Commonwealth of Massachusetts
Executive Office of Health & Human Services
Department of Mental Retardation

ANNUAL
QUALITY ASSURANCE REPORT
For Fiscal Year 2005

Period Covering
July 1, 2004 – June 30, 2005

Deval Partick, Governor
Commonwealth of Massachusetts

JudyAnn Bigby, M.D., Secretary
Executive Office of Health & Human Services

Gerald J. Morrissey Jr., Commissioner
Department of Mental Retardation

Prepared by the DMR
OFFICE OF QUALITY MANAGEMENT

In Partnership with the UMASS Medical School,
Center for Developmental Disabilities Evaluation and Research

February 2007

The Commonwealth of Massachusetts
Executive Office of Health & Human Services
Department of Mental Retardation
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February, 2007

Dear colleagues and interested citizens:

Enclosed is the Annual Quality Assurance Report for FY 2005 for the Department of Mental Retardation compiled in collaboration with the Center for Developmental Disabilities Evaluation and Research (CDDER) of the University of Massachusetts Medical School. Each year, the Department reports on outcomes important to the health, safety and quality of lives of the individuals we support. Information is gathered from the numerous quality assurance systems the Department has in place and is reported in an easy to understand format.

The Annual Quality Assurance Report is a critical component of the Department's quality management and improvement system. It allows us to look critically at areas where we can take pride as well as areas where we can direct our service improvement efforts. The Department's four regional quality councils and one statewide quality council review and analyze our quality assurance reports and make recommendations regarding service improvement targets. As a result of reviewing the most recent Annual Quality Assurance Report, members of the councils developed two key service improvement targets upon which to focus particular attention and energy: improving employment outcomes for individuals and improving community membership and relationships.

It takes a great deal of maturity, both from our own staff and outside stakeholders, to review this information, ask critical questions and share recommendations for improvement. The Department and its stakeholders can be proud of the quality of supports provided each day to thousands of individuals. We must, however, always strive to improve services and supports. This report, the work of the quality councils and our combined dedication to quality will serve us well in this endeavor.

I remain committed to sharing information regarding how well we are doing in supporting the health, safety and quality of life of the individuals we serve. I trust that this report will be used to further our shared goals and continue an open, honest dialogue on behalf of individuals we serve.

Thank you.

Sincerely yours,

Gerald J. Morrissey, Jr.
Commissioner

Executive Office of Health & Human Services
Massachusetts Department of Mental Retardation
ANNUAL QUALITY ASSURANCE REPORT
For Fiscal Year 2005

February 2007

EXECUTIVE SUMMARY

The Massachusetts Department of Mental Retardation (DMR) has published Annual Quality Assurance Reports since 2001. Since the FY2002/03 report, annual reports have been prepared in partnership with the University of Massachusetts Medical School's Center for Developmental Disabilities Evaluation and Research (CDDER), an arm of the E.K. Shriver Center. These quality assurance and improvement reports are designed to share information regarding the quality of the services and supports provided by DMR with a broad audience, including persons receiving supports and their families, the service provider community, DMR personnel and the public at large. Information contained in the reports is extensive in nature and is derived from a wide variety of sources and is intended to serve as a starting point for the collective review and analysis of service quality. The reports provide a very comprehensive look at the overall service/support system in Massachusetts and are used to help identify agency performance, progress in meeting goals and areas in need of improvement.

The 2005 Report, like reports covering fiscal years 2002-2004, is structured around 12 important outcomes that have been established as important indicators of system quality and performance:

1. *People are supported to have the best possible **health**.*
2. *People are **protected from harm**.*
3. *People live and work in **safe environments**.*
4. *People understand and practice their **human and civil rights**.*
5. *People's **rights are protected**.*
6. *People are supported to make their **own decisions**.*
7. *People use integrated **community resources** and participate in everyday community activities.*
8. *People are connected to and are **valued members of their community**.*
9. *People gain and maintain **friendships and relationships**.*
10. *People are supported to develop and **achieve goals**.*
11. *People are supported to obtain **work**.*
12. *People receive services from **qualified providers**.*

Each of these 12 outcomes has a variety of measures that are based on information and data that is routinely collected and analyzed by the department. The report uses easy-to-read charts and graphs to facilitate the review of findings. It also incorporates color-coded symbols (arrows) to identify trends.

Findings for fiscal year 2005 were generally quite favorable. Comparison of performance with FY04 shows that 37 measures experienced little or no change from 2004, suggesting relative stability in the service/support system. Seven (7) measures showed improvement (±10%) and four were suggestive of possible improvement (slightly less than the 10% criterion) from levels achieved in the prior year. In contrast, only four (4) measures suggested a decline in performance/quality.

Some selected **HIGHLIGHTS** for fiscal year 2005 include the following findings:

- Individuals served by DMR continue to receive **physical and dental examinations** at a consistently higher rate than both New England and National benchmarks.
- **Medication safety** appears to continue to improve, with decreases noted in the number and percentage of medication "hotlines" and the number of action required reports associated with medication. Both measures have shown a steady decrease (improvement) since 2002. In FY05 Hotlines were half of what they were in FY02. Medication Occurrence Reports (MOR) have continued to drop since 2003 (with 70% of all MORs in 2005 due to "wrong time").
- FY05 experienced a slight reduction in the number of substantiated **Abuse and Neglect** investigations. The rate of substantiated investigations (number substantiated/number people served) has shown a consistent decline since 2002 (although there was variation among the different types of findings).
- The percentage of providers without **CORI violations** continued to increase (it has increased from 52% to 89% since 2002).
- A large reduction was noted in FY05 for action required reports re: issues of **evacuation** with the number of such reports falling from 108 in 2002 to 20 in FY05.
- The vast majority (93%) of people reviewed through the Survey and Certification process in FY05 were considered to live/work in **safe environments** that were secure and in good repair.
- The total number of **emergency restraints** – across all settings – fell slightly in FY05 compared to FY04 (although it is still higher than it was in 2002).
- The percentage of DMR consumers who report they can see **family and/or friends** when they want to is higher in Massachusetts than the national average on the National Core Indicators (NCI) survey.
- There was a slight increase in the **hourly wage** for persons in group employment and a larger increase for those in facility work programs (although facility work still pays significantly less than the other types of employment). A very large percentage (93%) of all persons in individual supported employment earned at least the minimum wage in FY05.
- There was a slight increase in the percentage of providers given a **2-year license with distinction** in FY05 and a slight decrease in those with only a one year license – under the "old" system. No providers had a 1-year license with conditions in

FY05. Under the "new" licensing system 96% of providers surveyed were awarded a 2-yr license and only 4% were given a 1-yr license. Under the "new" system 75% were given certification that met all 6 of the 6 quality of life areas. The average **number of citations** per provider (those with citations) dropped to an all time low (1.8).

- The number and rate of **critical incidents** increased again in FY05. The rate (number of reports per 1000 people served) has been steadily increasing, jumping from 19.6/1000 in 2002 to 33.5/1000 in FY05. However, it is important to note that the incident reporting system has been undergoing significant changes over the past few years, and it is not possible to determine whether or not those changes are primarily responsible for the increase in reports.
- There was an increase in the number of action required reports associated with **environmental** issues and concerns in FY05.
- There has been a steady increase in the percentage of the DMR population experiencing **restraint** since 2002. For people residing in facilities the number of people restrained increased in FY05 (although the average number of restraints per person restrained declined). In FY05 the percentage of people restrained within facilities rose to the same level as in community programs (5.9%).
- National Core Indicator results for Massachusetts were generally lower than the national average for all measures of **choice** and **community inclusion**.
- Compared to national averages, individuals in MA DMR programs spend significantly less **time working** than their peers spend across the country. This results in a much lower average monthly income, despite the fact that average wages are higher.

The publication of Annual Quality Assurance Reports, including this one for fiscal year 2005, represents a continued commitment by DMR to transparency and the sharing of information with the public. This commitment will enhance the ability of interested stakeholders to better guide efforts to improve services and supports provided by the Commonwealth to individuals with developmental disabilities. Overall the findings contained in this report suggest that the DMR system is stable and strong. They also point to areas where improvement initiatives can potentially enhance the quality of life for persons served by DMR.

Annual Quality Assurance Report for FY05

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INTRODUCTION

In March of 2001 the Department of Mental Retardation (DMR) began a strategic management planning process to develop a department-wide quality management and improvement system. An integral component of this process involved the development of a series of personal and provider outcomes that stakeholders identified as important to measure and upon which to report on a periodic (e.g., annual) basis. This broad set of outcomes has formed the foundation for the Department's annual quality assurance reporting process.

A description of these outcomes and their associated indicators and data sources is contained in Appendix A and a summary listing is presented to the right and on the next page of this report.

QUALITY OUTCOMES

reflect what is important for people and form the foundation for evaluating progress toward meeting DMR's strategic objectives.

- **Health**
- **Protection from Harm**
- **Safe Environments**
- **Human & Civil Rights**
- **Decision-making & Choice**
- **Community Integration & Membership**
- **Relationships**
- **Achievement of Goals**
- **Work**
- **Qualified Providers**

The first Annual Quality Assurance Report was published in December of 2001. It focused primarily on health, safety and human rights issues. The reports for FY2002, 2003, and 2004 expanded upon information concerning health, safety and rights by including outcomes related to choice, control, community integration, relationships and work. The current report is modeled on the ones issued for the past few years and includes data and information that reflects performance during fiscal year 2005 (FY05: July 2004 – June 2005).

All of the Quality Assurance Annual Reports since 2003 derive information from a variety of quality assurance systems and databases (See Appendix B

for a description of the databases utilized for this report). As noted in the past, these reports are only intended to be a starting point in our collective review and analysis of service quality. It is extremely important to recognize that the data provided in this report represents an opportunity to point out areas where the department is *doing well* as well as areas *where improvements are needed.* It is also important to keep in mind that data is but one source of information about quality and should not be taken out of context. Premature conclusions about what the information tells us should be avoided. Data should only be used as one component of an analytical and probative process, not a singular basis for decision making.

Quality assurance and improvement is a shared and ongoing responsibility – both for those within DMR as well as all of our external partners. Because of this the Department has established regional and statewide Quality Councils that include a broad representation of stakeholders (self-advocates, family members, providers and DMR staff). These councils are designed to assist the department to identify strategic quality improvement targets and help monitor performance over time. Use of the data and information contained in this – and earlier – reports serves as an essential ingredient in helping make the review and feedback from the Quality Councils focused, meaningful and extremely useful.

It should be noted that based on review of earlier Quality Assurance Reports the Statewide Quality Council has provided a series of recommendations to the DMR Commissioner for establishing improvement targets. General priority areas identified by the Council include:

1. Employment
2. Community Inclusion
3. Friendships

In response to these recommendations the Department is in the process of establishing a series of service quality workgroups that will lead system-wide efforts to effect meaningful change in these three areas and significantly improve the quality of life for the persons we serve. Activity has begun in earnest on addressing the first of the targets identified above.

OUTCOMES & INDICATORS

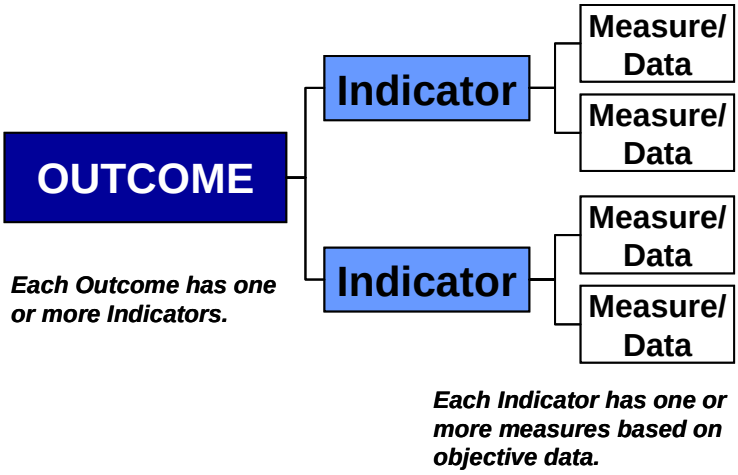
The data that forms the basis for this report is drawn from a wide variety of quality assurance processes in which the department is routinely engaged. These quality assurance processes allow for continuous review, intervention and follow-up on issues of concern in a timely manner. Additionally, the aggregation of information in this report facilitates the identification and analysis of important patterns and trends and allows for a more objective evaluation of performance over time. Such integration of information represents an important strength of the quality assurance system in that no one process or data set is used in isolation to draw any firm conclusions, but rather, conclusions flow from convergence of information obtained from many different perspectives.

In the pages that follow, major sections are based on each of the following12 major ***outcomes***:

1. People are supported to have the best possible health.
2. People are protected from harm.
3. People live and work in safe environments.
4. People understand and practice their human and civil rights.
5. People's rights are protected.
6. People are supported to make their own decisions.
7. People use integrated community resources and participate in everyday community activities.
8. People are connected to and are valued members of their community.
9. People gain/maintain friendships and relationships.
10. People are supported to develop and achieve goals.
11. People are supported to obtain work.
12. People receive services from qualified providers.

Information regarding each of the identified outcomes is presented in the form of ***indicators*** and their associated ***measures*** or ***data***. The relationship between outcomes, indicators and measures is illustrated below in Figure 1. As can be seen, each of the outcomes will have one or more indicators or statements regarding how that outcome is evaluated. Each of the indicators, in turn, will have one or more specific objective sets of data that help determine whether or not the criteria contained in the indicator are being met. A description of the data sources is contained in Appendix B.

Figure 1
Relationship between Outcomes, Indicators & Data



DATA SOURCES

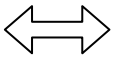
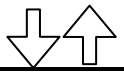
As noted above, the Quality Assurance Report derives its information from a wide variety of different sources, including:

Survey and Certification	*Data based on the number of individual surveys conducted during each fiscal year for persons over the age of 18-yrs served in settings that are licensed and/or certified by DMR. The number of individual surveys will vary depending upon whether the indicator is measured for all supports or for residential or day/employment supports only.*
National Core Indicators	*Data reported by the NCI initiative that includes over half of all the U.S. state MR/DD systems. Data is derived from face to face interviews with consumers.*
Medication Occurrence Reporting System	*Data based on the number and distribution of Medication Occurrence reports provided by over 168 service/support providers and 2,291 Medication Administration Program registered sites.*
Investigations	*Data regarding complaints filed and substantiated by the Disabled Persons Protection Commission or DMR for persons served by DMR who are over the age of 18.*
Critical Incident Reporting System	*Data based on the number and type of critical incident reports filed in each of the fiscal years.*
Restraint Reporting	*Data based on the number of restraints used during each of the fiscal years.*
Employment Report	*Data based on a point in time study conducted annually of providers offering employment supports.*

HOW TO REVIEW THE DATA

As noted above, information is presented in sections based on the major outcomes. The first page of each section states the associated indicators (important predictors of the outcome) and presents a brief summary of findings including arrows in the last column that illustrate the trends present for 2004 and between 2004 and 2005. Arrows pointing upward indicate an increase in the measure. Arrows pointing down indicate a decrease, and arrows pointing left-right indicate a stable trend (no meaningful change). Colors and "+" or "-" signs are used to illustrate whether or not the trend is positive or negative; green indicating the change is positive, red indicating it is negative. White represents a neutral trend (no change) or relatively minor change. Green (+) or Red (-) arrows indicate the change was $\pm$10%. White arrows are used to illustrate a potential trend, *i.e.*, some change of interest was present but was less than the $\pm$10% criteria. See Figure 2 for a description of the symbols.

Figure 2
Symbols Used to Illustrate Type of Change

TYPE OF CHANGE	SYMBOL
Positive Increase	 +
Negative Increase	 -
Positive Decrease	 +
Negative Decrease	 -
Neutral Stable Trend	
Potential Trend	

The first section for each outcome is immediately followed by a more detailed review of each indicator and its related measures. These sections include a variety of tables and graphs that, in most instances, will reference data for a four-year period (fiscal years 2002, 2003, 2004 and 2005). Narrative provides a very brief explanation of findings and trends. At the end of each major section there is a simple "plain language" summary of the major findings entitled ***What Does this Mean?***

Special Note: Readers are cautioned to use the information contained in this report as only one avenue for conducting a thorough and complete assessment of quality and progress toward improvement in the services and supports provided by DMR. More in-depth analyses should always be conducted and probative questions explored before drawing any definitive conclusions with respect to patterns and trends.

DATABASE CHANGES

This report covers the period from July 1, 2004 through June 30, 2005.
One of the strengths of the reports published to date lies in their ability to compare data across several years.

Several changes to different components of DMR's data systems have been implemented. These changes will substantially improve the Department's ability to provide detailed data on various components of its service delivery system, including but not limited to reporting on minor and major incidents. While these changes represent improvements to data collection capabilities, they will make cross-year comparisons difficult to achieve.

The first change noted is to the DMR Survey and Certification system. This change took effect in April, 2004. As a result of this change, the processes of licensure and certification were separated. Providers are now licensed based on their adherence to essential health, safety and human rights safeguards. Additionally, they are certified

based on the combination of their performance on essential safeguards ***and*** the quality of their supports in other life domains including community integration, relationships, choice/control and growth and accomplishments. During FY 05 a number of providers were licensed and certified utilizing the revised system. Other providers, not scheduled for a routine review, maintained the certification status they received under the previous system. In order to compare like processes, the data is divided between those providers reviewed under the revised system ("new") and those reviewed under the previous system ("old") in this transition year.

In addition, DMR has re-designed and fully implemented a Department of Mental Retardation Information System (DMRIS). The system has two basic components. The first is client information system, known as the Meditech system. The second is a web-based incident management system known as the Home and Community Services Information System (HCSIS). Full implementation of both systems statewide was completed in July, 2006. The HCSIS system enables the Department to report on data specifically pertaining to incidents, restraints, medication occurrences and deaths in a more detailed fashion. Data collected through these new systems will not directly affect the Fiscal Year 2005 report. It will, however, impact the Fiscal Year 2006 report and those that follow.

HEALTH

OUTCOME: People are supported to have the best possible health.

Indicators:
1. Individuals are supported to have a healthy lifestyle.
2. Individuals get annual physical exams.
3. Individuals get routine dental exams.
4. Individual's medications are safely administered.
5. Serious health and medication issues are identified and addressed.

RESULTS:

The quality of health-related services, as evaluated using five major indicators and eight (8) specific measures is summarized below in Figure 3. As can be seen all but one indicator/measure experienced either a positive change or remained stable between FY 2004 and 2005. The one measure that was "negative" experienced only a very slight change (+2 cases), but due to the small number of overall cases, this translated into a 12% increase (just above the 10% criteria established for determining type of change). Comparison of DMR outcomes related to health as measured by the National Core Indicators Project, suggests that individuals served by DMR may be less physically active and have more weight concerns than their peers in other parts of the county. However, fewer individuals in Massachusetts appear to use tobacco products. In general, these findings and trends suggest consistency and/or improvement in the quality and safety of health-related services and care for persons served by the Massachusetts DMR.

Figure 3
Summary of Trends for Health Indicators and Measures
2004-2005

OUTCOME	Indicator	Measure	Change FY03-FY04	Change FY04-FY05
Health - *people are supported to have the best possible health.*	1. Healthy Lifestyle	Receive Support	⇔	⇔
	2. Physical Exams	Receive Annual Exams	⇔	⇔
	3. Dental Exams	Receive Annual Exams	⇔	⇔
	4. Safe Medication	MOR No. and Rate	↓ +	⇔
		Percent/No. Hotlines	↓ +	↓ +
	5. Issues Identified and Addressed	Action Required Reports	↓ +	↓ +
		Medication Investigations	↓ +	↑ -
		Denial of Tx Investigations	↓ +	⇔

Direction of Arrow = increase, decrease, stable
Green = positive trend (+)
Red = negative trend (-)
White = slight change/neutral trend

Note: Medication investigations increased by 2 cases (from 17 to 19). However, this small no. represented a 12% increase.

OUTCOME: People are supported to have the best possible health.

Indicator 1: Individuals are supported to have a healthy lifestyle.

Measures: Percentage of persons who receive support to eat healthy foods and exercise on a regular basis (who live in settings that received a DMR survey during the fiscal year)

Data Source: Survey and Certification

FINDINGS: Over the past four years almost all individuals reviewed during Survey and Certification reviews have been found to be receiving support necessary for the promotion of a healthier lifestyle. These findings have remained remarkably consistent (98%) over the time period between FY02 and FY05.

Table 1
Support for Healthy Lifestyle

Healthy Lifestyles	2002	2003	2004	2005	Change 2004 - 2005	Type of Change
No. People Reviewed	1091	1000	1118	1314		
Percent with Support for Healthy Lifestyle	98%	98%	98%	98%	0%	⇔

NCI and CDC Benchmarks: Comparative data related to wellness and healthy lifestyle from both the NCI and Centers for Disease Control (CDC)[1] suggest that individuals served by the Massachusetts DMR have fewer unhealthy lifestyle behaviors than the general population, but, may exhibit higher rates of weight control problems and physical inactivity when compared to their peers in New England and other NCI states. As can be seen in Table 2 below, fewer DMR consumers smoke/use tobacco than their counterparts in other New England MRDD systems and/or the general U.S. or Massachusetts adult population.

