of race, color, or national origin;

Title VII of the Civil Rights Act of 1964, prohibits discrimination in employment;

Subtitle A of Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, [both] regulations prohibit discrimination against otherwise qualified individuals on the basis of disability;

Title IX of the Education Amendments of 1972, prohibits discrimination on the basis of sex (gender) in federally-assisted education programs;

Section 508 of the Rehabilitation Act of 1973, prohibits discrimination on the basis of disability in electronic information and technology in federally-assisted programs and activities.

OCR carries out its stated mission through conducting investigations, voluntary dispute resolution, compliance reviews, policy development, and providing technical assistance to ensure understanding of and compliance with federal non-discrimination laws and regulations.

During FY 2010-2011, the Complaint Resolution System (CRS) became part of the Office of Civil Rights. Since then CRS staff have been trained to become Ombudsmen for the Department. Currently all CRS staff have been trained to perform the following tasks: Ombudsman, mediation, conflict resolution, investigations, respectful workplace investigations (Title VII) and complaint resolution. In addition, CRS has ensured that all contracted provider staff have active in-house Complaint Resolution systems to meet the needs of the persons they support and their families.

Complaint Resolution System

The Complaint Resolution System accomplished the following during FY 2010-2011:

- Logged and responded to an average of 28 complaints per month from families, conservators and persons supported;
- Conducted approximately 28 conflict resolution meetings per month to resolve communication disputes between providers, conservators, family members and persons supported;
- Presented statewide training to DIDD service providers to address conflict resolution and communication barriers and
- Provided ten provider-to-provider mediations to improve relationships between providers and improve service delivery to persons supported.

CRS has hosted focus groups for persons supported in Chattanooga, Greeneville, Memphis and Nashville since February 2011. The focus groups are open to all persons supported who wish to make suggestions for improving their services. Approximately 75 people are participating in the focus groups statewide.

CRS reached its targeted benchmark of quality assurance by resolving 99% of all complaints within 30 days. Out of over 200 complaints, one complaint did not meet the 30 day deadline by one day.

Complainants report that they are very satisfied with CRS staff and case resolutions over 94% of the time. CRS continues to resolve complaints that are reported via the People Talking to People (PTP) consumer experience surveys.

Consumer Experience Surveys

The Department contracts with The Arc of Tennessee to conduct consumer experience surveys for individuals receiving DIDD funded residential and community services. The Arc of Tennessee developed a survey program called "*People Talking to People*" (PTP) through which face-to-face interviews are conducted with individuals with intellectual disabilities and persons who know them well. PTP employs 27 part-time interviewers across Tennessee. Twenty of the 27 interviewers have diagnosed disabilities including Cerebral Palsy, Dilated Cardio Myopathy, general disability from military service, mental illness, Intellectual Disability, Polio, Spinal Muscular Atrophy, and Traumatic Brain Injury. PTP is a simple, yet innovative, program to assure quality services for the people who receive them. PTP is leading by example to promote a more inclusive and integrated local and statewide community, while continuing to better the support service system as a whole. PTP interviewers use the Participant Experience Survey (PES), an instrument developed by the U.S. Department of Health and Human Services Centers for Medicaid and Medicare Services contractor, to gather information on four primary areas of the person's experiences: choice and control; respect and dignity; access to care; and community integration and inclusion. The survey addresses customer satisfaction utilizing the following types of questions:

- | | |
|-------------------------|---|
| 1. Choice and Control: | Do participants have input in services they receive? Do participants make choices about their living situations and daily activities? |
| 2. Respect/Dignity: | Are participants being treated with respect by others? |
| 3. Access to Care: | Are participant needs such as personal assistance, equipment, and community access being met? |
| 4. Community Inclusion: | Do people receiving services participate in activities and events outside their homes when and where they want? |

During calendar year 2010, 1,671 individuals receiving DIDD services were successfully interviewed. These valid interviews collected by PTP again surpassed the 1,200 that were asked for by DIDD, exceeding the goal by 40%.

Results for reports going back to 2004 may be viewed at:
<http://www.tn.gov/didd/PeopleTalkingToPeople/index.html>.

Results for the 2010 report may be viewed at the following link:

<http://www.tn.gov/didd/PeopleTalkingToPeople/PTP%20Year%206%202009%20report%2010-28-10.pdf>.

STAFF DEVELOPMENT

The Department believes that a strong provider network is built upon solid training systems. Through the provision of the nationally recognized College of Direct Support (CDS) as an online training resource, the Department offers cost free training options to contracted provider staff. During FY 2010-2011, 30,674 staff persons were enrolled in the system, with 884,142 lessons completed, representing an 85% completion rate of required and requested online training.

The CDS online training program includes accessibility twenty-four hours a day, seven days a week for competency-based pre and post tests. The curriculum emphasizes core values, person-centered practices, protection of health and well-being. Interactive training modules are created by nationally recognized experts and updated for best practice operations.

In an effort to determine agency satisfaction with all the training offered by DIDD to agencies and their staff, a survey was conducted by the staff development department. The results showed that not all agencies were using the online training option for a variety of reasons, but most of those who did were satisfied with the curriculum and the training management platform of College of Direct Support. DIDD continues to work with CDS on improving their reporting tools and to modify existing reports in response to survey comments.

In addition to the online training offered through College of Direct Support, the department created and posted training materials on it's website for use by families and other interested parties.

The Department's Regional office Staff Development units provided classroom training opportunities, promoted through quarterly calendars posted on the Department's website. Classes are offered monthly and upon request both at the regional office locations and at provider locations. Classroom training opportunities include the following:

Employment

CB Day/Discovery
Supported Employment
Job Coach Training

Protection from Harm

Incident Management
Risk Assessment
Abuse Prevention

Professional Growth

Effective Training Techniques
Sensitivity and Ethics
Rights and Choice

Therapeutic / Health

Diabetes and Nutrition
Nutrition Resources and Menu Planning
Physical Status Review (PSR)
Falls: Causes and Preventative Strategies
Challenges in Physical Management
Communication Overview
CPR/AED First Aid
Medication Administration for Unlicensed Personnel

Person Centered Thinking

Person Centered Practices
Writing Outcomes / Action Steps
Person Centered ISP's

Independent Support Coordination

Revised training modules

Orientation

New Provider Orientation
Therapeutic Services Orientation
Title VI
Individual Rights and the ADA

Seizure Training
Sign Language
Supporting the Deaf / Blind
Universal Precautions / Infection Control
Healthcare Oversight Forms
Mealtime Challenges
Aspiration
Dysphasia Overview /
Swallowing Disorders

In FY 2010-2011 the Protection from Harm Incident Reporting training was updated after changes were made to the *Provider Manual*, Chapter 18-Protection from Harm. That new training material was formatted for online instruction as well as presentation in a classroom setting and continues to be offered both ways.

