



The State of Tennessee

Department of Finance and Administration

Division of Mental Retardation Services

Annual Report July 1, 2007 – June 30, 2008



STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF MENTAL RETARDATION SERVICES
ANDREW JACKSON BUILDING
500 DEADERICK STREET, 15th FLOOR
NASHVILLE, TENNESSEE 37243

Dear Reader:

The Division of Mental Retardation Services (DMRS) is the state agency responsible for services for Tennesseans with mental retardation. Programs designed by DMRS are provided with funding from state revenues as well as various grants and federal Medicaid Waiver monies. In an effort to be transparent and to provide information to stakeholders the DMRS Compliance Unit created the Annual Report.

During Fiscal Year 2007–2008, DMRS worked diligently toward the goal of improving the community-based delivery system in order to ensure sufficient and quality services. The purpose of the annual report is to measure performance based data and determine if progress is being made in various service delivery systems. 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. The narrative and data, when taken together, should provide the reader with an 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 2007 - 2008

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 2007-2008: Steady Progress Forward

Steady progress was achieved during Fiscal Year 2007-2008 in both the developmental center and the community arenas. The number of people residing in the facilities continued to decline as people chose to move out of the centers and to live in community placements. On the community side, the oversight of Waiver services was enhanced when DMRS rewrote its application for the renewal of the SD Waiver in accordance with the new Centers for Medicare and Medicaid Services (CMS) requirements. Satisfactory resolution of issues for individuals will continue to be emphasized.

Highlights of productive DMRS activities during Fiscal Year 2007-2008 are as follows:

- **Building a Person-Centered System – From Person-Centered Thinking to Person-Centered Practice**
 - In October 2007, CMS awarded funding for a six-state collaborative of developmental disabilities (DD) agencies to incorporate person-centered planning (PCP) tools and practices as integral components within the infrastructure of each state's service delivery system. Support Development Associates and the National Association of State Directors of Developmental Disability Services has been providing leadership in this initiative. The project extends efforts currently underway in Tennessee and the other participating states to train provider agency staff, support coordinators, individuals receiving support, families and others in person-centered methods. The project is based on the implementation of a model process for "Becoming a Person-Centered Organization" that results in changes at three levels:

- *Level One*: changes in day-to-day practice that impact persons' lives and their relationships with formal and informal supports; *Level Two*: changes in provider agency management and leadership affecting organizational policy, practice, and program outcomes; and *Level Three*: changes in service delivery system infrastructure statewide resulting from changes in regulation, state policy, and system design.
- The initiative, also known as “Good to Great”, has been jointly funded by the Tennessee Council on Developmental Disabilities and Centers for Medicare and Medicaid Services (CMS) Real Choice Systems Change grant. The State of Tennessee has been pleased to join a number of other states (and countries) in this effort to embed person-centered practices within all levels of the system. The desired end result is for organizations to be more efficient in their work while helping the people who use their services have lives of their own choosing as included members of their communities.
- This initiative has resulted in the development of strong, outcome-focused partnerships between DMRS, participating provider organizations and Independent Support Coordination (ISC) agencies. We have had three agencies participating during the first year with plans to expand in subsequent years. There has been an incredible level of commitment from all involved.
- Tennessee’s first year activities have included a number of training activities addressing topics such as person-centered thinking, person centered plan development and building community connections. In addition, each site has developed a coaches group consisting of front line managers, Independent Support Coordinators and others. The coaches have received extensive training and support every other month and have implemented a number of “Level One Changes”.
- Each site has also developed a Leadership Team whose membership includes senior managers from the provider organizations, DMRS leadership, collaborating ISC agencies, persons receiving services and coaches. DMRS participation has included a diverse group of leaders from both the central and regional offices. Having decision makers at the table has been critical to ensure the implementation of needed “level two” and “level three” changes. The leadership teams meet every other month to take advantage of learning from the coaches regarding what is working/not working from the perspective of people receiving services. Barriers to person-centered practice are identified and actions are taken to promote needed change.
- The grant-funded initiative extends for an additional two years. DMRS leadership has been meeting to address identified Level Three Changes and to plan for next steps. The focus will be on continuing support of the three focus sites, expanding the initiative, including moving forward with needed level three changes, and building in-state capacity to further efforts to become a person-centered system.

- **Budget**

The Governor's Budget for FY 07-08 was \$28.0 billion. Of this amount, \$857,748,300 was allocated for the DMRS operating budget. An additional supplemental appropriation of \$4,958,000 and \$1,080,600 in ISIS funding was added to the Division's budget for a total operating budget of \$863,786,900. Actual expenditures totaled \$864,750,300 or .11 percent over budget. The Governor's budget also included \$200,000 in capital appropriation for the Greene Valley Developmental Center Master Plan.

- **Quality Assurance**

- The DMRS Quality Assurance tools for provider performance have now been used throughout four consecutive years, providing valuable data that is utilized by multiple stakeholders to identify and study performance trends, as well as make decisions about quality improvement, across the multiple Domains, Outcomes and Indicators of quality.
- A process for reduced monitoring frequency has continued to be implemented to reward providers achieving multiple criteria signifying the highest standards of performance.
- Inter-rater reliability exercises continue to be utilized to measure the degree of agreement among surveyors reviewing Day-Residential providers. The data resulting from inter-rater reliability reviews is utilized to identify opportunities for improvement in interpretation and implementation of Quality Assurance guidelines and processes.
- Throughout the year, Quality Assurance has been involved in development and refinement of processes associated with specific monitoring of the Self-Determination Waiver.

- **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.
- 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. With that goal in mind, DMRS and TEC collaborated on an extensive redesign of the Job Coach Training Curriculum. DMRS is piloting the revised curriculum through the College of Direct Support.

- **Family Support**

BACKGROUND

The Division of Mental Retardation established the Family Support program in FY 1988-1989 with a small allocation of \$108,000. The Division chose to administer it via Division field staff rather than provide services under contract. There was a very small amount of funding, and the Division wanted to assure that all of it would go for services. During the years that the program was small, this method of administration was effective.

As a result of a significant push by several advocacy groups to target the area of Family Support as one which could be further strengthened by enabling legislation, a bill was introduced and passed in 1992 which dealt with the importance of Family

Support services and the need for broad-based consumer support of it (Title 33; 33-1-101 and 33-5-201 thru 33-5-211). The legislation highlights principles which are universally accepted about Family Support (family focused, easy to access, consumer driven). It also broadened the eligibility criteria from the division's traditional criteria, which depend largely upon the definition previously sanctioned by AAMR. The Family Support eligibility criteria are functional in nature and loosely follow those of the federal developmental disabilities definition. Finally, the legislation created the Family Support State Council, a group of 15 members, the majority of whom are consumers or representatives of consumers. The State Council has one representative from each developmental district in the state and a representative of the Tennessee Council on Developmental Disabilities, Tennessee Disability Coalition, Tennessee Community Organizations, Centers for Independent Living, and two at-large members for the Department of Mental Health and Developmental Disabilities. Additional Division staffs provide administrative support for the Council which meets at least quarterly.

The State Council, established in July 1992, initiated several changes in the program. The most significant of these is the move to a system of contracting for Family Support services. During FY 1992-1993, the State Council developed a request for proposal document as well as guidelines for the program as it would be delivered by private, non-profit agencies. The result of this change is during December 1993; all counties in Tennessee are receiving Family Support services from local community agencies. Local and District Councils have been established for the purpose of oversight of the program.

Due to the success and the overwhelmingly positive response that the family Support program had with consumers, the yearly allocations continued to grow. The program grew for the initial allocation of \$108,000 to \$7.6 million. The Family Support program has been one of the most successful service components in Tennessee. It provides funding for all disabilities and all ages.

- 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 that have severe disabilities other than mental retardation 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.

FY 2007-2008

\$6,583,912 million was spent on direct services.

The average expenditure per family was \$1,523.

4,324 families received services.

6,256 families are waiting for services.

- **Communication**
 - The DMRS Communications Office placed strong emphasis on image in 2008. 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 webpage was updated in an effort to create a uniform look with other state departments. 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. 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.

- **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 2007-08, OCFS participated in numerous statewide special education and advocacy forums as presenters of DMRS information. Furthermore, OCFS conducted thirty-five (35) statewide family training sessions that were held in the evenings and on Saturdays with an overall attendance of 180 persons. The purpose of these trainings was to educate persons with a diagnosis of 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, conservatorship, 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 Self-Determination Waiver Program**
 - Prior to renewal of the Self-Determination Waiver Program, CMS requested evidentiary-based information from the state of Tennessee concerning service provision in the Self-Determination Waiver Program. In June 2007, based upon its review of Tennessee’s evidentiary package submission, CMS recommended that the State should obtain technical assistance from a Thompson (Medstat) consultant regarding CMS expectations for waiver quality assurance. After receiving the technical assistance, the State submitted the revised evidentiary-based information to CMS in October 2007.

- In late September 2007, the state of Tennessee formally submitted its request to CMS to renew the Self-Determination Waiver Program. CMS granted extensions of the waiver program to allow the State time to convert the waiver submission to the newly-developed Version 3.5 format and to develop a comprehensive workplan that included a revised quality assurance program. On July 25, 2008, CMS approved the Self-Determination Waiver Program for the 5-year period beginning January 1, 2008.

Status of Federal Lawsuits

United States v. State of Tennessee (Arlington)

On September 11, 2007, the Western District Federal Court approved the agreed upon definition for the 'at risk' category of the class. Since that time, potential new class members have been screened and 269 class members have been enrolled. Efforts to screen and enroll new class members continue. In addition, efforts to implement the 2006 Settlement Agreement, including the Closure Plan for Arlington Developmental Center, also continue. In February 2008, People First filed a motion seeking to hold the State in contempt for alleged failure to comply with the 2006 Settlement Agreement. The State filed an answer in response denying these allegations. As of June 2008 this motion has not yet been set for a hearing.

People First v. Clover Bottom

Following the filing of the motion to have the Harold Jordan Center dismissed from this action on the basis of substantial compliance with the institutional requirements of the Settlement Agreement, the parties conducted discovery and expert reviews. A hearing on this motion is set for January 7, 2009. 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.

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. Following an impasse on the attempt to reach an agreement on the number of class members to be enrolled for years three through five of the settlement agreement, the plaintiffs filed a motion asserting that DMRS failed to comply with the requirements for the first two years. At the same time, a motion was filed on behalf of DMRS to vacate and dismiss the settlement agreement based on a change in law. Based upon a recent decision of the Sixth Circuit Court of Appeals, the State asserted that the settlement agreement was based upon a mistaken legal premise and should be dismissed. The Middle District Federal Court denied the motion to vacate in September 2007 and the State appealed this decision to the Sixth Circuit Court of Appeals. DMRS has continued to enroll individuals from the waiting list at a rate of 50 per month. During Fiscal Year 2007 – 2008, the net effect in change to the Waiting List was an increase of 369 people.