Table 2
Prevalence of Smoking and Tobacco Use

Smoking	MA DMR NCI	New England NCI	MA Gen Pop	US Gen Pop
Percent Adults who Smoke/Use Tobacco	7.7%	8.2%	18.1%	20.6%

[1] Benchmarks are provided only for very general comparative purposes. Data is not risk adjusted for age, disability or morbidity. Data for the general MA and US population from statehealthfacts.org, 2006, summarized from the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data (BRFSS), 2006. Data for MA DMR and NE NCI from National Core Indicators, 2005

Table 3 provides comparative data related to weight. This comparison suggests that persons served by the Massachusetts DMR may be experiencing a somewhat higher rate of weight concerns than peers in New England, but lower rates than the general population.[2]

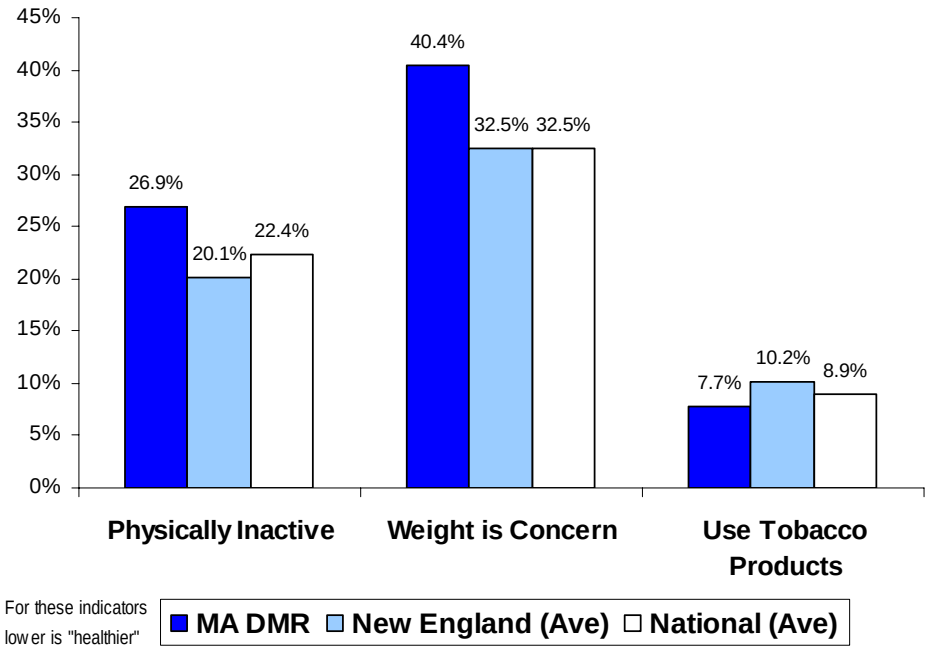
Table 3
Prevalence of Weight Issues

Weight	MA DMR NCI	New England NCI	National NCI	MA Gen Pop	US Gen Pop
Percent Adults: Weight Concern	40.0%	32.5%	32.5%		
Percent Adults: Overweight	33.2%	27.3%		52.9%	58.5%

Data for general MA and US population from statehealthfacts.org, 2006
Data for MA DMR and NE NCI from National Core Indicators, 2005

Figure 4 provides additional information re: three indicators of healthy lifestyle from the NCI.[3] As can be seen in Figure 4 and Table 2, while Massachusetts has a lower rate of tobacco use than either the New England or national averages, the rates are higher for both physical inactivity and all categories of weight concern (overweight and underweight).

Figure 4
NCI Healthy Lifestyle Measures



[2] Different methods were utilized to collect and analyze data used for the comparison between general population and the NCI. The "Weight is a Concern" category in the NCI combines both underweight and overweight. The NCI data is also based on individuals "perception" of weight issues. Therefore, caution should be exercised in drawing any conclusions regarding this variable.
[3] NE = average from CT, RI, VT - special report from HSRI on NE Health Indicators. MA data from special HSRI report issued in 2006. National NCI from the 2005 NCI report.

WHAT DOES THIS MEAN? *Almost all persons in Survey & Certification reviewed services are receiving support to live a healthier lifestyle. Very few persons served by DMR use tobacco products, even when compared to the general population or peers across New England. A higher percentage of persons served by DMR appear to have weight and physical activity concerns than peers in New England and across the U.S. who receive MRDD services. However, the percentage of DMR consumers with "concerns about being overweight" is less than the percentage of adults in the general population of Massachusetts or the U.S. who are actually overweight.*

Indicator 2: Individuals receive annual physical exams.

Measure: Percentage of persons who receive annual physical exams over time and compared to a national benchmark (NCI).

Data Source: DMR Survey and Certification
National Core Indicators

FINDINGS: The extent to which individuals receive at least an annual physical exam is a simple measure of access to and receipt of basic health care. As can be seen in Table 4 during 2005 approximately 88% of the individuals included in the DMR Survey and Certification process received such an annual physical exam. This represents a slight decrease from levels achieved in both 2003 and 2004.

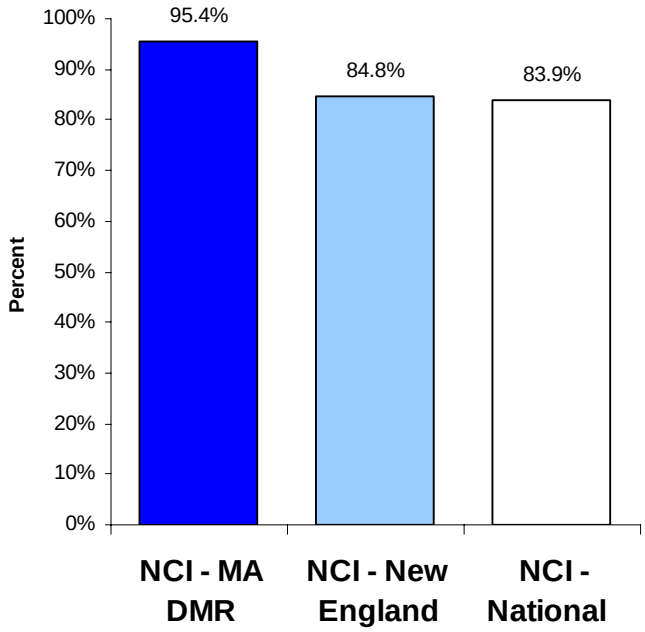
Comparing the Massachusetts DMR data from the National Core Indicators with that collected through the NCI for both a New England and the national sample suggests however, that persons receiving services in Massachusetts continue to receive annual health exams at a higher rate than their peers in other MR/DD service systems. This comparison is illustrated more clearly in Figure 5. [Note: the NCI sample includes individuals who are supported by programs evaluated by the DMR Survey & Certification process as well as other persons not in these programs and is therefore potentially a more representative sample of the total population served by DMR.]

Table 4
Percentage of Persons Receiving Annual Physical Exams
2002-2005

Physical Exams	2002	2003	2004	2005	Change 2004 - 2005	Type of Change
MA DMR - S&C	87.0%	94.0%	92.0%	88.0%	-4%	⇔
NCI - MA DMR				95.4%		
NCI - New Eng				84.8%		
NCI - National	83.0%	80.0%	83.5%	83.9%		

MA DMR - Survey/Certification findings for 2005
NCI-MA DMR - NCI report issued 2006
NCI New England = CT, ME, RI, VT, special report issued 2006
NCI National = 15 states and 1 large county in CA, 2005

Figure 5
Comparison of MA, New England and National NCI Results
For Physical Health Exam within the Past Year



Indicator 3: Individuals receive routine dental exams.

Measures: Percentage of persons who have received dental exams over time and compared to a national benchmark (NCI).

Data Source: DMR Survey and Certification
National Core Indicators

FINDINGS: Table 5 presents information pertaining to routine dental exams for the Massachusetts DMR and the NCI across a four year time period from 2002 to 2005. DMR data obtained from Survey and Certification reviews represents a criterion that is different from that of the NCI, *i.e.,* the NCI reports on dental exams within the past 6 months whereas the DMR Survey and Certification data is based on an exam within the past year.

The percentage of persons served by DMR in residential programs reviewed by the Survey and Certification unit who have received a dental exam within the past 12 months remained relatively stable from the prior year, with about 86% of persons served in programs evaluated by the Survey and Certification process having such an exam. Interestingly, a more direct comparison of Massachusetts with both a sample of New England MRDD systems and the national average from the NCI suggests that a higher percentage of individuals who receive DMR services in Massachusetts have had a dental exam within 6-months of review than for either of the other two comparison groups. Figure 6 illustrates this comparison.

Table 5
Percentage of Persons Receiving Routine Dental Care
2002 – 2005

Dental Exams	2002	2003	2004	2005	Change 2004 - 2005	Type of Change
MA DMR - S&C	83.0%	88.0%	87.0%	86.0%	-1%	⇔
NCI - MA DMR				69.7%		
NCI - New Eng				58.1%		
NCI - National	50.0%	51.0%	53.5%	52.0%		

NCI criteria is exam every 6 months. DMR S&C criteria is exam every 12 months.

NCI New England = CT, ME, RI, VT, report issued 2006

NCI National = 15 states and 1 large county in CA, 2005

Figure 6
Comparison of MA, New England and National NCI Results
for Dental Exam within 6-months
2005

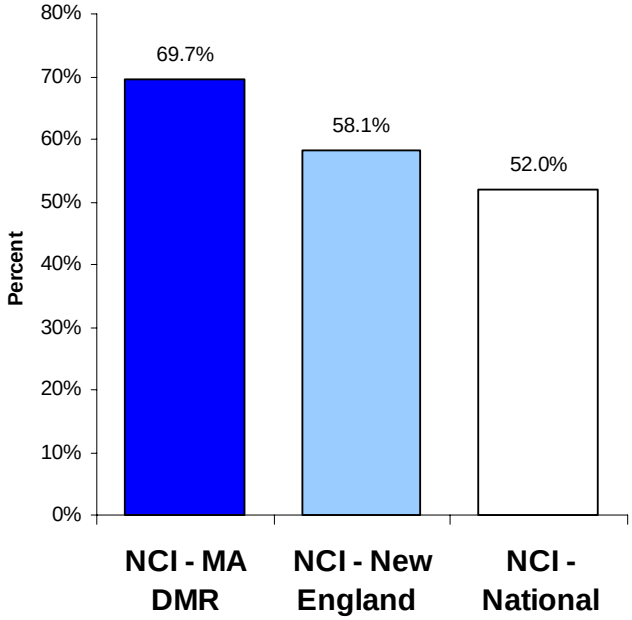


Table 6 provides additional benchmarks regarding access to and receipt of dental services. As can be seen, a higher percentage of individuals receiving support from programs evaluated by the Survey and Certification process receive dental services than for either the Massachusetts or U.S. general populations.

Table 6
Comparison of DMR and General Population for
Dental Visits within Past Year

Dental Visit	MA DMR S&C	MA Gen Pop	US Gen Pop
Percent: Dental Visit in Past Year	86.0%	79.5%	70.2%

Data for general MA and US population from statehealthfacts.org, 2006
Data for MA DMR - 1-yr criteria - DMR Survey/Certification, 2005

WHAT DOES THIS MEAN? *A relatively high percentage of persons served by DMR are receiving basic health care, represented by a minimum of an annual physical and dental exam, and are therefore experiencing at least one health care encounter each year. Compared to MRDD systems in New England and nationally, more persons served by DMR have had both physical and dental exams, and, the percentage of persons served by DMR who receive dental care is higher than that for the general populations of both Massachusetts and the U.S.*

Indicator 4: Medications are safely administered.

Measures: Medication Occurrence Report (MOR) Rate
No. of Medication Occurrence Reports (MORs) by Cause
No. of MOR Hotlines and Percent of MORs classified as "Hotlines"

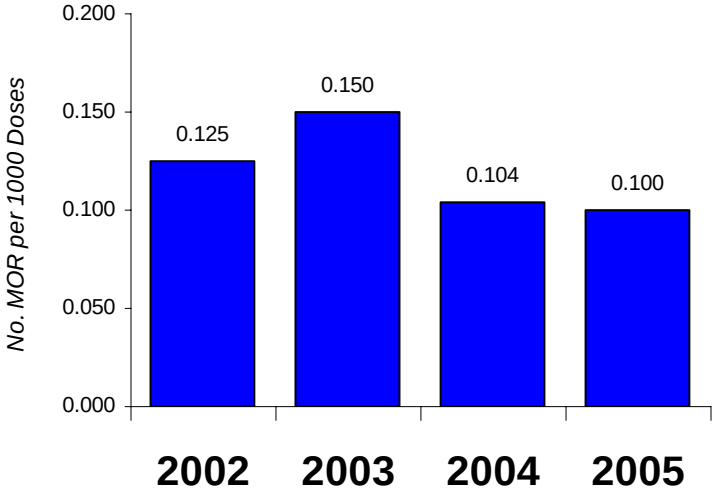
Data Source: DMR Medication Occurrence Reports

FINDINGS: MOR Rate. 2005 experienced a continuation in the reduction of actual Medication Occurrence Reports (MORs). As can be seen in Table 7, during FY05 DMR estimates that over 36.5 million doses of medication were administered to service recipients by personnel working in DMR operated/funded residential services. During this same time period there were 3,667 medication occurrences reported, resulting in an occurrence rate of 0.100 per 1,000 doses. This rate is slightly less than that estimated for 2004 and continues the previous trend of a reduction in medication occurrences since FY03. Figure 7 illustrates this trend, and suggests that the service system is experiencing a relatively consistent improvement in the safe administration of medication for persons receiving residential services and supports.

Table 7
Medication Occurrence Reports
2002 – 2005

Medication Occurrence Reports	2002	2003	2004	2005	2004-2005 Change	Percent Change	Type of Change
No. MORs	4,370	4,043	3,599	3,667	68	1.9%	⇔
Est. No. Doses Adm	34,950,936	27,010,000	34,461,676	36,716,007	2,254,331	6.5%	
Occurrence Rate (per 1000)	0.125	0.150	0.104	0.100	-0.005	-4.4%	⇔

Figure 7
MOR Rates for 2002 – 2005



FINDINGS: Type of MOR.

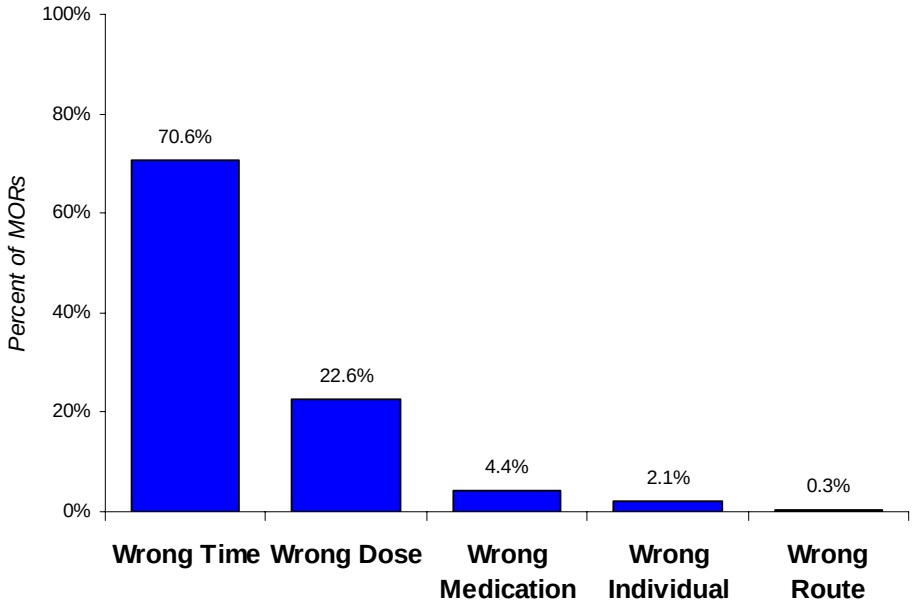
The relative proportion of MORs by cause has remained relatively stable over time. As can be seen below in Table 8, there has been little change between 2002 and 2005 in the percentage of MORs attributed to the five primary types of reported medication errors.

Table 8
Percentage of MORs by Cause
2002 – 2005

Type of Medication Occurrence	2002	2003	2004	2005	2004-2005 Change
Wrong Dose	21.9%	18.8%	19.4%	22.6%	3.2%
Wrong Individual	2.4%	2.3%	2.3%	2.1%	-0.2%
Wrong Medication	5.6%	2.9%	3.2%	4.4%	1.2%
Wrong Route	0.9%	0.3%	0.2%	0.3%	0.1%
Wrong Time	69.1%	75.7%	75.0%	70.6%	-4.4%

Figure 8 illustrates the distribution of MORs by cause for 2005. As can be seen, about 70% of medication occurrences are associated with administering medication at the wrong time. A MOR is listed as "Wrong Time" when the medication is given more than an hour before or after the specific time ordered by the prescriber or if the medication is not given at all. Approximately 1 out of every 4 reported occurrences is due to providing the wrong dose. As reported in previous years, very few (less than 7% combined) of the MORs are related to administering medication to the wrong person, via the wrong route or using the wrong medication.

Figure 8
Percentage of MORs by Cause for 2005

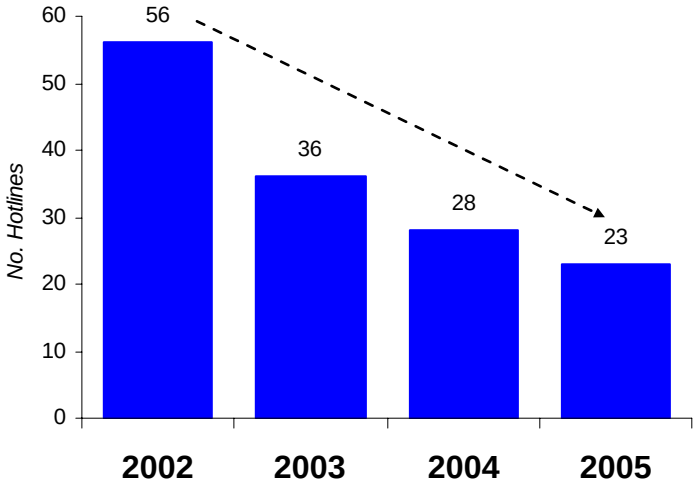


FINDINGS: Hotlines. A medication occurrence that results in any type of medical intervention (e.g., lab test, emergency room visit, hospital admission) is categorized as a "Hotline." During 2005 there were 23 recorded Hotlines, a 18% reduction from 2004. As can be seen in Table 9 and Figure 9, over the past three years there has been a relatively steady and consistent reduction in these more serious medication occurrences.

Table 9
No. and Percentage of MOR "Hotlines"
2002 – 2005

MOR Hotlines	2002	2003	2004	2005	2004-2005 Change	Percent Change	Type of Change
No. MORs	4,370	4,043	3,599	3,667	68	2%	⇔
No. Hotlines	56	36	28	23	-5	-18%	↓ +
Percent Hotlines	1.28%	0.89%	0.78%	0.63%	-0.15%	-19.38%	↓ +

Figure 9
4 Year Trend in MOR Hotlines
2002 – 2005



During FY05, only two individuals required hospitalization due to a medication occurrence. The relatively consistent trends in the MOR rate and the steady reduction in MOR hotlines for the past few years suggest that there has been consistent improvement in the safety of medication administration practices within DMR programs and services.

WHAT DOES THIS MEAN? *Over the past four years there has been a steady decrease in Medication Occurrence Reports and Hotlines, indicating a consistent improvement in the safety of medication administration within DMR. Out of over 36.5 million doses of medication administered during the year, less than 0.01% were associated with an error. Of those errors that do occur, the vast majority are due to giving the medication at the wrong time.*

Indicator 5: Serious health and medication issues are identified and addressed.

Measures: No. and Percent of Action Reports re: Health/Medication Issues

No. of substantiated Medication related Investigations.

No. of substantiated Denial of Treatment/Medical Neglect Investigations.

Data Source: Survey and Certification Action Reports, DMR Investigations

FINDINGS: Action Reports. Action Required forms are completed during surveys when issues relating to health, medication, human rights, safe evacuation, safe environments or consumer funds are identified. Providers must respond within 24-48 hours for issues of "immediate jeopardy" and within 30-60 days for less serious issues of concern.

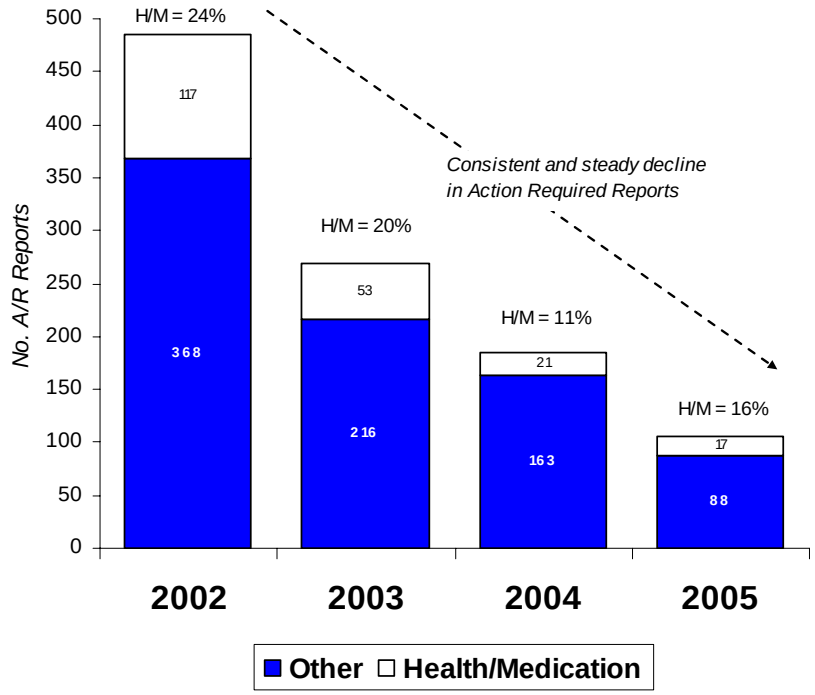
Table 10 summarizes the number of Action Required Reports by type over the past four years. As can be seen, a significant reduction in all types has taken place since FY02. Reports associated with health and medication have decreased from a high of 117 per year in FY02 to just 17 in FY05.

Table 10
Action Required Reports
2002-2005

Type of Action Required Report	2002 No.	2003 No.	2004 No.	2005 No.	Change FY04-05	Percent Change	Type of Change
Health/Medication	117	53	21	17	-4	-19%	+
Other	368	216	163	88	-75	-46%	+
Total	485	269	184	105	-79	-43%	+

Figure 10 illustrates this change over time. As can be seen, a consistent and very positive trend is present for health related Action Required Reports. Such a trend is indicative of fewer and fewer serious issues related to medical care and medication practices being identified during the Survey and Certification process, an indication of improved safety in the delivery of health care within DMR.