The Staff Development department provided training for Registered Nurse trainers and oversight of the Medication for Unlicensed Personnel training program. An additional 6,016 new staff and 4,064 previously certified staff were trained during the fiscal year. Since the program started in the 1990's, there have been a cumulative total of initial and repeated participant training sessions of 90,808.

PROVIDER DEVELOPMENT

The Department is committed to assuring that persons requesting DIDD services can choose between sufficient numbers of providers. Each provider is approved for one or more HCBS waiver service and may operate in one or more of the three grand regions of East, Middle or West. In addition to Departmental approval, various waiver services may require external licenses or certifications that the provider must obtain. Prior to provision of any waiver service, the provider is thoroughly reviewed and approved by the Department for all required licenses and certifications.

To better inform persons of the available provider network, the Department maintains an online DIDD Provider Agency Directory. The directory is divided by region identifying the name, administrative location, service approved to provide and contact information for the agency.

By the end of June 30, 2011, the Department had a statewide network of 470 providers. During FY 2010-2011, the Department added 42 new providers. In addition, the current provider network was expanded as approximately 60 approved providers submitted applications to add a service(s) or to expand into additional regions of the state.

New provider orientation meetings are routinely held for persons interested in becoming a DIDD provider and for newly approved DIDD providers. Meetings are held regionally and centrally for providers to begin learning the DIDD service delivery system and statutory requirements.

POLICY UNIT

The Policy Unit is responsible for the development of internal and program policy. In addition, the unit assures that Commissioner correspondence with providers are released and logged appropriately. Policy Unit staff are dedicated as needed to facilitate and coordinate public hearings, DIDD Advisory Council meetings and Regulatory Relief Task Force activities.

In FY 2010-2011, the Unit organized an internal policy committee that strengthened Departmental structure through policy revision and development. The committee organized appropriate updates and reviews for the *Provider Manual* with special focus on Chapter 7-General Provider Requirements Provider Training and Chapter 11-Conservatorship and Advocacy Services. Chapter 18-Protection from Harm was revised with new requirements for provider agencies.

Along with updates to the *Provider Manual*, the policy committee issued six policies for the state operated ICF/ID community homes. The statewide policies include:

- Protection from Harm in DIDD ICF/ID
- Governing Bodies in DIDD ICF/ID
- Administrator of the Day in DIDD ICF/ID
- Protection of Rights in DIDD ICF/ID
- Uniform Individualized Records in DIDD ICF/ID
- Ensuring Coverage and Scheduling Overtime in DIDD ICF/ID

Additionally, the unit was responsible for ensuring compliance with all statutory requirements for public meetings or for securing approval from the Bureau of TennCare prior to issuing any policy as appropriate.

As the Department and TennCare made several amendments to the HCBS waiver programs, the Policy Unit assured all applicable steps were taken for stakeholder input. The amendments were approved by the Centers for Medicare and Medicaid Services (CMS) on February 15, 2011.

REGULATORY RELIEF TASK FORCE PUBLIC CHAPTER 808

The Tennessee Legislature established a Regulatory Relief Task Force in September 2010 to review regulations for the residential and day providers contracted with the Department and make recommendations with regard to relieving expensive and unnecessary regulations. The appointed Task Force began meeting on November 3, 2010. The first annual report was submitted to the legislature and Governor on January 1, 2011. The report included six viable recommendations for possible reductions or eliminations of regulatory actions placed upon providers. The Task Force will continue to meet and further discuss areas where fiscal impact of regulations can be reduced and streamlining processes may help in regulation overlap between state agencies.

PERSON CENTERED PRACTICES

In FY 2010-2011, the Department continued working towards "*Becoming a Person Centered Organization*" by transforming the current system to recognize that what is ***important to*** people must be balanced with what is ***important for*** people. DIDD is establishing person centered practice models throughout the service delivery system in order that people receiving services can have meaningful lives.

The Person Centered Practice initiative is funded by the Tennessee Council on Developmental Disabilities and the Centers for Medicare and Medicaid Services (CMS) Real Choice Systems Change Grant. The work is facilitated by Support Development Associates and the National Association of State Directors of Developmental Disability Services. Implementation of the program for this year included five target sites: four residential providers and one developmental center. Once a site is committed to the program, their associated partners become a part of the process as well. Associated partners include other professionals involved in supporting the person such as: the DIDD Regional Office and Central Office employees, Advocate agencies, DD Council employees, and Independent Support Coordinators.

A focal point for this program year was strengthening the work of leadership and program coaches at each site. The leadership and program coaches worked alongside their partners on identifying barriers that prevented the necessary level 1, 2, and 3 changes from occurring within the statewide service delivery system.

Accomplishments for the year:

- Relationship building and better (open) communication between the various providers, DIDD Regional and Central Office employees, and Independent Support Coordinators;
- Consistent use of the Person Centered Thinking Tools in Individual Support Plan and Circle of Support meetings;
- More people trained in Person Centered Thinking;
- Providers experiencing the benefits of Person Centered Practices through positive interactions with Direct Support Professionals;
- Individual Support Planning was revised to include Person Centered Prompts and information is sorted in a bulleted format;
- Individual Support Plan Training was updated to include Person Centered philosophy;
- The first Tennessee Gathering was held in May 2011, allowing people an opportunity to share learning experiences that have occurred as a result of the project;
- Six new Person Centered Thinking Trainers have been credentialed and
- Eight people are currently in the process of being credentialed as People Planning Together Trainers.

Person Centered Practices continues to grow and become a cornerstone of the Department service delivery system. The philosophy and belief of this program is becoming everyday business of the Department. Along with the continued support from the Tennessee Council on Developmental Disabilities, further growth and impact on the service system in Tennessee is expected.

SERVICE SYSTEMS

As stated previously, the Department operates three Home and Community Based Service waiver programs in the community. Contracted community agencies provide the approved waiver services with direct oversight from the Department. The Bureau of TennCare and the federal CMS office also provide oversight of the programs.