The People DMRS Serves

People in the Community

DMRS provides a wide range of services contracting with approximately 450 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 7400 individuals. DMRS, in partnership with the Bureau of TennCare and the Division of Developmental Disability Services, operates these Waivers. The federal government provides about 63 percent of this funding, and the state government provides the remaining 37 percent.

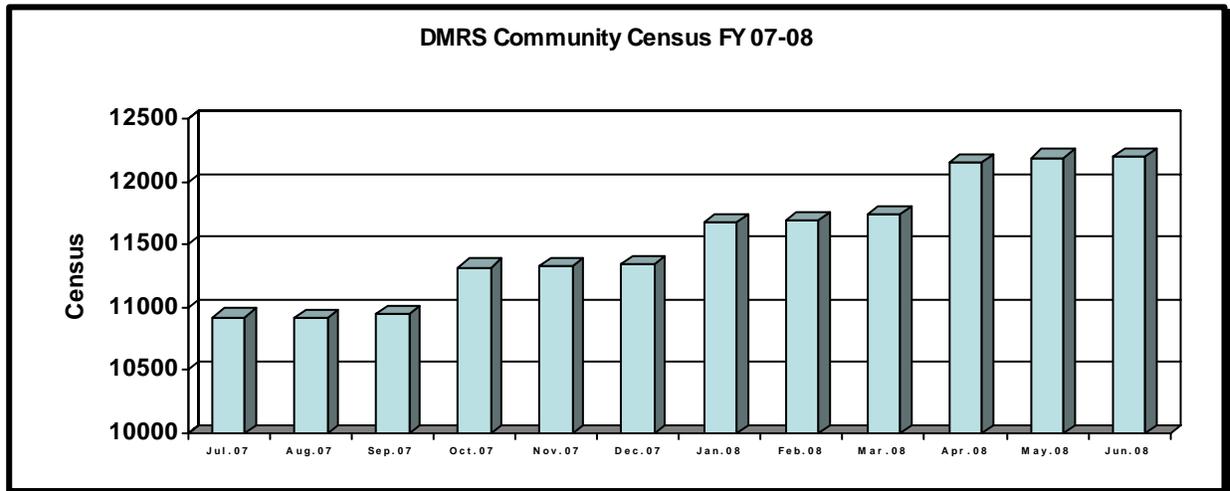
The state government also provides funding for more than 4324 people in the Family Support program. Local organizations, such as the United Way, and individual contributors provide additional support to local service providers. The Medicaid Waiver program, however, is by far the largest source for funding services.

The following table gives specific monthly census numbers of persons enrolled in each DMRS community program during FY 07-08. 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-07 | Aug-07 | Sept-07 | Oct-07 | Nov-07 | Dec-07 | Jan-08 | Feb-08 | Mar-08 | Apr-08 | May-08 | Jun-08 |
|-------------------------|--------|--------|---------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| Statewide Waiver | 6026 | 6032 | 6053 | 6058 | 6062 | 6064 | 6078 | 6079 | 6080 | 6092 | 6091 | 6062 |
| ADC Waiver | 224 | 227 | 230 | 231 | 232 | 232 | 233 | 237 | 241 | 245 | 256 | 289 |
| SD Waiver | 944 | 959 | 968 | 973 | 984 | 988 | 1000 | 1017 | 1052 | 1065 | 1091 | 1116 |
| State Funded | 481 | 447 | 443 | 440 | 431 | 439 | 428 | 425 | 430 | 425 | 430 | 414 |
| Family Support | 3250 | 3250 | 3250 | 3620 | 3620 | 3620 | 3936 | 3936 | 3936 | 4324 | 4324 | 4324 |
| Census Total | 10925 | 10915 | 10944 | 11322 | 11329 | 11343 | 11675 | 11694 | 11739 | 12151 | 12192 | 12205 |

Chart 1: DMRS Census by Month for Community Waiver Services



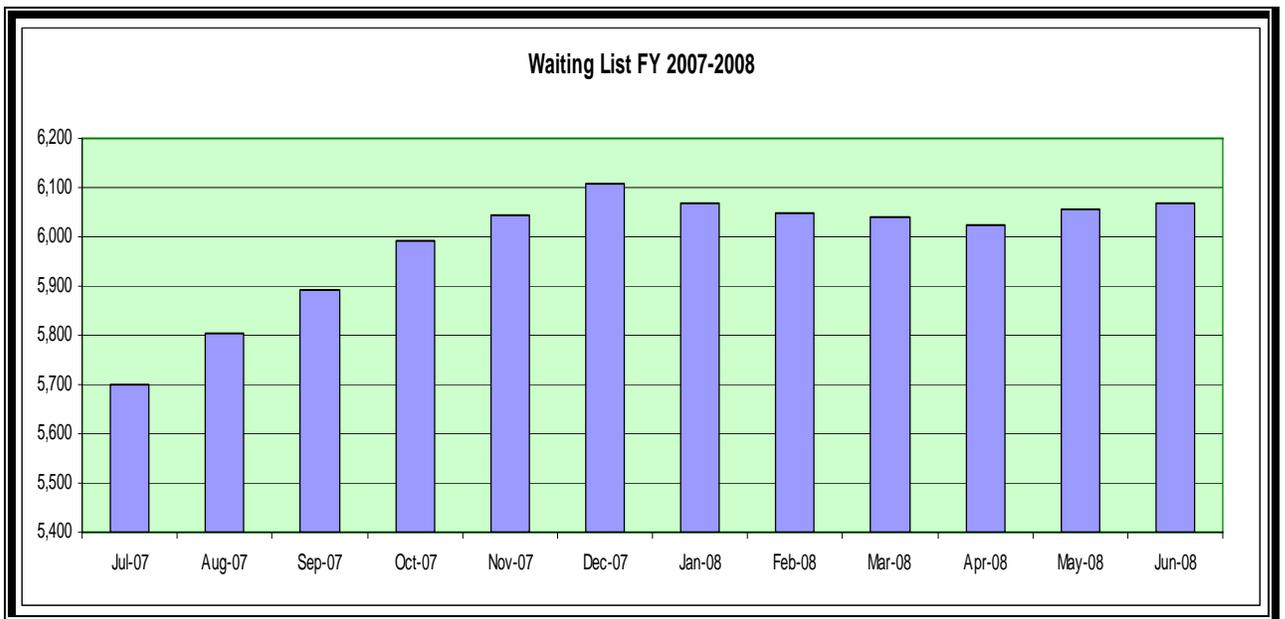
Waiting List

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 2007-2008, the Division saw a net increase in the waiting list of 369 people. In July 2007, the wait list was at 5,700 people. By June 2008, the list was at 6,069. This was a dramatic drop from the previous fiscal year in which the wait list increased by over a thousand people.

The following chart shows the wait list census for the fiscal year.

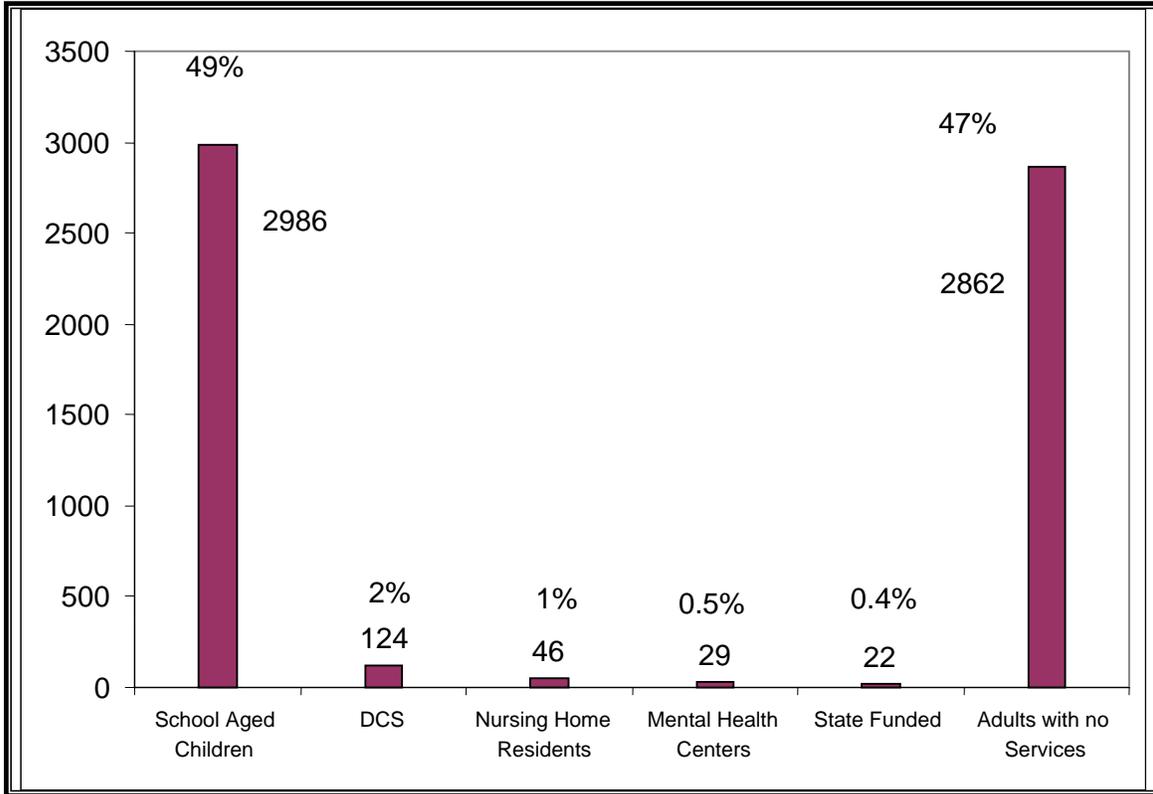
Chart 2: DMRS Wait List Census by Month for Waiver Services



Waiting List Demographics

The Division maintains demographic information of people who are seeking services. The wait list was broken down by categories of people who have mental retardation and are in one of the following: school aged children (age 0-22), children in DCS custody, persons in Nursing Homes, persons in Mental Health Centers, persons receiving DMRS state funded services, and adults with no services. The chart below identifies the percentage of those populations on the DMRS Waiting List as of June 30, 2008.