Figure 10
No. and Percentage of Health/Medication Action Reports
2002 – 2005



FINDINGS: Medication Investigations. Table 11 presents information regarding DMR investigations associated with medication incidents. As can be seen, in FY05 there were 19 substantiated investigations, a slight increase (+2) from the prior year, but representing a substantial decrease in the number of investigations from 2002 and 2003.

Table 11
Medication Investigations
2002 – 2005

Medication Investigations	2002	2003	2004	2005	Difference 2004-2005	Type of Change
No. Investigations re: Medication	51	40	29	29	0	⇔
No. Investigations Substantiated	34	24	17	19	2	⇧
Percent Investigations Substantiated	67%	60%	59%	66%	7%	⇧

FINDINGS: Denial of Treatment Investigations. A review of investigations data shows that both the actual number of investigations and those that were substantiated during 2005 for denial of medical treatment/medical neglect remained the same from the prior year, representing a substantial reduction from levels experienced in 2002 and 2003.

In fact, substantiated investigations fell by 42% between 2003 and 2004. This continuation of a lower level of investigations regarding medical care is illustrated below in both Table 12 and Figure 11, and suggests stability in health-related care across the DMR system.

Table 12
Investigations for Denial of Medical Treatment/Medical Neglect
2002 – 2005

INVESTIGATIONS: Denial of Treatment & Medical Neglect	2002	2003	2004	2005	Percent Change 2004-2005	Type of Change
Total Investigations	109	102	73	73	0%	⇔
No. Substantiated	50	50	29	29	0%	⇔
Percent Investigations Substantiated	46%	49%	40%	40%	0%	⇔

Figure 11
No. Substantiated Investigations for Denial of Medical Treatment/Medical Neglect
2002 – 2005

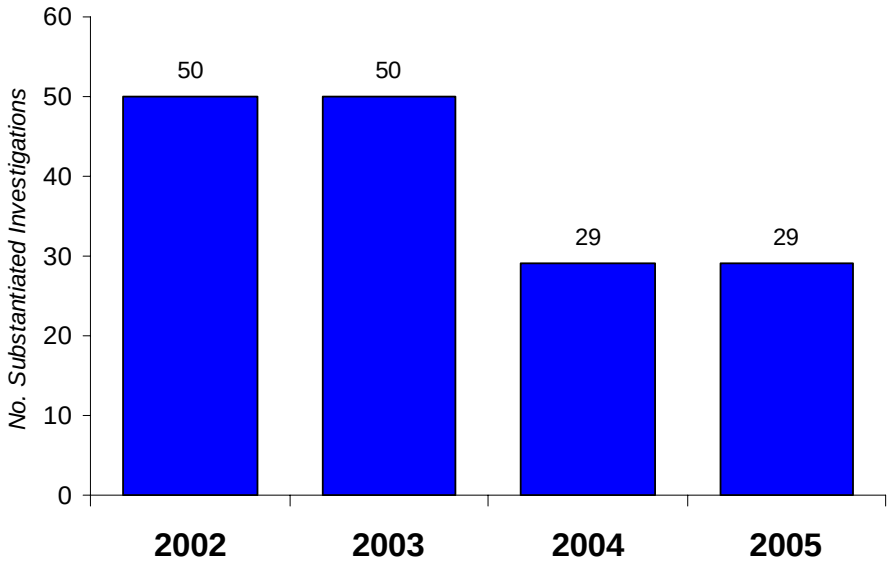
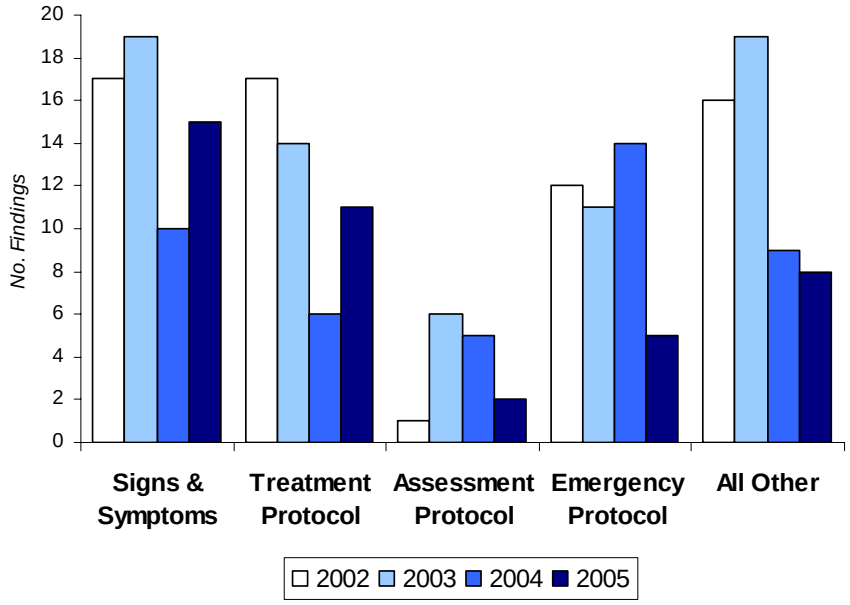


Table 13 and Figure 12 illustrate the number of substantiated findings[4] by cause across a four year time period. Data suggest there has been a rather substantial reduction in investigation findings pertaining to failure to follow proper emergency protocols and procedures (a reversal of the trend from last year) and for failure to follow proper assessment protocols. Findings associated with signs and symptoms and treatment protocols increased from 2004.

Table 13
Findings re: Substantiation of Denial of Medical Treatment and Medical Neglect
2002 – 2005

TYPE of FINDINGS: Denial of Treatment & Medical Neglect	2002	2003	2004	2005	Difference 2004-2005	Percent Change 2004-2005	Type of Change
Signs & Symptoms	17	19	10	15	5	50%	↑ -
Treatment Protocol	17	14	6	11	5	83%	↑ -
Assessment Protocol	1	6	5	2	-3	-60%	↓ +
Emergency Protocol	12	11	14	5	-9	-64%	↓ +
All Other	16	19	9	8	-1	-11%	↓ +
TOTAL	63	69	44	41	-3	-7%	⇩

Figure 12
Leading Causes for Substantiated Denial of Medical Treatment/Medical Neglect
2002 – 2005



[4] Figure 12 includes data related to findings resulting from each investigation, whereas Figure 11 illustrates investigations. Since one investigation may result in more than one finding there is a difference in the totals.

It should be noted that year to year shifts in the distribution of causes for medical neglect are very sensitive to minor change (i.e., one or two cases) due to the relatively small number of substantiated findings per category. Therefore, this data must be viewed carefully and with caution.

WHAT DOES THIS MEAN? *During FY2005 the DMR system experienced a reduction in most health and medication issues that required intervention by DMR. The lower level of investigations and substantiated findings for medication and medical neglect witnessed in 2004 continued into 2005, although the types of findings differed somewhat from last year. Together with other results, data suggest an improvement in most aspects of safety and delivery of health-related care for persons served by DMR.*

PROTECTION FROM HARM

OUTCOME: People are protected from harm.

Indicators:
1. Individuals are protected when there are allegations of abuse, neglect or mistreatment.
2. CORI checks are completed for staff and volunteers working directly with individuals.
3. Safeguards are in place for individuals who are at risk.

RESULTS:

Basic protection from harm for persons served by DMR is evaluated using three (3) primary indicators and nine (9) measures, seven of which can be used for year to year comparisons. During Fiscal Year 2005 five of the seven measures remained relatively consistent with findings in 2004 and improvement was seen for one (the percent of providers with no CORI violations). The trends for the number and rate of critical incident reports is difficult to establish due to rather substantive changes in reporting that were introduced in FY05 and that are continuing into FY06 and FY07, including the establishment of a number of new reporting categories. A small increase in the rate of critical incidents is noted for FY05 compared to FY04.

These results are summarized below in Figure 13 and explained in more detail in the remainder of this section of the report.

Figure 13
Summary of Trends for Protection from Harm Indicators and Measures
2004 – 2005

OUTCOME	Indicator	Measure	Change FY03-FY04	Change FY04-FY05
Protection - *people are protected from harm.*	1. Investigations	No. & Percent Substantiated	⇓ +	⇔
		Trends: Most Common Types	NA	NA
	2. CORI checks	Percent Without Violations	⇑	⇑ +
		Violations per Provider	⇓ +	⇔
		Percent Lack of Records	⇓ +	⇔
	3. Safeguards for Persons at Risk	Corrective Action	⇔	⇔
		Preventive Action	⇔	⇔
		CIR Rates	⇑ -	⇑
		CIR by Type	NA	NA

Direction of Arrow = increase, decrease, stable
Green = positive trend (+)
Red = negative trend (-)
White = slight change/neutral trend

OUTCOME: People are protected from harm.

Indicator 1: Individuals are protected when there are allegations of abuse, neglect or mistreatment.

Measures: No. of Investigations and Percentage Substantiated

Rate of Substantiated Abuse/Neglect Investigations (No. per 1000)

Trends in Most Common Types of Substantiated Abuse/Neglect

Data Source: Investigations

FINDINGS: As can be seen in Table 14, the total number of investigations for complaints of abuse/neglect remained relatively stable between 2004 and 2005, increasing by just 10 cases (1%). The number of investigations for the past two years appears substantially lower than for the period between 2002 and 2003. The actual number of substantiated investigations (a more accurate measure of Abuse/Neglect incidents) for 2005 was about the same as last year, falling by 3% from 2004. In addition, the percentage of completed investigations that resulted in a substantiation of abuse or neglect fell by 5% between 2004 and 2005.

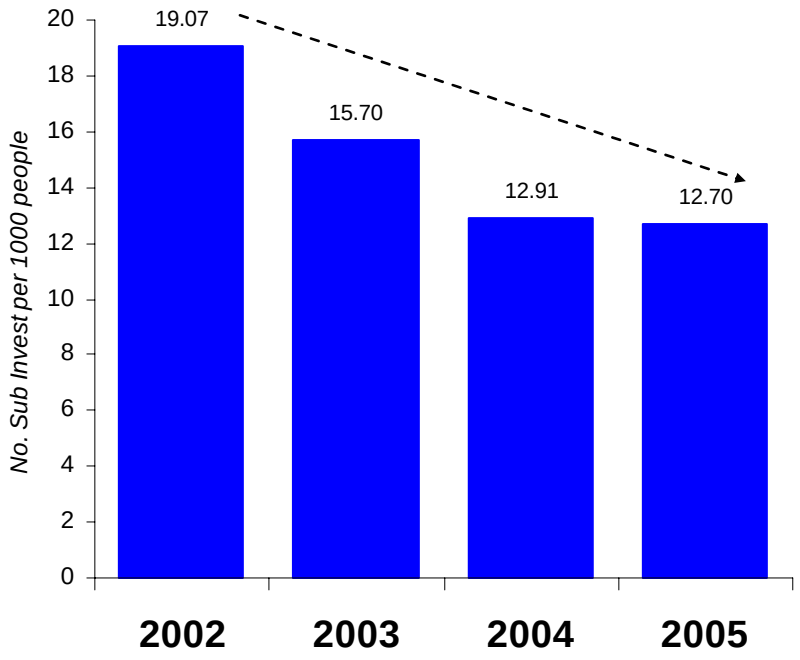
Table 14
No. of Abuse/Neglect Investigations, Percent and Rate Substantiated
2002 – 2005

Abuse/Neglect Investigations	2002	2003	2004	2005	Difference 2004-2005	Percent Change 2004-2005	Type of Change
Total Investigations	1,351	1,257	1,083	1,093	10	1%	⇔
Completed	1,311	1,148	913	934	21		
No. Substantiated	431	358	299	291	-8	-3%	⇔
Open	40	109	170	159	-11		
Percent Substantiated	33%	31%	33%	31%	-2%	-5%	⇔
Population (> 18 yrs)	22,604	22,802	23,157	22,916	-241		
No. of Substantiated Investigations per 1000	19.07	15.70	12.91	12.70	-0.21	-2%	⇔

Change criteria: ±10%

As can be seen in Figure 14, when the DMR population is also included in the analysis, the actual rate of substantiated investigations (no. per 1000 persons served) has continued to fall. It should be noted that data regarding investigations reflects information as of the end of each fiscal year. As of September 2006, there were a total of 159 open cases for 2005.

Figure 14
Four Year Trend in the Rate (n/1000) of
Substantiated Abuse/Neglect Investigations
2002 – 2005



The top ten (10) causes for substantiation of abuse/neglect – based on investigation findings[5] - have remained relatively stable over time and include:

1. **Omission** on part of caregiver, placing individual at risk
2. **Physical** abuse or assault by caregiver
3. **Emotional** abuse by the caregiver
4. **Medical** neglect and/or denial of treatment
5. **Verbal** abuse
6. **Failure** to report
7. **Medication** incident or error
8. **Failure** to provide for basic needs
9. **Injury** of unknown origin
10. **Restraint** – inappropriate/illegal use (physical and mechanical)

Table 15 provides information on the total number of substantiated complaints by type of finding for the ten leading causes between 2002 and 2005. As can be seen, substantiated complaints pertaining to acts of omission show a positive reduction from levels in 2004. Relative stability (approximately the same levels from the prior year) are noted for substantiated complaints associated with physical abuse, failure to report, medical

[5] It is common for substantiated investigations to include multiple findings, i.e., more than one type of abuse or neglect. Therefore, the number of findings associated with "type" of abuse/neglect will usually be greater than the number of substantiated investigations.

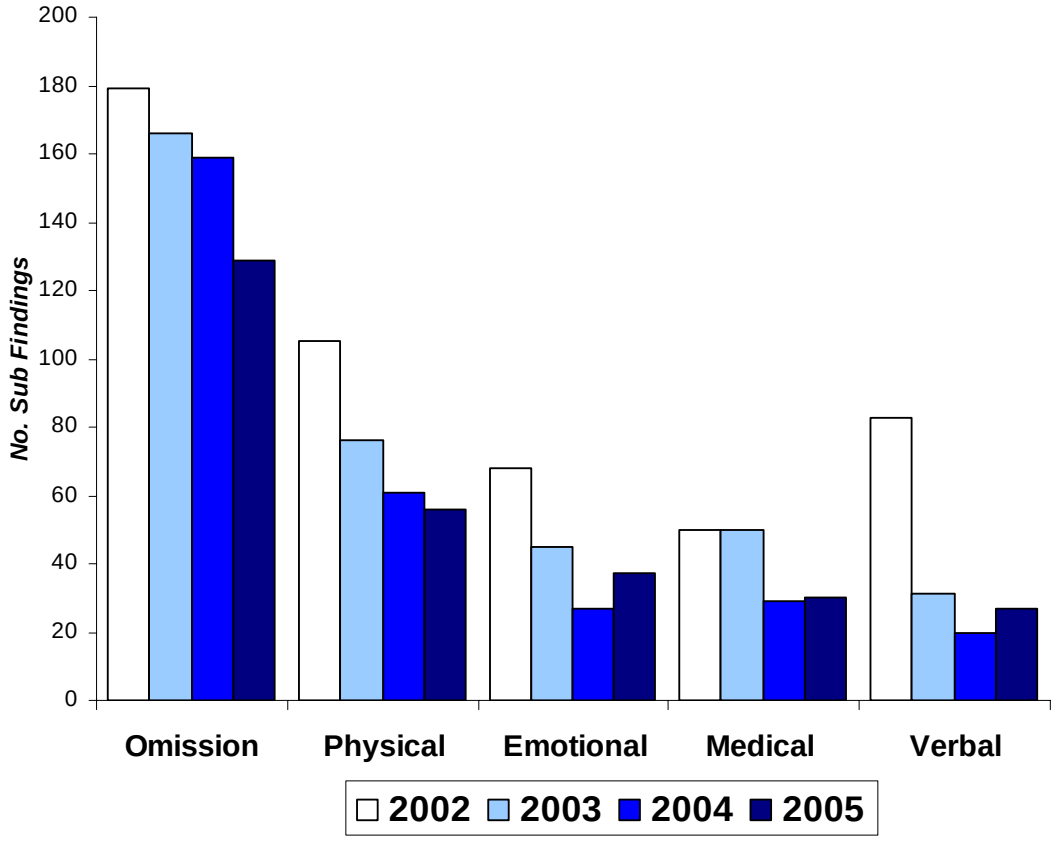
neglect, injuries of unknown origin and inappropriate use of restraint. Increases in the number of substantiated complaints related to emotional and verbal abuse, medication and failure to meet needs are present when compared to the prior year, although a rather substantial reduction in these types of complaints is present when viewed over the four-year time period since FY02.

Table 15
Changes in the No. Substantiated Complaints for the
Top 10 Leading Types of Substantiated Abuse/Neglect
2002 – 2005

Top 10 Types of Substantiated Abuse	2002	2003	2004	2005	Difference 2004-2005	Percent Change 2004 - 2005	Type of Change
Omission	179	166	159	129	-30	-19%	+
Physical	105	76	61	56	-5	-8%	
Emotional	68	45	27	37	10	37%	-
Medical	50	50	29	30	1	3%	
Verbal	83	31	20	27	7	35%	-
Failure: Report	39	32	22	23	1	5%	
Medication	34	24	17	19	2	12%	-
Failure: Meet Needs	24	26	12	17	5	42%	-
Unk Injury	15	21	14	13	-1	-7%	
Inapprop Restraint	11	14	11	12	1	9%	

Figure 15 illustrates these changes over the past four years for the top five (5) types of complaints (accounting for 77% of all complaints) and shows that a positive trend (i.e., complaints declining in number) is occurring for two of these leading types of substantiated complaints, with a slight increase in 2005 noted for two of these categories: emotional and verbal abuse.

Figure 15
Trends in the 5 Most Common Types of Substantiated Abuse/Neglect
2002 – 2005



WHAT DOES THIS MEAN? *The trends over time present for the number of abuse/neglect (A/N) investigations, the number of substantiated complaints and the A/N rate suggests that individuals served by DMR may be experiencing less abuse and neglect. Reductions in substantiated complaints from last year are present for two of the five leading types of substantiated complaints, with verbal and emotional abuse showing a slight increase from 2004. Over a four year time period, reductions are seen for all major types of substantiated complaints.*

Indicator 2: CORI checks are completed for staff and volunteers working directly with individuals.

Measures: No. of providers without CORI violations over time

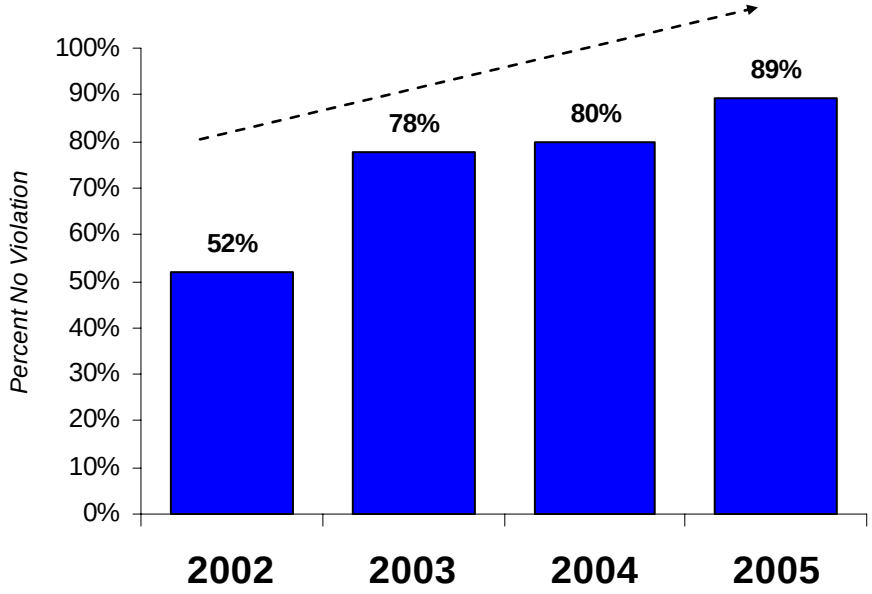
Average No. Violations per Provider

Percentage of violations caused by lack of records

Data Source: CORI Audit Database

FINDINGS: The past four years have seen a relatively consistent improvement in the number and percent of providers that have no CORI violations, with this percentage almost reaching 90% for FY05. This trend is illustrated below in Figure 16 and demonstrates that the vast majority of providers are complying fully with required new employee background checks and associated documentation.

Figure 16
Percentage of Providers with No CORI Violations
2002 – 2005



Interestingly, and as can be seen in Table 16 below, DMR efforts to audit a larger number of providers continued into FY05. The number of actual violations also continued to fall, leading to a continuation in the relatively low rate of violations (average no. of violations per provider audited) observed last year. This trend is illustrated in Figure 17.