In addition to and in conjunction with the HCBS waiver programs, the Department has developed unique support systems that enhance the provision of waiver services through Regional Resource Centers, Assistive Technology Clinics, Employment Opportunities, Day Services, Personal Assistance, varied models of Residential Supports and comprehensive Behavioral Supports. All of the enhanced systems are described below.

RESOURCE CENTERS

Each region of the Department operates a Regional Resource Center that provides clinical and assistive technology services. The Centers provide specific clinical services not readily available in the community. Persons served by the Centers are those enrolled into any of the three HCBS waiver programs the Department offers, persons living in state operated ICF/ID homes and/or specified protected class members.

Assistive technology services include assessment, design and the manufacturing of customized seating and alternative positioning equipment. Traditional and alternative funding mechanisms for manufactured equipment are pursued as needed. Assistive technology services are the most frequently utilized service at the Centers.

In April 2011, the West Resource Center began operating with full service availability. The Middle Tennessee Resource Center is providing assistive technology services only, and the East Tennessee Resource Center is providing clinical and assistive technology services to individuals who have transitioned from Greene Valley Developmental Center to the state operated ICF/ID homes.

The Core Workgroup of the Resource Centers, with the guidance of a Steering Committee and private sector consultants, has continued to build upon previous strategic planning. Staffing, funding, policies, services, service delivery standards, training, and data systems support continue to be addressed.

ASSISTIVE TECHNOLOGY CLINICS

The Assistive Technology (AT) Clinics and Custom Fabrication Shops are components of the Regional Resource Centers. There is both an AT Clinic and a Custom Fabrication Shop located in each of the three Centers.

Each AT Clinic is staffed with a experienced therapy staff including Assistive Technology Practitioners (ATP) certified by the Rehabilitation Engineering & Assistive Technology Society of North America (RESNA), physical therapists, occupational therapists, occupational therapist assistants, and physical therapist assistants. The Custom Fabrication Shop staff includes custom design fabricators and rehabilitation technicians with extensive experience in the areas of construction, carpentry, upholstery, and electronics.

EMPLOYMENT OPPORTUNITIES

The Department is collaborating with The Tennessee Department of Labor and Workforce Development, the Division of Rehabilitation Services and a host of other state and community-based agencies to implement the *Tennessee Ticket to Work Initiative (TTWI)*.

Designated by Commissioner Henry as one of his top priorities, the early stages of this initiative have established the groundwork for an unparalleled level of partnership with other major employment systems to increase the number of Tennesseans who are employed.

The Department has also collaborated with a variety of state agency partners and community stakeholders on applications for approximately \$3 million in federal funding to assist in Tennessee’s employment efforts.

DAY SERVICES

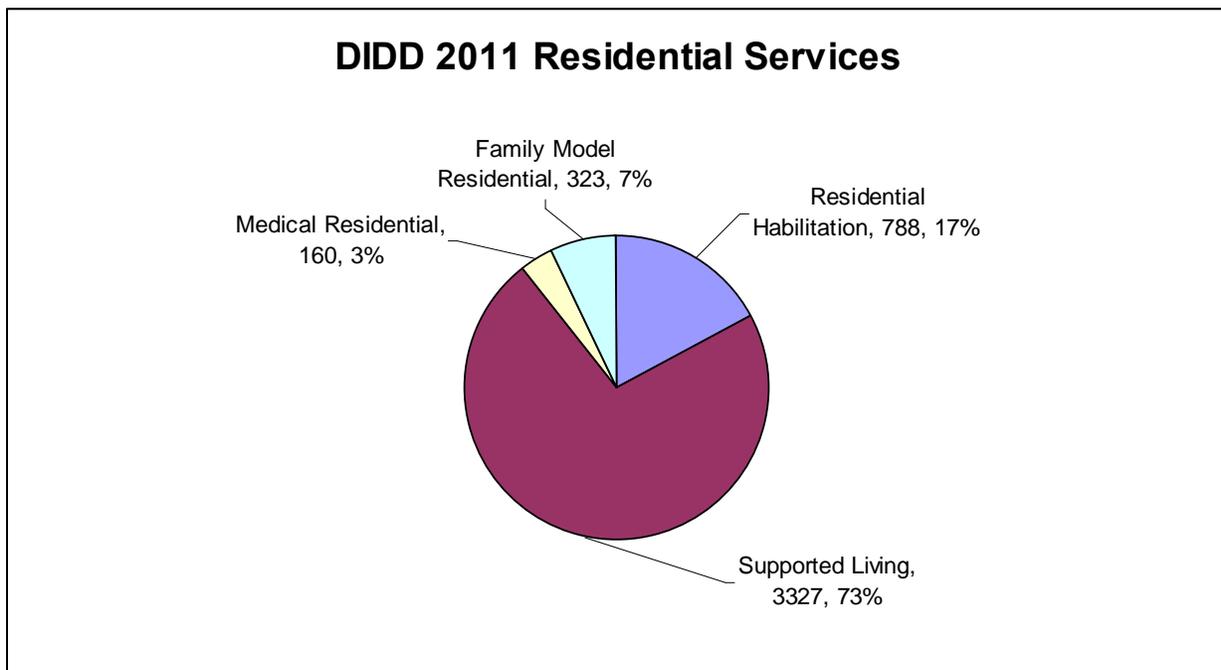
In addition to employment, the Department also funds community-based day and facility-based day services. The tenet of “productivity, inclusion and independence” is at the core of Day Services. Inclusion in the community develops a person’s potential for work or volunteering; establishing friendships; greater independence as well as the ability to realize one’s own talents and skills.

PERSONAL ASSISTANCE

Personal Assistance includes supports with activities such as bathing, dressing, building social skills and attending appointments. Individuals who live with their families often use this service to supplement the support their family members are able to provide.

RESIDENTIAL SERVICES

At the end of the FY 2010-2011, 4,598 people were enrolled in a residential service. Residential supports represent the highest cost of all waiver services. The chart below identifies the census and percentages of each residential model at the end of the fiscal year.



Below are the four basic types of residential services available and the most distinct differences between the types of services available under each service model.

Residential Habilitation: requires that no more than four persons live in the home unless the home was in existence prior to July 1, 2000. The Provider agency owns or rents on behalf of the persons living in the home. Room and board charges are applicable but can be no more than 80% of this year's maximum Supplemental Security Income (SSI) payment. Most often, the provider arranges housemates and selects the staff. While the people supported have some say in how they carry out their daily activities there is less choice available to a person receiving residential habilitation services. Each home must be licensed by the Department of Mental Health.