Chart 3: Waiting List Demographics for Waiver Services



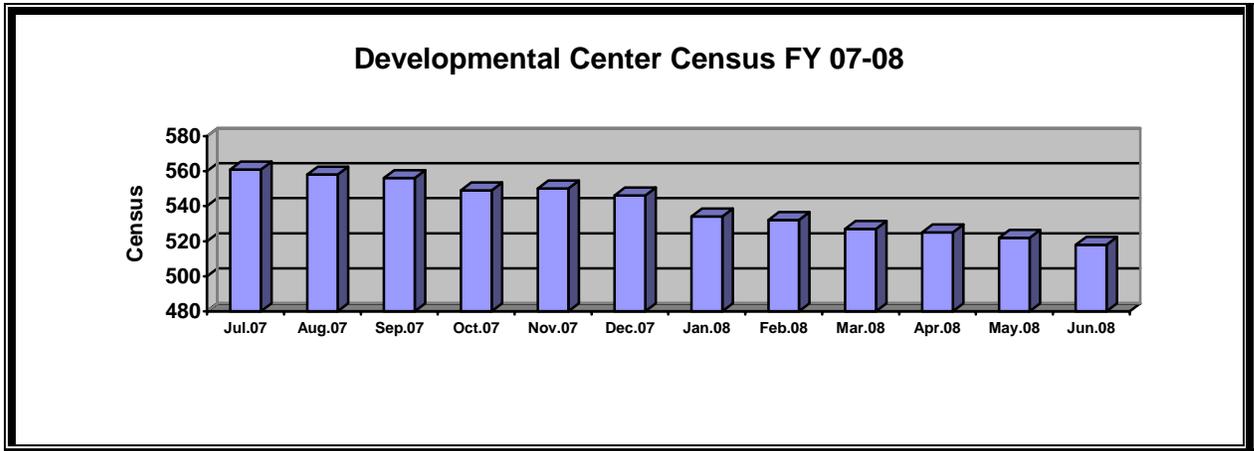
Throughout the fiscal year, these same demographic statistics remained relatively the same. When people are placed on the Waiting List, there are some options available. To provide some help, the Division continued its Consumer-Directed Supports (CDS) program. This program provides financial assistance to those who qualify. The monies can be used for respite services, as well as short-term, in-home support. A total of \$4,576,686 was provided to families during this past fiscal year.

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. These Assistive Technology clinic services are available to both people living in the ICF/MR facilities and in the community. During FY 07/08, the number of people living at the Developmental Centers declined by 43 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.

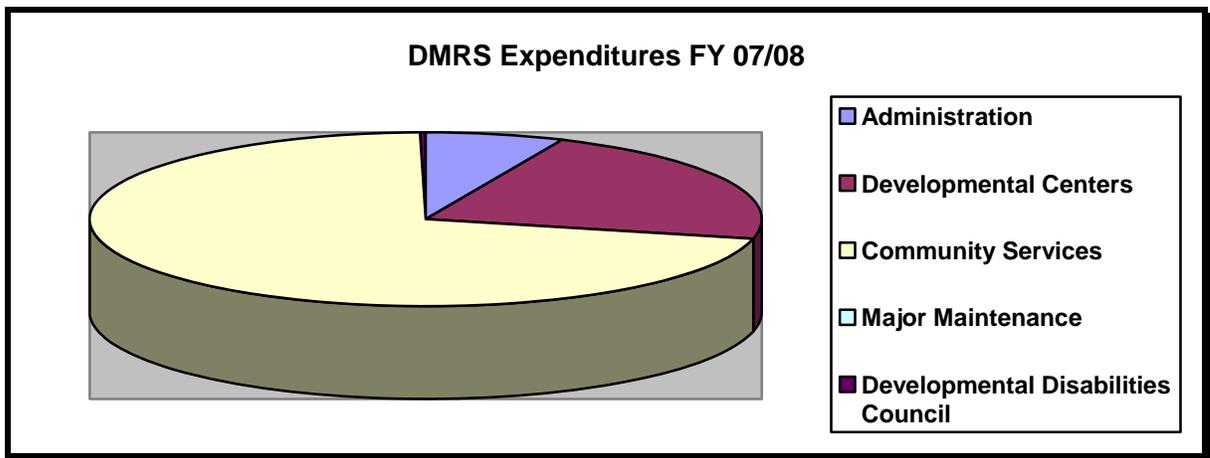
The Harold Jordan Center, located on the Clover Bottom Developmental Center campus, is a facility for persons with mental retardation who have been charged with a crime. The state petitioned the court for dismissal in June 2007. In its motion to dismiss Harold Jordan Center from the lawsuit, the state maintained it had demonstrated gains and maintenance of substantial compliance in the areas of institutional care and services, and protection from harm. An extensive review of Harold Jordan Center is in process for the duration of FY 07-08 and will continue into the FY 08-09 to determine if the center is in substantial compliance. Dismissal is pending.

Chart 4: Statewide DMRS Developmental Center Census



Where the Money Goes

Chart 5: Division Expenditures



As shown in chart 5 above, of the \$864,750,300 in DMRS expenditures, 71 percent of the money went to Community Services and 22 percent of expenditures for FY 07/08, went to the State's three Developmental Centers.

Quality Management System Activities

The DMRS Advisory Council

The DMRS Advisory Council (DAC) was formed to provide stakeholders the ability to periodically come together and have open forums and discussions regarding the overall management of the DMRS service delivery system, which includes the vision, mission, and philosophy that guides the management of the system. DAC is composed of representatives from the DMRS provider community and advocacy organizations, as well as, service recipients and their family members. The Deputy Commissioner chairs the meetings and other DMRS staff attend on a regular basis.

The DAC meets on the second Thursday of each month. During monthly meetings, members are provided with updates on a variety of DMRS business such as new or ongoing projects and initiatives, the status of lawsuits affecting DMRS, and any finalized reports about current service recipients, people waiting for services, and provider quality assurance survey results. 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, the DAC has reviewed and provided valuable input on proposed changes to DMRS internal operating policies, amendments to the waiver programs and revisions to the provider manual. In addition, DAC members have provided feedback following the implementation of new 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), continued training for families with input from the Family Volunteer Committee. Families received training 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 March of 2008, 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, 35 trainings were conducted statewide between April and July of 2008, with an overall attendance of 180 persons.

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, Teacher Conferences, Faculty Meetings, Colleges, 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, 11 separate family training sessions were conducted. The trainings were held in Paris, Memphis, Covington, Millington, Humboldt, Brownsville, Bolivar, Dyersburg, Trenton, Lexington and Jackson.

| <u>West Tennessee Total Attendance</u> | <u>Average Evaluation Rating</u> |
|---|---|
| 81 | 4.3 on 5.0 scale |

In East Tennessee, 13 separate family training sessions were conducted. The trainings were held in Cleveland, Dandridge, Dayton, Chattanooga, Kingston, Farragut, Knoxville, Sevierville, Maryville, Loudon, Bristol, Johnson City and Rogersville.

| <u>East Tennessee Total Attendance</u> | <u>Average Evaluation Rating</u> |
|---|---|
| 24 | 4.8 on 5.0 scale |

In Middle Tennessee, 11 separate family training sessions were conducted. The trainings were held in Dickson, Gallatin, Franklin, Shelbyville, McMinnville, Dover, Winchester, Nashville, Smithville, Lebanon and Crossville.

| <u>Middle Tennessee Total Attendance</u> | <u>Average Evaluation Rating</u> |
|---|---|
| 75 | 4.5 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 DMRS, Consumer-Directed Supports, the Family Support Program, the HCBS Waiver Programs and services available through the different waivers, how to apply for DMRS services, the differences between the category of needs on the waiting list, the correct procedure and steps to follow in order to access services, how to report changes in family circumstances, available community/generic resources, and DMRS contacts.

I really liked this about the training.

The overall comments from attendees who completed this section indicated they were overwhelmingly satisfied with the organization and presentation of so much in-depth information, the presentation handouts, and the presenters' professionalism, knowledge, and friendliness. They also noted satisfaction with the Question and Answer period, the ability to network with others who share the same concerns and the small group setting. A number of attendees noted they were pleased that the locations of the facilities were in close proximity to their homes.

This could have been done differently during the training.

There were very few comments given and two of them pertained to reserving facilities that included tables in the meeting rooms. The majority of attendees stated nothing could have been done differently.

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 after school recreational activities for their children, Legal Matters (i.e., conservatorship, special needs trusts, estate planning), secondary transitioning process, microboards, respite and support care in the home, procedures to make changes within the system, procedures to advocate/lobby for their cause, vocational job training, employment opportunities for persons with disabilities, and Self Determination Waiver.

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 2009. This unit will also begin to revise the Family Handbook.

Consumer Experience Surveys

The Division of Mental Retardation Services (DMRS) contracts with the Arc of Tennessee to conduct consumer experience surveys for individuals receiving DMRS residential and community services throughout Tennessee. The Arc of Tennessee 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 and telephonic interviews with persons served. Survey interviews are conducted using the Center for Medicaid and Medicare Services (CMS) approved Participant Experience Survey. The process includes nine teams of two individuals (nine individuals with a disability paired with nine individuals familiar with disabilities) working 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?

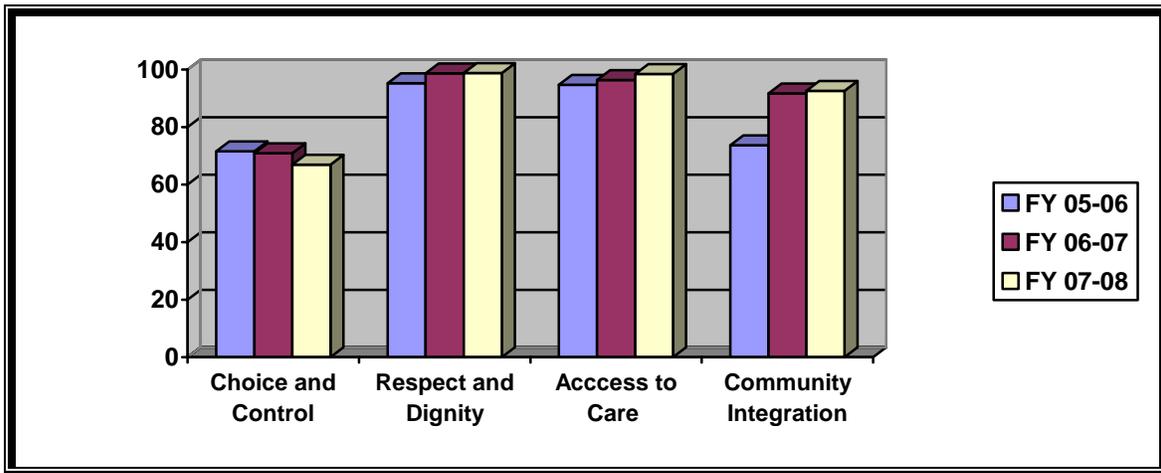
Results

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.