Table 16
Summary of 4-Year Trends in CORI Audits
2002 – 2005

CORI	2002	2003	2004	2005	Change 2004-2005	Type of Change
No. Providers Audited	181	89	229	234	5	
No. Providers w/ Violations	87	20	46	25	-21	
No. w/ No Violations	94	69	183	209	26	
Percent w/ No Violations	52%	78%	80%	89%	9%	↑ +
No. of Violations	108	200	62	59	-3	
No. Violations per Prov (all audited)	0.60	2.25	0.27	0.25	-0.02	⇔
No. per Prov with Violations	1.24	10.00	1.35	2.36	1.01	↑ -

Figure 17
Average No. CORI Violations per Provider Audited
2002 – 2005

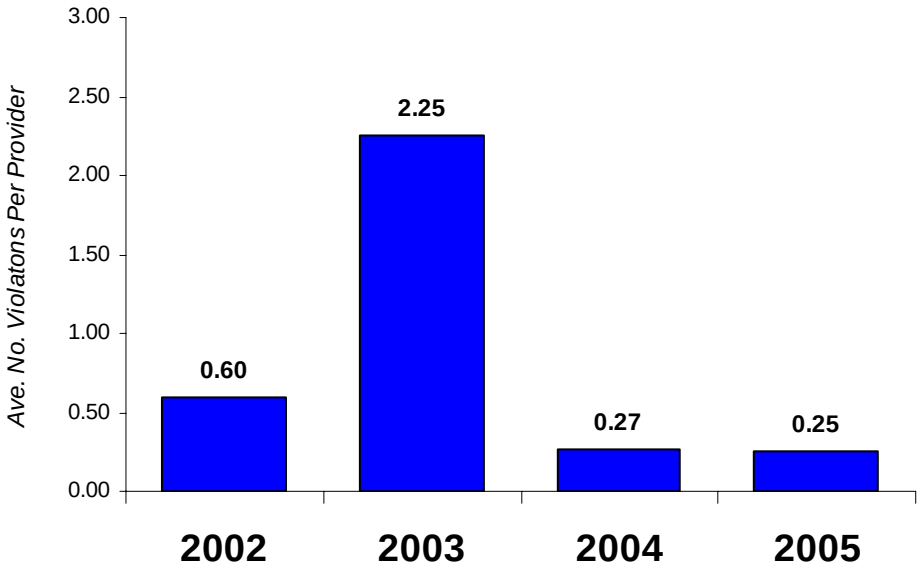
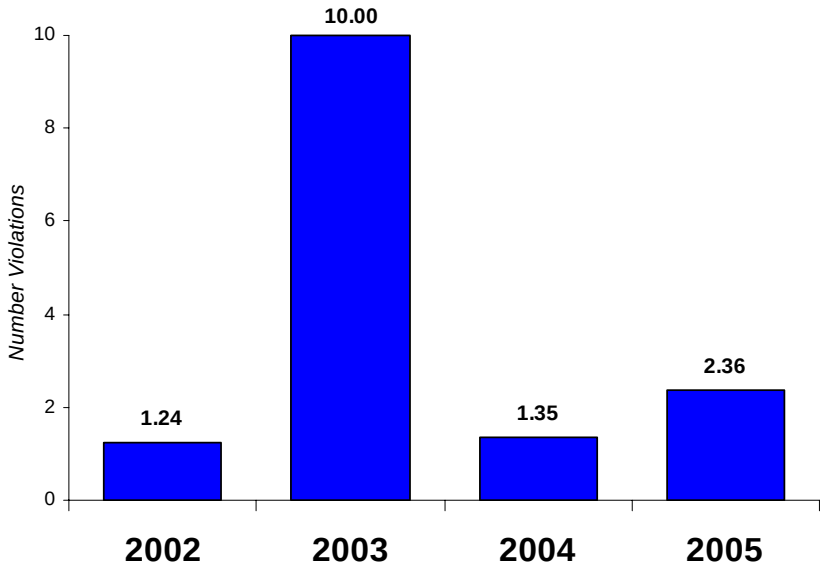


Figure 18 below illustrates the average number of CORI violations for only those providers who were cited (*i.e.*, had violations). As can be seen, the average rose slightly in FY05. This relatively low rate further strengthens the suggestion in last year's report that the very high level of violations per provider reported for FY03 were most likely an anomaly and not reflective of CORI compliance.

Figure 18
Average No. Violations per Provider
Only for those Providers with Violations
2002 -2005



Lack of adequate records[6] continues to be a large reason for CORI citations. However, in FY05 it was no longer the majority cause. The category of "Other Causes," which has shown a steady increase from 2003 as a proportion of all causes, includes issues such as hiring applications not conforming to CORI regulations and/or the provider not adhering to the 5- or 10-yr disqualification requirement. A summary of causes for violations between 2002 and 2005 is presented below in Table 17.

Table 17
Summary of Causes of CORI Violations
2001 – 2004

Type of CORI Violation	*Percentage of Violations*			
	2002	2003	2004	2005
Lack of Records	56.9%	98.0%	46.8%	47.5%
Other Causes	24.8%	1.5%	40.3%	49.2%
Open Cases*	18.3%	0.5%	12.9%	3.4%

* No determination made at time of data analysis

WHAT DOES THIS MEAN? *Provider compliance with CORI requirements appears to continue to improve over time. Lack of records may be decreasing as a cause of violations.*

[6] This category is listed as a violation when a provider cannot produce formal documentation that it requested a CORI on individuals in its employ.

Indicator 3: Safeguards are in place for individuals who are at risk.

Measures: Percentage of situations in which people have been mistreated where corrective actions are taken.

Percentage of situations in which people have been mistreated in which steps are taken to prevent the situation from occurring again.

Critical incident report (CIR) rates.

No. of CIR's by type.

Data Source: Survey and Certification (5.2C and 5.2D)

Critical Incident database

FINDINGS: Corrective and Preventive Action. During the Survey and Certification process surveyors identify situations where concerns exist re: possible mistreatment (e.g., abuse/neglect) of the individuals being reviewed. This is done through a review of substantiated investigations and action plans that have occurred since the last review. Surveyors also identify whether or not the provider has taken appropriate actions to correct the situation and to prevent it from occurring in the future.

Data from the Survey and Certification database (Indicators 5.2C and 5.2D) are presented below in Tables 18 and 19. Findings indicate there is a relatively high rate for both corrective and preventive actions by providers, with 94% of concerns corrected and 93% showing evidence of preventive action during 2005. Slight improvement from the last two years is evident for both of these measures, as illustrated in Figures 19 and 20.

Table 18
Corrective Actions Taken for Concerns about Mistreatment
2004 – 2005

Corrective Action: Mistreatment (5.2C)	2002	2003	2004	2005	Change 2004-2005
No. w Concerns	510	269	368	392	
No. w Corrective Action	491	250	339	370	
Percent Corrected	96%	93%	92%	94%	⇔

Table 19
Preventive Actions Taken for Concerns about Mistreatment
2002 – 2005

Preventive Action: Mistreatment (5.2D)	2002	2003	2004	2005	Change 2003-2004
No. w Concerns	509	269	368	390	
No. w Corrective Action	492	248	340	363	
Percent Corrected	97%	92%	92%	93%	⇔

Figure 19
4 Year Trend for Corrective Action re: Concerns about Mistreatment
2002 – 2005

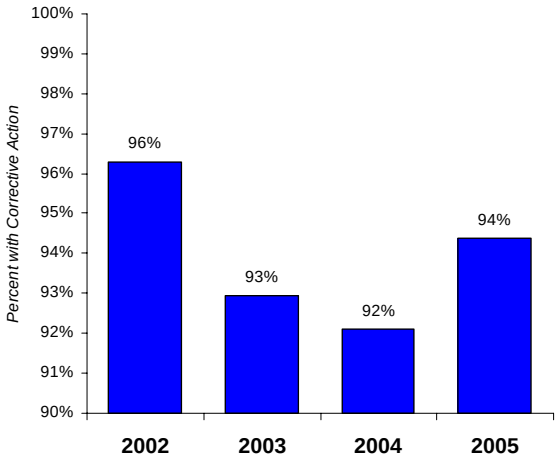
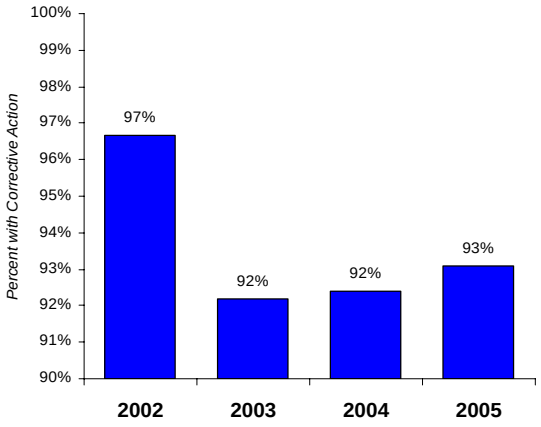


Figure 20
4 Year Trend for Preventive Action re: Concerns about Mistreatment
2002 – 2005



WHAT DOES THIS MEAN? *When concerns are raised re: past or potential abuse/neglect, providers take corrective and preventive action more than 90% of the time. These rates have risen slightly from the levels identified in 2004.*

FINDINGS: Critical Incident Reports. Staff and providers are required to report unusual incidents that place individuals at risk in order to provide DMR with a mechanism to both track incidents and assure appropriate corrective actions are taken in a timely fashion. DMR has been undertaking ongoing improvements to the incident reporting system over the past few years. Starting in March 2006 and fully implemented in July 2006, DMR moved from a "paper" to an electronic web-based reporting system. In preparation for the move to the web-based system, the existing Critical Incident Reporting system (CIR) was modified to expand the number of reporting categories and change the operational definitions of critical incidents, including new reporting requirements for unplanned hospitalizations. **These significant changes to the methods and elements of the system complicate comparisons across years and between incident categories. Extreme caution must therefore be exercised in reviewing the CIR data.**

Table 20 and Figure 21 below illustrate changes in CIR data over the past four years. In order to allow a more appropriate – although not exact – comparison of FY05 with previous years, the number of critical incident reports for 2005 includes two measures: (1) the actual number of reports (with the new categories included) and (2) the number of reports minus the new categories. In 2005 there were 1,920 reports. Of these, 1,058 were in reporting categories present in prior years. The rate (no. of reports per 1000 people served) rose by about 9% from 2004 levels due to both this increase in reports and an adjustment to the DMR population (resulting from database "clean-up" or corrections associated with the Department's protocol regarding determination of the active or inactive status of individuals with respect to Departmental services). As noted, changes to the system make it difficult to draw any firm conclusions regarding this increase (i.e., whether it is due to an actual increase in incidents or a result of increased emphasis on reporting, improvements to the process of reporting, and/or changes in reporting categories and definitions of incident types). Nonetheless, the rate of increase appears to be slowing despite these aforementioned factors. More reliable comparisons will be available next year and beyond.

Table 20
No., Percent and Rate of Critical Incidents
2002 – 2005

CIR Rates	No. CIR (with new categories)	Population	Rate with new categories (no. per 1000)	No. CIR (minus new categories)	Rate minus new categories (no. per 1000)	Percent Change (rate minus new categories)	Type of Change 2004-2005
2002		31,718		623	19.6		
2003		32,004		875	27.3		
2004		32,144		985	30.6		
2005	1,920	31,592	60.8	1,058	33.5	9.3%	⇧

No. and rate with new categories will be used to help establish trends beginning in FY06.

Figure 21
Critical Incident Report Rate (No. per Thousand)
Reports Minus New CIR Categories
2002 – 2005

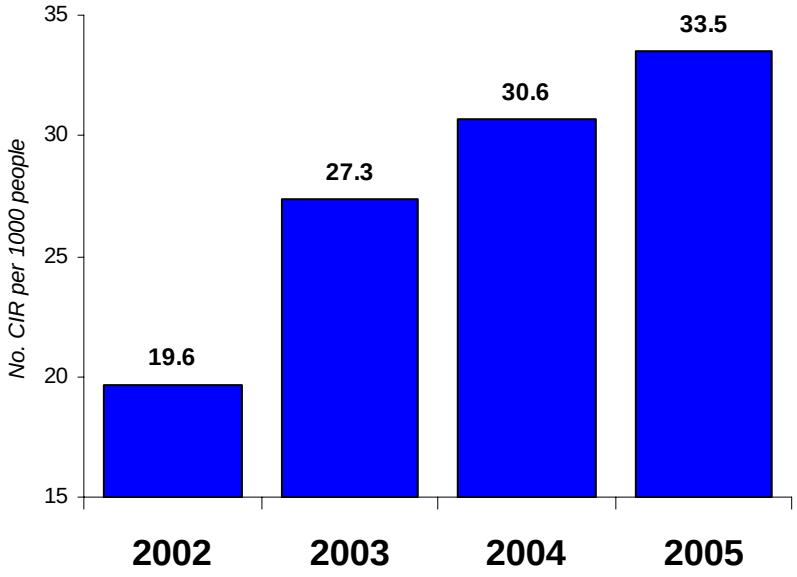


Table 21 provides more detailed information regarding the type of reported incidents. As can be seen, in 2005 there were a total of 1,920 critical incidents reported to DMR. With the "new categories" removed, there were 1,058 reported incidents. The major difference is associated with the category of "unplanned hospitalization" (accounting for 761 reports in FY05). Changes to the other categories over the course of 2005 are

difficult to evaluate since some definitions were modified, training of reporters took place at different times throughout the year and slight adjustments to the reporting system were (and continue to be) introduced. **Therefore, it is strongly recommended that this data (i.e., specific data associated with critical incident categories) <u>not</u> be used to draw any conclusions until the new system has been fully implemented and stabilized.** With that in mind, the data is provided here as a foundation for later reports.

Table 21
No. Critical Incident Reports by Type
2002 – 2005

Type of Critical Incident Report	2002	2003	2004	2005	2004-2005 Change	Percent Change	Type of Change
Accident	53	104	113	149	36	32%	↑ -
Assault	104	137	201	58	-143	-71%	⇧
Caretaker	32	40	27	45	18	67%	↑ -
Criminal	116	139	105	114	9	9%	⇔
Inapp Behavior	109	166	142	298	156	110%	↑ -
Medical	25	33	46	63	17	37%	↑ -
Missing	69	75	90	67	-23	-26%	↓ +
Other	90	120	218	221	3	1%	⇔
Physical Abuse	4	10	0	0	0	0%	⇔
Inapp Sexual	11	28	26	23	-3	-12%	↓ +
Fire	10	23	17	20	3	18%	↑ -
Sexual Assault	Not Available before 2005			31	New Categories in 2005 Comparison Not Appropriate		
Unplanned Hospital				761			
Victim of Crime				70			
Total No. Incidents with New Categories				1920			
Total <u>minus</u> New Categories	623	875	985	1058	73	7%	⇔

WHAT DOES THIS MEAN? *The introduction of new reporting requirements, methods and categories of critical incidents makes comparisons with prior years difficult and unreliable. It is therefore recommended that such direct comparisons wait until the new Incident Management System is fully implemented and reporting becomes stable. Comparative trends analyses will most likely not be meaningful until FY07.*

SAFE ENVIRONMENTS

OUTCOME: People live and work in safe environments.

Indicators:

1. Homes and work places are safe, secure and in good repair.
2. People can safely evacuate in an emergency.
3. People and their supporters know what to do in an emergency.

RESULTS:

Survey and certification findings demonstrate that over 90% of persons reviewed lived and/or worked in an environment that was determined to be safe, secure, in good repair and in which no specific safety issues were identified. As part of the review process, any safety issues that were identified (e.g., relating to smoke detectors, required inspections, etc.) were immediately noted, and follow-up was conducted within 24-48 hours. An even higher percentage (97%) was present for the ability of individuals to safely evacuate their residence or work site. Ninety-three percent of persons were determined through Survey and Certification reviews to either possess the knowledge themselves and/or have support staff knowledgeable of what to do in emergency situations. All of these measures remained relatively stable from previous years, although each did show a very slight improvement.

Action Required Reports related to safe environments increased. However, reports related to evacuation continued to show improvement, with a slight decrease in the number of reports.

Figure 22 illustrates the general trends for this outcome for both FY04 and FY05.

Figure 22
Summary of Trends for Safe Environments Indicators and Measures
2004 – 2005

OUTCOME	Indicator	Measure	Change FY03-FY04	Change FY04-FY05
Safe Environments - *People live and work in safe environments.*	1. Safe homes and work places	Percent Safe Environment	⇔	⇔
		Action Required Reports	↓ +	↑ -
	2. Evacuate Safely	Percent - Safely Evacuate	⇔	⇔
		Action Required Reports	↓ +	↓ +
	3. Know what to do in Emergency	Percent - Know what to do	⇔	⇔

Direction of Arrow = increase, decrease, stable
Green = positive trend (+)
Red = negative trend (-)
White = slight change/neutral trend

OUTCOME: People live and work in safe environments.

Indicator 1: Homes and work places are safe, secure and in good repair.

Measures: Percentage of individuals found to be living and working in safe environments

Percentage of Action Required citations due to environmental concerns

Data Source: Survey and Certification (5.1A)
NCI data

FINDINGS: Living/working in safe environments. Table 22 below provides summary Survey and Certification data related to the number and percentage of persons surveyed who were determined to live and work in environments that are safe, secure and in good repair. As can be seen, this percentage has remained relatively stable over the past four years, ranging between 92% and 94%.

Table 22

No. and Percent of Persons Who Live and Work in Safe Environments
2002 - 2005

Safe Environments	2002	2003	2004	2005	Type of Change 2004-2005
No. Applicable	2161	1881	1882	2126	
No. Safe, Secure & Good Repair	2025	1742	1726	1969	
Percent Safe, Secure & Good Repair	94%	93%	92%	93%	⇔

NCI Indicators for Safety. Two survey items contained in the 2005 National Core Indicators evaluation conducted for DMR addressed service participants' perceived sense of safety. It should be noted that such "perception" is not a direct measure of actual safety and can be influenced by a myriad of factors. Nonetheless, how safe individuals feel is an important consideration in their overall quality of life. Results for this measure are presented below in Table 23 for Massachusetts compared to the national average. As can be seen, about 80% of DMR consumers indicated they felt safe in their homes and in their neighborhoods. These percentages are slightly lower than the average for the 16 states reporting data in the 2005 NCI.

Table 23
NCI Safety Indicators
2005

NCI Safety	MA DMR NCI	National NCI
Not Afraid at Home	80.6%	84.0%
Not Afraid in Neighborhood	79.4%	83.6%

National NCI based on average for 16 states, 2005 survey
MA DMR NCI based on special 2005 survey

Action Required Reports. Action Required Reports are issued by Survey and Certification personnel whenever there is a concern regarding the safety and welfare of individual consumers, including for issues associated with environmental safety. The action reports are divided into those that need to be corrected within 24 hours and those that pose a less immediate threat. Table 24 depicts both types of actions. As can be seen, there was an increase in the total number of reports issued for concerns over the living and/or work environments for persons served by DMR in 2005 compared to 2004; however, the number remained lower than in 2002 and 2003. This increase in FY05 also occurred for the percentage of all Action Required Reports that were related to environmental concerns.

Table 24
Action Required Reports for Environmental Issues
2002 - 2005

Action Required Reports: Environmental Issues	2002	2003	2004	2005	Percent Change 2004-2005	Type of Change 2004-2005
No. Reports for Environmental Issues	140	90	62	75	21%	↑ -
Percent of Total Reports	29%	33%	34%	59%		

Indicator 2: People can safely evacuate in an emergency.

Measures: Percentage of individuals who can safely evacuate in an emergency

Data Source: Survey and Certification 5.1C

FINDINGS: Table 25 presents findings related to the ability of persons to safely evacuate[7] their living and/or working environments. Data demonstrates the continuation of a very stable trend over time for this measure. In addition, the actual number of Action Required Reports related to safe evacuation (see Table 26) experienced a major

[7] Safe evacuation is defined as being able to leave a residence with or without assistance within 2.5 minutes.

decrease from prior years, including a reduction in the relative proportion of all reports associated with evacuation. Figure 23 illustrates the relative proportion of Action Required Reports associated with Evacuation and Environmental issues.

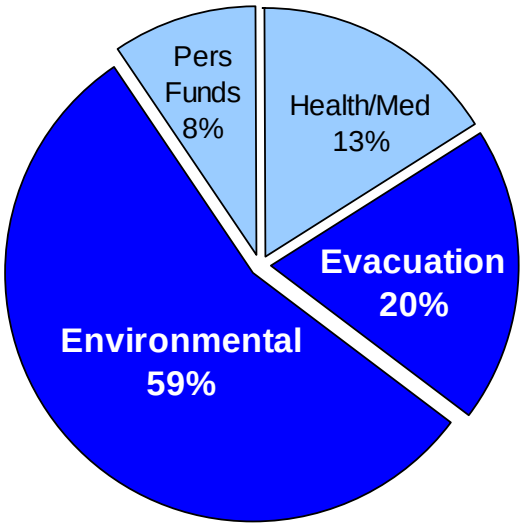
Table 25
Percentage of Persons Able to Safely Evacuate
2002 - 2005

Safely Evacuate	2002	2003	2004	2005	Type of Change 2004-2005
No. Reviewed	2514	2162	2184	2438	
No. able to Evacuate	2412	2079	2103	2360	
Percent able to Evacuate	96%	96%	96%	97%	⇔

Table 26
Action Required Reports for Evacuation Issues
2002 - 2005

Action Required Reports: Evacuation	2002	2003	2004	2005	Percent Change 2004-2005	Type of Change 2004-2005
No. Reports for Evacuation Issues	108	48	41	20	-51%	↓ +
Percent of Total Reports	22%	18%	23%	19%		

Figure 23
Distribution of Action Required Reports for FY2005



Indicator 3: People and their supporters know what to do in an emergency.

Measures: Percentage of individuals who know what to do in an emergency

Data Source: Survey and Certification (5.1B)

FINDINGS: Survey and Certification findings suggest that the vast majority of individuals reviewed (95%) possessed knowledge about how to respond properly to an emergency situation, as summarized below in Table 27.

Table 27
No. and Percentage of Persons Who Know What to do in an Emergency
2002 - 2005

Emergency Response	2002	2003	2004	2005	Type of Change 2004-2005
No. Reviewed	2514	2162	2184	2438	
No. Know What to Do	2368	2030	2036	2306	
Percent Know What to Do	94%	94%	93%	95%	⇔

WHAT DOES THIS MEAN? *Almost all individuals who were reviewed live and work in safe and secure environments, with about 80% expressing that they feel safe most of the time. 2005 experienced a slight increase in quality measures related to the ability of people to safely evacuate and to possess knowledge on how to respond to an emergency. However, an increase in Action Required Reports related to safe environments was present. With the exception of action reports related to safe environments, other findings are generally suggestive of gradual improvement in the safety of individuals who live and/or work in settings reviewed by the DMR Survey and Certification process.*

PRACTICE HUMAN & CIVIL RIGHTS

OUTCOME: People understand and practice their human and civil rights.

Indicator: 1. People exercise their rights in their everyday lives.

RESULTS:

Survey and certification findings continue to demonstrate very high percentages of individuals who appear to understand and practice their human and civil rights and who are treated with respect by staff and others. Over time this finding has remained quite stable, with no change observed between 2004 and 2005.

