

**Division of Mental Retardation Services
Department of Finance and Administration
December 2004**

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John G. Morgan
Comptroller

December 22, 2004

The Honorable John S. Wilder
Speaker of the Senate
The Honorable Jimmy Naifeh
Speaker of the House of Representatives
The Honorable Thelma M. Harper, Chair
Senate Committee on Government Operations
The Honorable Mike Kernell, Chair
House Committee on Government Operations
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the performance audit of the Division of Mental Retardation Services, Department of Finance and Administration. This audit was conducted pursuant to the requirements of Section 4-29-111, *Tennessee Code Annotated*, the Tennessee Governmental Entity Review Law.

This report is intended to aid the Joint Government Operations Committee in its review to determine whether the department should be continued, restructured, or terminated.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/dlj
03-105

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Performance Audit

Division of Mental Retardation Services
Department of Finance and Administration
December 2004

AUDIT OBJECTIVES

The objectives of the audit were to determine the division's legislative mandates and the extent to which it has carried out those mandates efficiently and effectively and to make recommendations that might result in more efficient and effective operation of the division.

FINDINGS

The Division Has Failed to Assure Compliance With All the Terms of the Settlement Agreement Covering Arlington Developmental Center

Arlington Developmental Center had achieved compliance with the terms of the settlement agreement in many areas as of the last quarter of calendar year 2003, but the center had not complied or had achieved only partial compliance in other areas. For example, for the last quarter of calendar year 2003 (on average), Arlington Developmental Center was found to be in compliance with the terms of the settlement agreement for 13 of 20 subcategories under Protection from Harm, 29 of 39 applicable subcategories under Psychology and Habilitation, 7 of 11 subcategories under Nursing Services, 25 of 29 subcategories under Physical and Occupational Therapy, and 1 of 5 subcategories under Record Keeping. Failure to fully comply with the terms of the settlement agreement increases the likelihood

that residents are not receiving the level of services and protection to which they are entitled, and this failure to comply could possibly increase the state's liability if problems do occur. In addition, such failure could result (and has resulted in the past) in the court assessing fines or taking other actions against the division (page 13).

Placements of Developmental Center Residents Into the Community Have Declined in Recent Years

The 1997 consent decree entered into by the parties involved in *People First et al. v. Clover Bottom Developmental Center et al.* required that the state find community placements for those residents of its institutions who are deemed suitable for assignment into the broader population. Since 1997, populations at the developmental centers have declined substantially; however, in the last several years, fewer patients have been moved from

developmental centers into the community. According to Quality Review Panel members and division staff, placements of developmental center residents into the community have been inhibited by several factors. There are an insufficient number of community providers and staff to deliver the intensive types of services needed by many developmental center residents. Also, because of the Centers for Medicare and Medicaid (CMS) moratoriums, federal funds are not available for community placements in Tennessee, except in cases where patients are "in crisis." In addition, because of problems with community providers (e.g., allegations of abuse and neglect, weaknesses identified by CMS, and service gaps), many families or caretakers of mentally retarded individuals have resisted placement of those individuals into the community (page 17).

As a Result of the CMS Moratoriums, the Lack of Funding, and Insufficient Numbers of Providers, the Division Has Not Adequately Addressed the Needs of Over 3,000 Individuals on Its Waiting List

According to the division's Monthly Waiting List Report, as of December 31, 2003, there were 3,163 people on the waiting list for services. The number of people on the

waiting list has increased in recent years, from 2,175 in December 2000 to 2,646 in December 2001 to 3,053 in December 2002. The inability to receive needed services can negatively affect the ability of a person with mental retardation to meet his or her full potential, detract from that person's quality of life, negatively impact the health and safety of that individual and others, and place an increased burden on family members and other caregivers (page 19).

There Are an Insufficient Number of Providers to Address the Needs of Mentally Retarded Persons Living in the Community; in Addition, There May Be Many Other Mentally Retarded Persons Who Need (or Will Need) Community Services But Who Have Not Been Identified by the Division

Although the division is taking steps to identify service gaps and recruit new community service providers to fill those gaps, there are currently insufficient services available to meet the identified needs of mentally retarded persons in the community. In addition, the division has only limited information concerning current and future needs of mentally retarded individuals and their families throughout the state (page 21).

OBSERVATIONS AND COMMENTS

The audit also contains information on the following issues: (1) at least partial compliance achieved by Clover Bottom and Greene Valley Developmental Centers in nearly all treatment areas covered by the settlement agreement and (2) the recent changes the division has made in its processes for monitoring community providers (pages 7-13).

Performance Audit
Division of Mental Retardation Services
Department of Finance and Administration

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
Purpose and Authority for the Audit	1
Objectives of the Audit	1
Scope and Methodology	1
Organization and Responsibilities	2
Revenues and Expenditures	4
Lawsuits and the Division of Mental Retardation Services	5
Centers for Medicare and Medicaid Services (CMS) Moratoriums	6
OBSERVATIONS AND COMMENTS	7
Clover Bottom and Greene Valley Developmental Centers Have Achieved at Least Partial Compliance in Nearly All Treatment Areas Covered by the Settlement Agreement	7
The Division Has Made a Number of Changes in its Processes for Monitoring Community Providers	11
FINDINGS AND RECOMMENDATIONS	13
1. The division has failed to assure compliance with all the terms of the settlement agreement covering Arlington Developmental Center	13
2. Placements of developmental center residents into the community have declined in recent years	17
3. As a result of the CMS moratoriums, the lack of funding, and insufficient numbers of providers, the division has not adequately addressed the needs of over 3,000 individuals on its waiting list	19
4. There are an insufficient number of providers to address the needs of mentally retarded persons living in the community; in addition, there may be many other mentally retarded persons who need (or will need) community services but who have not been identified by the division	21

TABLE OF CONTENTS (Cont.)

	<u>Page</u>
RECOMMENDATIONS	24
Administrative	24
APPENDIX	26
Title VI Information	26

**Performance Audit
Department of Finance and Administration
Division of Mental Retardation Services**

INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

This performance audit of the Department of Finance and Administration's Division of Mental Retardation Services was conducted pursuant to the Tennessee Governmental Entity Review Law, *Tennessee Code Annotated*, Title 4, Chapter 29. Under Section 4-29-225, the department was scheduled to terminate on June 30, 2004. As provided for in Section 4-29-115, however, the department will continue through June 30, 2005, for review by the designated legislative committee. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the department and to report to the Joint Government Operations Committee of the General Assembly. This performance audit is intended to aid the committee in determining whether the department should be continued, restructured, or terminated.

OBJECTIVES OF THE AUDIT

The objectives of the audit were

1. to determine the authority and responsibility mandated to the division by the General Assembly;
2. to determine the extent to which the division has met its legislative mandate;
3. to evaluate the efficiency and effectiveness of the division's activities and programs; and
4. to recommend possible alternatives for legislative or administrative action that may result in more efficient and effective operation of the division.

SCOPE AND METHODOLOGY

We reviewed the division's activities and procedures, focusing on procedures in effect during fiscal years 2003 and 2004. The audit was conducted in accordance with the standards applicable to performance audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and included

1. review of applicable legislation, executive orders, and division policies and procedures;
2. attendance at relevant legislative meetings;
3. examination of the division's records, reports, and information summaries;
4. interviews with division staff; and
5. interviews with members of the Quality Review Panel overseeing compliance with the Consent Decree affecting Clover Bottom and Greene Valley Developmental Centers, and interviews with Centers for Medicare and Medicaid Services staff.

ORGANIZATION AND RESPONSIBILITIES

The Division of Mental Retardation Services within the Department of Finance and Administration is responsible for providing services and support to Tennesseans with mental retardation and other developmental disabilities and their families. The division, which is headed by a deputy commissioner, provides services (either directly or through contracts with community providers) in a variety of settings, ranging from institutional care to individual supported living in the community. The division also provides support to the Council on Developmental Disabilities, which consists of members appointed by the Governor and represents a broad range of disabilities.

The state law granting the division authority and responsibility for individuals with mental retardation and other developmental disabilities is Title 33 of *Tennessee Code Annotated*. The division must also adhere to various portions of the Bureau of TennCare's General Rules relating to the Medicaid Waiver Home and Community-Based Services program. (See page 6 for additional information regarding the waivers.) The division's contract providers who require a license must also follow the appropriate Department of Mental Health and Developmental Disabilities Licensing Rules.

The division provides facility-based long-term care at three developmental centers—Greene Valley in Greeneville, Clover Bottom in Nashville, and Arlington Developmental Center in Arlington. (The Clover Bottom campus also includes the Harold Jordan Center, which houses mentally retarded persons who have been convicted of criminal offenses but are judged to be ill-suited for assignment to a correctional facility.) The division contracts with community agencies across the state to provide a comprehensive system of support services. Services provided include the following:

Residential Habilitation encompasses services provided in a group home where the provider of the service owns or leases the home. Services are designed to assist a person in acquiring, retaining, and improving self-help; socialization; and adaptive skills necessary to reside successfully in home- and community-based settings.

Family-Based Living encompasses services provided in a family home with family other than the family of origin. Families who provide these services in their homes are recruited, screened, and trained for this support.

Supported Living provides individually tailored services and supports enabling a person to live in his or her own home and to access the community.

Respite consists of services provided to an individual on a short-term basis for relieving the family or caregiver or to meet planned or emergency needs.

Physical and Nutritional Management includes therapy and nutrition services that are available through the Medicaid Waiver Home and Community-Based Services program. These services include occupational therapy, physical therapy, speech and language pathology, audiology, and nutrition services.

Community Regional Nursing provides nurses who are available to offer nursing consultation and technical assistance.

Developmental Center Nursing provides a link to the community transition process.

Central Office Nursing provides nursing consultation, training, and technical assistance to both the community and the developmental centers.

Health Related Training is available to all interested parties. Each region within the state has a regional nurse educator who is available to offer technical assistance and training.