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 6: People Talking to People Satisfaction Survey Results

These percentages were calculated by removing interview responses that were not applicable/unsure/unclear/no response--ie. percentage of people responding affirmatively to only the people responding either affirmatively or negatively.



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. The project will continue to conduct approximately 1,200 interviews on an annual basis.

Statewide Annual Training Report

Previously in FY 2006-2007 DMRS Implemented a 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

In FY 2007-2008 DMRS Continued Efforts to Implement a Nationally Recognized Web-Based Training Program State-wide for all DMRS Stakeholders

- DMRS' commitment to implement a nationally recognized web-based training program for direct support professionals was drafted into the Arlington Developmental Center Closure and Community Transition Plan and was conditionally approved
- DMRS granted numerous contracted service providers access to the College of Direct Support as participants in the pilot of the CDS web-based training
- DMRS Central and Regional Office training staff partnered with TNCO members to develop an action plan for implementing the CDS web-based training
- DMRS developed a Technology Survey for determining technology resources available and needed for implementing the CDS web-based training
- DMRS Mentor Guide and Skill Standards Tool workgroup completed the development of the guide and the tool and initiated a pilot for implementing the on-the-job mentor guide and skills standard tool
- DMRS Regional Training Staff facilitated monthly forums for contracted service providers' training staff to keep them updated on the implementation of the CDS web-based training program
- DMRS training staff partnered with contracted service providers' training staff to draft proposed changes to the DMRS Provider Manual Chapter 7 to accommodate the implementation of the CDS web-based training program
- DMRS training staff drafted and posted recommended Tennessee specific annotations to the CDS web-based training
- DMRS training staff drafted a Tennessee DMRS College of Direct Support Administrators Handbook
- DMRS announced a July 1, 2008 "Go Live" implementation date for the CDS web-based training
- DMRS, in partnership with the College of Direct Support staff, facilitated regional forums for contracted service providers' executive directors and designated CDS administrators to prepare organizations for the July 1, 2008 "Go Live" implementation date for the CDS web-based training

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.
- 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.
- Provide oversight/monitoring of the Medication Administration Training Program for Unlicensed Personnel.

Mortality

DMRS Death Review and Death Reporting

The United States Government Accountability Office (GAO) Report conducted in May 2008 (released July, 1, 2008) specified that “The Centers for Medicare and Medicaid Services should encourage states to conduct comprehensive Mortality Reviews when people with developmental disabilities die while receiving care through Medicaid home and community-based services.” Six basic Mortality Review components were identified in the GAO report as most important by the experts when reviewing deaths among individuals with developmental disabilities.

- In 2001, DMRS had already undertaken steps that established compliance with the GAO 2008 report. These steps included a significant event reporting and root cause process that systematically documents and assesses significant events (unexpected deaths and other safety issues).
- Listed below are the GAO Basic Components and DMRS Policy requirements that began in 2001.

| GAO Basic Components Recommendations | DMRS Policy 2001 |
|---|---|
| 1. Screen individual deaths with standard information | ✓ DMRS requires all deaths are reported using standardized forms to include an incident form within 4 hours of the death. |
| 2. Review unexpected deaths at a minimum | ✓ Deaths as defined in the DMRS definition of unexpected or suspicious death are reviewed at the local and central level. |
| 3. Routinely include medical professionals in mortality reviews | ✓ Per policy participants in the Mortality Review must include: independent physician, administrator of the agency, one program staff person, Independent Support Coordinator, Advocate or attorney who is not represented and will not represent, DMRS Death Review Nurse who prepared the Summary, additional members, PCP, Agency Director of Nursing and unrelated parent or guardian. Others may be necessary as deemed by the Commissioner. |
| 4. Document mortality review process, findings, or recommendation's | ✓ Minutes of the Mortality Review findings and recommendations are recorded and disseminated in accordance with policy. |
| 5. Use of mortality information to address quality of care | <ul style="list-style-type: none"> ✓ Recommendations must be responded to within 30 calendar days ✓ Each region has a tracking system to track and review all recommendations |
| 6. Aggregate mortality data over time to identify trends | ✓ DMRS has a data base for capturing demographic data, circumstances and events associated with the death, cause of death. |

Death Rates (Unadjusted)

Table 2:

| | FY 03-04 | FY 04-05 | FY 06-07 | FY 07-08 | 4-Year Average |
|---|-----------------|-----------------|-----------------|-----------------|-----------------------|
| Developmental Center and Community Death Rate | 1.2 per 100 | 1.1 per 100 | 1.4 per 100 | 1.76 per 100 | 1.36 per 100 |
| Developmental Center Death Rate | 2.3 per 100 | 2 per 100 | 2 per 100 | 2.74 per 100 | 2.26 per 100 |
| Community Death Rate | 1.1. per 100 | 1 per 100 | 1.4 per 100 | 1.59 per 100 | 1.27 per 100 |

At first glance, the four year death rate average appears steady in fiscal years 2004, 2005, and 2006. 2007 data demonstrates a slight upward trend of which DMRS is closely tracking.

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).

Behavior Supports

A statewide system to review the quality of behavior support plans (BSPs) 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. The number of plans each month, that included restraints or other restricted interventions were also tabulated. Regional Behavior Analysts provided feedback to the author of any plan that fell below the 80 percent correct on a standard checklist.

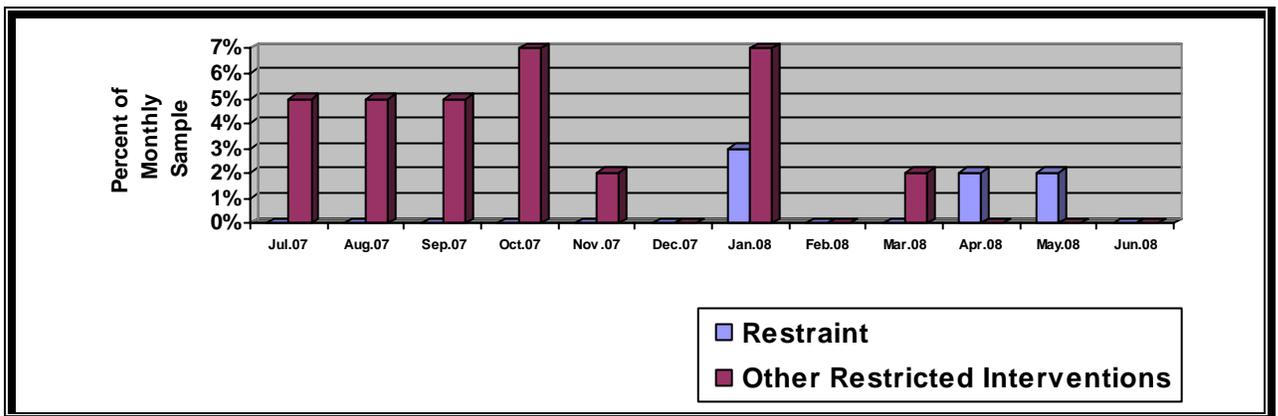
For each of the 12 months of this fiscal year, the bench marks were achieved across all the dimensions. Table 3 shows the average percentages for the previous fiscal year of 2006-2007 and for the current year. There were improvements in all the dimensions for this fiscal year. The percentages of the plans that included restraint or other restricted interventions were also quite low for this year as shown in Chart 7. These data suggest that DMRS has a quality stable behavior support system with relatively low use of restraint and restricted interventions.

This year, a multidisciplinary planning group was formed, titled the MR Psychiatric Planning Group. This group included psychiatrists, behavior analysts, psychologists, Intensive Consultation Team Directors, and legal, residential and behavioral staff from the Central Office staff. The group has discussed important service issues related to the treatment and service provision for complex individuals with mental health and behavioral issues.

Table 3: Behavior Support Plan Review

| Quality Measures | FY 2006-2007 Average Percent | FY 2007-2008 Average Percent |
|---|------------------------------|------------------------------|
| Proper Design | 89% | 95% |
| Proper Implementation | 89% | 94% |
| Progress on Objectives | 91% | 95% |
| Plans with Restraints | 1% | .6% |
| Plans with Other Restricted Interventions | 7% | 2.8% |

Chart 7: Monthly Sample with Behavior Plans involving Restraints and other Restricted Interventions FY 2007-2008



Behavior Service Provider Developments

During fiscal year 2007-2008, 22 applications for behavior analyst providers and 6 applications for behavior specialist providers were approved. All of these individuals, except one, chose to work for existing behavior agencies. The applications were somewhat evenly distributed across the three Regions. There was one behavior agency that expanded their existing services to another region and one behavior specialist that moved from an inactive status to an active status. See the summary tables below.

Table 4: Behavior Analyst, Behavior Specialist Application Activity FY 2007-2008

| Applicant Type | Requesting Credential Approval | Requesting Provider Agreement | Requesting Expansion of Existing Provider Agreement to add another Region | Requesting Reactivation |
|---------------------|--------------------------------|-------------------------------|---|-------------------------|
| Behavior Analyst | 22 | 1 | 1 | ----- |
| Behavior Specialist | 6 | ----- | ----- | 1 |

Table 5: Behavior Analyst, Behavior Specialist Approvals across Regions FY 2007-2008

| Applicant Approval Type | East Region | Middle Region | West Region |
|-------------------------|-------------|---------------|-------------|
| Behavior Analyst | 7 | 6 | 9 |
| Behavior Specialist | 1 | 2 | 3 |

Activities continue that are directed toward building and maintaining the professional quality of behavior providers. The number of behavior analyst providers with credentials from the Tennessee Health Related Board for Psychologists or certification from the Behavior Analyst Certification Board® has increased. Presently there 166 behavior analyst providers approved by DMRS, and 89 of these providers have credentials. There are currently 77 behavior specialists approved by DMRS. However, none of the providers are credentialed. Some of the behavior specialists are currently attending graduate training to become behavior analysts. There are currently 36 DMRS approved behavior analysts on provisional status and 10 behavior specialists on provisional status. Those providers on approved for provisional status have a three year period to acquire a credential. See charts below.

Regional behavior staffs continue to provide a rigorous clinical orientation for new behavior providers and the State Behavior Analyst provides monthly Behavior Seminars in each of the three Regions to share information about DMRS procedures and to share current research on behavior services.