Figure 24 illustrates the general trends for this outcome.

Figure 24
Summary of Trends for Human and Civil Rights Indicators and Measures
2004 – 2005

OUTCOME	Indicator	Measure	Change FY03-FY04	Change FY04-FY05
Practice Rights - *People understand and practice their human and civil rights.*	1. People exercise their rights	Percent Exercise Rights	⇔	⇔
		Percent Treated Same	⇔	⇔
		Percent Treated with Respect	⇔	⇔

Direction of Arrow = increase, decrease, stable
Green = positive trend (+)
Red = negative trend (-)
White = slight change/neutral trend

OUTCOME: People understand and practice their human and civil rights.

Indicator 1: People exercise their rights in their everyday lives.

Measures: Percentage of individuals found to be exercising their rights

Percentage of people who receive the same treatment as other employees at work

Percentage of people who experience respectful interactions compared to NCI

Data Source: Survey and Certification (1.2B, 1.2C, 1.1A)
NCI

FINDINGS: Exercise rights. Table 28 below presents the results from Survey and Certification reviews of the extent to which people were seen as exercising their rights in their everyday lives. While a very stable trend is present across the past four years, a slight improvement is noted for FY05, with 97% of persons who were reviewed having been determined to be exercising their rights in surveyed supports.

Table 28
No. and Percentage of Persons Who Exercise Their Rights
2002 - 2005

Exercise Rights	2002	2003	2004	2005	Type of Change 2004-2005
No. Applicable	2514	2162	2184	2438	
No. Exercising Rights	2375	2027	2082	2356	
Percent Exercising Rights	94%	94%	95%	97%	⇔

Same treatment. Survey and Certification reviews also review the extent to which DMR consumers within employment settings are treated the same as other employees. Results for this measure are presented below in Table 29. Once again findings indicate the presence of a very stable trend, with 97% of individuals reviewed determined to be treated in the same manner as other non-disabled employees. This percentage has remained the same over the four year time period between 2002 and 2005.

Table 29
No. and Percentage of Persons Who Receive the Same Treatment
as Other Employees (Day Only)
2002 - 2005

Treated Same as Other Employees	2002	2003	2004	2005	Type of Change 2004-2005
No. Reviewed	960	948	914	1000	
No. Treated Same	930	916	888	974	
Percent Treated Same	97%	97%	97%	97%	⇔

Respectful interactions. Survey and certification reviews by the Massachusetts DMR in 2005 determined that within day and residential settings, 99% of individuals experience respectful interactions from staff and others. These results are somewhat higher than those obtained in a special National Core Indicators evaluation conducted for DMR in 2005.[8] As can be seen below in Table 30 and Figure 25, NCI results for DMR suggest that about 88% of individuals who receive residential services indicate that staff treats them with respect. A slightly higher percentage indicate staff in day service programs treats them with respect. These NCI findings are very similar to results reported by other states in the National Core Indicators (average for all participating states).

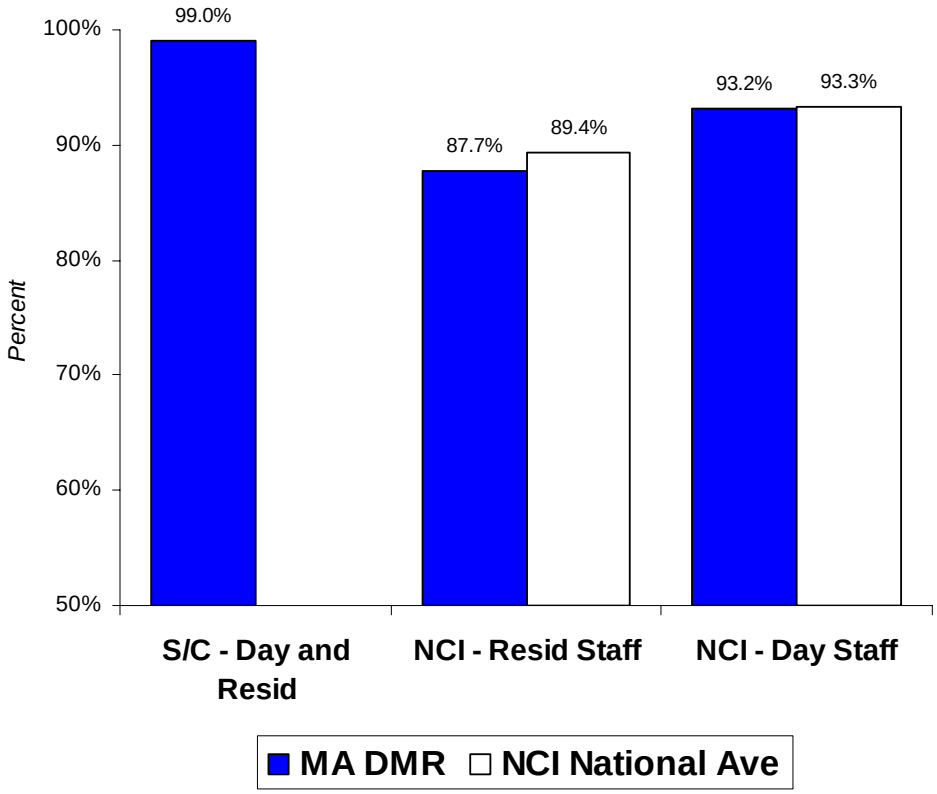
Table 30
Percentage of Persons Experiencing Respectful Interactions
Comparison of Massachusetts DMR with National Core Indicators
2002 – 2005

Respectful Interactions	2002	2003	2004	2005	Type of Change 2004-2005
MA Day & Residential	98.0%	97.0%	98.0%	99.0%	⇔
MA DMR NCI - Resid				87.7%	
MA DMR NCI - Day				93.2%	
National NCI - Resid	90.0%	89.0%	88.4%	89.4%	
National NCI - Day	94.0%	94.0%	93.5%	93.3%	

MA Day/Res from Survey and Certification reviews for 2,438 persons in FY05
MA DMR NCI from special NCI report issued in 2006
National NCI based on state averages for each respective year

[8] It should be noted that the Massachusetts Survey and Certification data combines residential and day settings, whereas the NCI data is reported separately for each type of service/support setting. The specific measures and sample are also slightly different, with the NCI results based on consumer interview responses and representing a more broad-based population.

Figure 25
Percent of Persons Experiencing Respectful Interactions
Comparison of DMR Survey and Certification Findings with NCI Results for MA and the National NCI Average in 2005



WHAT DOES THIS MEAN? *For individuals receiving supports that are reviewed by the DMR Survey and Certification unit, 99% are determined to be adequately practicing their civil and human rights. The percentage of persons reported to experience respectful interactions within Massachusetts DMR is also relatively high, with NCI results suggesting more respect is shown by staff in day service settings than in residential programs, a finding that parallels that found across the nation.*

RIGHTS ARE PROTECTED

OUTCOME: People's rights are protected.

Indicators:

1. Less intrusive interventions are used before implementing a restrictive intervention.
2. People and/or guardians give consent.
3. People know where and how to file a complaint.
4. Amount of emergency restraint used.

RESULTS:

Figure 26 below presents a summary of findings for indicators associated with the protection of rights for persons served by DMR in both FY04 and FY05. Findings demonstrate relative stability for measures related to the use of less restrictive interventions, presence of consent and the ability of persons to file complaints. Data related to the use of restraint show mixed results in FY05. Little change is noted for the percent of persons experiencing restraint in community settings. However, the percentage of persons in developmental centers (facilities) who had restraint utilized increased from levels experienced in FY04. Despite this possible increase in the relative percentage of persons restrained, the actual average number of restraints used decreased in facilities. The average number of restraints remained approximately the same within community programs.

Figure 26
Summary of Trends for Rights are Protected Indicators and Measures
2004 – 2005

OUTCOME	Indicator	Measure	Change FY03-FY04	Change FY04-FY05
Rights Protected *People's rights are protected*	1. Less Intrusive Interventions	Percent - Less Intrusive Used	⇔	⇔
	2. Consent - Restrictive Interventions	Percent - with Consent	⇑	⇔
	3. File Complaints	Percent - Able to File Complaint	⇔	⇔
	4. Restraint Utilization	Facility: Percent Restrained	⇓ +	⇑ -
		Community: Percent Restrained	⇔	⇔
		Facility: Ave No. Restraints	⇑	⇓ +
		Community: Ave No. Restraints	⇑	⇔

Direction of Arrow = increase, decrease, stable
Green = positive trend (+)
Red = negative trend (-)
White = slight change/neutral trend

OUTCOME: People's rights are protected.

Indicator 1: Less intrusive interventions are used before implementing a more restrictive intervention.

Measures: Percentage of individuals who have had less intrusive interventions tried.

Data Source: Survey and Certification (1.3A)

FINDINGS: Table 31 below presents the results of Survey and Certification reviews regarding the use of less intrusive interventions for fiscal years 2002 through 2005. As can be seen, the same percentage of individuals who were reviewed in 2005 compared to 2004 had evidence that less intrusive interventions were utilized before moving to more intrusive approaches. The trend for this quality indicator appears very stable over time.

Table 31
No. and Percentage of Persons with Less Intrusive Interventions Used First
2002 - 2005

Less Intrusive Interventions	2002	2003	2004	2005	Type of Change 2004-2005
No. Reviewed	1663	1155	1548	1776	
Less Intrusive Interventions Used First	1610	1097	1509	1730	
Percent Less Intrusive Interventions Used First	97%	95%	97%	97%	⇔

Indicator 2: People and guardians give consent for restrictive interventions.

Measures: Percentage of individuals who provide informed consent for the use of restrictive interventions

Data Source: Survey and Certification (1.3C)

FINDINGS: A review of the presence or absence of informed consent regarding the use of restrictive interventions occurs during the Survey and Certification process. This review includes an analysis as to whether a full explanation is provided re: the risks and benefits of a procedure and the presence of an appropriate explanation of a person's rights to withdraw that consent at any time. Survey and Certification reviews in FY05 indicate that 82% of persons with restrictive interventions had all appropriate processes followed with respect to obtaining informed consent. As can be seen in Table 32, this rate is consistent with that obtained in FY04.

Table 32
No. and Percentage of Persons with Restrictive Interventions Who Provided Informed Consent
2002 - 2005

Consent for Restrictive Interventions	2002	2003	2004	2005	Type of Change 2004-2005
No. Applicable	1238	921	991	1148	
No. with Consent	1047	716	811	939	
Percent with Consent	85%	78%	82%	82%	⇔

Indicator 3: People know where and how to file a complaint.

Measures: Percentage of individuals who know where and how to file complaints.

Data Source: Survey and Certification (5.2E)

FINDINGS: Survey and Certification reviews indicate that almost all persons in reviewed programs (98%) have knowledge of how to file a complaint. This is the same level as observed over the prior three years, suggesting this measure is extremely stable over time.

Table 33
No. and Percentage of Persons Able to File Complaints
2002 - 2005

Know How to File Complaint	2002	2003	2004	2005	Type of Change 2004-2005
No. Reviewed	2514	2162	2184	2438	
No. Able to File Complaint	2476	2110	2148	2386	
Percent Able to File Complaint	98%	98%	98%	98%	⇔

WHAT DOES THIS MEAN? *Almost all individuals reviewed in the Survey and Certification process know how to file complaints and are provided with less intrusive interventions prior to the use of more restrictive procedures. A somewhat lower percentage of individuals have been provided with all the necessary steps for informed consent prior to the use of a restrictive procedure. All trends appear very stable.*

Indicator 4: Restraint utilization.

Measures: Number and percentage of individuals served by DMR who experience emergency restraint

Average number of restraints used per person restrained

Data Source: DMR Restraint database

FINDINGS: Percent Restrained. An analysis of data regarding the utilization of restraint shows that approximately the same percentage of persons served by DMR in FY05 experienced an emergency restraint as in FY04.[9] A comparison of the percentage of the population with an incident of restraint for those served within developmental centers (facilities) versus in community programs is presented below in Table 34. As can be seen, in FY05 this percentage increased from 4.4% to 5.9% for individuals in facilities. Little change was noted for persons in community programs (6.0% in FY04 compared to 5.9% in FY05). Figure 27 illustrates the four year trend in restraint utilization for the combined DMR population. As can be seen, there has been a small but gradual increase over time.

Table 34
Restraint Utilization for Persons in Facilities and Community Settings
2002 - 2005

Percent Population Restrained	Setting	No. People Served	No. Restrained	Percent of Poulation Restrained	Type of Change 2004-2005
2002	Facility	1,193	65	5.4%	
	Community	11,892	615	5.2%	
	Combined	13,085	680	5.2%	
2003	Facility	1,157	68	5.9%	
	Community	12,417	711	5.7%	
	Combined	13,574	779	5.7%	
2004	Facility	1,109	49	4.4%	
	Community	12,301	733	6.0%	
	Combined	13,410	782	5.8%	
2005	Facility	1,067	63	5.9%	↑ -
	Community	12,574	746	5.9%	⇔
	Combined	13,641	809	5.9%	⇔

[9] The number of people subject to restraint was derived from the CRS database of all active individuals over the age of 18. Persons in family and individual support services are not included.

Figure 27
Percent Population Restrained
Combined Facilities and Community
2002 - 2005

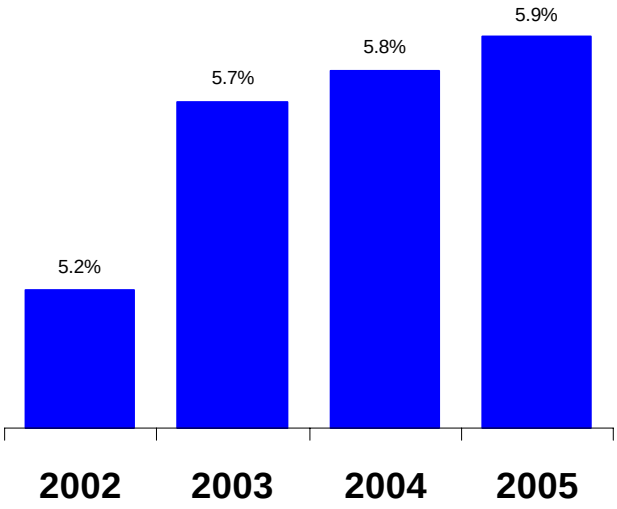
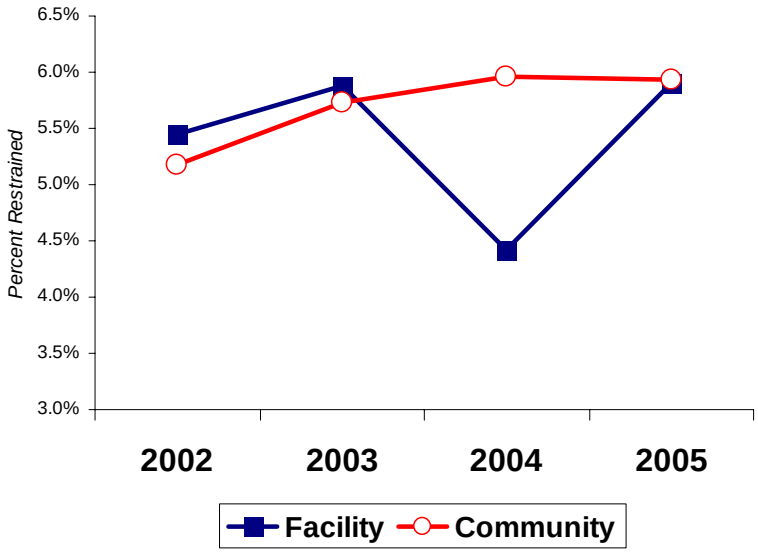


Figure 28 provides an illustration of trends over time for both facilities and community programs. As can be seen, relatively little change in the percentage of persons who have experienced restraint has taken place within community settings. The trend for persons within facilities is more erratic, falling in FY04 from prior years but increasing in FY05. The increase in FY05 for facilities is due to both an increase in the number of restraints (49 in FY04 compared to 63 in FY05) and a reduction in the facility population over this two year time period.

Figure 28
Trends in Percent of Population Restrained in Facilities v. Community Programs
2002 - 2005



FINDINGS: Average No. of Restraints. Table 35 presents findings related to the average annual number of restraints per person - for those individuals who experienced restraint - for the four year time period between FY02 and FY05.[10] As can be seen, the average number of restraints per person restrained was reduced in facilities during FY05. A very slight decrease is noted for community programs, suggesting a relatively stable trend. The reduction in the total number of instances of restraint is illustrated in Figure 29, where data suggest the actual number of restraints in FY05 was slightly lower than in the previous two years.

Table 35
Average No. Restraints per Person
2002 - 2005

Ave No. Restraints per Person Restrained	Setting	No. People Restrained	Total No. of Restraints	Average per Person Restrained	Type of Change 2004-2005
2002	Facility	65	365	5.6	
	Community	615	3079	5.0	
	Combined	680	3444	5.1	
2003	Facility	68	340	5.0	
	Community	711	4043	5.7	
	Combined	779	4383	5.6	
2004	Facility	49	267	5.4	
	Community	733	4542	6.2	
	Combined	782	4809	6.1	
2005	Facility	63	242	3.8	↓ +
	Community	746	4522	6.1	⇔
	Combined	809	4764	5.9	⇔

Figure 30 provides a comparison of the average number of emergency restraints per person restrained for individuals in facilities and community programs. As can be seen, this average experienced a large decrease for facility programs and a smaller reduction for community programs in FY05. Data suggest, however, that the amount of restraint on average - for those individuals who are restrained - is higher for those in community programs than for those within facilities. This difference has been present since 2003.

[10] The average is calculated by dividing the total no. of incidents of restraint by the no. of people who experienced restraint. Data is provided for persons in facilities, community programs and for the combined total.

Figure 29
Total No. of Emergency Restraints Utilized in DMR
2002 - 2005

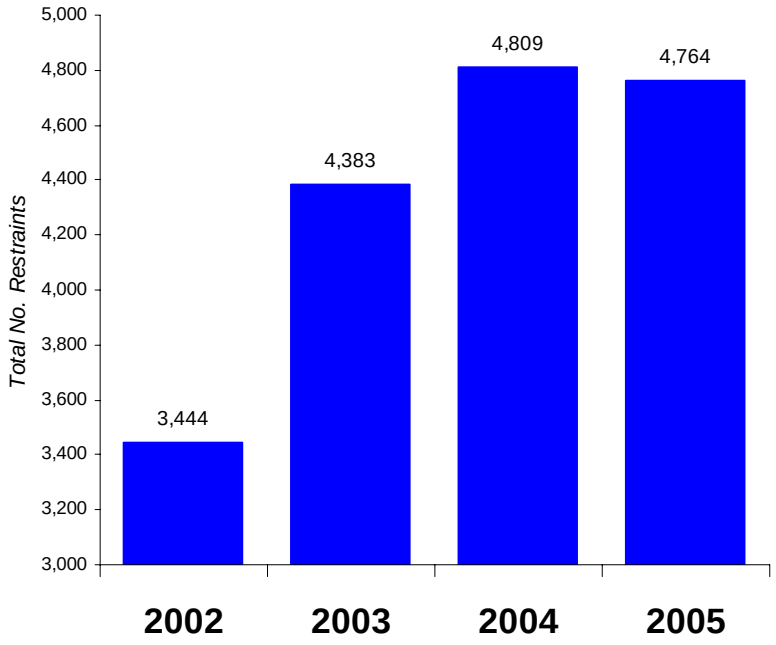
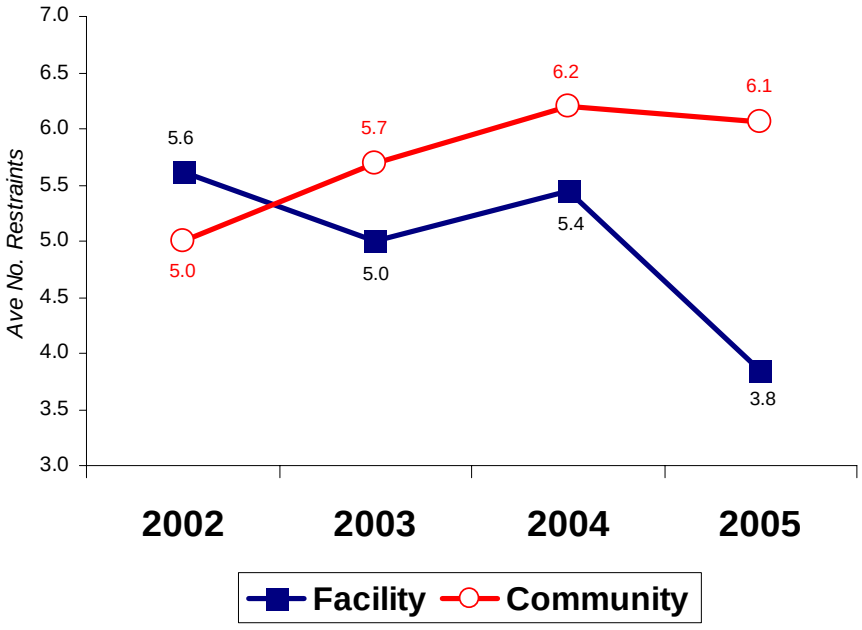


Figure 30

Average Annual No. of Restraints per Person Restrained
Facility v Community
2002 – 2005



An analysis of factors affecting the use of emergency restraint as a consumer management and safety intervention is extremely complex and strongly related to individual characteristics and changes in population over time. More detailed data is available from the DMR Office of Human Rights. Interested readers are encouraged to peruse this more detailed information to supplement the summary data provided in this report.

WHAT DOES THIS MEAN? *The number of instances of emergency restraint across the DMR system decreased in FY05 from levels present in 2003 and 2004. This resulted in a reduction in the average number of restraints for persons who experienced restraint in both community programs and facilities. The reduction was much greater for facility programs. However, the number of persons within facilities who were restrained actually increased in FY05, leading to an increase in the percentage of persons in facilities who experienced emergency restraint. This measure did not undergo any substantial change for community settings.*

CHOICE & DECISION-MAKING

OUTCOME: People are supported to make their own decisions.