The Family Support Grant Program is administered by the division through contracts with community agencies across the state. To be eligible, an individual must have a severe disability and must be residing in the community in an unsupported setting. (A supported setting is a residential setting that is state or federally funded and includes supportive services in institutions, group homes, supported living, or foster-based homes.) Services are designed to be flexible and responsive to family needs and include (but are not limited to) respite care, day care, home and vehicular modifications, specialized equipment and repair/maintenance, specialized nutrition/clothing/supplies, personal assistance, transportation, homemaker services, housing costs, health-related expenses, nursing/nurse's aides, family counseling, recreation/summer camp, and evaluation and training.

Early Intervention Services for children and families are provided in a variety of settings, such as center-based programs, the home, childcare settings, and Early Head Start. There are currently 36 Early Intervention programs located throughout Tennessee, funded through division grants. The division participates in the provision of Early Intervention services under the rules and regulations formulated in Part C of the Individuals with Disabilities Education Act (IDEA). IDEA requires each state to ensure the implementation of a statewide comprehensive, coordinated, multidisciplinary,

interagency system of services for infants and toddlers with disabilities and their families. An array of service providers in cooperation with the Department of Education make up Tennessee's Early Intervention System (TEIS) including TEIS District Offices, the Department of Health, contract providers, public/private providers, and various local advisory boards.

Day Supports include community participation, day habilitation, personal assistance, and supported employment. Employment opportunities are available to every person regardless of the severity of disability. Working in cooperation with the Department of Human Services' Division of Rehabilitation Services, an array of supports for employment is available.

Behavior Supports are the components of a person's environment that are dedicated to encouraging behaviors that help the individual attain his or her desired quality of life. The supports are based on an understanding of the total individual and are adjusted, as needed, to respond to challenging behaviors. Support strategies may include teaching the person to better communicate with others, expanding the opportunities for developing relationships, or improving the quality of living environments.

Behavior Services are services provided in response to an assessed behavior need that is presenting a significant barrier to safe participation in habilitative and preferred activities. These services incorporate the use of behavior analysis to assess, design, implement, and evaluate systematic environmental modifications for producing changes in behavior. Behavior analysts carry out formal behavior and functional assessment, analyze the possible variables influencing the behavior, and develop written strategies to improve the situation. Behavior specialists assist with collecting behavior information, carrying out the strategies, training others to carry out the strategy, and monitoring the service.

Three regional offices located in Knoxville, Nashville, and Bartlett coordinate services for individuals in the community, developmental centers, and for individuals transitioning from institutional settings to the community. These offices assist individuals and their families in finding the most appropriate, least restrictive placement.

The division has a Quality Assurance/Protection from Harm Section that surveys (i.e., reviews/monitors) community providers to ensure people receive the services and supports they need and have the necessary protections relating to their health and welfare. This section also investigates complaints, including allegations of abuse and neglect. There is also a Compliance Unit that monitors the programs for compliance with the settlement agreements and the Centers for Medicare and Medicaid Blueprint (see page 7).

REVENUES AND EXPENDITURES

For the year ended June 30, 2004, the Division of Mental Retardation Services had budgeted revenues and expenditures of \$637,476,800. The division revenues were derived from state appropriations (16%), interdepartmental revenues (83%), and current services and federal

revenues (1% combined). Interdepartmental revenues consist of interdepartmental transfers related to TennCare/Medicaid. The major categories of expenditures were as follows:

Category of Expenditure	Percent of Total Division Expenditures
Central Office	1.8%
Council on Developmental Disabilities	.4%
Community Mental Retardation Services	62.8%
West Tennessee Regional Office	2.3%
Arlington Developmental Center	11.3%
Middle Tennessee Regional Office	1.1%
Clover Bottom Developmental Center/ Harold Jordan Center	8.7%
East Tennessee Regional Office	1.2%
Greene Valley Developmental Center	10.4%

LAWSUITS AND THE DIVISION OF MENTAL RETARDATION SERVICES

Lawsuits directed against the Division of Mental Retardation Services have had a major effect on the division's operations in recent years. All three developmental centers are currently monitored under the supervision of the federal courts.

Arlington. In January 1992, the U.S. Department of Justice sued the State of Tennessee for violations of the Civil Rights of Institutionalized Persons Act (CRIPA) at the Arlington Developmental Center. Since November 1993, the facility has been under a U.S. District Court order to correct conditions at the facility. A court-appointed monitor ensures that Arlington Developmental Center complies with the terms of the remedial order. The remedial monitor's staff review treatment programs at Arlington twice a year and also perform quarterly reviews of community services in West Tennessee.

Clover Bottom/Greene Valley. In April 1996, the department entered into a settlement agreement with the advocacy group People First, which had sued the state, charging violations of CRIPA at Clover Bottom and Greene Valley Developmental Centers. (The Department of Justice strongly suggested that the state settle and, in December 1996, sued the state to become a party in the settlement negotiations.) Among other things, the 1997 settlement agreement calls for the state to provide adequate community placements for all eligible residents of the two developmental centers. A four-member Quality Review Panel plus a Special Assistant oversee the operations at Clover Bottom and Greene Valley, as required by the consent decree. The state is required to report monthly on compliance with the settlement agreement, and the Quality Review Panel is required to monitor the developmental centers and community annually. According to Quality Review Panel members, their major focus has been reviewing transition plans (i.e., for patients to transition from a developmental center into the community) and investigating complaints of abuse and neglect.

As of May 2004, the 1997 settlement agreement was still being implemented. There is a motion pending (filed by the state in March 2001) for partial dismissal of the agreement as it pertains to Greene Valley Developmental Center. According to a representative of the Attorney General's Office, the state has experts working with staff at Greene Valley to address some final concerns. The goal is to have representatives of the Department of Justice and the Quality Review Panel revisit Greene Valley in March or April 2005, and to get an agreement on dismissal. There is also a contempt motion pending (filed by the Parent/Guardian Association) which has been on hold for several years while the parties attempt to mediate. The Court routinely holds status conferences to monitor the state's compliance with the settlement agreement.

There are also two lawsuits related to the division's waiting list for services. The *Brown v. Tennessee Department of Finance and Administration and Warren C. Neel* lawsuit, which was filed in 2000, is the main class action lawsuit. The settlement agreement applies to everyone on the waiting list (see page 19) and requires the expansion of home- and community-based services. The *People First v. Neel* lawsuit, also filed in 2000, covers eligible persons who have never sought services from the division. Under the settlement agreement in that case (which was approved by the court on June 17, 2004), the division is required to provide an ongoing public information campaign to inform persons eligible for Home and Community-Based Waiver Services what services are available and how they can apply. The state is also to gather information (from agencies that provide services to persons with mental retardation) on the number of persons eligible for waiver services. The information compiled is then to be used to modify outreach efforts if warranted.

CENTERS FOR MEDICARE AND MEDICAID (CMS) MORATORIUMS

The State of Tennessee operates two home- and community-based waiver programs for persons with mental retardation and developmental disabilities. These waivers provide services in community-based settings to individuals who would otherwise require institutionalization in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). The Waiver for Adults and Children with Mental Retardation and Developmental Disabilities serves a large number of individuals (4,353 as of June 30, 2004) of all ages with mental retardation and developmental disabilities and provides a wide range of services including in-home, residential care, habilitation, special services and therapies, health care, and transportation. The smaller Waiver for Individuals with Mental Retardation (168 participants as of June 30, 2004) serves persons with mental retardation who are class members of a settlement agreement (see page 5).

Waiver for Adults and Children with Mental Retardation and Developmental Disabilities

On July 27, 2001, the federal Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) imposed a moratorium on new community placements by the Division of Mental Retardation Services. The moratorium was based on a CMS review of Tennessee's Home and Community Based Waiver for Adults and Children with Mental Retardation and Developmental Disabilities. CMS found that Tennessee had not met its obligations to protect the health and safety of waiver participants as required under Title 42,

Section 441.302(a), of the *Code of Federal Regulations*. While CMS conceded that the waiver “provide[d] key supports and services to many Tennessee citizens who have mental retardation/developmental disabilities,” the agency reported that in “too many instances, important safeguards to protect program participants are either absent or inadequate.” As of August 2004, the moratorium was still in effect. See finding 3 for a discussion of the impact of the moratorium on the division’s waiting list for community services.

Waiver for Individuals with Mental Retardation

In March 2003, CMS conducted a review of Tennessee’s Home and Community Based Waiver for Individuals with Mental Retardation. In December 2003, CMS provided the state a draft report of the review. The accompanying letter stated that, because of “significant problems with client health and welfare and administration of the waiver program,” CMS was also placing a moratorium on new admissions into that program.

State Corrective Actions

The state submitted the *Blueprint for Improving the Service Delivery System for Persons with Mental Retardation in Tennessee* in July 2003 and the Master Workplan in October 2003, as its corrective action plan in response to the CMS reviews. (See page 11 for a description of some of the changes the division has recently made related to its monitoring of community providers.) The state is to submit to CMS monthly updates of the workplan and a monthly summary statement of outcomes related to each section of the blueprint. According to the letter from CMS, “the moratorium on both waiver programs will remain in effect until CMS determines that systemic issues have been corrected.” The state may request that CMS conduct a review at any time the state believes it has made adequate improvements to the service delivery system to assure the health and welfare of waiver participants. On September 14, 2004, the state submitted renewal requests to CMS for both waivers.

OBSERVATIONS AND COMMENTS

CLOVER BOTTOM AND GREENE VALLEY DEVELOPMENTAL CENTERS HAVE ACHIEVED AT LEAST PARTIAL COMPLIANCE IN NEARLY ALL TREATMENT AREAS COVERED BY THE SETTLEMENT AGREEMENT

Based on a review of the Quality Review Panel’s 2003 evaluation of Clover Bottom Developmental Center, the facility has achieved either full or partial compliance with all but one of the treatment areas (Transition Profiles) covered by the terms of the 1997 settlement agreement. According to the evaluation, Greene Valley Developmental Center achieved substantial compliance with all but two of the areas (Transition Profiles and Emergency Medical Care) under supervision of the federal court.