Chart 8: Total Behavior Providers FY 2007-08

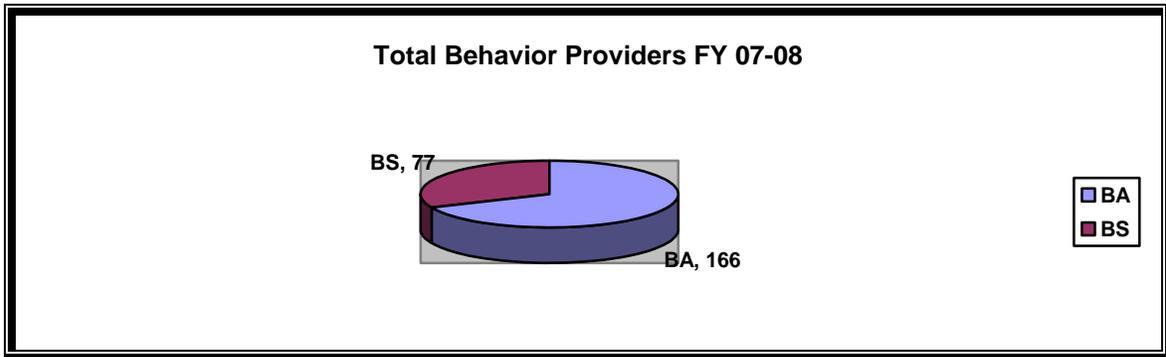
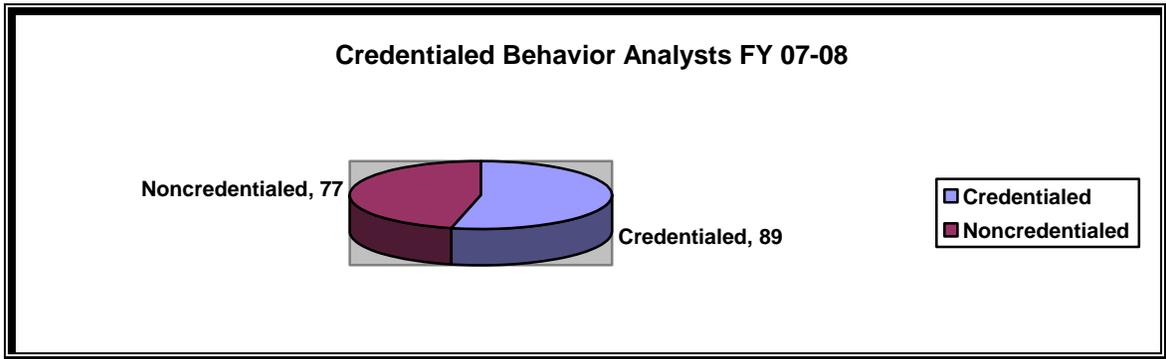


Chart 9: Total Credentialed Behavior Analysts FY 2007-08



Service System Performance and Analysis

Quality Assurance Reviews

Quality Assurance continued into Fiscal Year 2007-2008 with utilization of individual and provider reviews directed toward improvement of services throughout the system. As this is the fourth year of the revised Quality Assurance system within DMRS, the Division continued to utilize the resulting data to guide provider improvement and facilitate positive changes.

As with recent years, relatively few revisions to the Quality Assurance processes were made during the fiscal year. Adjustments on the QA processes primarily focused on refinement of surveyor skills and efforts toward increased surveyor reliability. The implementation of Three and Four Star Achievement criteria for reduced monitoring frequency allowed numerous providers to skip an annual Quality Assurance survey as high performance and other criteria were achieved. Fifteen agencies attained Star designations during the 2007-2008 Fiscal Year.

As with the revised process implemented in 2004, up to ten QA Domains continued to be assessed in FY 07-08, 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.

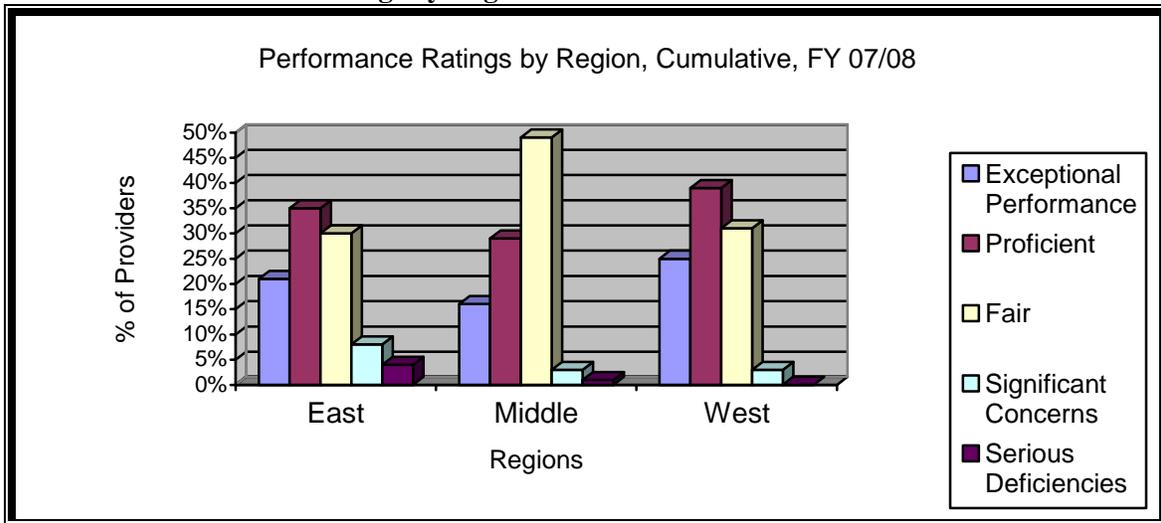
Review of Data Resulting from QA Review in Fiscal Year 2007-2008

The data that follows is representative of the variety of surveys conducted in FY 07-08, for the following provider types:

- 131 Day-Residential providers
- 13 Personal Assistance
- 21 ISC providers
- 18 Behavioral providers
- 5 Nursing providers
- 37 Therapy providers

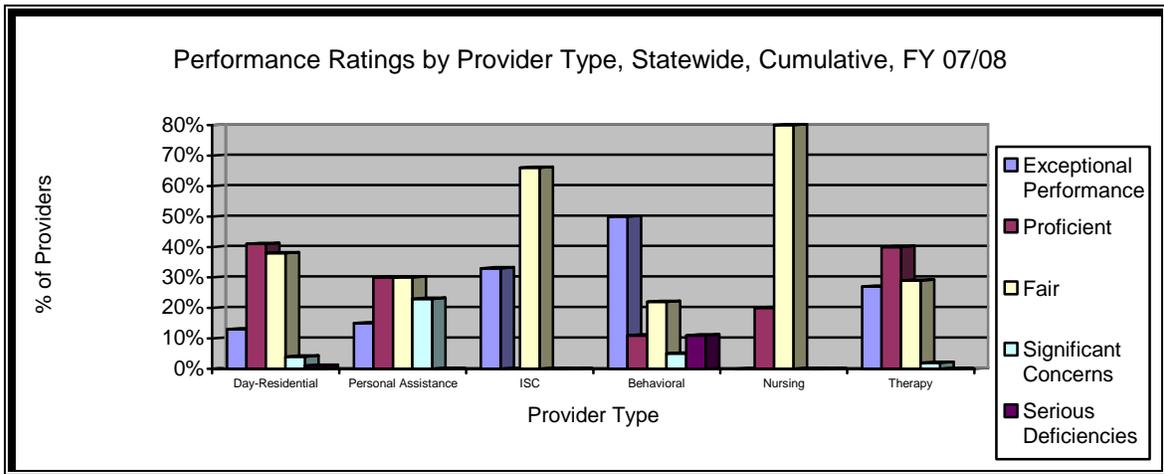
The following charts represent the distribution of performance rating categories regionally and by provider type in FY 07-08. Of note, providers in both the East and West regions, during FY 07-08, scored higher in the Proficient category of performance than compared to last fiscal year. While distribution of provider performance in the Middle region remained similar to last fiscal year, it is noted that the Middle region did experience and increase in the percentage of providers achieving the Proficient category of performance in FY 07-08.

Chart 10: Performance Ratings by Region



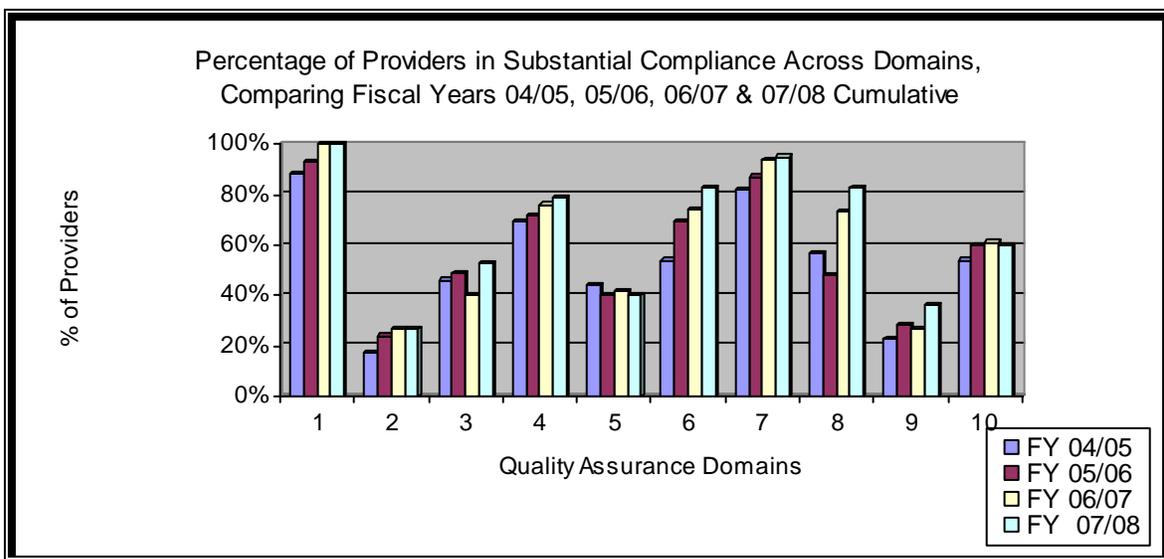
Similarly, Day-Residential providers in FY 07-08 demonstrated an increase in the number of providers scoring in the Proficient category. ISC providers demonstrated an increase in Fair performance. Behavioral providers were shown to have a marked increase in the percentage of providers in the Exceptional category while Therapy providers experienced increases in Proficient performance.