Supported Living: is a home environment in which three or fewer persons reside. Persons supported have assistance to rent or own the dwelling of their choice, pay their own bills, choose housemates and participate in the selection of their staff. Choice is a large part of the supported living experience. Supported living represents the largest number of people receiving a residential service. A housing inspection is required. The Provider who supports the person must obtain a license to provide the service.

Medical Residential: is a specialized residential habilitation or supported living service for people who require skilled nursing services on an ongoing basis. This service requires additional licensing by the Department of Health for the medical component. The home would be either licensed or inspected as required.

Family Model Residential Services: are modeled after the adult foster care program. Persons supported live in the home of the caregiver family. Room and board charges are applicable but can be no more than 70% of this year's maximum Supplemental Security Income (SSI) payment. No more than three persons may reside in the home under this service. For children under 18 in the waiver program, it is the only residential service available. This service is well suited to meet the needs of some people and generally provides longevity of caregivers. The contracted agency is licensed for the service by the Department of Mental Health.

During FY 2010-2011, the Department assisted in finding shared living arrangements for 52 persons who had previously been in a single person placement, enabling the leverage of funding to support more people in our waiver programs. During the fiscal year, 122 persons started receiving a residential service.

The Department utilizes the Inventory for Client and Agency Planning (ICAP) as the required uniform assessment by the Centers for Medicare and Medicaid Services (CMS) for determining appropriate level of need for residential and day services. The contractual administration of the ICAP is completed by a third party assessor, Ascend Management Innovations. During the past fiscal year over 4,000 ICAPs were completed.

DIDD employs two full time Housing Inspectors as well as contracting with Kingsport Housing Authority for the inspection of all supported living homes. Each year over 2,000 homes are inspected and approved for the continuing habilitation needs of persons supported.

BEHAVIORAL SERVICES

An important initiative in FY 2010-2011 were the efforts by the Department to support an increasing number of individuals with high risk challenging behaviors. High risk challenging behavior is "behavior of such an intensity, frequency, or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behavior that is likely to seriously limit the use of, or result in the person being denied [independent] access to, ordinary community facilities" (Emerson & Einfeld, S.L. (2011). Challenging Behavior (3rd Edition) p. 7. New York: Cambridge University Press). Often people with these types of behaviors have complex biological, social, and mental health needs which require special approaches to supports.

Initiatives were taken in the program areas of Residential Services, Protection from Harm, Person Centered Planning, and Training:

- The Positive Change leadership group was initiated in the DIDD Central Office to bring together administrative and clinical staff to assess current supports for persons with high risk behaviors and to propose innovative, new ideas for this group of consumers.
- The Behavioral Advisory Council composed of five residential providers that actively support individuals with high risk challenging behaviors was formed. The Advisory Council was instrumental in providing input on the development of a new residential model for high risk behavior and to refinements of the Protection from Harm system.
- A new residential model was designed to serve individuals with intense, high risk challenging behaviors. The Behavior Advisory Council and the Psychiatric Planning Group had important input in the development of this new model. The Psychiatric Planning Group is a group of clinicians who have years of clinical experience serving individuals with high risk challenging behavior and mental health issues. The Intensive Behavior Residential model was submitted to TennCare for review.
- Continuous efforts to recruit new providers who had successful experience in supporting individuals with high risk challenging behaviors were made. The Director of Provider Development and the Coordinator of Behavior Services worked together to communicate the need for this service and to screen for providers with expertise.
- There has been increased monitoring of new enrollees for specific needs related to behavioral health supports. This effort identifies the person's unique needs and then helps match them with a residential provider that can support those needs. A successful pairing will result in a more stable placement and less risk for the individual with challenging behaviors.
- The Intensive Behavior Protection From Harm group was formed to study the practical protection from harm challenges involved in supporting high risk individuals in the community. This group is composed of the five residential agencies on the Behavior Advisory Council, the DIDD Central Office Protection from Harm staff, the Central Office Medical, Therapy, Nursing and Behavior Directors, and the Regional Behavior Analyst Directors. The work group is discussing issues and barriers to serving this population and how resources can be developed to help residential providers achieve success. Issues being addressed are legal, training, and psychological concerns involved when providing such specified services.
- Person Centered Planning approaches to risk were reviewed in order to assist behavior providers and human rights committees to incorporate these ideas in their process.

QUALITY MANAGEMENT AND SERVICE SYSTEM PERFORMANCE

In FY 2010-2011, the Department continued to utilize the Quality Assurance domains, outcomes and indicators as the foundation for the department's quality management system. The QA Unit utilized survey tools to measure overall provider performance levels in areas such as planning and implementation, safety, rights, health, work, provider capacity and financial accountability. In conjunction with the comprehensive provider surveys, QA surveyors also conducted individual reviews of a sample of persons enrolled in each of the state's three HCBS waiver programs. These reviews determined provider compliance with specific performance measures that addressed the Centers for Medicaid and Medicare Services (CMS) established assurance areas such as service plans, health and welfare and level of care.

The Department adjusted its methodology for monitoring the performance of Support Coordination agencies in FY 2010-2011. These surveys were based on the whole of the performance of support coordination agencies throughout the survey year, instead of reviewing based on a discrete sample pulled immediately prior to the survey.

The Department continued to utilize a data collection system that allows for trending of survey results over multiple years. Additionally, DIDD developed other automated processes for gathering and analyzing data from the performance measure reviews that are mandated by CMS.

The Department also continued to recognize providers that operate as outstanding performers and granted them relief by monitoring them on a less frequent basis than other providers. These providers are acknowledged via a listing on the department's web site and the presentation of a certificate.

The Department continued to request feedback about the quality assurance survey process from all providers as each survey was completed. The information that was received from these questionnaires was collated and analyzed so that the quality assurance process can be improved for the future. Review tools were updated to reflect changes in requirements and consistency of application of the survey tools remained a high priority for DIDD.

During the fiscal year, the QA Unit in Central Office assumed the responsibility for providing qualitative consultation for the state operated ICF/ID facilities. Previously each facility functioned independently in this area; Quality Liaison staff positions were added so that there could be a consistent approach within these facilities for quality assurance and improvement activities, including focus on the response to certification surveys. Specific activities included the development of an internal qualitative self-assessment that can be utilized in both the developmental centers and regional homes.