A breakdown of the areas reviewed and the ratings received as of the end of 2003 is provided below:

Compliance

Clover Bottom Developmental Center

Advocacy
Administrative Structure for Quality Assurance
Abuse/Neglect Investigation System
Primary Care Physicians (staffing ratio)
Medical Specialists
Therapy Staff
Emergency Medical Procedures Training

Medication Errors/Side Effects
Mental Health Care/Psychotropic Medications
Staff Training on Dining Plans
Adaptive Equipment
Direct Care Staffing Ratios
Incident Reporting/Tracking
Abuse/Neglect Prevention Committee

Greene Valley Developmental Center

Advocacy
Consumer Education
Administrative Structure for Quality Assurance
Management Information Systems
Abuse/Neglect Investigation System
Consumer Satisfaction Surveys
Quality Assurance
Staff Training
Clinical Staffing
Nursing
Primary Care Physicians (responsibilities)

Medical Management of Feeding/Orthopedic Disorders
Medical Management of Behavior Disorders
Agreements with Local Hospitals
Dental Care
Mental Health Care/Psychotropic Medications
Active Treatment (behavior support)
Safe/Humane Living Environments
Direct Care Staffing Ratios
Incident Reporting/Tracking
Protection from Harm

Partial Compliance/Compliance

Clover Bottom Developmental Center

Class Member/Guardian Participation
Licensure/Certification*
Quality Assurance
Education on Rights/Responsibilities
Staff Training
Clinical Staffing
Primary Care Physicians (responsibilities)
Emergency Medical Care

Medical Management of Feeding/Orthopedic Disorders
Medical Specialist Care
Positioning
Active Treatment (behavior support)
Vision Services/Orientation and Mobility Environment
Safe/Humane Living Environment

*QRP noted, "Technical questions remain as to the Harold Jordan Center's status as a result of its withdrawal from the Medicaid ICFMR program."

Greene Valley Developmental Center

Class Member/Guardian Participation
Education on Rights/Responsibilities
Therapy Staff

Adaptive Equipment
Active Treatment (work, inclusion)
Environment

Partial Compliance

Clover Bottom Developmental Center

Total Quality Initiative Coordination
Person-Centered Evaluations
Individual Support/Transition Plans
Consumer Education
Management Information Systems
Consumer Satisfaction Surveys
Nursing
Mortality Review
Inter-Facility Peer Review
Dental Care

Nutritional Management
Physical Therapy/Occupational Therapy
Services
Staff Training on Positioning Plans
Active Treatment (work, inclusion)
Active Treatment (program reviews)
Hearing and Communication Services
Personal Possessions
Protection from Harm

Greene Valley Developmental Center

Total Quality Initiative Coordination
Person-Centered Evaluations
Individual Support/Transition Plans
Emergency Medical Procedures Training
Inter-Facility Peer Review

Staff Training on Positioning
Plans/Positioning
Active Treatment
Active Treatment (program reviews)
Vision Services/Orientation and Mobility

Partial Compliance/Noncompliance

Clover Bottom Developmental Center

Active Treatment
Education for School Age Citizens

Greene Valley Developmental Center

Mortality Review
Nutritional Management
Physical Therapy/Occupational Therapy Services
Hearing and Communication Services

Noncompliance

Clover Bottom Developmental Center

Transition Profiles

Greene Valley Developmental Center

Transition Profiles
Emergency Medical Care

Not Reviewed by the Quality Review Panel Because Those Areas of Treatment Were in Compliance at the End of 2002

Clover Bottom Developmental Center

Freedom of Choice
Expert Consultants in Transition Process
Six-Month Hold on Developmental Center Beds
Dispute Resolution Process
Behavior Support Staff
Internal/External Peer Review (medical and nursing)
Annual Medical Evaluations
Medical Management of Seizure Disorders
Medical Management of Behavior Disorders

Medical Participation in Transition Planning
Medical Management of Mechanical Restraints
Seizure Management
Agreements with Local Hospitals
Medication Administration
Mealtime Monitoring
Restraints/Restrictive Procedures
At-Risk Process
Staff Training on Abuse/Neglect

Greene Valley Developmental Center

Freedom of Choice
Expert Consultants in Transition Process
Six-Month Hold on Developmental Center Beds
Dispute Resolution Process
Licensure/Certification
Behavior Support Staff
Primary Care Physicians (staffing ratio)
Medical Specialists
Internal/External Peer Review (medical and nursing)
Annual Medical Evaluations
Medical Management of Seizure Disorders
Medical Participation in Transition Planning

Medical Management of Mechanical Restraints
Medical Specialist Care
Seizure Management
Medication Administration
Medication Errors/Side Effects
Staff Training on Dining Plans
Mealtime Monitoring
Restraints/Restrictive Procedures
Personal Possessions
At-Risk Process
Abuse/Neglect Prevention Committee
Staff Training on Abuse/Neglect
Education for School Age Citizens

The division should continue to improve conditions at the Clover Bottom and Greene Valley Developmental Centers by bringing into full compliance those areas found by the Quality Review Panel to be in noncompliance or partial compliance with the terms of the settlement agreement.

THE DIVISION HAS MADE A NUMBER OF CHANGES IN ITS PROCESSES FOR MONITORING COMMUNITY PROVIDERS

As previously noted, in 2001, the federal Centers for Medicare and Medicaid Services (CMS) imposed a moratorium on community placements by the division, because of concerns that Tennessee had not met its obligations to protect the health and safety of waiver participants in Tennessee's Home and Community-Based Waiver for Adults and Children with Mental Retardation and Developmental Disabilities program. (See page 6 for additional information on the moratorium.) That moratorium is still in effect, and in late 2003, CMS also placed a moratorium on new community placements under the Home and Community-Based Waiver for Individuals with Mental Retardation, because of similar concerns.

Quality Review Panel members (see page 5) acknowledge that it is not possible for the division to monitor community providers in the same way that it can control conditions in the state-operated facilities. However, they stated that the division should do a better job of monitoring community providers. The primary problem members identified was that the division has not adequately followed up on its own investigations of problems with community providers and has failed to require corrective action. Panel members indicated that they have repeatedly urged the division to impose sanctions against offending providers, but the division was reluctant to assess penalties.

In an attempt to address concerns raised by CMS and the court-appointed monitor/Quality Review Panel, the division has made many changes in its processes for approving and monitoring community providers. Some of the major changes are briefly described below.

Contracts With Community Providers

The division is responsible for approving contracts with all community providers. The standards for approval have become more stringent and have been revised three times since 2001. The division received assistance from the federal Centers for Medicare and Medicaid Services to produce the most current draft, which became effective in October 2003. The division uses a scoring system to evaluate community providers and help ensure that each provider is fiscally capable and programmatically experienced to provide the services. New providers must submit budgets and development costs, and must attend a nine-hour orientation class. The division also conducts reference checks of agencies that have provided services in other states.

As of fiscal year 2004, the new contract protocol defines sanctions for poor performance. The division has the power to partially take over a poorly performing agency and conduct technical assistance through a provider of the division's choosing. The new provider, at the expense of the deficient agency, is empowered to manage the operations of the contracted agency and, after six months, the division may decide to terminate the poor performer's contract. (See below for additional information regarding division sanctions.)

In addition, in response to CMS concerns that written guidance for providers (i.e., detailing program requirements, procedures, etc.) was cumbersome and confusing, the division developed a new provider manual, designed to be more streamlined and clear. The draft manual has been reviewed by an advisory group of stakeholders, and a revised manual is due to be submitted to the Bureau of TennCare for review in November 2004.

Monitoring of Community Providers

During fiscal year 2004, division management created a Quality Assurance/Protection from Harm section that is responsible for quality assurance surveys of community providers, as well as investigations of abuse and neglect allegations and other complaints. In response to concerns raised by CMS, division staff conducted special health and safety reviews of community providers during the last half of calendar year 2003. Effective July 1, 2004, new checklists were implemented to be used by division staff when surveying community providers. (CMS consultants assisted the division in developing these quality assurance tools.) There are separate checklists for day and residential services, clinical services (e.g., nursing services), and independent support coordination services. For each group of services, there are two sets of checklists—one focusing on the provider and its processes and policies and one focusing on the quality of service to individual clients. The checklists appear detailed and comprehensive, requiring interviews, direct observation by monitoring staff, and review of relevant documents. The division goal is to survey each residential services provider, day service provider, and independent support coordination provider annually, with clinical service providers being surveyed every three years. Providers would be reviewed more frequently if complaints arise.

As noted above, external monitors/reviewers have expressed concerns about division actions to ensure that identified problems with community providers' services were fully addressed and corrected. Fiscal year 2004 sanction information provided by the regional offices noted the imposition of monetary sanctions, required technical assistance, moratoriums on new admissions or specific services, and in a few cases, termination of the provider agreement. Follow-up visits by division staff and the results of those visits were noted. There were, however, differences in the types and amount of information tracked among regions. For example, one region tracked how (i.e., through what process—annual survey, etc.) the issue was identified and whether the provider had been sanctioned for the same deficiency in the recent past. It seems that such information could be helpful in assessing the usefulness of different types of reviews and the appropriateness of sanctions imposed.

In addition, although the central office had general information about provider sanctions, the specific details were (according to staff) only available in the region. In its December 2003 draft report, CMS stated, "The state should work to streamline and improve the effectiveness of the quality assurance and improvement system. A system that identifies and effectively resolves problems and subsequently uses the information to make improvements to the system is crucial in assuring participant health and welfare." In order for division management to track the efficiency and effectiveness of staff and the systems in place and make any needed changes, it seems that more detailed summary information, that is consistent among regions, would be helpful.

The division should continue to work, in consultation with CMS, to improve its monitoring of community providers. Where necessary, the division should impose sanctions and/or moratoriums on contracts with community providers to enforce compliance with state and federal requirements and to address the problems identified in the CMS reviews. Division management should assess the types of information they need to evaluate the effectiveness of staff and the monitoring systems they have put in place. Management should then ensure that all regional staff track those types of information and that such information is available to central office staff.