Indicators:

1. People make choices about their everyday routines and schedules.
2. People control important decisions about their home and home life.
3. People choose where they work.
4. People influence who provides their supports.

RESULTS:

Analysis of Survey and Certification data related to choice and decision-making suggests the continuation of a relatively stable trend across all measures. This trend can be seen in Figure 31 below.

Figure 31
Summary of Trends for Choice & Decision-making Indicators and Measures
2004 – 2005

OUTCOME	Indicator	Measure	Change FY03-FY04	Change FY04-FY05
Choice & Decision making *People are supported to make their own decisions.*	1. Choices re: everyday routines	Percent - Choose schedule	⇔	⇔
		Comparison with NCI		
	2. Decisions re: home and home life	Percent - Control decisions	⇔	⇔
		Comparison with NCI		
	3. Choose where work	Percent - Choose where work	⇑	⇔
		Comparison with NCI		
	4. Influence who provides support	Percent - Influence who supports	⇔	⇔
		Comparison with NCI		

Direction of Arrow = increase, decrease, stable
Green = positive trend (+)
Red = negative trend (-)
White = slight change/neutral trend

OUTCOME: People are supported to make their own decisions.

Indicator 1: People make choices about their everyday routines and schedules.

Measures: Percentage of individuals who choose their own schedule

Comparison to NCI

Data Source: Survey and Certification (2.2A)
NCI

FINDINGS: Survey and Certification findings show that a very high percentage of persons are able to choose their daily schedule. No change is noted between 2004 and 2005. Table 36 presents both Survey and Certification results and data from the recent NCI evaluation for DMR along with national NCI results for 2005 for this measure. As can be seen, the NCI results are somewhat lower for Massachusetts than the Survey and Certification findings. These differences may reflect the more extensive population assessed with the NCI or subtle differences in the methods used to evaluate this measure of choice.

Table 36
Percent Who Choose Daily Schedule
Survey and Certification and NCI
2002 – 2005

Choose Daily Schedule	2002	2003	2004	2005	Change MA 2004-2005
Choose Schedule - DMR S&C	97%	96%	97%	97%	⇔
Decide Daily Schedule - DMR NCI				76%	
Decide Daily Schedule - Nat Ave NCI	82%	84%	83%	82%	

DMR S&C only reviews persons in certified programs
NCI - sample of all persons served by the state agency; sum of receive help and choose without help

Indicator 2: People control important decisions about their home and home life.

Measures: Percentage of individuals who control important decisions about home life

Comparison to NCI

Data Source: Survey and Certification (2.3C)
NCI

FINDINGS: Table 37 below presents the results of the Survey and Certification reviews in FY05 for the extent to which individuals have exercised control over decisions regarding their home life between FY02 and FY05. As can be seen, a stable trend is noted.

Results from the NCI show a substantially lower proportion of people who control important decisions about home life as measured by response to two more specific questions: people choose where they live and with whom they live. The NCI questions represent a much more rigorous standard in that they measure actual choice and decision-making over an important quality of life standard rather than influence over and input into general decisions. In all instances the NCI results are substantially lower than the Survey and Certification results. Also, and as can be seen in Table 37, the NCI results for Massachusetts are somewhat lower than the national average for the two measures related to choice and home life.

Table 37
Percent Who Control Important Decisions
Survey and Certification Reviews and NCI
2002 – 2005

Control Important Decisions	2002	2003	2004	2005	Change MA 2004-2005
Decisions re: Home/life - DMR S&C	93%	92%	93%	91%	⇔
Choose Where Live - DMR NCI				43%	
Choose Where Live - Nat Ave NCI	48%	49%	54%	56%	
Choose Who Live With - DMR NCI				36%	
Choose Who Live With - Nat Ave NCI	47%	44%	47%	49%	

Indicator 3: People choose where they work.

Measures: Percentage of individuals who choose where they work and what type of work/day activity they are involved in.

Comparison to NCI

Data Source: Survey and Certification (2.3D)
NCI

FINDINGS: Survey and Certification findings show that the percentage of persons reviewed who had exercised choice over where they work (or if not engaged in employment, were able to control their day activity) fell slightly in 2005 compared to the prior year. Once again the Survey and Certification findings for this measure are higher than the NCI data. A review of 2005 NCI data for Massachusetts versus the NCI national average also indicates that a substantially lower percentage of Massachusetts consumers

are able to choose where they work compared to their counterparts in many other state Developmental Disability systems.

Table 38
Percent Who Choose Where They Work
Survey and Certification Reviews and NCI
2002 – 2005

Choose Where Work	2002	2003	2004	2005	Change MA 2004-2005
Choose Work - DMR S&C	89%	82%	88%	85%	⇔
Choose Work - DMR NCI				46%	
Choose Work - Nat Ave NCI	58%	61%	62%	64%	

Indicator 4: People influence who provides their support.

Measures: Percentage of individuals who influence who provides their support (staff)

Comparison to NCI

Data Source: Survey and Certification (2.3B)
NCI

FINDINGS: Survey and Certification findings for this indicator are presented below in Table 39. As can be seen, after FY02 there was a dramatic improvement in the percentage of individuals who exercised influence over who provided them with support. A stable trend is noted for the period of FY03 through FY05, with over 90% of those individuals reviewed by the Survey/Certification process determined as exercising such influence.

As with other indicators, the NCI comparison measures are more specific and related to actual choice (selection) of staff for both residential and day supports. As can be seen in Table 39, the percentages of persons indicating they either chose or had assistance choosing staff support was lower than that obtained in the Survey and Certification reviews (e.g., only 53% of respondents to the NCI in Massachusetts during 2005 indicated they could choose or have input into the selection of their residential support staff). Persons served by DMR would appear to have less choice in selecting residential staff than their peers in other states (based on the NCI national average for this indicator.) On the other hand, they exercise about the same level of choice for selecting who assists them in work/day programs (67%).

Table 39
Percent Who Choose Support Staff
Survey and Certification Reviews and NCI
2002 – 2005

Influence Who Provides Support	2002	2003	2004	2005	Change MA 2004-2005
Influence Support - DMR S&C	58%	91%	93%	92%	⇔
Choose Staff Home - DMR NCI				58%	
Choose Staff Home - Nat Ave NCI	61%	61%	63%	63%	
Choose Staff Work - DMR NCI				67%	
Choose Staff Work - Nat Ave NCI	62%	67%	66%	68%	

National Core Indicators Comparison for Measures of Choice and Control

Table 40 and Figures 32 to 34 below present a summary of findings on the NCI for both Massachusetts and the national average (16 states) for indicators and measures associated with choice and control. As can be seen, Massachusetts falls below the national average on all of these measures. The largest discrepancies are present for choices associated with where to live, who to live with and where to work.

Table 40
Comparison of MA DMR and National Average
NCI Measures re: Choice

NCI: Choice and Control *Person chooses or has help with the decision*	MA DMR NCI	Nat Ave NCI	Difference MA - National Ave
Schedule	76%	82%	-6%
Spend Free Time	88%	91%	-3%
Use Spending Money	83%	88%	-6%
Where Live	43%	56%	-13%
Who Live With	36%	49%	-13%
Where Work/Day	46%	64%	-18%
Staff - Home	58%	63%	-5%
Staff - Work	67%	68%	-1%
Case Manager	48%	52%	-4%

Figure 32
Comparison of Massachusetts and National Average
NCI Measure of Choice re: Routine and Money

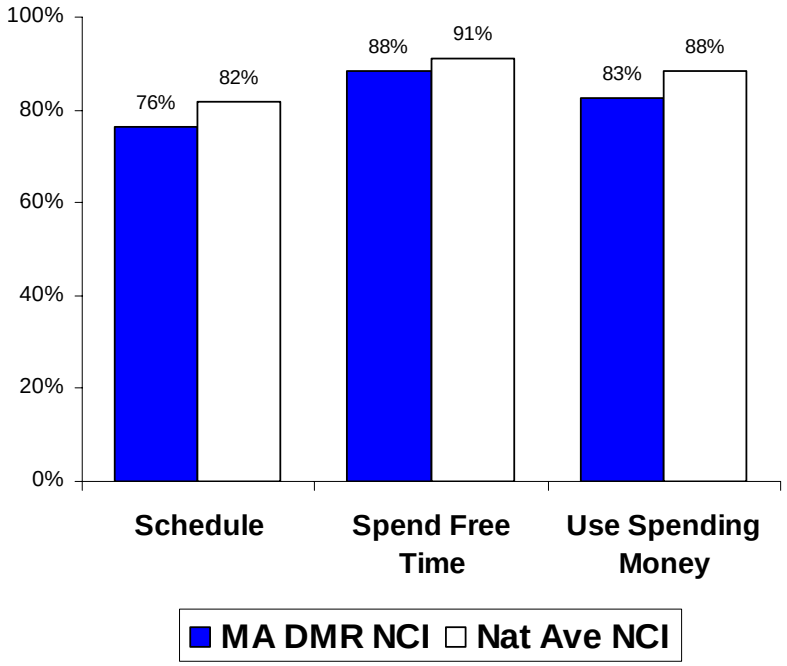


Figure 33
Comparison of Massachusetts and National Average
NCI Measure of Choice re: Residence and Work

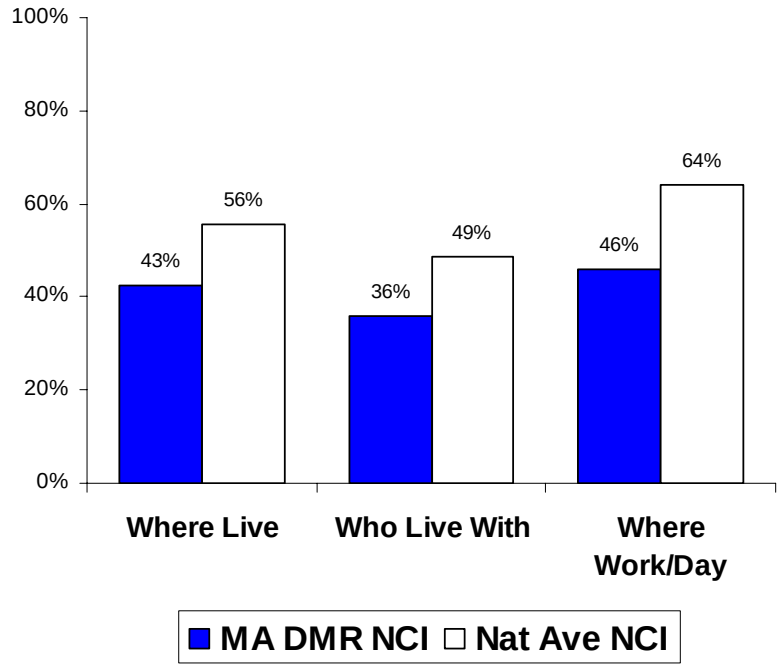
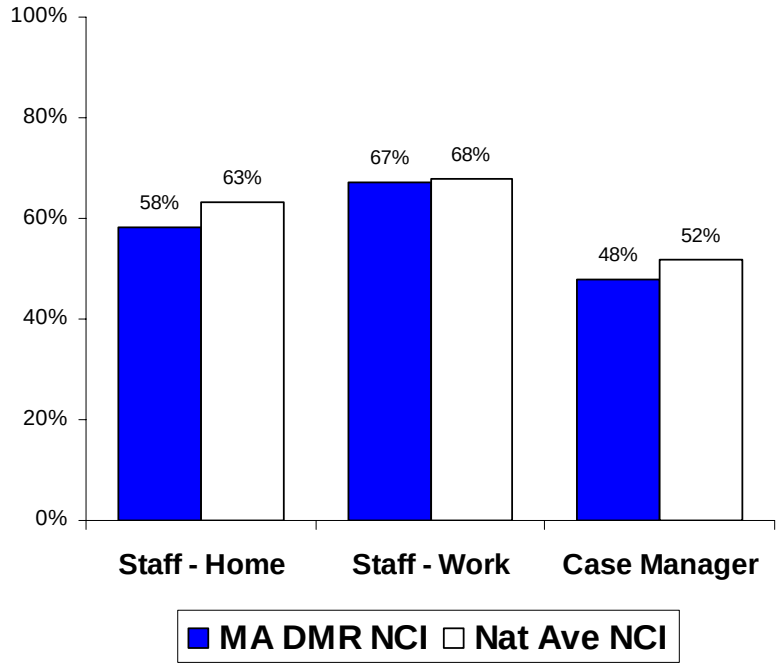


Figure 34
Comparison of Massachusetts and National Average
NCI Measure of Choice re: Staff



WHAT DOES THIS MEAN? *Individuals served in programs that are reviewed by the DMR Survey and Certification process appear to experience relatively high levels of input into choice and personal decision-making. Over the past three years, these levels have remained about the same. However, findings from the National Core Indicators suggest there may be a much lower level of personal choice and control. Compared to the average of 16 other states, persons served by DMR express less choice and control over almost all aspects of their residential and work lives. The greatest disparities would appear to be related to choices re: where to live, who to live with and where to work/attend a day program.*

COMMUNITY INTEGRATION

OUTCOMES: People use integrated community resources and participate in everyday community activities.

People are connected to and valued members of their community

Indicators:

1. People use the same community resources as others on a frequent and on-going basis.
2. People are involved in activities that connect them to other people in the community.

RESULTS:

Analysis of Survey and Certification data related to community integration shows the continuation of a relatively stable trend for the extent to which people use community resources and are involved in community activities that connect them to others. Summary findings are illustrated in Figure 35, and more detailed information, including comparisons with National Core Indicator results, is presented below.

Figure 35
Summary of Trends for Community Integration Indicators and Measures
2004 – 2005

OUTCOME	Indicator	Measure	Change FY03-FY04	Change FY04-FY05
Community Integration - *People use integrated community resources and participate in everyday community activities.*	1. Use the same community resources as others	Percent Use Community Resources	⇔	⇔
		Comparison to NCI		
People are connected to and valued members of their community.	2. Involved in acitivities that connect to other people	Percent Involved in Community Activitie	⇔	⇔
		Comparison to NCI		

Direction of Arrow = increase, decrease, stable
Green = positive trend (+)
Red = negative trend (-)
White = slight change/neutral trend

OUTCOME: People use integrated community resources and participate in everyday community activities.

Indicator 1: People use the same community resources as others on a frequent and ongoing basis.

Measures: Percentage of individuals who use community resources

Comparison to NCI

Data Source: Survey and Certification (3.1B)
NCI

FINDINGS: Survey and Certification findings from 2002 to 2005 show that the percentage of persons who regularly use community resources has remained relatively stable over time, falling slightly in 2005 from the prior year. These results suggest that about 9 out of every 10 individuals in a support/service reviewed by the DMR Survey and Certification process are using community resources on a relatively regular basis.

Table 41
Use of Community Resources
4 Year Trends in Survey and Certification Findings
2002 – 2005

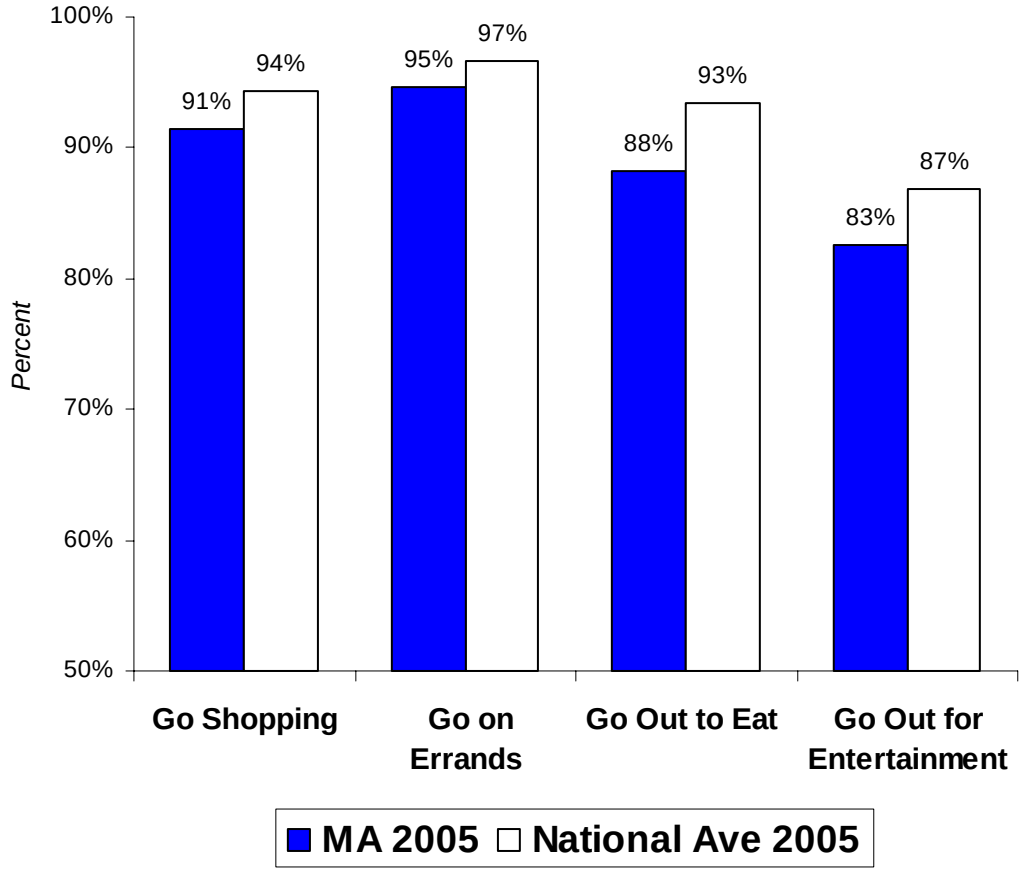
Community Resources: [DMR S&C]	**2002**	**2003**	**2004**	**2005**	**Change 2004-2005**
Use Community Resources	91%	88%	90%	89%	⇔

On the other hand, a comparison of National Core Indicator survey results for Massachusetts (2005) and the national average from 15 other states indicates that persons served by DMR may be accessing community resources at a slightly lower level than their counterparts in other parts of the country. This comparison is illustrated below in Table 42 and Figure 36.

Table 42
Comparison of NCI Findings for DMR v the National Average
For Measures of Community Resource Use

Use Community Resources [NCI]	**MA 2005**	**National Ave 2005**	**Difference: MA - National**
Go Shopping	91%	94%	-3%
Go on Errands	95%	97%	-2%
Go Out to Eat	88%	93%	-5%
Entertainment	83%	87%	-4%

Figure 36
Massachusetts DMR v National Average on NCI Measures
For Use of Community Resources
2005



OUTCOME: People are connected to and valued members of their community.

Indicator 1: People are involved in activities that connect them to other people in the community.

Measures: Percentage of individuals involved in activities that connect them to others

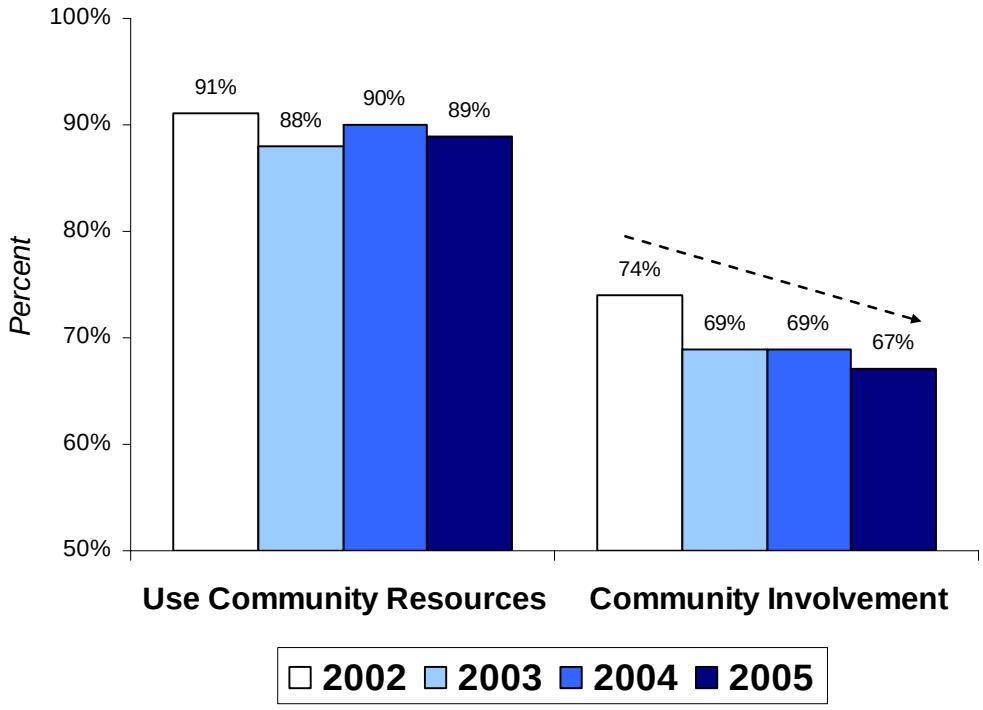
Comparison to NCI

Data Source: Survey and Certification (3.2B)
NCI

FINDINGS: Survey and Certification findings suggest that the percentage of persons who are involved in community activities that allow them to interact with and connect to

others in the community has experienced a slight decrease from 2004 to 2005. However, and as can be seen in Figure 37 below, the percentage of individuals who are involved in their community is not only less than those who use community resources, but there has been a relatively steady and consistent decline for this measure since FY02.