QUALITY ASSURANCE REVIEWS

During FY 2010-2011, Quality Assurance conducted and analyzed 205 provider reviews directed toward improvement of services throughout the system.

The survey tools continued to focus on ten Quality Assurance Domains and related Outcomes, applied as applicable based upon the type of services an agency provides.

Domains:

1. Access and Eligibility
2. Individual Planning and Implementation
3. Safety and Security
4. Rights, Respect and Dignity
5. Health
6. Choice and Decision-Making
7. Relationships and Community Membership
8. Opportunities for Work
9. Provider Capabilities and Qualifications
10. Administrative Authority and Financial Accountability

Data obtained from these Quality Assurance reviews is utilized to guide provider improvement and facilitate positive change.

Table 1: Quality Assurance Performance Levels Across Years:

Quality Assurance Performance Levels cumulatively across all provider types across multiple fiscal years are shown in the chart below.

* The categories of Exceptional and Proficient performance continue to show overall trends toward increased performance with the Proficient category showing slight reduction following last year's peak.

* It is noted that a significant change in the process for monitoring Independent Support Coordination agencies was implemented during FY 2010-2011. Instead of determining a sample of individuals to survey to assess the quality of services to the individual during the ISC QA survey, data gathered throughout the year during the various waiver Individual Record Reviews is now utilized to assess the provider's performance in regard to established Quality Assurance Outcomes and Indicators.

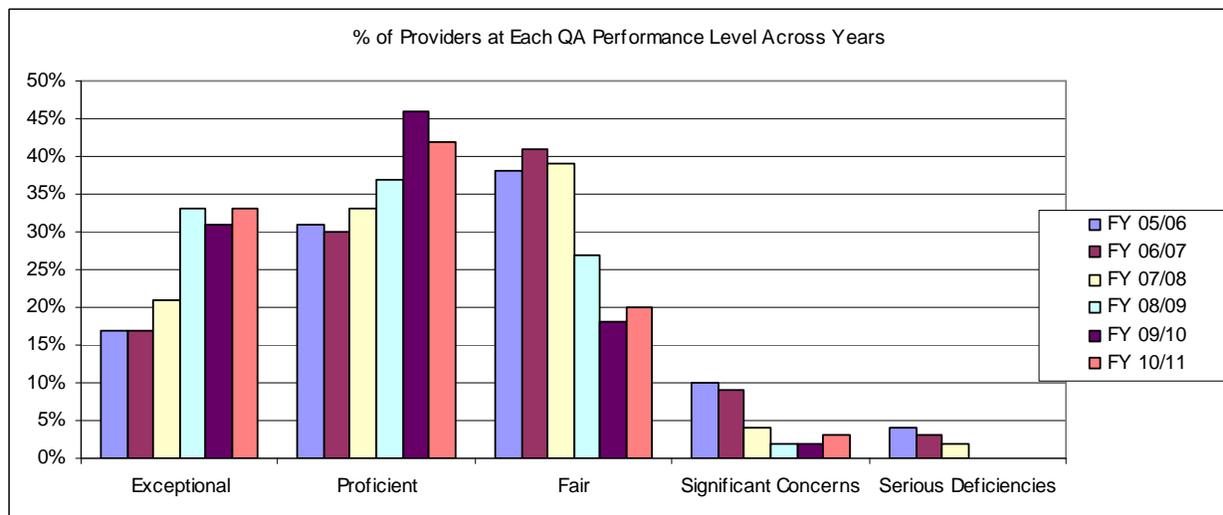


Table 2 represents the distribution of the 205 Quality Assurance surveys conducted among the various provider types in FY 2010-2011.

Quality Assurance surveys are conducted for the various types of providers annually, except for independent clinical providers (which may be surveyed every three years) and providers achieving either three-star or four-star status, the designation of which allows for these providers to be surveyed every other year.

Table 2: Number of Quality Assurance Surveys Completed, FY 2010-2011:

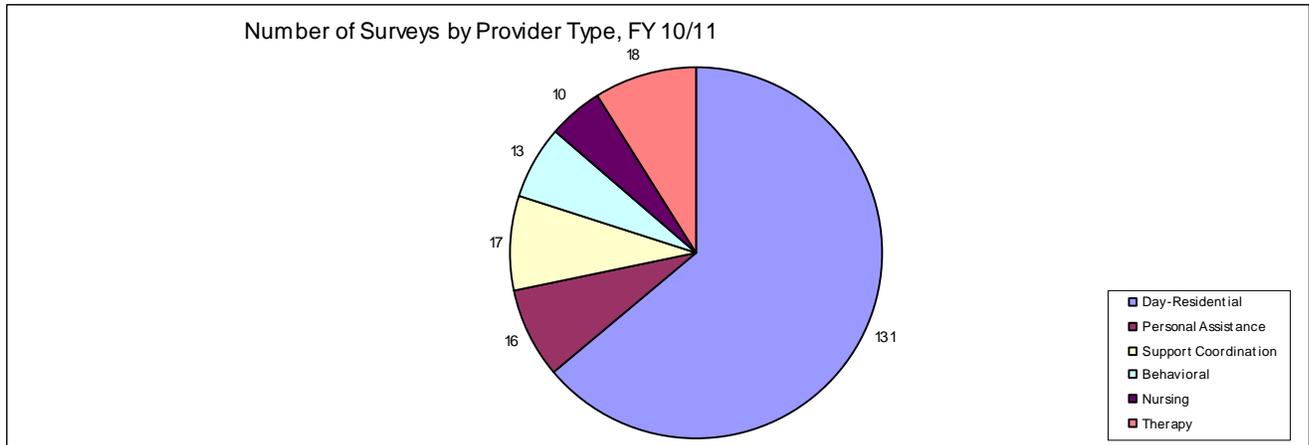


Table 3 (below) shows the distribution of Quality Assurance performance ratings regionally for FY 2010-2011.

* In the East region, the majority of providers continue to perform in the Exceptional category, despite a reduction from 48% to 44% of providers at this level in FY 2010-2011.

* In the Middle region there has been an increase in the number of providers achieving both Exceptional and Proficient performance during this past fiscal year.

* The West region has experienced an increase among Exceptional and Fair performance with a decrease in the number of providers achieving Proficient performance.