FINDINGS AND RECOMMENDATIONS

1. The division has failed to assure compliance with all the terms of the settlement agreement covering Arlington Developmental Center

Finding

Arlington Developmental Center had achieved compliance with the terms of the settlement agreement in many areas as of the last quarter of calendar year 2003, but the center had not complied or had achieved only partial compliance in other areas. The division produces a monthly report on conditions at the developmental center as required by the settlement agreement entered into by People First of Tennessee (the plaintiff), the federal government, and the State of Tennessee (the defendant). Under Section III of the agreement, titled “State Planning, Implementation, and Oversight,” the Department of Mental Health and Mental Retardation was required to continue to implement the statewide initiative embodied in the Tennessee Quality Initiative (TQI). (The TQI is a detailed improvement plan developed by the division for persons residing in the developmental centers and the community to guarantee protection of their federal constitutional rights.) The Department of Finance and Administration assumed those responsibilities with the transfer of the Division of Mental Retardation Services to F&A in 1996. The TQI Director is responsible for coordinating and monitoring compliance with all provisions of the agreement and for identifying variance within the system for timely correction.

The Central Monitoring Monthly Review for Arlington Developmental Center covers 14 major areas:

Protection from Harm (§I)	Hearing, Vision, and Communication
Staffing (§II)	Services (§IX)
Psychology and Habilitation (§III)	Physical and Occupational Therapy (§X)
Restraints (§IV)	Educational Services (§XI)*
Psychiatry and the Use of Drugs (§V)	Record Keeping (§XII)
Medical Services (§VI)	Resident Property (§XIII)
Physical and Nutritional Management (§VII)	Admission and Placements (§XIV)
Nursing Services (§VIII)	

* Not applicable because no school-age individuals in sample.

For the last quarter of calendar year 2003 (on average), Arlington Developmental Center was found to be in compliance with the terms of the Settlement Agreement for the following:

- 13 of 20 subcategories under Protection from Harm;
- 8 of 8 subcategories under Staffing;
- 29 of 44 subcategories (5 were not applicable) under Psychology and Habilitation;
- 2 of 10 subcategories (7 were not applicable) under Restraints;
- 15 of 18 subcategories (1 was not applicable) under Psychiatry and Use of Drugs;
- 38 of 51 subcategories (10 were not applicable) under Medical Services;
- 31 of 33 subcategories under Physical and Nutritional Management;
- 7 of 11 subcategories under Nursing Services;
- 2 of 4 subcategories (1 was not applicable) under Hearing, Vision, and Communication Services;
- 25 of 29 subcategories under Physical and Occupational Therapy;
- 1 of 5 subcategories under Record Keeping;
- 0 of 1 subcategories under Resident Property; and
- 1 of 23 subcategories (20 were not applicable) under Admission and Placement.

Table 1 details the areas of noncompliance (scores under 80%) and partial compliance (scores of 80% to 89%) during the fourth quarter (October through December) of 2003. Scores of 90% or above indicate compliance.

Table 1
Central Monitoring Monthly Review-Arlington Developmental Center
Areas of Partial and Non-Compliance—Average for Fourth Quarter 2003

Paragraph Reference		Average for Fourth Quarter 2003
§I	Safe and Humane Environment	80%
§I	Supervision/Protection from Harm	74%
§I	Provision of One-to-One Coverage	80%
§I.B	Adequately Trained and Supervised	35%
§I.C	All Reports Reviewed by ANPC	0%
§I.D	Protection from Abuse, Neglect, and Preventable Injuries	74%
§I.E	Direct Care Staff Trained to Supervise Residents	50%
§III.C	Development of Training Programs	88%
§III.C.3	Activities Scheduled for Weekend and Weekdays	89%
§III.C.4	Monitor Implementation	75%
§III.C.4	Enable Modifications as Necessary	76%
§III.D	Training Staff to Implement Programs	60%
§III.F	Qualified Professional to Supervise Implementation	66%
§III.G	Implementation of Procedures to Assess Progress	70%
§III.H	Staff Training in Data Collection	65%
§III.H	Staff Trained to Perform Tasks Required in the Provision of Psychology and Habilitation Services	65%
§III.I	Periodic Review of Training Programs	69%
§IV.C	Each Committee Makes Recommendations Related to Appropriateness and Continued Use of Restraint	50%
§V.F	Require Psychiatrist to Serve on IDT	0%
§V.G	Train Staff to Recognize Signs of Mental Illness	83%
§VI.B.3	Respond to Recommendations of Specialists	75%
§VI.E	Ensure Consults Obtained	89%
§VI.F.1	Neurology Exam Annually for Residents on 2 or More ATC Medications or Having 5 or More Seizures in 12-Month Period	83%
§VII.J.1	Engaged in Continuous Education Activities	0%
§VII.L.8	Quarterly Review of Nutritional Management Plans	86%
§VIII.D	Respond to Crucial Information	64%
§VIII.E	Timely Examine Results of Medical Tests	50%
§VIII.F	Familiar with Residents and Their Medication	61%
§VIII.H	Properly Record Medication Administration	80%
§IX.A.	Direct Care Staff on Each Shift Trained in Sign Language	50%
§X.	Adequate and Appropriate Physical and Occupational Therapy Services	89%
§X.C.	Provide Therapy Services to Develop Functional Skills	81%
§X.G.	Provide Training to Implement Programs	54%
§X.K.	Retain Therapy Consultant	0%
§XII	Individual Support Plans	76%
§XII	Achieving ISP Outcomes	64%
§XII	Community Outings	86%
§XII	Vocational Services	84%
§XIII	Ensure Resident's Right to Own/Keep/Use Personal Possessions	89%
§XIV.A	Reduce the Population of ADC to 200 by 9/30/97	0%
§XIV.B.2	Residents Under 21 as of 1/21/92 Placed in Community by 9/30/97	0%

Compliance with terms of the settlement agreement would help the division better ensure the safety and well-being of Arlington residents. Failure to fully comply with the terms of the settlement agreement increases the likelihood that residents are not receiving the level of services and protection to which they are entitled and could possibly increase the state's liability if problems do occur. In addition, such failure could result (and has resulted in the past) in the court assessing fines or taking other actions against the division. According to division staff, the division was scheduled to appear in court in July 2004, to "show cause" for why it should not be held in contempt for failure to comply with some provisions of the agreement. The hearing was continued to November 15, 2004, to allow the parties to discuss possible settlement, and an agreed order is pending that would further continue the hearing. According to a representative of the Attorney General's Office, the state has been engaged in talks with the plaintiffs in an attempt to avoid further litigation.

Recommendation

The division should seek to bring all areas of treatment at Arlington Developmental Center into compliance with the terms of the settlement agreement. Division management should meet again with the Court Monitor (and other appropriate parties) to (1) reset priorities for reaching compliance, focusing first on those areas most vital to the safety and well-being of patients at Arlington; and (2) agree on specific steps the division needs to take to achieve compliance in those areas not yet in compliance.

Management's Comment

We concur with the finding. The Division has been actively engaged in meeting on a regular basis since January 2004 with the Court Monitor and Parties of the Arlington lawsuit for the purpose of reaching an agreement regarding the state's compliance efforts. Substantial progress has been accomplished to the extent that an agreement is close to being signed by the Parties, pending review by the Court. For both the developmental center and the community, the proposed Agreement addresses class member compliance issues such as Individual Support Planning, Direct Support Staff Training, Employment, Protection from Harm, Active Treatment, Behavior Supports, Use of Restraints, Communication Skills, and Clinical Therapies. Quarterly meetings with the Division, Court Monitor, and the Parties will continue. These meetings will serve as a forum for discussing the state's effort of achieving compliance with the proposed Agreement.

2. Placements of developmental center residents into the community have declined in recent years

Finding

The 1997 consent decree entered into by the parties involved in *People First et al. v. Clover Bottom Developmental Center et al.* required that the state place into community placements those residents of its institutions who are deemed suitable for assignment into the broader population. The state was also required by the agreement to ensure that those residents' safety and treatment remained in compliance with the substantive requirements of the settlement agreement. Further, the consent decree mandated that the state develop a plan outlining how these services would be delivered. The division created the *Master Workplan for Community Residential Placements* as a guideline for the transition planning of approximately 750 persons living in the Arlington, Greene Valley, and Clover Bottom Developmental Centers. Since 1997, populations at the developmental centers have declined substantially; however, in the last several years, fewer patients have been moved from developmental centers into the community.

Documentation provided by the division and the Quality Review Panel details the decrease in population at the developmental centers between 1997 and 2003:

Facility	Population as of July 1997	Population as of September 2003	Population Change	Percent Change
Clover Bottom/Harold Jordan	370	203	167	(45%)
Greene Valley	455	312	143	(31%)
Arlington	351	210	141	(40%)

Total placements from the development centers to the community between July 1997 and February 2004 were 137 from Clover Bottom/Harold Jordan, 102 from Greene Valley, and 104 from Arlington. As noted above, however, placements have decreased in recent years:

	Patient Placements From Developmental Center to Community				
	Fiscal Year 2000	Fiscal Year 2001	Fiscal Year 2002	Fiscal Year 2003	July 2003 to February 2004
Clover Bottom/Harold Jordan	29	16	14	13	7
Greene Valley	13	13	9	6	1
Arlington	14	15	17	11	3

Quality Review Panel members expressed frustration that although the state has insisted that almost all patients at Clover Bottom and Greene Valley are eligible for placement in the community, a relatively small number have actually been removed to a suitable placement. According to panel members and division staff, placements of developmental center residents into the community have been inhibited by several factors. First, there are an insufficient number of community providers and staff to deliver the intensive types of services needed by many developmental center residents. (See finding 4.) Second, because of the Centers for

Medicare and Medicaid (CMS) moratoriums (see page 6), federal funds are not available for community placements in Tennessee, except in cases where patients are “in crisis.” (See page 19.) State funds can and are being used for community placements, and there were differences of opinion among those interviewed as to how much impact the moratoriums have had on community placements of developmental center residents. However, it seems clear that the moratoriums have restricted placements into the community overall and required the use of state funds in some cases where federal funds would have been used before. In addition, according to division staff, the moratoriums increased the focus on assessment of community providers and the quality of their services, which (although a positive effect) may have slowed down placements. (See page 11 regarding changes made by the division in its assessments of community providers.) Finally, because of problems with community providers (e.g., allegations of abuse and neglect, weaknesses identified by CMS, and service gaps), many families or caretakers of mentally retarded individuals have resisted placement of those individuals into the community.