Figure 37
Percentage of People Involved in Community Activities
2002 - 2005

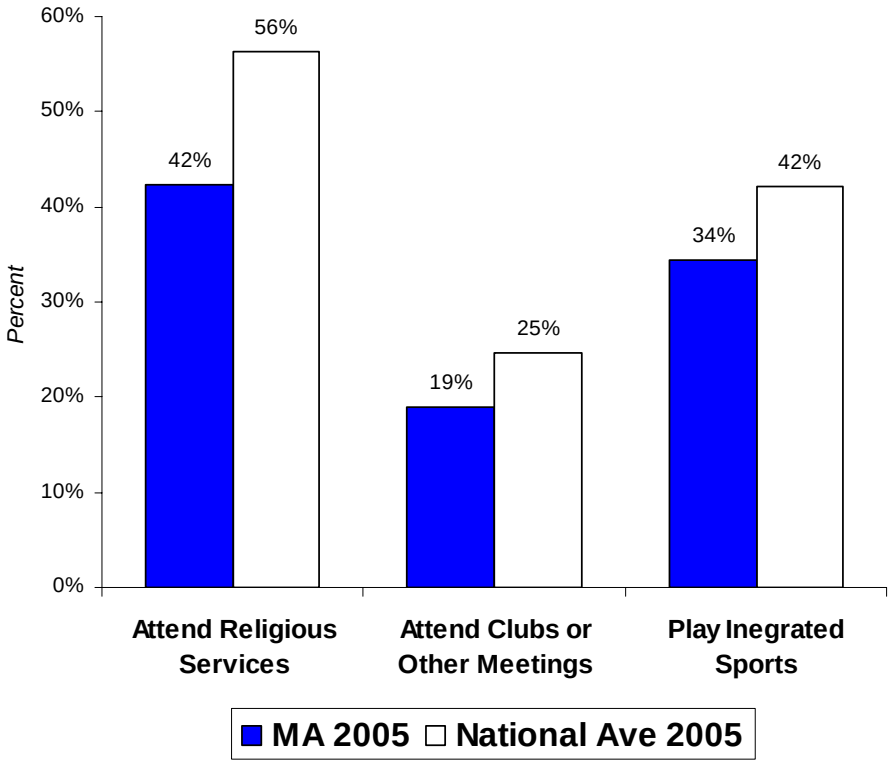


A further comparison of findings for Massachusetts on the recent NCI survey with the national averages indicates that persons supported by DMR may be less actively involved in community activities than their counterparts in other states. This comparison is presented below in Table 43 and Figure 38. As can be seen, respondents to the NCI survey in Massachusetts may be attending religious services and participating in clubs/meetings less than individuals in other states. They may also be involved in integrated sports activities less often.

Table 43
Comparison of 2005 NCI Findings for DMR v the National Average
For Measures of Community Involvement and Activity

Involvement in Community Activities [NCI]	MA 2005	National Ave 2005	Difference: MA - National
Attend Religious Services	42%	56%	-14%
Attend Clubs or Other Meetings	19%	25%	-6%
Play Inegrated Sports	34%	42%	-8%

Figure 38
Massachusetts DMR v National Average on NCI Measures
For Community Involvement
2005



WHAT DOES THIS MEAN? *Over time there has been little if any change in the levels of community integration for persons served by DMR. Data suggest that actual involvement in the community occurs at a much lower rate than presence in the community, as measured by use of community resources. Persons served by DMR may be less actively involved in their communities than their peers in other parts of the country.*

RELATIONSHIPS & FAMILY CONNECTIONS

OUTCOME: People maintain/gain relationships with family and friends.

Indicators:

1. People are supported to maintain relationships with family, friends and co-workers.
2. People are supported to develop new friendships.
3. Individuals have education and support to understand and safely express their sexuality.

RESULTS:

Findings from Survey and Certification reviews for 2005 show a very high percentage of persons who are supported to maintain existing relationships with family and friends. However, fewer individuals appear to be supported in efforts to gain new friendships, a distinction noted in previous reports. A relatively stable trend is present for all three indicators associated with relationships and family connections, as illustrated below in Figure 39.

Figure 39
Summary of Trends for Relationships and Family Connections
2004 – 2005

OUTCOME	Indicator	Measure	Change FY03-FY04	Change FY04-FY05
Relationships & Family Connections - *People maintain and gain relationships with family and friends.*	1. Support to maintain relationships	Percent Maintain Relationships	⇔	⇔
	2. Support to gain new relationships	Percent - New Relationships	⇑	⇔
	3. Receive education about intimacy	Percent - Educated re: Intimacy	⇑	⇔

Direction of Arrow = increase, decrease, stable
Green = positive trend (+)
Red = negative trend (-)
White = slight change/neutral trend

OUTCOME: People maintain and gain relationships with family and friends.

Indicator 1: People are supported to maintain relationships with family, friends and co-workers.

Measures: Percentage of individuals who maintain relationships.

Data Source: Survey and Certification (3.3A)

FINDINGS: Survey and Certification reviews for 2002 – 2005 show a very consistent and stable trend in the percentage of persons reviewed who are determined to be receiving support to maintain their relationships with other people. As illustrated below in Table 44, almost all (98%) individuals who were reviewed received such support in FY05.

Table 44
Percentage of Persons Supported to Maintain Relationships
FY02-FY05

Maintain Relationships	2002	2003	2004	2005	Type of Change 2003-2004
No. Reviewed	2170	1968	1821	1879	
No. Maintain Relationships	2155	1933	1789	1843	
Percent Maintain Relationships	99%	98%	98%	98%	⇔

Indicator 2: People are supported to gain new relationships.

Measures: Percentage of individuals who gain new relationships.

Data Source: Survey and Certification (3.3B)

FINDINGS: Survey and Certification reviews for 2002 – 2005 indicate that a lower percentage of persons were supported to gain new relationships compared to those with support for maintenance of relationships. As can be seen in Table 45 below, during FY05 there was a slight reduction for this indicator, with only 77% of those persons reviewed receiving sufficient support to gain new relationships.

Table 45
Percentage of Persons Supported to Gain New Relationships
FY02-FY05

New Relationships	2002	2003	2004	2005	Type of Change 2003-2004
No. Reviewed	1580	1208	1255	1257	
No. with New Relationships	1290	921	999	969	
Percent with New Relationships	82%	76%	80%	77%	⇔

Indicator 3: Individuals have education and support to understand and safely express their sexuality.

Measures: Percentage of individuals who are educated about intimacy.

Data Source: Survey and Certification (3.3C)

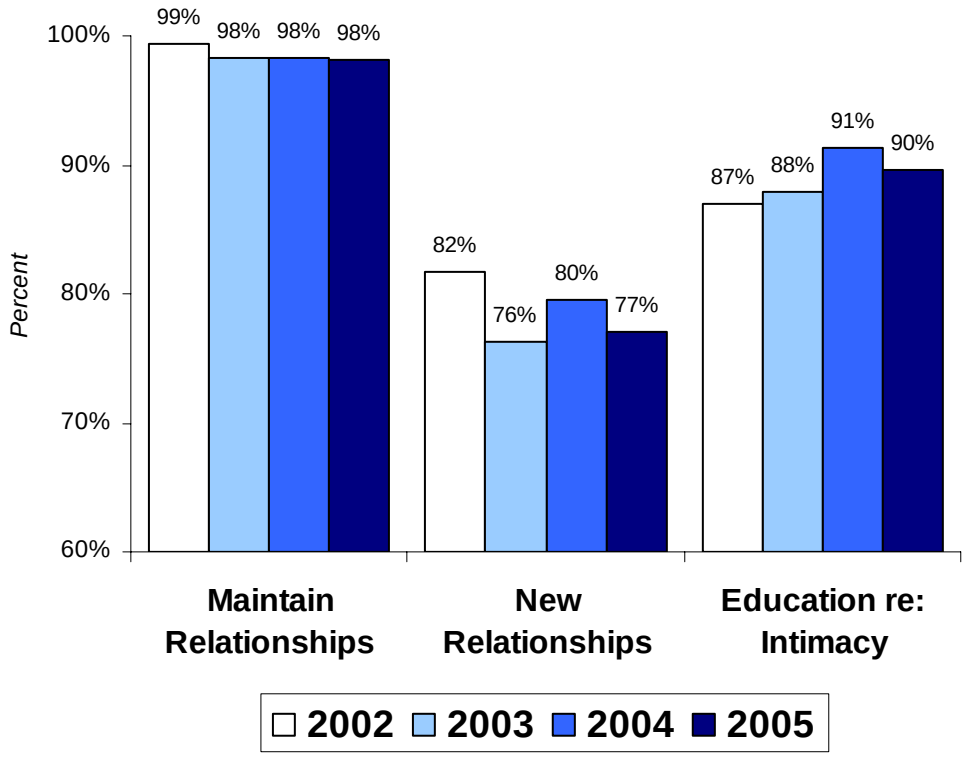
FINDINGS: Survey and Certification reviews suggest that 90% of individuals reviewed in 2005 were receiving support and education to assist them in understanding and appropriately expressing intimacy and sexuality. A relatively stable trend is noted for this indicator over time.

Table 46
Percentage of Persons Educated about Intimacy and Sexuality
2002 - 2005

Intimacy	2002	2003	2004	2005	Type of Change 2003-2004
No. Reviewed	1238	1014	984	1075	
No. Educated re: Intimacy	1077	892	899	963	
Percent Educated re: Intimacy	87%	88%	91%	90%	⇔

A comparison of the three indicators used to assess DMR performance in the area of relationships is illustrated below in Figure 40. As can be seen, a substantially greater percentage of individuals received needed support to maintain relationships compared to receipt of support to gain new friendships and relationships. Assistance in the area of intimacy falls in between these other two indicators: maintaining existing relationships and developing new ones. The same pattern has been present for the past four years.

Figure 40
Comparison of Indicators for Reviewing Relationships
2002 - 2005



WHAT DOES THIS MEAN? *Almost everyone receiving supports reviewed by the Survey and Certification process appear to receive adequate support to maintain existing relationships with family and friends. About 90% of the people reviewed receive support to express intimacy. However, a much smaller proportion of people (about 3 out of 4) receive sufficient support in their efforts to develop new friendships.*

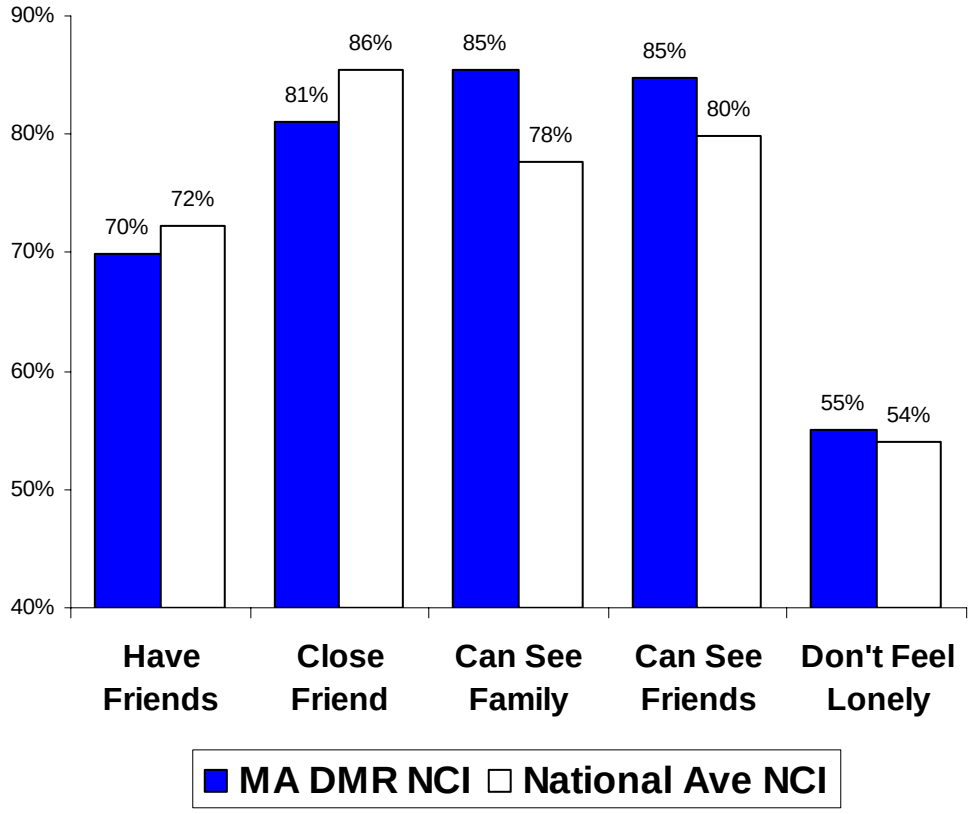
National Core Indicators. The Massachusetts DMR results for questions related to relationships compared to the national NCI average (2005) are presented below in Table 47 and Figure 41. As can be seen, and as compared to the national average, Massachusetts had a higher percentage of respondents indicating they can see their family and/or friends when they want to. About the same percentage of respondents indicated that they do not feel lonely most of the time. However, a lower percentage of Massachusetts respondents indicated they have a close friend or have friends other than staff or family compared to the national average.

Table 47
2005 National Core Indicator Results for Questions re: Relationships
Comparison of Massachusetts DMR to the National NCI Average
2005

NCI: Relationships	MA DMR NCI	National Ave NCI	Difference MA - National Ave
Have friends other than staff/family	69.9%	72.2%	-2.3%
Have a close friend	81.1%	85.5%	-4.4%
Can see family when want to	85.4%	77.7%	7.7%
Can see friends when want to	84.7%	79.9%	4.8%
Feel lonely (Not Often/Never)	55.1%	54.1%	1.0%

Percent responding "Yes" except for the question re: feeling lonely

Figure 41
Comparison of Massachusetts Performance to the National Average on the National Core Indicators Questions re: Relationships
2005



WHAT DOES THIS MEAN? *Individuals receiving support from the Massachusetts DMR appear to have more access to family members and friends than their peers in other states. However, they may also have fewer friends and/or a "close" friend than their counterparts across the country. Approximately half of all Massachusetts respondents on the National Core Indicators feel lonely some of the time – about the same percentage as other persons served by DD agencies in other parts of the nation.*

ACHIEVEMENT OF GOALS

OUTCOME: People are supported to develop and achieve goals.

Indicators:
1. People develop their personal goals.
2. People have support to accomplish their goals.

RESULTS:

Survey and Certification data for 2004 through 2005 illustrate a relatively stable trend with regard to the extent to which people develop their personal goals and the percentage of persons who have access to needed resources to achieve their goals. No appreciable change is noted in 2005 from 2004 levels. These trends are illustrated in Figure 42 below.

Figure 42
Summary of Trends for Community Integration Indicators and Measures
2004 – 2005

OUTCOME	Indicator	Measure	Change FY03-FY04	Change FY04-FY05
Achievement of Goals - *People are supported to develop and achieve goals.*	1. Develop Personal Goals	Percent Develop Goals	⇔	⇔
	2. Support to Accomplish Goals	Percent - Access to Resources	⇔	⇔

Direction of Arrow = increase, decrease, stable
Green = positive trend (+)
Red = negative trend (-)
White = slight change/neutral trend

OUTCOME: People are supported to develop and achieve goals.

Indicator 1: People develop their personal goals.

Measures: Percentage of individuals who develop their personal goals.

Data Source: Survey and Certification (2.3A)

FINDINGS: Survey and Certification reviews for 2005 found that 90% of the individuals reviewed were determined to be developing their personal goals (see Table 48). This level is the same as found in 2004, with a very stable trend for this indicator evident over the past four years.

Table 48
Percentage of Persons Who Develop Goals
2002 - 2005

Develop Goals	2002	2003	2004	2005	Type of Change 2004-2005
No. Surveyed	2186	1965	1821	1875	
No. Develop Goals	1970	1720	1638	1685	
Percent Develop Goals	90%	88%	90%	90%	⇔

Indicator 2: People have support to accomplish their goals.

Measures: Percentage of individuals who have access to resources to accomplish their personal goals.

Data Source: Survey and Certification (4.1C)

FINDINGS: Survey and Certification reviews show that about 87% of individuals reviewed in 2005 consistently had access to the resources they need to accomplish their personal goals. This represents a slight increase from 2004, although a relatively stable trend is also seen for this indicator over the past four years.

Table 49
Percentage of Persons with Access to Resources to Accomplish Goals
2002 - 2005

Resources to Accomplish Goals	2002	2003	2004	2005	Type of Change 2004-2005
No. Surveyed	2193	1970	1824	1880	
No with Access to Resources	1879	1617	1534	1627	
Percent with Access to Resources	86%	82%	84%	87%	⇔

National Core Indicators

The NCI also includes survey questions closely related to achievement of personal goals and receipt of supports necessary for such. Findings for the 2005 Massachusetts NCI and for the national average are presented below in Table 50. As can be seen, interview responses from individuals in Massachusetts were relatively similar to, although slightly lower than, the average of responses from peers in other states with regard to the extent to which people receive sufficient help to reach their goals and/or have opportunities to do new things. Responses from Massachusetts consumers were almost identical to, although slightly higher than, those of their peers on the extent to which they receive needed supports.

Table 50
Comparison of MA DMR and National Average for NCI Questions Related to Achievement and Access
2005

NCI: Achievement and Access	MA DMR NCI	Nat Ave NCI	Difference MA - National Ave
Receive Help to Reach Goals/do New Things	77.6%	79.9%	-2.3%
Want More Help to do New Things ("No")	27.6%	25.7%	1.9%
Get Needed Services	82.7%	82.0%	0.7%

Lower is better for "Want more help..."

WHAT DOES THIS MEAN? *A relatively high proportion (9 out of 10) of individuals being served in programs that are reviewed by the DMR Survey and Certification process are determined to be developing personal goals. Almost the same percentage (84%) have access to the necessary resources to accomplish those goals. Measured on a wider population served by DMR through the National Core Indicators, slightly less (about 78%) believe they receive sufficient help to reach their goals and do new things. About 83% feel they receive needed supports. On average, responses from Massachusetts are very similar to those obtained from other state DD systems.*

WORK

OUTCOME: People are supported to obtain work.

Indicators:
1. Average hourly earnings by type of job support.
3. Average no. hours worked per month by type of job.

Special Note: As recommended by the DMR Statewide Quality Council, the department established a quality improvement goal in 2005 that focuses on increasing opportunities for individuals to be employed in more integrated and community-based work settings and activities. Increased earnings, greater community inclusion and more opportunities for establishing relationships represent potential benefits associated with this employment improvement target. The data in this report, for fiscal year 2005, does not reflect initiatives undertaken by DMR following the establishment of this improvement target.

RESULTS:

This report summarizes the key findings from the most recent data collection Employment Supports Performance Outcome information for a designated four week period in April 2005. This employment outcome information is reported for all individuals receiving services through DMR funded employment supports contracts which serve approximately 5,700 individuals. The information collected represents 96 employment support providers that provide information regarding work setting, wages, hours and employment retention for each individual served. The report does not include individuals who receive DMR services and may be working independently in the community, or who participate in other day programs including Community Based Day Supports in which some individuals receive support to work part-time. It is important to note that the number of individuals for whom outcome information is reported has decreased. This is a result of both changes in how the data is collected as well as exclusion of incomplete or inconsistent information on some individuals. It is also important to note that the data represents a duplicate count since many individuals spend time working in more than one employment setting, or receive services across multiple settings.

A review of employment support data for FY05 continues to show a substantial difference in the amount of money people make based upon their type of employment and employment support, with persons in individual employment enjoying the highest wages and the highest number of hours worked. Trends over the three year time period between 2003 and 2005 indicate that there has been a slight increase in the wages for persons in sheltered (facility) work and group employment. Despite this increase, individuals in sheltered facility work settings on average earn approximately ¼ of the minimum wage per hour. No change was present with regard to the number of monthly hours worked across all three types of employment support (i.e., individual, group and sheltered facility). These trends are illustrated in Figure 43 and explained in greater detail below.

Figure 43
Summary of Trends for Work Indicators and Measures
2004 – 2005

OUTCOME	Indicator	Measure	Change FY03-FY04	Change FY04-FY05
Work - *People are supported to obtain work.*	1. Average Hourly Wage	Individual Job - Average Wage	⇧	⇔
		Group Job - Average Wage	⇔	⇧
		Facility Job - Average Wage	⇩	⇧ +
	2. Monlthy Hours Worked	Individual Job - Mo. Hrs. Worked	⇔	⇔
		Group Job - Mo. Hrs. Worked	⇧ +	⇔
		Facility Job - Mo. Hrs. Worked	⇔	⇔

Direction of Arrow = increase, decrease, stable
Green = positive trend (+)
Red = negative trend (-)
White = slight change/neutral trend

OUTCOME: People are supported to obtain work.

Indicator 1: Average hourly earnings by type of job support.

Measures: Hourly wage

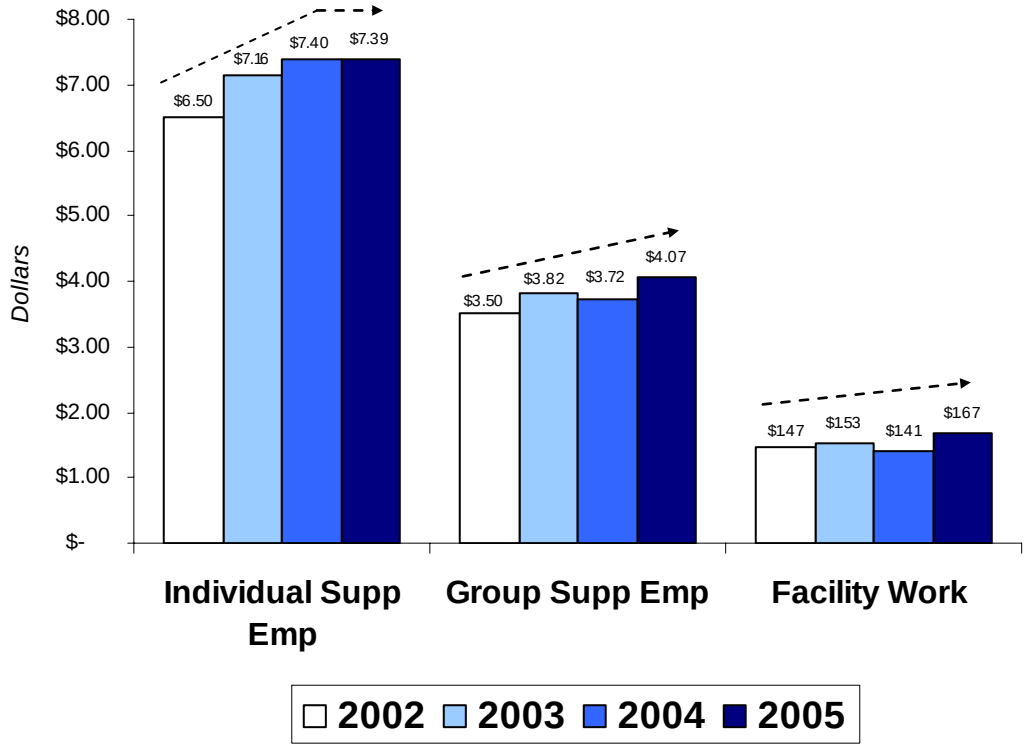
Data Source: DMR Employment Support Study (April 2005)

FINDINGS: There is a large and rather substantial difference in the hourly wages earned by individuals based upon the type of employment support they receive. As can be seen below in Table 51, persons who are involved in individual employment earn substantially more than their counterparts who were involved in group employment or sheltered (facility-based) employment. Persons employed in facilities (e.g., sheltered employment) continued to be paid substantially less during 2005 than those individuals with either group or individual employment, although, for the first time since FY02 this group of individuals did experience more growth in hourly wages than persons working in either individual or group employment. These trends in hourly wages from 2002 to 2005 are illustrated in Figure 44. As can be seen, up until FY05, the rate of wage increase for individual employment was much higher than for the other two types of employment support.