Chart 11: Performance Ratings by Provider Type



The chart below shows performance across all providers for each Quality Assurance Domain throughout the four years that the review system has been utilized. As shown, 90% of all Domains have demonstrated progress between FY 04-05 and FY 07-08; furthermore, 50% of all Domains have shown consistent upward trends/improvements from year-to-year during this period.

Chart 12: Percentage of Providers in Substantial Compliance

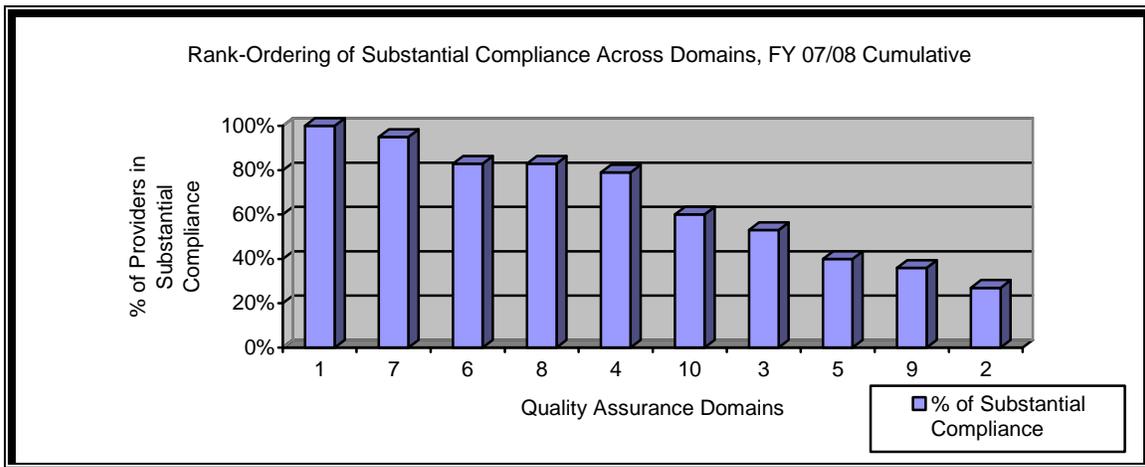


The most significant progress noted during the past year has been in Domain 6- Choice and Decision Making (from 69% Substantial Compliance in FY 06-07 to 83% in FY 07-08) and Domain 8- Opportunities for Work (from 73% Substantial Compliance in FY 06-07 to 83% in FY 07-08).

07-08). 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; however, both of these Domains have continued to show improvement in FY 07-08.

The following chart displays the rank-order of Substantial Compliance performance on QA Domains across all provider types and regions in FY 07-08.

Chart 13: Rank-Ordering of Substantial Compliance across Domains



As Quality Assurance continues with implementation of individual and provider performance reviews, preparations have been underway in FY 07-08 to develop and implement a quality review of performance measures associated with the Self-Determination Waiver. Quality Assurance anticipates that utilization of original QA data and new waiver specific data will continue to be utilized in the coming year toward further improvement of services to individuals supported.

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 07-08. 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 2007-2008, the Complaint Resolution System continued to make significant progress in establishing complaint resolution systems in each agency across the State. A statewide QA 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 addressing complaint issues, keeping records and working to resolve complaint issues at the provider level. Informational letters are sent to all new DMRS program enrollees inviting them to use the provider DMRS complaint resolution systems. During the period of 2007-08, many significant new aspects were 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. Trending reports can be easily generated from the website facilitating the tracking of complaint issues and contributing to the active remediation of chronic complaint issues.
- In 2007-2008, Complaint Resolution System coordinators and the Complaint Resolution System statewide director held face to face meetings with provider administrators and provider complaint contact personnel. Training was provided on a variety of topics such as conflict resolution, conservatorship, and customer service. Complaint Resolution System staff evaluated each provider's complaint contact log and checked to ensure that providers were sending informational letters to all their consumers describing the Complaint Resolution System process at their agency.
- Client satisfaction surveys were completed each month on ten percent of all complaints filed with DMRS statewide. During 2007-2008, 53 satisfaction surveys were completed; less than 5% of complainants contacted expressed dissatisfaction on the manner in which his/her complaint was handled. There are plans for the Complaint Resolution System coordinators to begin mailing satisfaction surveys to all complainants in August 2008 so they can critique the Complaint Resolution System process and make written suggestions or comments concerning their experiences using the complaint process.
- 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 2007-2008, 15 service recipients filed complaints; 14 of 15 recipients interviewed indicated that they were satisfied with the resolution of their complaints. The one service recipient was unhappy since they were unable to receive a satisfactory outcome to their request, but the request was not permitted in accordance with waiver guidelines.
- 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 2007-2008, the complaint resolution average was 97% 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 average for Fiscal Year 2006-07 was 98%. 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. Each unresolved complaint issue goes through a formal remediation process coordinated by the statewide director of the Complaint Resolution System. 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 2007-2008, there were a total of 431 complaints resulting in 556 issues that were addressed by the Complaint Resolution Coordinators. 69 of these 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 continued using a strategy called Intervention. The analysis of staffing issues indicated that there were some long-standing challenging 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 134 of these situations in this fiscal year. All of the Complaint Resolution staff has completed Mediation, as well as Investigations training. It is the goal for 2008-2009, to increase interventions and to also work to resolve chronic issues in the areas of environmental modifications and community-based transitions.
- Staffing issues comprised 49% of all complaint issues in 2007-2008. Special documentation and trending was created to capture staffing issues of staff supervision and staff communication. New strategies and policies are being developed statewide to improve the delivery of services in these areas. Specifically, the areas of Personal Assistance services, transitions and the process of obtaining environmental modifications were highlighted as problematic, and management teams are developing new strategies to improve these areas. Human Rights, health related, financial related, environmental related and ISC related complaints accounted for 51% of the remaining issues reported.
- Complaint Resolution staff continue to resolve any complaints referred by TennCare, and there were eight complaints resolved this year with TennCare. In 2007-2008 there were three complaints from TennCare and three complaints from CMS. All of these complaints were adequately resolved within the 30-day time period. Complaint Resolution staff continue to meet with TennCare staff on a monthly basis as part of the DMRS/TennCare Partners system.

Chart 14: Statewide Rate of Complaint Issues per 100 People

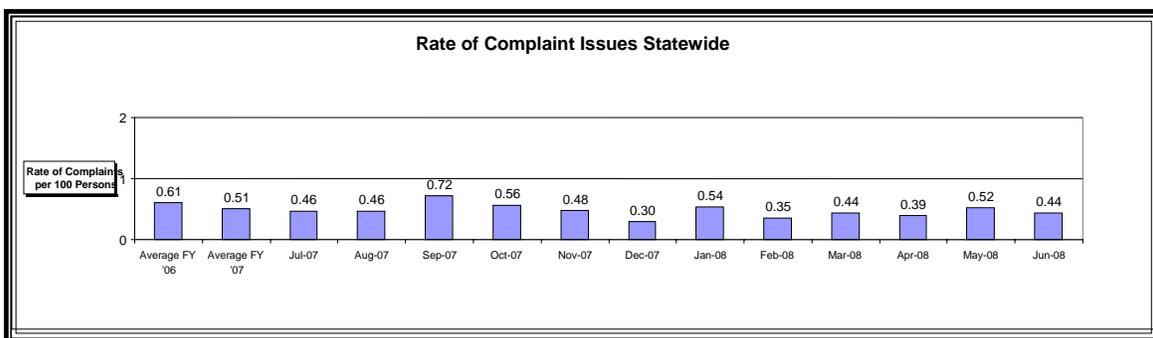


Chart 15: Complaint Issues by Category 07/08

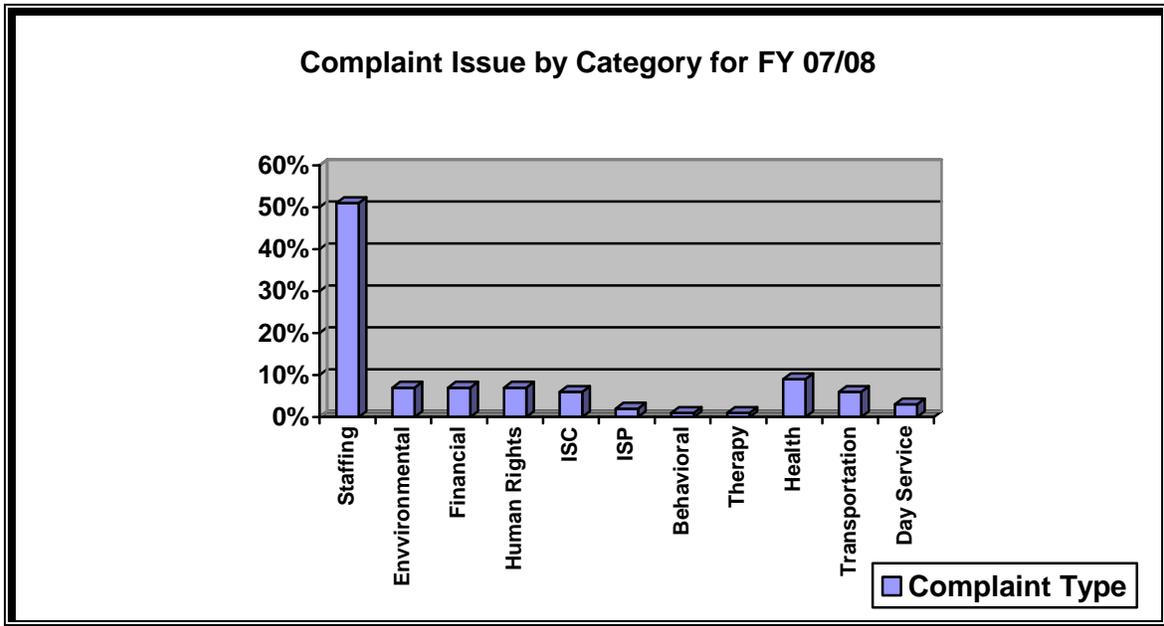
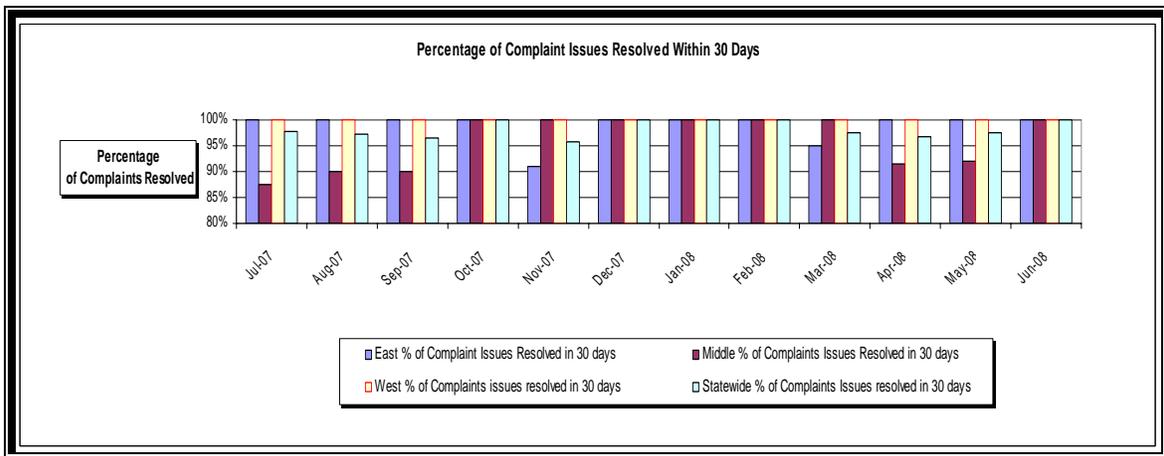


Chart 16: Percentage of Complaint Issues Resolved within 30 Days



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 those medical, behavioral, and psychiatric incidents 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 current DMRS Provider Manual was promulgated. Most pertinent to this report, the scope of medical and staff 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 internal 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 07-08, 11,703 incidents were entered into the DMRS Incident & Investigation database.