Recommendation

The division should continue efforts to place in the community residents of the developmental centers who are deemed appropriate for community placements. In the short term, division staff should ensure that assessments are realistic, given the resident’s needs and the availability of services in the community. Division staff should also continue efforts to recruit the numbers and types of quality providers needed to allow as many individuals as possible to move from the developmental centers into the community. Staff should continue to work with residents’ families and guardians to help ensure that each individual receives the best possible placement.

Management’s Comment

We concur. The Division will continue its efforts to place in the community residents of the developmental centers who are deemed appropriate for community placement. A more comprehensive assessment process has been initiated in the developmental centers which will better identify a person’s support needs to ensure a successful community placement. The new assessment process incorporates the results of the Inventory for Client and Agency Planning (ICAP), the Physical Status Review (PSR), and the assessments of clinical and staff professionals.

Regarding community provider recruitment, please see the Division’s response to Finding 4.

3. As a result of the CMS moratoriums, the lack of funding, and insufficient numbers of providers, the division has not adequately addressed the needs of over 3,000 individuals on its waiting list

Finding

According to the division's Monthly Waiting List Report, as of December 31, 2003, there were 3,163 people on the waiting list for services. The number of people on the waiting list has increased in recent years, from 2,175 in December 2000 to 2,646 in December 2001 to 3,053 in December 2002. The inability to receive needed services can negatively affect the ability of a person with mental retardation to meet his or her full potential, detract from that person's quality of life, negatively impact the health and safety of that individual and others, and place an increased burden on family members and other caregivers.

Because of the Centers for Medicare and Medicaid (CMS) moratoriums (see page 6), there are no federal funds for new community placements in Tennessee. (Therefore, state funds would have to be used for such placements.) There is, however, an exception for "crisis" admissions for home and community placements. A crisis situation is defined as one where the person seeking services is (1) on the verge of becoming homeless, (2) left vulnerable because of the death or incapacitation of all available caregivers, and/or (3) a danger to himself/herself or others.

The 3,163 persons on the December 2003 waiting list were classified as follows:

- 79 as "in crisis" (see definition above).
- 413 as "urgent." The person is at risk of meeting the criteria for "in crisis," or one or more of the following criteria are met: aging or failing health of caregiver and no alternative available to provide supports, living situation presents a significant risk of abuse or neglect, increasing risk to self or others, stability of current living situation is severely threatened because of extensive support needs or family catastrophe, and discharge from other service system (e.g., Children's Services or a mental health institute) is imminent.
- 1,961 as "active." The person and/or family or guardian is requesting access to services as of now but does not have intensive needs that meet the criteria for the above levels.
- 710 as "deferred." The person and/or family or guardian does not have intensive needs at the current time but is requesting access to services at some point in the future (after 12 months or more).

The total number of individuals removed from the waiting list from July 1, 2003, through January 31, 2004, was 420—52 in July, 34 in August, 33 in September, 40 in October, 157 in November, 67 in December, and 37 in January. The division's regional directors for community services voiced concerns that the division has not been able to move patients off the list into the

community as rapidly as they would like because of insufficient funding and too few quality community providers (see page 21). Other problems identified as limiting the division in serving more persons in community settings included too few qualified staff to deliver certain types of services; a disproportionate number of community providers in urban areas, with much less coverage in rural areas; and high rates of complaints involving abuse and neglect in community settings. The regional directors also discussed the burden on the families of those patients who are not assessed as being “in crisis,” that is, those individuals who need services but for whom no placement can be made because of the CMS moratoriums or because of insufficient services available. Frequently, the only thing that can be done for this population is to provide some respite care and make telephone inquiries regarding the continued need for services.

Recommendation

Division management should develop a plan for dealing with the waiting list, particularly those individuals classified as “in crisis” or “urgent.” Management should work with CMS to get the moratoriums lifted as soon as possible and should review the proposed uses of available state funds to identify any funds that could be better used to serve persons classified as “urgent” on the waiting list.

Division staff should ensure that families or guardians of individuals on the “active” or “deferred” lists know who to contact if the individual’s situation worsens or needs change.

Management’s Comment

We concur. On June 17, 2004, Judge Echols signed and approved the *Brown* Settlement Agreement. At that time, the *People First* Waiting List Lawsuit was dismissed (with implementation of the settlement actions enforced under the *Brown* Settlement Agreement).

The implementation of this settlement agreement will address all of the recommendations of this finding. As such, the Division is providing auditors with a copy of the signed Settlement Order and compliance matrix of the agreement (updated as of 10/25/04).

The *Brown* Settlement Agreement calls for the division to make several changes in existing policies and procedures, as well as: (1) seek approval of a new Self-Determination Medicaid Waiver (hereinafter the “SD Waiver”); (2) enroll up to 1,500 people into SD Waiver services during the first two years after approval; (3) provide interim state-funded supports in the amount of \$500,000 per month to people in the “crisis,” “urgent,” and “active” categories of the waiting list until the SD Waiver is approved; (4) provide all persons on the waiting list with a Division case manager to assist them through the registration process and connect them with other community and generic resources (food stamps, WIC, etc.) while they remain on the waiting list; (5) begin a new state-funded program (up to an annual appropriation of \$5 million) to help people who are in the “crisis,” “urgent,” and “active” categories purchase a small amount of supports, services, and/or equipment while they are waiting to be enrolled into Waiver services; and (6) begin a public information campaign to provide updated and accurate

information to people already on the waiting list, and also to provide information to other citizens of Tennessee on how to register for services through the Division through the use of public service announcements, posters, brochures, flyers, etc.

Additional tasks and efforts already undertaken by the Division to implement the *Brown Settlement Agreement* can be found in the Compliance Grid provided to auditors.

4. There are an insufficient number of providers to address the needs of mentally retarded persons living in the community; in addition, there may be many other mentally retarded persons who need (or will need) community services but who have not been identified by the division

Finding

Although the division is taking steps to attempt to identify service gaps and recruit new community service providers to fill those gaps, there are currently insufficient services available to meet the identified needs of mentally retarded persons in the community. In addition, the division has only limited information on the true extent of current and future needs of mentally retarded individuals and their families throughout the state.

The division could not provide information detailing the need for services versus the services available in the different areas of the state. However, based on numerous interviews with division central office staff, regional officials, and representatives of the Quality Review Panel and advocacy groups, there are significant gaps in service, not enough providers, and not enough service options in each county. Division staff identified several types of treatment for which there is a lack of services, particularly in the behavior analyst and speech and language pathologist positions. Specifically, behavioral analysts are needed in the Middle Tennessee, Cumberland Plateau, and South Central regions, and there is a shortage of speech and language pathologists in all nine regions. According to division staff, the waiting time for speech and language services is eight to nine months. Staff also reported difficulty in recruiting an adequate number of providers of residential housing and nursing services. (Difficulties in recruiting residential housing providers may be worsened because the division has no regional staff available to help recruit such providers.).

Division staff also reported problems recruiting providers to take certain types of patients, such as individuals (particularly medically fragile individuals) with extreme behavior problems or others requiring highly specialized care. Although individuals are given lists of providers to choose from, this list may be very short for some patients requiring specialized services.

As of December 31, 2003, the division had a list of 3,163 persons waiting for needed services. Other factors, such as the Centers for Medicare and Medicaid moratoriums (see page 6) and insufficient funds, contribute to the size of the waiting list, but a lack of suitable providers also has an effect. (See Finding 3 for additional information regarding the waiting list.) In

addition, there are probably a substantial number of mentally retarded persons who are not currently receiving division services and are not on the waiting list but who need or will need the division's services in the future. Division staff estimated that up to 60% of the mentally retarded population are not currently being served and voiced concern that the state has no way of accounting, or planning, for those persons not currently in the system who need, or will need in the future, the division's services. Quality Review Panel members raised concerns about large numbers of mentally retarded children who are not receiving services the division offers, primarily because the division does not know about these children. They blamed the problem on poor communication between the division and local school authorities.

In 2001, the division began using the TennCare Annual Gaps Forums to help identify areas where services were needed. These forums are held annually in each of the nine Developmental Districts. Participants identify what services are available and which are needed in their area. The division then analyzes this information and attempts to recruit providers for the services that are needed. Documentation provided by division staff indicates that there are approximately 160 community providers throughout the state who offer residential day services. According to staff, the division has added 50 providers, although not all of them are new to the network (some are existing providers who have been encouraged to expand and provide services in other counties). Other improvements include recruiting a provider of services in Shelby County for medically fragile individuals who exhibit extreme forms of behavior and recruiting at least two providers to serve violent/dual diagnosis individuals in each region.

In 2003, the division received a grant of \$61,000 (designated as the Development Incentive for new agencies) to provide new agencies with start-up assistance for services in certain areas. The division also has \$2 million in the budget to encourage existing providers to accept clients from the developmental centers or from the waiting list. The division will provide \$4,800 for each patient an agency takes from any of the three developmental centers or from the list of over 3,100 people who are currently on the waiting list. These incentives are designed to cover costs for providers that were not reimbursed previously (e.g., marketing, training, and development). Based on a review of documentation provided by division staff, there are now 20 to 30 provider choices in each region.

The division has also provided technical assistance in Shelby County to help minorities begin their own provider organizations. As of the end of audit fieldwork, there were five minority-owned providers developing housing supports in the Memphis area.

Recommendation

Division management should continue efforts to expand the network of community providers throughout the state and to encourage quality providers already in the system to expand into areas of the state where additional services are needed. The division should consider increasing the use of regional staff to recruit service providers (e.g., housing providers) in their areas. The division should check with surrounding states to identify providers who may be willing to expand their services into Tennessee.

The division should also expand its information regarding current and future needs for services in the different regions, and use that information to focus efforts when recruiting providers. As part of that process, the division should work with other agencies (e.g., the Department of Education and local school districts) to obtain information that may already be available on numbers of additional clients needing services and the types of services needed.