Table 3: Quality Assurance Performance Across Regions:

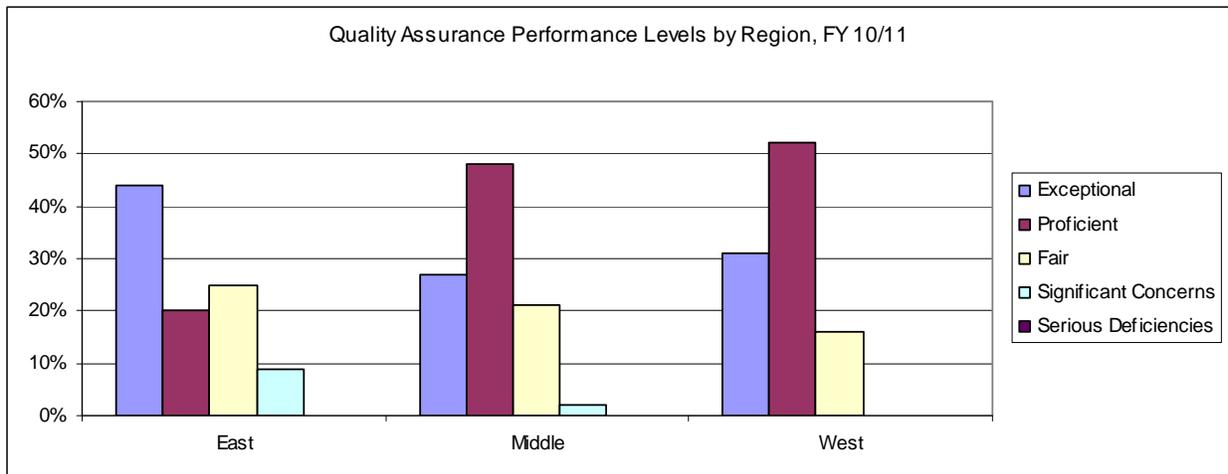


Table 4 represents the distribution of performance levels across all provider types for FY 2010-2011.

* In comparison, the percentage of providers achieving Exceptional Performance has increased from 31% in FY 2009-2010 to 33% in FY 2010-2011, with a similar increase in Fair performance from 18% to 20% for the same periods.

* Providers in both the East and West regions have contributed to an overall statewide reduction in the percentage of providers achieving Proficient performance (from 46% in FY 2009-2010 to 42% in FY 2010-2011).

Table 4: Percentage of Providers at Each Quality Assurance Performance Level:

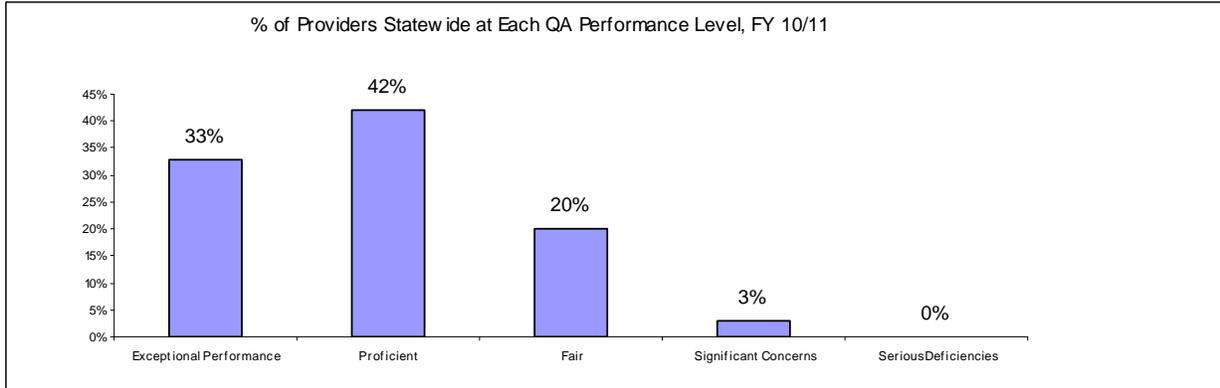


Table 5 shows the distribution of the various provider types reviewed by Quality Assurance among the QA performance levels in FY 2010-2011.

* Across all provider types, 75% of providers scored within either the Exceptional Performance or Proficient levels, 20% were at the Fair level, with 3% at the level of Significant Concerns.

* No providers were found to be within the category of Serious Deficiencies during the FY 2010-2011.

Table 5: Quality Assurance Performance Levels by Provider Type:

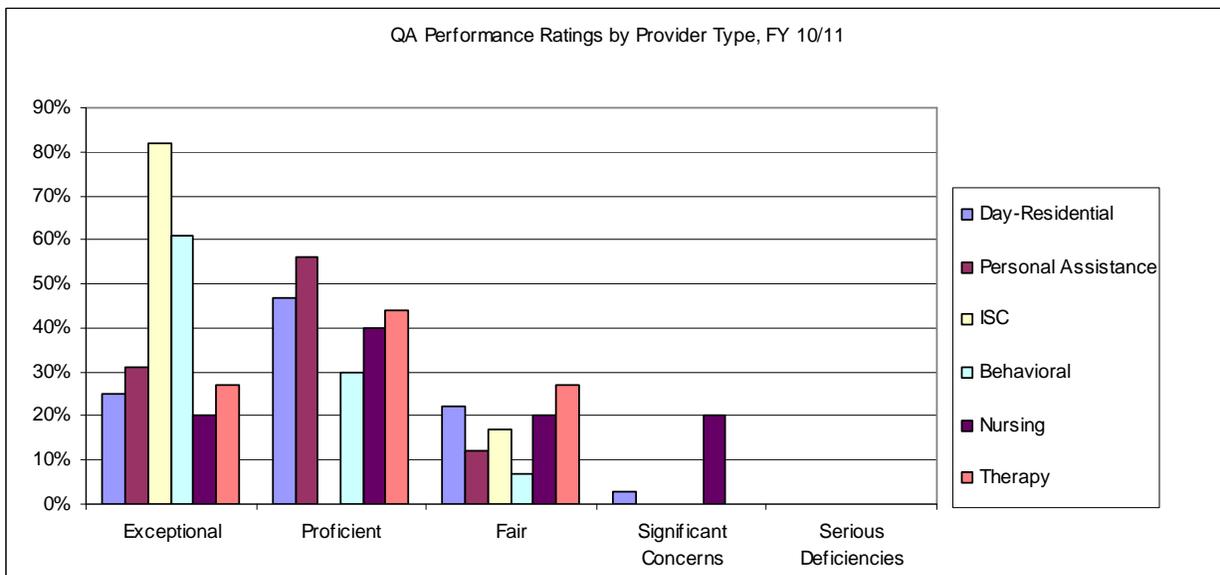


Table 6 shows the distribution of Substantial Compliance by Quality Assurance Domain across fiscal years.