The DMRS Incident & Investigations database:

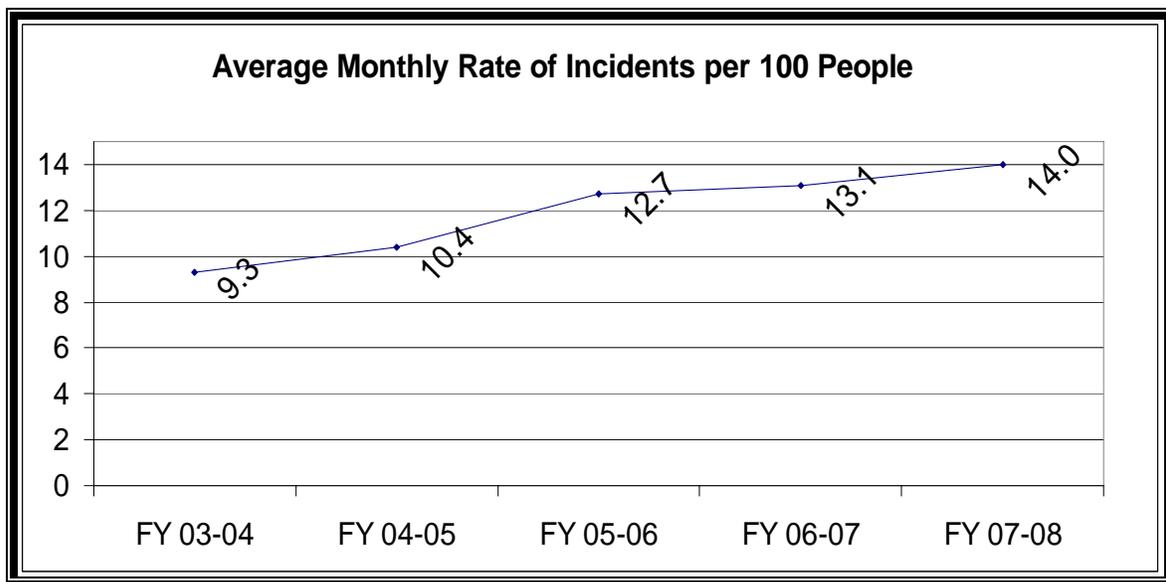
- Generates “alerts” about specific incidents that are e-mailed to designated DMRS management and specialists for follow-up as needed.
- Generates regular summary reports to designated DMRS management and specialists, and to the DMRS Regional and Statewide Quality Management Committees.
- Generates incident 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 07-08:

- Quarterly provider Incident Management Coordinator training & information sharing sessions were continued in each of the three DMRS regions. Numerous topics as listed below were covered, but a small group activity was also started this Fiscal Year in which attendees reviewed and analyzed a small number of prepared anonymous incident reports in small groups and then discussed with the full group.
 - Dysphagia and mealtime support
 - Medication Variance reporting and Incident reporting
 - Maltreatment in Developmental Disabilities
 - Provider Incident Review Committee issues – documenting follow-up, etc.
 - Correlation between Monthly Reportable Incident rates and Average Monthly temperature
 - Provider presentation on using trend analysis to reduce medication variances
 - Introduction to Run Charts and Control Charts
 - Staff Substance Abuse issues

- Ensured that service provider follow-up was implemented for all at-risk service recipients that were identified by DMRS through the annual trend study of falls.
- In coordination with DMRS Therapies staff, incorporated several discrete fall prevention initiatives into *Preventing Falls: A Resource Manual* (Fall Risk Screening Tool, Fall Environmental Checklist, Post Hip Fracture guide, etc.)
- Continued training as requested for Direct Support Professionals on fall prevention issues.

Chart 17: Average Monthly Rate of Incidents per 100 People



From Chart 17 above: FY to FY changes in Reportable Incident rates were:

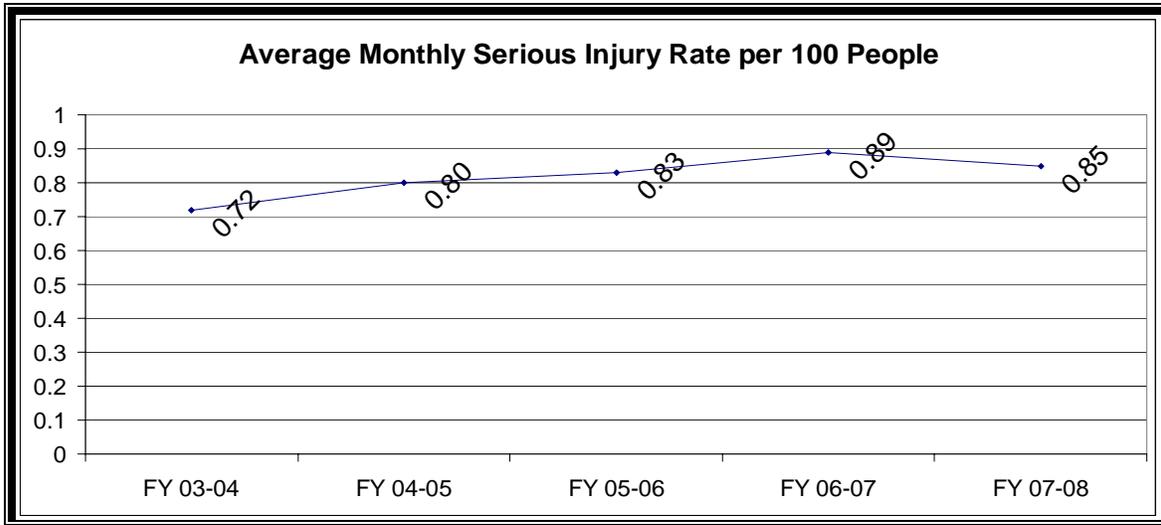
- FY 03-04 to FY 04-05: **12%** increase
- FY 04-05 to FY 05-06: **22%** increase
- FY 05-06 to FY 06-07: **3%** increase
- FY 06-07 to FY 07-08: **7%** increase

Most of the increase in the monthly rate of Reportable Incidents over the past five Fiscal Years is attributed to FY 05-06. This large change in rate 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 three 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.

The incident reporting rate has essentially continued at this higher “plateau” during FY 06-07 and FY 07-08.

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

Chart 18: Average Monthly Serious Injury Rate per 100 People



From Chart 18 above, it is apparent that the rate of serious injuries (0.85 per 100 service recipients per month for FY 07-08) is much lower than the rate of incidents in general (14.0 per 100 service recipients per month). Only 6.1 percent of incidents resulted in a serious injury in FY 07-08.

FY to FY changes in Serious Injury rates were:

- FY 03-04 to FY 04-05: **11.1%** increase
- FY 04-05 to FY 05-06: **3.8%** increase
- FY 05-06 to FY 06-07: **7.3%** increase
- FY 06-07 to FY 07-08: **4.4% decrease**

While the average monthly rate of serious injuries per 100 people rose more gradually than the corresponding rate of incidents over the first four Fiscal Years shown above, this rate actually decreased the most recent year. The average increase of 7.4% per year in the rate of serious injuries over the first four years reported is lower than the comparable rate of increase for incidents in general (which showed an increase of 12.4% per year over the same period). It has been the experience of DMRS that serious injuries have been consistently reported to DMRS over the past five years (and more) and have not been affected significantly by unrelated changes in incident classifications and general reporting issues. Serious injuries believed to be almost always well-documented and known to DMRS. They would be difficult to overlook or cover up. Also, as mentioned previously, there was essentially no change in the DMRS definition of “serious injury” during these five years.

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 generally comparable to the DMRS definition of serious injury. Comparisons of this rate with the DMRS rate in FY 07-08 finds the DMRS system to have a significantly lower rate per year (08.5 per month times 12 months equals **10.2** per 100 people per year).

As discussed in last year’s *Annual Report*, DMRS expected an eventual decline in the serious injury rate. Although the decline noted this year may not be significant, it is not an increase.

DMRS will continue to implement current initiatives and attempt to develop new ones that are intended to reduce injuries.

*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

DMRS Regional Investigators completed 2,556 investigations in FY 07-08. Investigators found preponderance to substantiate abuse, neglect or exploitation in 999 or 39% of these cases. Neglect, specifically, supervision neglect, where a staff person is sleeping or otherwise not engaged in providing appropriate supports to a service recipient, remains the most common type of substantiation in our system.

Substantiated Investigation Search (SIS) usage increased throughout the year. Agencies utilizing this secure website search have found the information to be useful when utilized as part of the initial background checks for hiring new staff. When agency personnel run the name and social security number through the SIS, they are alerted to any past substantiation within the DMRS system. When a signed release of information form is received from the applicant, DMRS releases details of the past substantiation(s), and the agency can weigh this information with all other background checks in determining whether or not to hire a person. This system check is used regularly by seventy-nine (79) contracting agencies, as of the end of FY07-08. Approximately 12,000 names have been submitted for a check through SIS since its inception (2006), and matches are found at about a 10% rate.