Management's Comment

We concur. An adequate network of qualified service providers is essential to ensuring that people can choose the service and providers that best meet their needs. The Division is committed to recruiting and maintaining quality providers of services. Each year, the Division holds forums around the state to identify gaps in the provider network and to develop strategies to address the identified needs. The forums, held during fiscal year 2004, identified gaps in service needs statewide, regionally, by county and for those waiting for services. The findings from the forum resulted in the following actions during the past twelve months:

- Five additional respite providers were enrolled and 2 facilities (one in Middle Tennessee and one in West Tennessee) dedicated for respite services were secured. The respite facility in West Tennessee opened in October. The facility in Middle Tennessee will open in January 2005.
- The rates for respite services were improved.
- A medical residential service was created to improve the capability to make better use of the limited nursing resources.
- An increase in the funding in rates for nursing was secured.
- Sixteen additional nurses were enrolled as providers.
- Nineteen new physical therapists were enrolled.
- Seventeen new occupational therapists were enrolled.
- Thirty-two personal assistance providers were enrolled since January 2004.
- Recruitment of one additional provider for residential services in Chattanooga and the Cumberland Plateau for people with significant behavioral challenges.
- Recruitment of three additional providers for residential and day services, including employment, in the Jackson area.
- Recruitment of three additional providers for residential and day services, including employment, in the Memphis area. Two of the three specialize in providing services for medically involved consumers.

- Recruitment of one provider to West Tennessee for residential and day services, including employment, for individuals with severe behavioral challenges.
- Recruitment of one additional provider for residential services in Middle Tennessee for people with significant behavioral challenges.
- Recruitment of an employment and personal assistance provider in the Tri-Cities area.
- Development of two dental clinics for people requiring sedation (one in Jackson and one in Knoxville) which opened in September 2004.

In attempting to identify individuals with mental retardation who have not registered for services, the Division has requested other state departments, agencies, as well as statewide advocacy service providers (Tennessee Disability Coalition, Developmental Disabilities Council, etc.) for data on the number of people they serve who might be eligible for services through the Division as well. Once the Division receives the data, a report will be compiled that will be used for provider recruitment efforts, as well as specifically targeting areas of the state with the public information campaign mentioned in the response to Finding 3 above.

RECOMMENDATIONS

ADMINISTRATIVE

The Division of Mental Retardation Services should address the following areas to improve the efficiency and effectiveness of its operations.

1. The division should seek to bring all areas of treatment at Arlington Developmental Center into compliance with the terms of the settlement agreement. Division management should meet again with the Court Monitor (and other appropriate parties) to (1) reset priorities for reaching compliance, focusing first on those areas most vital to the safety and well-being of patients at Arlington, and (2) agree on specific steps the division needs to take to achieve compliance in those areas not yet in compliance.
2. The division should continue efforts to place in the community residents of the developmental centers who are deemed appropriate for community placements. In the short term, division staff should ensure that assessments are realistic, given the resident's needs and the availability of services in the community. Division staff should also continue efforts to recruit the numbers and types of quality providers needed to allow as many individuals as possible to move from the developmental centers into the community. Staff should continue to work with residents' families

and guardians to help ensure that each individual receives the best possible placement.

3. Division management should develop a plan for dealing with the waiting list, particularly those individuals classified as “in crisis” or “urgent.” Management should work with CMS to get the moratoriums lifted as soon as possible and should review the proposed uses of available state funds to identify any funds that could be better used to serve persons classified as “urgent” on the waiting list.
4. Division staff should ensure that families or guardians of individuals on the “active” or “deferred” lists know who to contact if the individual’s situation worsens or needs change.
5. Division management should continue efforts to expand the network of community providers throughout the state and to encourage quality providers already in the system to expand into areas of the state where additional services are needed. The division should consider increasing the use of regional staff to recruit service providers (e.g., housing providers) in their areas. The division should check with surrounding states to identify providers who may be willing to expand their services into Tennessee.
6. The division should also expand its information regarding current and future needs for services in the different regions, and use that information to focus efforts when recruiting providers. As part of that process, the division should work with other agencies (e.g., the Department of Education and local school districts) to obtain information that may already be available on numbers of additional clients needing services and the types of services needed.

Appendix
Tennessee Department of Finance and Administration
Title VI Information

All programs or activities receiving federal financial assistance are prohibited by Title VI of the Civil Rights Act of 1964 from discriminating against participants or clients on the basis of race, color, or national origin. In response to a request from members of the Government Operations Committee, we compiled information concerning federal financial assistance received by the Department of Finance and Administration, and the department's efforts to comply with Title VI requirements. The results of the information gathered are summarized below.

The Department of Finance and Administration's executive leadership team (comprised of the Deputy Commissioner of Operations and the eight Executives of the department's divisions) establishes Title VI policy. Each Executive is responsible for setting Title VI goals and objectives, ensuring implementation, and tracking performance in his or her division. The department's Title VI Coordinator has a variety of responsibilities concerning development, implementation, and evaluation of the Title VI plan and the compliance review process.

Two sections of the Department of Finance and Administration (excluding the Bureau of TennCare and the Division of Mental Retardation Services, which are discussed separately) receive and administer federal funds: the Office of Criminal Justice Programs and the Tennessee Commission on National and Community Service. The Office of Criminal Justice Programs funds a variety of local and state projects using federal funds from the following grants:

Grant	Fiscal Year 2004 Federal Funding
Edward Byrne Memorial Grant	\$9,301,217
STOP Violence against Women Grant	\$2,295,000
National Criminal History Records Grant	\$491,000
Family Violence Grant	\$3,055,000
Local Law Enforcement Block Grant	\$699,135
Victims of Crime Administration Grant	\$7,016,000
Total	\$22,857,352

During fiscal year 2004, the Tennessee Commission on National and Community Services received a little over \$5 million from the AmeriCorps program, through which Tennesseans provide community service in exchange for help financing their higher education or repaying student loans. The breakdown of AmeriCorps participants by gender and ethnicity is detailed on the following page.

**Tennessee AmeriCorps Participants
For the Period August 1, 2003, to July 31, 2004
By Gender and Ethnicity**

Category	Number of Participants	Percent of Total Participants
Female	140	72.0%
Male	54	28.0%
Participants with Disabilities	3	1.5%
White	120	62.0%
African American	66	34.0%
Hispanic	7	4.0%
American Indian or Alaskan Native	2	1.0%
Asian or Pacific Islander	1	.5%
Total*	194	100.0%

* Number and percentage breakdowns by ethnicity do not equal 194 or 100% because some participants may have designated more than one ethnicity category.

Subrecipients of the department are required to provide statements of assurance that address Title VI compliance. In addition, department divisions that have subrecipients are required to annually monitor a subset of their subrecipient contract population. (Title VI is one of the required core monitoring area.) During fiscal year 2004, the department conducted 158 post-award reviews (which involved both on-site reviews and desk audits)—8 reviews of Tennessee Commission on National Community Service subrecipients and 150 reviews of Office of Criminal Justice Programs subrecipients. There were no findings related to Title VI. According to department records, there were no unresolved complaints at the beginning of fiscal year 2004, and no Title VI complaints were received during fiscal year 2004. The table below summarizes the breakdown of department contractors by category, including ethnicity.

**Department of Finance and Administration
Contractor Diversity
Contracts Current during Fiscal Year 2003**

Contractor Category	Number	Percent of Total	Total Contracting Dollars	Percent of Total
African American	19	3.9%	\$1,199,453	.1%
Asian American	2	.4%	\$5,200,000	.4%
Hispanic American	1	.2%	\$75,000	0%
Native American	0	0%	0	0%
Other Minority	0	0%	0	0%
Disabled	0	0%	0	0%
Female	120	24.6%	\$7,980,196	.6%
Small Business	20	4.1%	\$14,631,768	1.1%
Government	187	38.4%	\$20,423,244	1.5%
Not Minority/Not Disadvantaged	125	25.7%	\$1,320,407,160	96.0%
Delegated Authority*	13	2.7%	\$4,880,283	.3%
Total	487	100.0%	\$1,374,797,104	100.0%

* Contractor description data not collected on individual contracts.

See below for a summary of the department's employees (including Bureau of TennCare and Division of Mental Retardation Services employees), broken down by gender and ethnicity. As of January 2004, the department had 5,049 staff, of whom 32% were male and 68% were female. Minorities constituted 39% of staff—36% were Black and the remaining 3% were Asian, Hispanic, Indian, and Other.

**Department of Finance and Administration
(Including the Bureau of TennCare and the Division of Mental Retardation Services)
Staff by Title, Gender, and Ethnicity
As of January 2004**

Title	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Account Clerk	0	14	0	4	0	0	10	0
Accountant	20	24	0	4	0	0	38	2
Accounting Manager	7	7	0	2	0	0	12	0
Accounting Technician	6	50	1	3	1	0	51	0
Adjunctive Therapy Director	1	2	0	1	0	0	2	0
Administrative Assistant	0	21	0	10	0	0	11	0
Administrative Secretary	1	61	0	11	0	0	51	0
Administrative Services Assistant	15	69	1	15	1	0	67	0
Administrative Services Assistant Superintendent	2	0	0	0	0	0	2	0
Administrative Services Director	0	1	0	0	0	0	1	0
Architect	8	0	0	0	0	0	8	0
Architect-State	1	0	0	0	0	0	1	0
Administrative Services Manager	0	1	0	0	0	0	1	0
Assistant Commissioner	4	1	0	0	0	0	5	0
Attorney	5	12	0	2	0	0	15	0
Audio Technician	1	0	0	0	0	0	1	0
Audiologist	0	2	0	0	0	0	2	0
Audit Director	1	1	0	0	0	0	2	0
Auditor	14	13	1	5	0	1	20	0
Barber	1	0	0	0	0	0	1	0
Beautician	0	4	0	1	0	0	3	0
Behavior Management Specialist	0	1	1	0	0	0	0	0
Boiler Operator	13	0	0	4	0	0	9	0
Boiler Operator Supervisor	2	0	0	0	0	0	2	0
Budget Administrative Analyst	8	6	0	1	0	0	13	0
Budget Administrative Assistant Director	1	0	0	0	0	0	1	0
Budget Administrative Coordinator	8	1	0	0	0	0	9	0
Budget Analysis Director	1	0	0	0	0	0	1	0
Budget Analyst	0	1	0	1	0	0	0	0
Building Maintenance Worker	20	2	0	3	0	0	19	0