* All Domains, except for Domain 1 (applicable only to ISC agencies) have shown trends toward improvement across the seven survey year periods reviewed, when comparing FY 2004-2005 to FY 2010-2011.

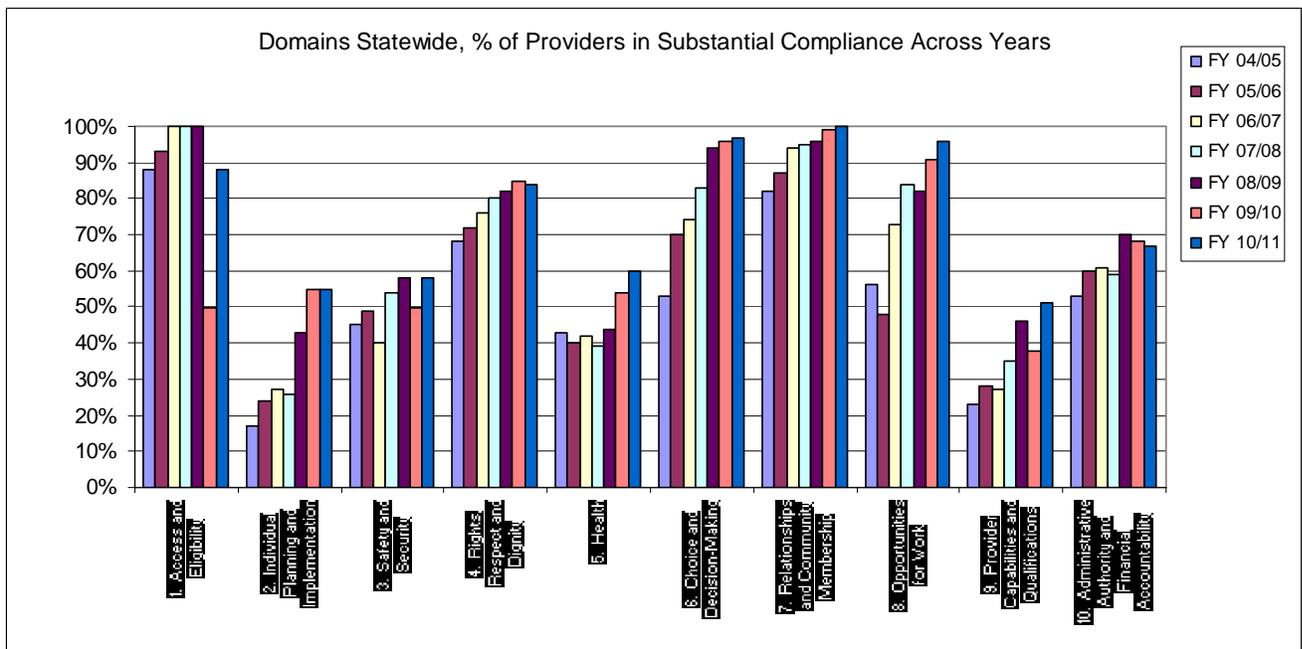
* Domains 6 and 7 have shown consistent improvement across all years (no upward / downward fluctuation).

* The most significant improvements across years have been in Domain 2 (increase from 17% to 55%); Domain 6 (increase from 53% to 97%) and Domain 8 (increase from 56% to 96%).

* Only Domains 4 and 10 were shown to have reduced performance from FY 2009-2010 to FY 2010-2011; however, this regression was minimal.

* Domain 1 demonstrated a marked improvement for ISC agencies from 50% compliance in FY 2009-2010 to 88% compliance this FY, rebounding to levels more closely resembling past performance.

Table 6: Domains Statewide, Percentage of Providers in Substantial Compliance Across Years:



HCBS Waiver Performance Reviews:

The QA Unit is also responsible for conducting Individual Record Reviews to determine compliance with CMS approved performance measures in the assurance areas of Level of Care, Health and Welfare and Service Plans. During FY 2010-2011 the QA Unit conducted 820 reviews, utilizing a random sampling process for each of the three approved waivers.

The QA Unit also conducted reviews for the Qualified Provider assurance area as a part of each agency performance review.

PROTECTION FROM HARM

The Department is committed to the health, welfare and safety considerations for all persons receiving services. The Protection from Harm (PFH) System was developed so that it would be a component in all program areas of the Department. PFH is focused on two areas: the Incident Management System and Investigations. Central Office PFH staff collect and enter provider and individual specific information into data management systems. Both regional and state Quality Management Committees review this information to make decisions regarding provider technical assistance and/or follow up actions. The data collected is used for trend analysis in incidents and investigations, determining training needs and identifying systemic issues that may need to be addressed.

The Department also ensures a safe service system through active participation in the Tennessee Department of Health's Abuse Registry program. The PFH system allows that any support staff substantiated for egregious incidents of abuse or neglect be considered for placement on the Tennessee Department of Health's Abuse Registry. Persons on this public registry are not able to provide care to vulnerable adults or children, especially in paid caregiver roles.

The PFH system partners with various statewide committees to ensure that incidents are reviewed fairly and consistently across the state. PFH staff participated with the Behavioral Analysis Committee in reporting requirements for individuals with mental health concerns, the Relationship Committee and the Regulatory Relief Committee. Internal system improvements have been a result of these participations. Most notably, Chapter 18-Protection from Harm, of the *Provider Manual*, was revised and released in March 2011. The changes in Chapter 18-Protection from Harm provided some systems changes that are beneficial to the persons supported and Provider agencies.

THE INCIDENT MANAGEMENT SYSTEM

In collaboration with providers, families/guardians, legal representatives and other stakeholders, the Department defined events and incidents that must be reported. All providers must develop and implement a system that provides for appropriate and timely reporting of reportable incidents, as well as appropriate and timely response to the incidents.

Contracted provider staff who witness or discover an incident are required to submit to the responsible provider and to the DIDD Central Office a written document of "reportable" incidents. DIDD defines Reportable Incidents, in its *Provider Manual*, as all allegations of abuse, neglect, exploitation, and staff misconduct, as well as those medical, behavioral, and psychiatric incidents that require an "external" intervention, such as an emergency room visit or intervention on the scene by police.