In FY 07-08, DMRS worked to introduce a new concept for the Abuse/Neglect Prevention Committees. Central Office Protection from Harm staff assisted these committees to refocus and expand their efforts toward the overall prevention of abuse, neglect and exploitation. Staff developed a training to include manuals and handouts of all the Protection from Harm related reports and data being tracked by DMRS. The committees were given an opportunity to read and to see the different reports. The committees now have the opportunity and expertise to decide to review specific challenges or concerns independently each month. DMRS provided “hands on” demonstrations on ways to study an agency through the various reports. Committees looked at Quality Assurance survey results, prevention plans, staffing plans and all the incidents and investigations in order to develop a set of measurable recommendations for a particular agency. Committees can choose to look at a particular agency or a particular type of investigation. The new concept gives the committees the flexibility to gain in-depth understanding of the PFH system and to make critical, measurable recommendations based on the system as a whole.

The Investigation Review Committee received 42 (2% of total investigations) requests for final investigation reviews. Sixteen final reports were upheld, ten were overturned and sixteen were not reviewed due to the requests not meeting the IRC protocol for review.

DMRS began receiving incident reports from the three west Tennessee private ICF/MR facilities, Open Arms Care, Winfrey Center and SRVS. In June, Regional Investigators began investigating allegations of abuse, neglect and exploitation at these three facilities. As of the end of the fiscal year, no data is available.

In FY 2007-08, DMRS proceeded with twenty-nine (29) contested referrals to the Tennessee Abuse Registry. Nineteen (19) were ruled either in DMRS favor or settled favorably. Five (5) others are being appealed to a higher authority, one (1) became moot upon the death of the respondent, two (2) were ruled in favor of the respondent with no appeal, and two (2) are awaiting a ruling by a judge. Additionally, twelve (12) individuals were placed on the Abuse Registry after appropriate due process expired.

In FY07-08, DMRS hired a registered nurse as a Clinical Investigator to work with PFH, and whose main function is medical consultation to Investigations. From 10/09/07 to the end of FY 07-08, the Clinical Investigator assisted with twenty-one (21) investigations and independently completed one (1) death investigation. The Clinical Investigator also provides daily consultations to investigators regarding various medical issues. In FY 07-08, the Clinical Investigator developed five trainings for education of investigators and provider agencies: Identifying Strangulation in Sexual Assault and Domestic Violence, drug testing, evaluating burn injuries, evaluating decubitus ulcers, and environmental mold hazards.

Medical complaint processes were developed and implemented by the Clinical Investigator. 17 complaints were referred to the TennCare Division of Quality Oversight, for further consideration by the various MCOs. Most (14) of these complaints involved TennCare funded nursing services.

A stream-lined process for referring licensed health practitioners to the Health-Related Boards was developed. Beginning the new process in December, 2007, five (5) LPNs and two (2) RNs have been referred to the Department of Health Office of Investigations for alleged violations of the Nurse Practitioner’s Act.

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

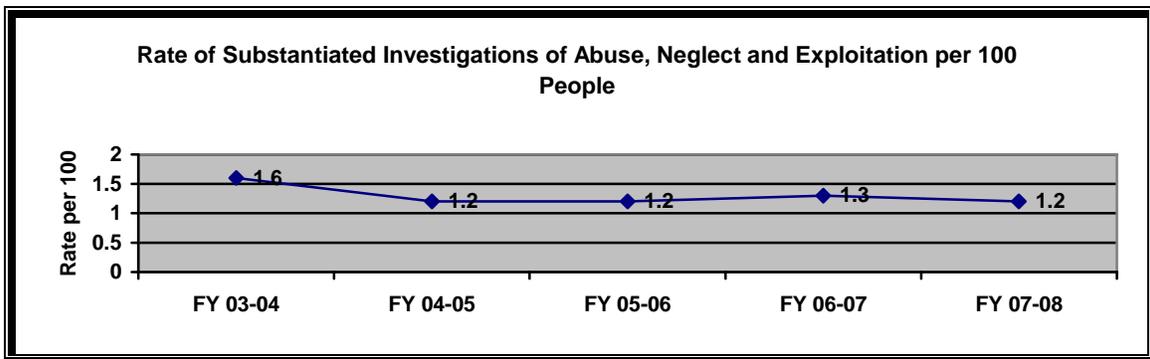
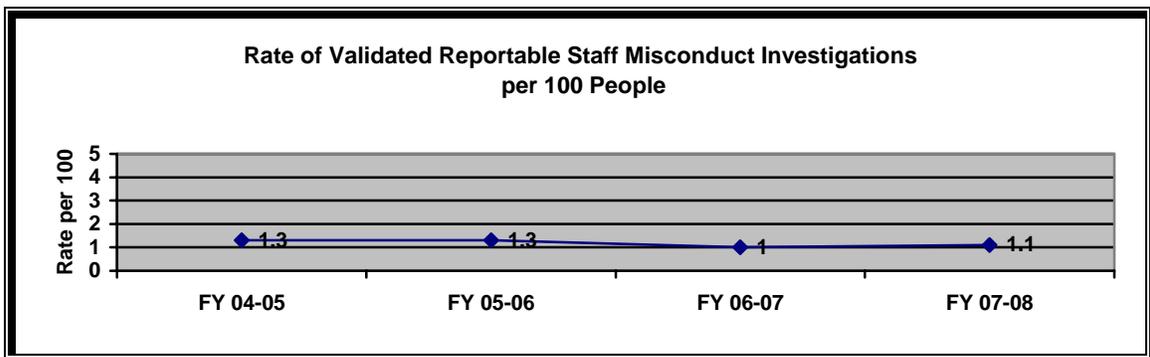


Chart 20: Rate of Validated Reportable Staff Misconduct Investigations per 100 People



Providers

Service Analysis and Provider Network

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.
- Recruiting existing providers to expand to other counties within their present DMRS region and to expand to other DMRS regions.
- Conducting regular orientation training for new providers and ongoing regional meetings for existing providers.
- Conducting a pre-application meeting for applicants interested in becoming DMRS providers. The purpose of these meetings is to educate interested applicants about the DMRS service delivery system and provide feedback necessary for the applicant to determine if they should continue in the process.

The following two tables summarizes the DMRS provider network by service type for FY 07/08

** Numbers are based on the number of providers who listed a particular service on their provider agreement. Since there are three DMRS regions, one provider agency may be counted as many as three times because one provider maybe approved to provide services across several regions. The numbers below reflect the total of all services available across the state.*

Long Term / Independent Support Coordination Providers by Service Type

Table 6:

| Type of Service Provider | Total Number Providers by Service FY 07/08 | Number of New Providers by service FY 07/08 | Number of Provider Exits FY 07/08 |
|--|---|--|--|
| Supported Living | 150 | 10 | 6 |
| Residential Habilitation | 79 | 5 | 3 |
| Family Model | 48 | 0 | 3 |
| Day Service- Facility Based | 129 | 8 | 5 |
| Day Service- Community Based | 148 | 13 | 7 |
| Day Service- Employment Supports | 141 | 14 | 6 |
| Personal Assistance | 162 | 10 | 6 |
| Behavioral Respite | 5 | 2 | 0 |
| Medical Residential | 22 | 3 | 1 |
| Independent Support Coordination (ISC) Providers | 23 | 0 | 0 |

Clinical/Ancillary Providers FY 07/08 by Service Type

Table: 7

| Type of Service Provider | Total Number Providers by Service FY 07/08 | Number of New Providers by Service FY 07/08 | Number of Provider Exits FY 07/08 |
|---|--|---|-----------------------------------|
| Behavioral Analyst | 69 | 4 | 1 |
| Behavioral Specialist | 38 | 0 | 0 |
| Dental | 49 | 3 | 0 |
| Environmental Accessibility Modifications | 70 | 12 | 3 |
| Nursing | 92 | 8 | 1 |
| Nutrition | 36 | 6 | 1 |
| Occupational Therapy | 42 | 4 | 7 |
| Orientation and Mobility Specialists | 6 | 1 | 0 |
| Physical Therapy | 44 | 5 | 7 |
| Specialized Medical Equipment Supplies and Assistive Technology | 80 | 5 | 3 |
| Speech-Language Hearing | 54 | 5 | 3 |
| Vehicle Accessibility Modifications | 15 | 1 | 0 |

DAY SERVICES

The Centers for Medicare and Medicaid Services’ tenet of “productivity, inclusion and independence” is at the core of Day Services. Inclusion in the community, not separation, develops a person’s potential for productivity (work or volunteering); inclusion (establishing friendships); and independence (the ability to realize one’s own talents and abilities).

Our obligation is to help people discover their talents and interests. When you find something you are good at, you also find a sense of belonging. Without this sense of belonging, people may experience a sense of separateness that can lead to isolation, depression and behaviors. Regardless of our backgrounds, we all yearn to be “a part of” and not “apart from” life.

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. With that goal in mind, DMRS and TEC collaborated on an extensive redesign of the Job Coach Training Curriculum. DMRS is piloting the revised curriculum through the College of Direct Support. The revised curriculum consists of five components:

- The Job Coaching Guide
- The Tennessee Job Coach Training Program
- Tools for Getting Organized
- Learning Preferences
- The Tennessee Employment Consortium Brochure

TEC and DMRS continue to explore how to make employment a reality for even more Tennesseans with intellectual disabilities.

Conclusion

Fiscal Year 2007-2008 was characterized by the progress made in several on-going DMRS endeavors and by the initiation of several new activities which offer exciting possibilities for the future. Examples of progress in on-going activities were illustrated by:

- The improvement of the performance of providers over a four year period as reflected in the data derived from QA surveys;
- The continual decline of facility census as more and more people choose to move out of large congregate living arrangements to community settings.

The new initiatives of FY 2007-2008 generate enthusiasm for the future. Several of these initiatives include:

- The College of Direct Support in which training is online and can be much more expansive, portable, and more easily tracked than the train-the-trainer model;
- Person centered thinking which offers the possibility of ISP development and implementation to be focused on individuals in very human individualistic and positive terms. The person centered thinking initiative could revolutionized one of the areas that has been marked for improvement by the lawsuits and the DMRS Quality Assurance system;
- The new Waiver compliance implementation and reporting activities will produce a bonus benefit of closer working ties between TennCare and DMRS. The exercise of submitting the renewal application of the SD Waiver in the CMS required 3.5 Format has already enhanced the cooperation and productivity of the TennCare and DMRS working relationship.

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:

Division of Mental Retardation Services
Attn: Compliance Unit
Andrew Jackson Building
500 Deaderick Street, 15th Floor
Nashville, Tennessee 37243

Or by phone:

Compliance Unit Director: Mr. John Kaufman
(615) 532-6542



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