Title	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Cabling Infrastructure Specialist	5	2	0	0	0	0	7	0
Cash Management Director	0	1	0	0	0	0	1	0
Chaplain - Psychiatric	0	1	0	0	0	0	1	0
Chief of Accounts	0	1	0	0	0	0	1	0
Chief of Information Systems	1	0	0	0	0	0	1	0
Clerk	7	64	1	28	2	0	40	0
Commissioner	1	0	0	0	0	0	1	0
Communications Systems Analyst	11	5	0	1	0	0	15	0
Computer Operations Manager	5	7	0	2	0	0	10	0
Computer Operations Supervisor	0	1	0	0	0	0	1	0
Cook	7	8	0	6	0	0	9	0
Counseling Associate	9	48	0	21	1	0	35	0
Custodial Worker	35	65	0	49	0	0	51	0
Custodial Worker Supervisor	4	5	0	5	0	0	4	0
Data Entry Operations Supervisor	0	1	0	1	0	0	0	0
Data Processing Operator	0	3	0	0	0	0	3	0
Database Administrator	3	2	0	0	0	0	5	0
Dental Assistant	0	5	0	1	0	0	4	0
Dental Hygienist	0	3	0	0	0	0	3	0
Dentist	2	0	0	0	0	0	2	0
Deputy Commissioner	3	0	0	0	0	0	3	0
Developmental Center Assistant Superintendent	3	5	0	2	0	0	6	0
Developmental Center Superintendent	3	0	0	0	0	0	3	0
Developmental Services Program Coordinator	6	20	0	5	0	0	21	0
Developmental Services Regional Director	2	1	0	0	0	0	3	0
Developmental Services Regional Monitor	5	21	0	4	1	0	21	0
Developmental Services Regional Program Administrator	0	1	0	0	0	0	1	0
Developmental Services Regional Program Director	1	9	0	1	0	0	9	0
Developmental Technician	405	1,137	8	849	5	3	671	6
Developmental Technician Supervisor	52	162	3	116	0	0	95	0
Developmental Training Technician	1	37	0	38	0	0	0	0
Dietitian	0	11	2	0	0	1	8	0
Dietitian Supervisor	0	3	1	0	0	0	1	1
Distributed Computer Operator	0	1	0	1	0	0	0	0

Title	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Distributed Programmer/ Analyst	0	1	0	0	0	0	1	0
EDP Auditor	2	0	0	0	0	0	2	0
Electronics Technician	1	0	0	1	0	0	0	0
Employee Assistance Program Coordinator	0	1	0	1	0	0	0	0
Employee Wellness Program Coordinator	0	1	0	0	0	0	1	0
Energy Management Administrator	1	0	0	0	0	0	1	0
Equipment Mechanic	6	0	0	1	0	0	5	0
Executive Administrative Assistant	6	12	0	1	0	0	17	0
Executive Housekeeper	2	0	0	1	0	0	1	0
Executive Secretary	0	8	0	1	0	0	7	0
Facilities Construction Director	3	0	0	0	0	0	3	0
Facilities Construction Regional Administrator	2	2	0	0	0	0	4	0
Facilities Construction Specialist	4	3	0	2	0	0	5	0
Facilities Management Director	2	0	0	1	0	0	1	0
Facilities Management Director - Special Projects	1	0	0	0	0	0	1	0
Facilities Manager	4	0	0	0	0	0	4	0
Facilities Planning Specialist	1	8	0	1	0	0	8	0
Facilities Planning Specialist Director	1	0	0	0	0	0	1	0
Facilities Revolving Fund Director	1	0	0	0	0	0	1	0
Facilities Safety Officer	3	0	0	0	0	0	3	0
Facilities Supervisor	9	0	0	1	0	0	8	0
Finance and Administration Program Director	6	6	0	0	0	0	12	0
Financial Director	1	0	0	0	0	0	1	0
Fiscal Director	6	0	0	0	0	0	5	1
Fiscal Director - Finance and Administration	6	3	0	0	0	0	9	0
Food Service Director	0	1	0	0	0	0	1	0
Food Service Manager	1	0	0	0	0	0	1	0
Food Service Supervisor	3	5	1	0	0	0	7	0
Food Service Worker	13	41	0	23	0	0	31	0
Funds Coordinator	0	8	0	0	0	0	8	0
General Counsel	1	2	0	0	0	0	3	0
Grants Program Manager	1	0	0	0	0	0	1	0
Grounds Worker	9	0	0	2	0	0	7	0
Habilitation Therapist	14	39	0	32	0	0	21	0
Habilitation Therapist Supervisor	3	8	0	4	0	0	7	0
Habilitation Therapy Director	2	1	0	2	0	0	1	0

Title	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Habilitation Therapy Technician	21	92	0	55	1	0	55	2
Health Information Manager	0	3	0	0	0	0	3	0
Heating and Refrigeration Mechanic	9	0	0	2	0	0	7	0
Information Officer	0	1	0	0	0	0	1	0
Information Resource Specialist	3	5	0	3	0	0	5	0
Information Resource Support Specialist	28	21	0	7	2	0	40	0
Information System Instructor	1	1	0	0	0	0	2	0
Information Systems Analyst	14	10	2	3	0	0	17	2
Information Systems Analyst Supervisor	1	2	0	0	0	0	3	0
Information Systems Consultant	5	4	0	1	0	0	8	0
Information Systems Director	1	1	1	0	0	0	1	0
Information Systems Manager	10	11	0	3	0	0	18	0
Information Systems Specialist	3	9	0	1	0	0	11	0
Information Systems Technology Consultant	38	17	0	2	1	0	51	1
Information Systems Technology Manager	7	0	0	0	0	0	6	1
Institutional Services Manager	1	0	0	1	0	0	0	0
Insurance Benefits Analyst	1	11	0	3	0	0	9	0
Insurance Benefits Manager	0	2	0	0	0	0	2	0
Insurance Benefits Specialist	0	3	0	0	0	0	3	0
Internal Service Fund Specialist	1	1	0	0	0	0	2	0
Laboratory Technician	0	1	0	1	0	0	0	0
Laundry Supervisor	1	1	0	1	0	0	1	0
Laundry Worker	7	5	0	4	0	0	8	0
Legal Assistant	24	25	0	24	0	0	25	0
Licensed Practical Nurse	7	128	0	35	0	0	99	1
Locksmith	3	0	0	0	0	0	3	0
Mail Technician	1	1	0	1	0	0	1	0
Mainframe Computer Operator	26	6	0	4	0	0	28	0
Mainframe Computer Technician	14	7	0	10	0	0	11	0
Maintenance Carpenter	8	0	0	0	0	0	8	0
Maintenance Electrician	6	0	0	1	0	0	5	0
Maintenance Mechanic	9	0	0	5	0	0	4	0
Maintenance Painter	11	0	0	3	0	0	8	0
Maintenance Plumber	7	0	0	1	0	0	6	0
Managed Care Director	4	3	0	2	0	0	5	0
Managed Care Manager	1	18	0	5	0	0	14	0

Title	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Managed Care Operator	6	31	0	14	3	0	20	0
Managed Care Specialist	15	49	0	28	0	0	36	0
Managed Care Tag Consultant	1	7	0	1	0	0	6	1
Managed Care Technician	4	23	0	14	0	0	13	0
Management Consultant	1	4	1	2	0	0	2	0
Managed Care Assistant Director - Program Integrity	0	1	0	0	0	0	1	0
Managed Care Director - Program Integrity	1	0	0	0	0	0	1	0
Meat Cutter	0	2	0	0	0	0	2	0
Medical Laboratory Technician	0	1	0	0	0	0	1	0
Medical Records Assistant	0	1	0	0	0	0	1	0
Medical Social Worker	0	1	0	0	0	0	1	0
Medical Technologist	0	4	0	0	0	0	4	0
Medical Transcriber	0	3	0	0	0	0	3	0
Mental Health Planning and Evaluation Specialist	1	0	0	0	0	0	1	0
Mental Health Program Specialist	1	1	0	1	0	0	1	0
Mental Health/Mental Retardation Nursing Consultant	0	1	0	0	0	0	1	0
Mental Health/Mental Retardation Planner	0	1	0	0	0	0	1	0
Mental Health/Mental Retardation Program Director	8	17	0	5	0	0	20	0
Mental Health/Mental Retardation Standards Coordinator	0	2	0	1	0	0	1	0
Mental Retardation Administrator	1	1	0	0	0	0	2	0
Mental Retardation Program Specialist	34	96	0	38	2	1	89	0
Mental Retardation Teacher	1	0	0	0	1	0	0	0
Mental Retardation Teacher Supervisor	0	1	0	0	0	0	1	0
MH/MR Institutional Program Coordinator	2	3	0	2	0	0	3	0
MH/MR Institutional Program Director	11	34	1	21	0	0	23	0
MH/MR Investigator	22	13	0	11	0	0	24	0
MR Quality Assurance and Improvement Coordinator	0	1	0	0	0	0	1	0
Music Therapist	1	0	0	0	0	0	1	0
Network Technical Specialist	6	0	0	0	0	0	6	0
Nurse Practitioner	0	3	0	0	0	0	3	0
Occupational Therapist	2	20	0	1	0	0	20	1