Providers also must implement internal incident management processes and maintain personnel sufficient to review and respond to all reportable incidents. Providers must ensure that they document each incident, and the initial response to the incident, on the Reportable Incident Form. They must review all provider incidents every other week to identify management actions needed to address the incidents and prevent similar future incidents. Finally, providers must review trends or patterns in their incident data to identify at-risk persons supported by services and provider-level incident prevention planning strategies.

During FY 2010-2011, DIDD recorded 12,876 reportable incident reports from providers.

Regional provider Incident Management Coordinator training and discussion sessions are held quarterly to keep providers updated on current trends and to serve as a system opportunity to continue prevention strategies. Meetings include small group activity involving the review and analysis of selected incident reports. In FY 2010-2011, quarterly sessions included the following topics and presentations:

- Revisions to the *Provider Manual*, Chapter 18-Protection from Harm, effective March 1, 2011;
- Supported Living housing inspections, with comments by the inspectors;
- Death investigation trends;
- Incident trends;
- In addition to requested training on fall prevention issues, a presentation of *Remembering When+* an integrated fall prevention and fire prevention training was provided and

- Identification of factors affecting staff staying awake during night shifts.

The Department has worked with providers on injury prevention initiatives and training, and while it is not possible to pinpoint definitively the effects of these efforts on injury rates, there has been no increase in serious injury rates despite increases in service population age from year to year.

THE INVESTIGATION SYSTEM

The Department Investigations Unit worked diligently in FY 2010-2011 to review reportable incidents and investigate all allegations of abuse, neglect, and exploitation. Over the course of the fiscal year the Investigations Unit continued its work to collaborate with other state agencies that also support vulnerable adults to best serve those that we work to support. Such collaboration was evidenced in the unit's involvement in CAARE (Communities Against Abuse in Residential Environments) and Adult Protective Services' Multidisciplinary Team (M-Team).

DIDD Regional Investigators completed 2,497 investigations in FY 2010-2011. Investigators found preponderance to substantiate abuse, neglect or exploitation in 855, or 34% of these cases. Neglect, specifically supervision neglect, where a staff person is not engaged in providing appropriate supports to a person supported by services, remains the most common type of substantiation, accounting for over 50% of all substantiations. The average rate at which investigations were substantiated during FY 2010-2011 was .82 substantiated investigations per 100 people served.

The DIDD Substantiated Investigation Search (SIS) web application (2006 inception) enables providers to verify that potential hires have not been identified as perpetrators in substantiated investigations within the DIDD service delivery system. While use of the system is not mandatory, it is used by 150 contracted agencies, and produces a match rate of approximately 23%.

The Statewide Investigation Review Committee (IRC) reviewed 25 final investigation reports at the request of the Provider agencies. Thirteen final reports were upheld and 16 were overturned based on new or additional evidence not available at the time of the initial investigation.

DIDD is an active participant in Tennessee's Department of Health Abuse Registry. During FY 2010-2011, a total of 89 former paid caregivers of contract providers were placed on the registry as a direct result of the efforts of DIDD investigative staff, the Abuse Registry Referral Committee, and the DIDD Office of General Counsel.

During FY 2010-2011, DIDD approved 300 of 311 (96%) provider requests for exceptions to required Administrative Leave during an investigation, as outlined in Chapter 18-Protection from Harm of the *Provider Manual*. These requests were also approved by the individuals' families or legal representative and accompanied by a plan to ensure the safety of the persons supported by services.

The Clinical Investigator provided nursing opinion and investigative assistance for 77 medical investigations during FY 2010-2011. The Clinical Investigator also developed and presented the Sexual Abuse/Assault for Providers training in Regional Provider Incident Management forums. During FY 2010-2011 the Clinical Investigator tracked investigations related to medication administration and complaints made against dental providers. The Clinical Investigator worked to refer nine licensed professionals to the Department of Health/Health Related Boards for review with regard to practice issues and two referrals were made to TennCare as they related to TennCare funded services. The Clinical Investigator continued to track death investigations over this reporting period, maintaining a log of all deaths which were investigated and their subsequent conclusions.

DEATH REVIEWS

The Department's comprehensive service system includes a review of all deaths of persons with intellectual and developmental disabilities. The purpose of the Departmental policy on death reviews is to establish a system for conducting systematic reviews of deaths of persons with intellectual or developmental disabilities to identify factors that may have contributed to the death, to recommend necessary preventive measures, and to improve supports and services for all persons in the system. Death Reviews are completed by DIDD Regional Office Death Review Committees.

Death Rates (Unadjusted)

	FY 06-07	FY 07-08	FY 08-09	FY 09-10	FY 10-11	Five-Year Average
Developmental Center and Community Death Rate	1.64 per 100	1.38 per 100	1.44 per 100	1.88 per 100	1.91 per 100	1.65 per 100
Developmental Center Death Rate	2.73 per 100	2.59 per 100	2.65 per 100	2.86 per 100	2.20 per 100	2.60 per 100
Community Death Rate	1.55 per 100	1.30 per 100	1.37 per 100	1.06 per 100	1.90 per 100	1.43 per 100

The information above is over five years. Persons living in developmental centers exhibit a slightly higher death rate than those who reside in the community. It is believed that the health risks of those residing in developmental centers is higher as evidenced by through the Physical Status Review/Health Risk Screen Tool (PSR). Persons in developmental centers have higher PSR scores than those in the community.

The PSR identifies risk factors for people as having two or more chronic health problems that changed at least once within the last 12 months; or, a combination of chronic health conditions that are predictably unstable and require intervention by a licensed nurse, primary care provider, and/or required licensed professional intervention more than every two hours in a 24 hour period.

Therefore, it is reasonable to expect a higher mortality rate in a more medically fragile population.



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Regional Offices

- Memphis 901-745-7200
800-308-2586
- Jackson 731-423-5670
- Nashville 615-231-5047
800-654-4839 - Intake and Referrals
- Chattanooga 423-634-6149
- Knoxville 865-588-0508
888-531-9876 - Intake and Referrals
- Greenville 423-787-6757
- Johnson City 423-434-6530

Developmental Centers

- Clover Bottom /HJC 615-231-5000
- Greene Valley 423-787-6800



Department of Intellectual and Developmental Disabilities, Authorization No. 344061, 20 copies, February, 2012. This public document was promulgated at a cost of \$11.84 per copy.