Title	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Occupational Therapy Assistant - Certified	3	21	0	4	0	1	19	0
Occupational Therapy Director	0	2	0	0	0	0	2	0
Occupational Therapy Technician	0	26	0	19	0	0	7	0
OIR Director	7	4	0	0	0	0	11	0
Orientation and Mobility Specialist	0	1	0	0	0	0	1	0
Patient Accounts Specialist	1	3	0	0	0	0	4	0
Personnel Analyst	4	7	0	2	0	0	9	0
Personnel Director	0	4	0	1	0	0	3	0
Personnel Manager	1	1	0	0	0	0	2	0
Personnel Technician	1	6	0	3	0	0	4	0
Personnel Training Supervisor	0	1	0	0	0	1	0	0
Pharmacist	4	5	0	0	0	0	9	0
Pharmacy Technician	1	9	0	3	0	0	7	0
Physical Therapist	4	11	2	3	0	0	10	0
Physical Therapy Assistant – Certified	4	12	0	4	0	0	12	0
Physical Therapy Director	2	1	1	0	0	0	2	0
Physical Therapy Technician	6	26	0	20	0	0	12	0
Physician	6	1	1	1	0	0	5	0
Physician - Psychiatrist	2	1	2	0	0	0	0	1
Physician - Specialty	8	4	5	2	1	0	4	0
Physician-Developmental Center Medical Director	0	1	0	0	0	0	1	0
Planning Analyst	11	12	0	4	0	0	19	0
Procurement Officer	3	7	0	2	0	0	8	0
Program Monitor – Finance and Administration	6	25	0	3	0	0	28	0
Program Monitor Regional Director - Finance and Administration	2	1	0	1	0	0	2	0
Programmer/Analyst	60	31	7	8	0	0	76	0
Property Officer	1	1	0	1	0	0	1	0
Psychological Examiner	7	11	0	2	0	0	16	0
Psychologist	4	4	0	0	0	0	8	0
Psychology Director	1	1	0	0	0	0	2	0
Public Health Administrator	1	0	0	0	0	0	1	0
Public Health Educator	0	1	0	0	0	0	1	0
Public Health Nurse Consultant	3	40	1	13	1	0	28	0
Public Health Nurse Consultant Manager	1	11	0	2	0	0	10	0
Real Estate Management Director	1	0	0	0	0	0	1	0
Real Property Agent	6	2	0	1	0	0	7	0
Recreation Therapist	13	22	0	27	0	0	8	0

Title	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Recreation Therapy Technician	4	8	0	2	0	0	10	0
Registered Nurse	14	110	22	23	1	1	77	0
Rehabilitation Technology Specialist	1	0	0	0	0	0	1	0
Residential Program Specialist	10	26	0	8	0	0	28	0
Respiratory Care Director	0	1	0	1	0	0	0	0
Respiratory Care Technician	6	12	0	8	1	0	9	0
Respiratory Care Therapist	1	5	0	0	0	0	6	0
Seamstress	0	2	0	0	0	0	2	0
Secretary	5	91	0	14	2	0	80	0
Security Chief	2	1	0	0	0	0	3	0
Security Guard	16	7	0	11	1	0	11	0
Social Services Director	0	1	0	0	0	0	1	0
Social Worker	0	8	0	7	0	0	1	0
Speech and Language Pathologist	2	17	1	1	0	0	17	0
Speech and Language Pathology Director	0	1	0	0	0	0	1	0
Statistical Analyst	1	0	0	0	0	0	1	0
Statistical Programmer Specialist	2	2	1	2	0	0	1	0
Statistical Research Specialist	0	1	1	0	0	0	0	0
Storekeeper	8	1	0	3	0	0	6	0
Stores Clerk	2	2	0	2	0	0	2	0
Stores Manager	0	1	0	1	0	0	0	0
Systems Programmer	74	23	1	8	0	0	87	1
Telecommunications Director	1	0	0	0	0	0	1	0
Telecommunications Manager	1	0	0	0	0	0	1	0
Telecommunications Operator	1	3	0	0	1	0	3	0
Telephone Operator	2	12	0	7	0	0	7	0
Telephone Operator Supervisor	0	1	0	0	0	0	1	0
TennCare Public Affairs Director	1	0	0	0	0	0	1	0
TennCare Director of Operations	1	0	0	0	0	0	1	0
TennCare Hearing Officer	1	3	0	0	0	0	4	0
Therapeutic Equipment Worker	12	1	0	1	0	0	12	0
Training Officer	1	2	0	1	0	0	2	0
Training Specialist	2	1	0	0	0	0	3	0
Vehicle Operator	28	5	0	17	0	0	16	0
Volunteer Services Coordinator	0	1	0	0	0	0	1	0
Warehouse Worker	1	0	0	1	0	0	0	0
Word Processing Operator	1	6	0	2	0	0	5	0

Title	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
X-Ray Technician	0	2	0	0	0	0	1	0
Total	1,592	3,457	70	1834	29	9	3,086	21

Both the Bureau of TennCare and the Division of Mental Retardation Services submit separate Title VI plans. (Information from the Bureau of TennCare’s plan is detailed in the performance audit of the bureau.) The Division of Mental Retardation receives federal funding directly for the Developmental Disabilities Council and indirectly (through the Bureau of TennCare) for the Home and Community-Based Waivers, the Statewide Mental Retardation Waiver, and the Arlington Waiver. As of 2004, the division has its own Title VI Coordinator who is responsible for such activities as developing the Title VI plan (with assistance from a Title VI coordinating committee), conducting and coordinating Title VI training, conducting pre-award and post-award compliance reviews, investigating Title VI complaints, submitting required Title VI data and reports, and monitoring service provider records for Title VI compliance. The division reported receiving no Title VI complaints during Fiscal Year 2004.

According to the division’s current Title VI plan (submitted to the Division of State Audit on June 30, 2004, as required), the division will focus on eight objectives:

- Increase beneficiaries’ knowledge about individual rights under Title VI.
- Improve the delivery of beneficiary services through the use of technology.
- Strengthen agency compliance with and enforcement of Title VI and other civil rights laws.
- Increase knowledge and awareness of state and federal statutory non-discrimination requirements.
- Strengthen relationships with federal agencies responsible for Title VI compliance.
- Develop procedures to improve outreach to protected beneficiary groups.
- Increase contract and procurement opportunities for qualified service providers representing protected beneficiary groups.
- Reduce barriers to services.

The plan includes a series of strategies (e.g., continue to partner with the Governor’s Office of Diversity Business Enterprise to identify and expand business opportunities for service providers from protected beneficiary groups) under each objective to help the division meet the objective.

The division provides services directly to clients in the community and in the state’s developmental centers and provides services indirectly to clients in the community through contracts with service providers throughout the state. On the following pages are (1) a breakdown of the division’s clients by ethnicity and region; (2) a breakdown of division staff by job category, gender, and ethnicity; and (3) a breakdown of service providers by ethnicity and gender.

**Division of Mental Retardation Services Clients
By Ethnicity and Region
As of June 1, 2004**

	Ethnicity					
	White	Black	Hispanic	Other	Unknown	Total
East Tennessee Region						
Percent of Population in Region (Based on Census Data)	91.3%	6.1%	1.4%	0.0%	1.2%	100%
Number of Residents-Greene Valley Developmental Center	289	21	0	0	0	310
Percent of Residents-Greene Valley	93.2%	6.8%	0.0%	0.0%	0.0%	100%
Number of Clients Receiving Community Services	2,285	221	3	0	48	2,557
Percent of Clients Receiving Community Services	89.4%	8.6%	0.1%	0.0%	1.9%	100%
Middle Tennessee Region						
Percent of Population in Region (Based on Census Data)	82.9%	13.9%	3.0%	0.0%	.2%	100%
Number of Residents-Clover Bottom Developmental Center	146	46	0	0	0	192
Percent of Residents-Clover Bottom	76.0%	24.0%	0.0%	0.0%	0.0%	100%
Number of Clients Receiving Community Services	1,945	403	6	17	0	2,371
Percent of Clients Receiving Community Services	82.0%	17.0%	.3%	.7%	0.0%	100%
West Tennessee Region						
Percent of Population in Region (Based on Census Data)	60.4%	36.4%	2.1%	0%	1.1%	100%
Number of Residents-Arlington Developmental Center	130	75	0	1	0	206
Percent of Residents-Arlington	63.1%	36.4%	0%	.5%	0%	100%
Number of Clients Receiving Community Services	1,025	638	1	5	13	1,682
Percent of Clients Receiving Community Services	60.9%	37.9%	.1%	.3%	.8%	100%
Statewide						
Percent of Population Statewide (Based on Census Data)	80.2%	16.4%	2.2%	1.0%	.2%	100%
Number of Residents in Developmental Centers	565	142	0	1	0	708
Percent of Residents in Developmental Centers	79.8%	20.0%	0%	.3%	0%	100%*
Number of Clients Receiving Community Services	5,255	1,262	10	30	63	6,620
Percent of Clients Receiving Community Services	79.4%	19.1%	.2%	.5%	1.0%	100%*

*Percentages may not add to 100% because of rounding.

**Breakdown of Mental Retardation Services Employees
By Job Category, Gender, and Ethnicity
As of June 16, 2004**

State EEO Job Category	White Male	Black Male	Other Male	White Female	Black Female	Other Female	Total
Administrator	62	9	48	75	42	1	237
Professional	121	37	19	376	156	34	743
Technician	9	3	0	104	34	1	151
Protective Services	10	7	1	4	5	0	27
Paraprofessional	204	295	25	739	845	8	2,116
Office and Clerical	18	5	0	160	48	2	233
Skilled Craft Worker	101	20	0	19	9	0	149
Service Maintenance	71	49	0	60	60	0	240
Total	596	425	93	1,537	1,199	46	3,896

Overall, division staff are 29% male, 71% female, 54.7% white, 41.7% black, and 3.6% other.

**Diversity of Division Service Providers
For the Period July 1, 2003 through June 16, 2004**

Total Number of Service Providers	534
Total Number of Female-Owned Service Providers	151 (28%)
Total Number of Minority Service Providers	41 (8%)
Number of African American Service Providers	30 (6%)
Number of Hispanic Service Providers	4 (.7%)
Number of Native American Service Providers	2 (.4%)
Number of Asian Service Providers	5 (.9%)

The division's total dollar value of contract awards for fiscal year 2004 was \$418.3 million. The division did not, however, have a breakdown of that amount by ethnicity of the service provider.

The division provides support to the Council on Developmental Disabilities, which is an independent office established through federal legislation to work on state policies and service systems that affect Tennesseans who have a disability. The membership of the council is detailed in federal law and is monitored by the federal Administration on Developmental Disabilities. According to division staff, as of October 2004, the council had 21 members—4 African Americans, 1 Hispanic, and 16 Caucasians.