Table 51
Average Hourly Wages by Type of Employment
2002 - 2005

Average Earnings per Hour	2002	2003	2004	2005	Difference 2004-2005	Percent Earnings Change 2004-2005	Type of Change FY04-FY05
Individual Supp Emp	$ 6.50	$ 7.16	$ 7.40	$ 7.39	$ (0.01)	0%	⇔
Group Supp Emp	$ 3.50	$ 3.82	$ 3.72	$ 4.07	$ 0.35	9%	⇧
Facility Work Prog	$ 1.47	$ 1.53	$ 1.41	$ 1.67	$ 0.26	18%	⇧+

Figure 44
Changes in Hourly Earnings by Type of Job
2002 - 2005



Indicator 2: Average monthly hours worked by type of job.

Measures: Hours worked (per month)

Data Source: Employment Support Study (April 2005)

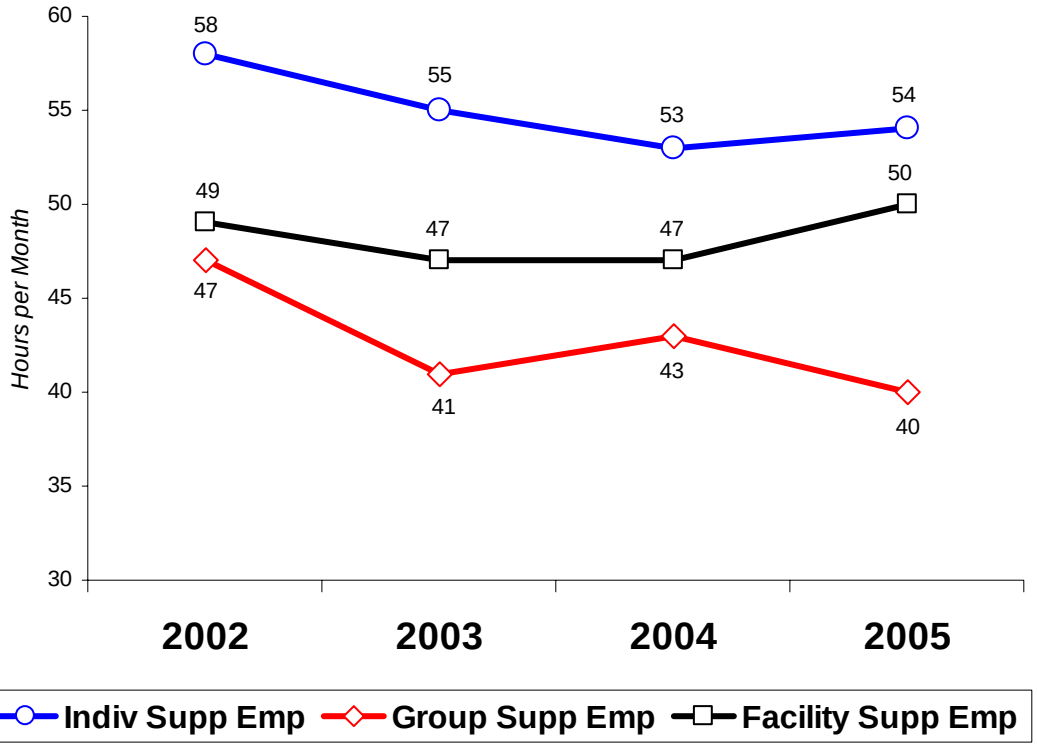
FINDINGS: A similar comparison across job categories for hours worked per month shows that once again persons with individual employment worked the greatest number of hours per month during 2005, with the average increasing by one hour (to 54 hours per month) between FY04 and FY05. Individuals in facility-based employment worked an average of 50 hours per month in FY05, increasing by 3 hours from averages during FY04. Persons working in group employment continued to work the least number of hours per month, with the average actually falling by 3 hours during FY05.
Table 52 and Figure 45 below illustrate these trends.

Table 52

Average Hours of Work per Month by Type of Job Support
2002 - 2005

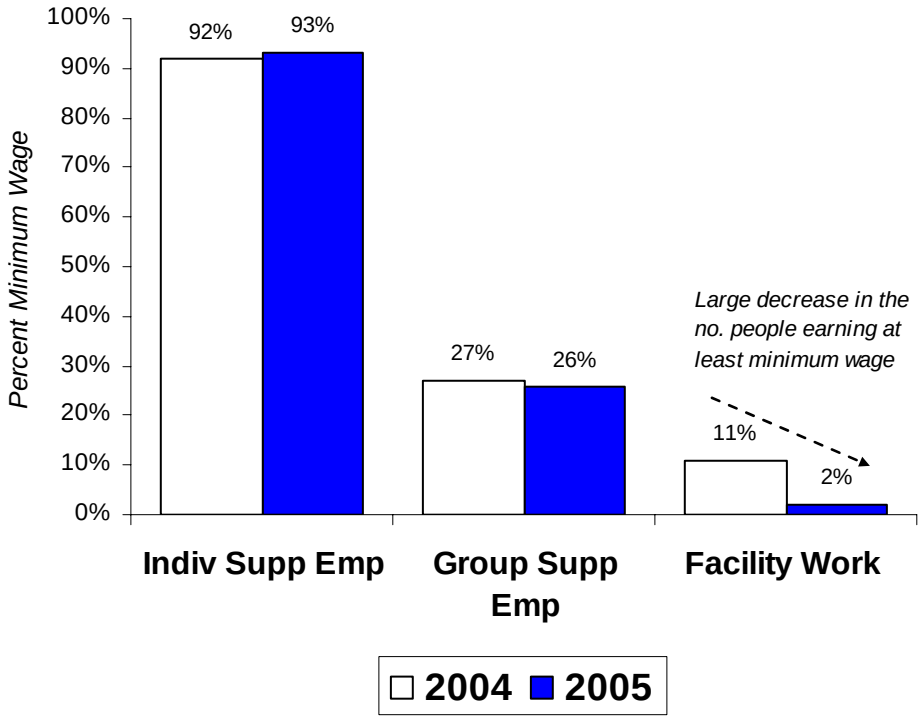
Average Monthly Hours Worked	2002	2003	2004	2005	Difference 2004-2005	Percent Change 2004-2005	Type of Change FY04-FY05
Individual Supp Emp	58	55	53	54	1	2%	⇔
Group Supp Emp	47	41	43	40	(3)	-7%	⇔
Facility Work	49	47	47	50	3	6%	⇔

Figure 45
Changes in Monthly Hours Worked by Type of Job Support
2002 - 2005



Minimum Wage. A review of earnings during 2004 and 2005 shows a dramatic difference in the relative proportion of persons who are earning at least minimum wage based upon the type of employment support they receive. As can be seen in Figure 46, over 90% of people involved in individual employment were earning minimum wage or higher during FY05. This compares to 26% engaged in group employment and only 2% in facility-based (sheltered) employment, where there was an actual decrease in the percentage of individuals earning at least minimum wage from levels found in FY04.

Figure 46
Percentage of Persons Earning at Least Minimum Wage
By Type of Employment Support
2004-2005



WHAT DOES THIS MEAN? *There is a substantial difference in how much people earn based upon the type of employment support they receive. The highest wages and number of hours worked are associated with individual employment. The lowest wages are present for sheltered employment. Almost all individuals (93%) engaged in individual employment are earning at least minimum wage compared to only about 2 out of every 100 people working in sheltered employment.*

Distribution of Employment Supports

Information pertaining to the number of individuals served by DMR in each of the three types of employment supports from FY02 to FY05 is presented as a baseline measure for evaluating progress in meeting the employment-related quality improvement target established by DMR and as recommended by the Statewide Quality Council. This distribution of employment supports is illustrated below in Table 53 and Figure 47. As can be seen, during FY05 a little more than half of all the individuals receiving DMR employment support spent some of their time in facility employment programs. The remaining 50% was split almost evenly between individual and group employment.

Table 53
No. People Working by Employment Setting
Employment Supports Contracts
2002-2005

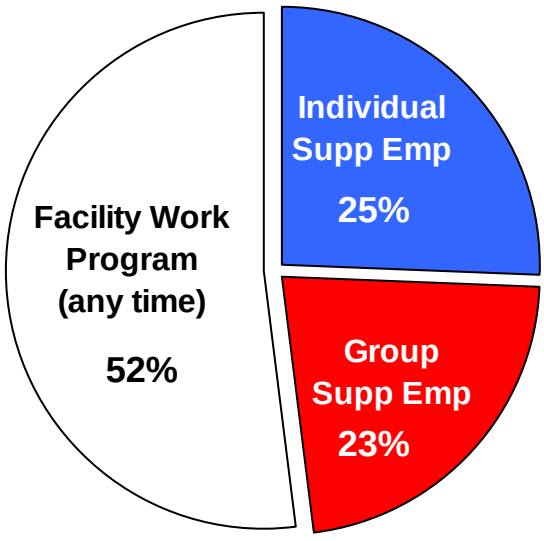
No. People by Employment Setting	2002	2003	2004	2005	Difference 2004-2005	Percent Change 2004-2005	Type of Change FY04-FY05
Total No. Individuals*	5759	5532	5514	5442	-72	-1%	⇔
Individual Supp Emp	1,686	1,527	1,654	1,591	(63)	-4%	⇔
Group Supp Emp	1,722	1,484	1,459	1,415	(44)	-3%	⇔
Facility Work Prog Only**	1963	2015	1971	2260	289	15%	↑ -
Facility Work Prog Any Time***	3,080	3,120	3,047	3,252	205	7%	⇔

* This number represents the total number of individuals receiving employment services for whom complete and accurate data was submitted.

** Facility work program only represents those individuals whose time is spent exclusively in facility based programs

*** Facility Work Prog Any Time includes individuals who spend any amount of time in a facility program and represents a duplicative count since some people may work part time in group or individual supported employment programs

Figure 47
Percentage of Persons Served by Type of Employment Support
2005

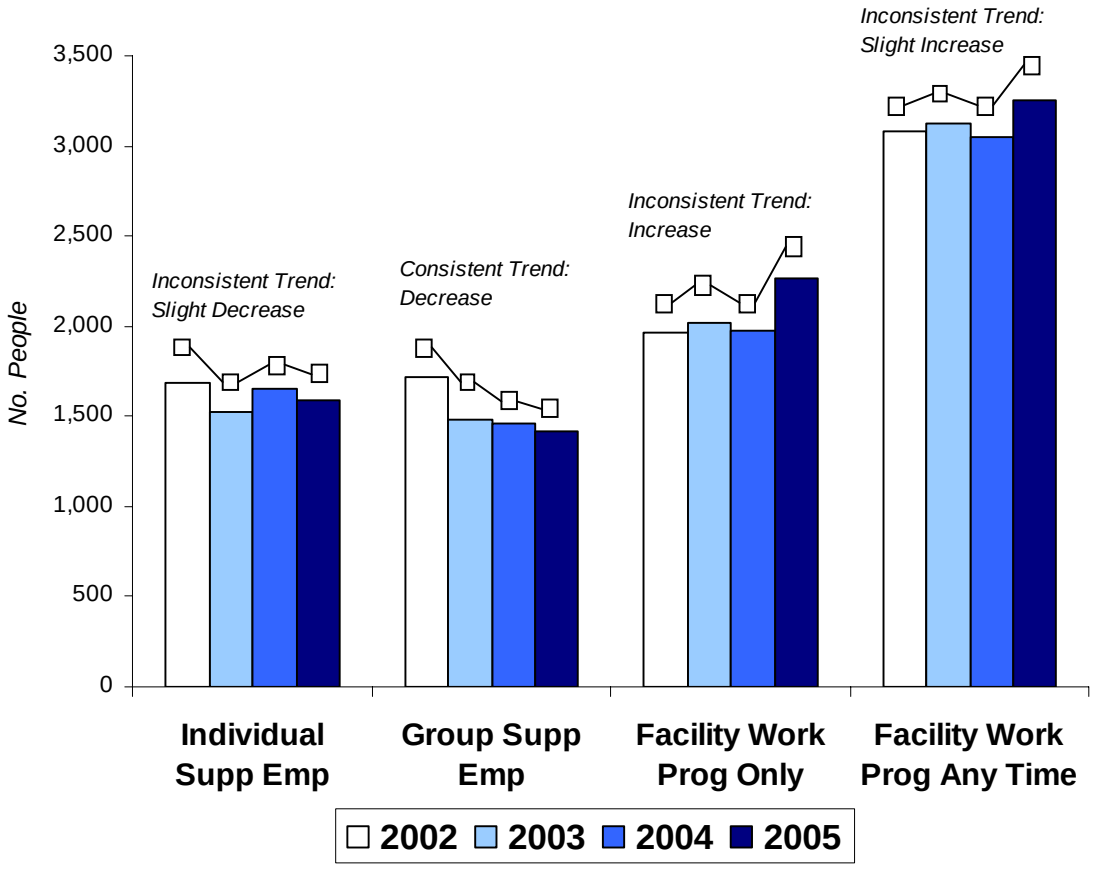


Facility Work Program = all individuals who spend any amount of time in a facility program. May include persons who also are involved in individual and/or group employment part time.

Over time, there has been a slight decrease in the number of people with either individual or group employment support. Interestingly, an actual increase has taken place within

facility work programs from FY04 to FY05. It is important to note however, that **the data pertaining to Facility Work Programs includes individuals who may spend only a small amount of time in sheltered (facility) work settings** as they are transitioning to and/or are spending the majority of their work time in either individual or group employment.

Figure 48
Four Year Trend in the Number of People Working by Type of Employment Setting
2002-2005



WHAT DOES THIS MEAN? *Half of the people receiving work/day supports participate in facility-based employment at least some of the time. Over time this number has increased. Between FY02 and FY05 the number of individuals receiving group employment support has shown a relatively consistent decrease.*

Comparison to National Data

The 2005 Quality Assurance Report utilizes benchmark comparison data from the Institute on Community Inclusion's (ICI) 2004-2005 National Survey of Community Rehabilitation Providers (CRPs). This survey is a sample of providers nationally who

reported information on the last five people they assisted to enter integrated jobs in the community. These providers work with a broad range of individuals with disabilities, not solely with individuals served by MR/DD agencies. This benchmark data is the same as that contained in the Annual QA report for 2004 since it represents the most current data that is available for comparative purposes. As in the 2004 report, comparison data for sheltered (facility) employment is not presented since on a national level sheltered employment is no longer considered a desirable employment outcome for individuals with disabilities.[11] The comparative data collected by the Institute for Community Inclusion and that is available for sheltered employment represents a different consumer population than those persons in Massachusetts' sheltered work programs (*i.e.*, the CRP data is based on persons who have moved from sheltered to integrated employment and is therefore not representative of the population now in Massachusetts sheltered employment programs). Consequently, there is little if any comparable national data that can be used as a valid benchmark for sheltered employment.

Hourly Wages. Table 54 compares the average hourly wages earned by DMR consumers in Massachusetts during FY05 with the national average (ICI data from 2004/05). As can be seen, the average in Massachusetts was higher than the national average for individual employment but lower for group employment.[12]

Table 54
Comparison of Average Hourly Wages for
Massachusetts DMR and a National Benchmark (ICI)

Ave Hourly Wages	MA DMR 2005	National: ICI 04/05
Individual	$ 7.39	$ 6.86
Group	$ 4.07	$ 4.35
Facility	$ 1.67	

ICI: Institute on Community Inclusion's 2004-2005 National Survey of Community Rehavilitation Providers

Hours Worked. Table 55 provides comparative data on the average number of hours worked each month for consumers served by DMR with ICI national data. As can be seen, consumers in Massachusetts work substantially less than their counterparts across the nation. In fact, persons in individual employment jobs in Massachusetts work 43% less than their counterparts in other parts of the country. Those in group employment

[11] The Rehabilitation Services Administration (RSA), which collects survey benchmark data pertaining to employment, no longer considers sheltered work to be an employment outcome.

[12] It should be noted that the minimum wage in Massachusetts is higher than the national average. This difference may account for the higher average wage for individual employment in Massachusetts. http://www.dol.gov/dol/topic/wages/minimumwage.htm, January 6, 2006.

work less than half the amount of time. This disparity in the amount of time individuals are employed directly influences their total earnings, potentially negating any benefit from the higher hourly wages for those in individual employment in Massachusetts. An estimate of this difference (hourly wage X monthly hours worked) is presented in Table 56.

Table 55
Comparison of Average Monthly Hours Worked for Massachusetts DMR with a National Benchmark (ICI)

Ave Monthly Hours Worked	MA DMR 2005	National: ICI 04/05
Individual	54.0	97.0
Group	40.0	91.5
Facility	50.0	

ICI: Institute on Community Inclusion's 2004-2005 National Survey of Community Rehavilitation Providers

Monthly Earnings. A very general estimate of monthly earnings is provided by multiplying the average hourly wage by the average monthly hours worked. As can be seen in Table 56 and Figure 49, individuals receiving both individual employment and group employment support in Massachusetts have substantially lower monthly earnings than the average of their counterparts across the country.[13] Of perhaps equal importance, and as can be seen in Table 56, is the rather large difference in gross monthly earnings for persons in facility-based (sheltered) employment in Massachusetts compared to their peers receiving either individual or group employment supports (i.e., on average they earn half of what persons in group employment earn and less than one fourth of the amount earned by persons in individual employment).

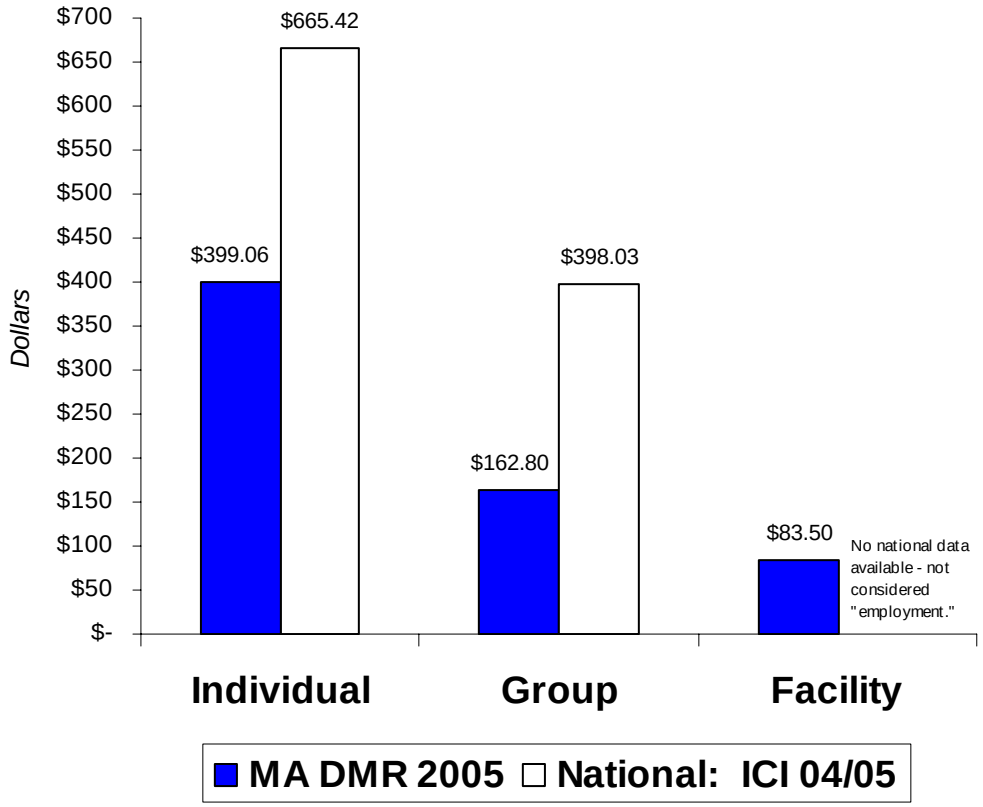
Table 56
Comparison of Estimated Average Gross Monthly Earnings Massachusetts DMR v National Benchmark (ICI)

Estimated Ave Mo. Gross Earnings	MA DMR 2005	National: ICI 04/05	Difference
Individual	$ 399.06	$ 665.42	$ 266.36
Group	$ 162.80	$ 398.03	$ 235.23
Facility	$ 83.50		

Estimated monthly earnings = average hrs/mo X average hourly wage

[13] It is important to note that the data presented in this section of the report is based upon averages, therefore there is most likely a wide variation in both wages and hours worked within both the Massachusetts and the national benchmark groups. Some individuals earn substantially more than the average, and some earn less.

Figure 49
Comparison of Estimated Gross Monthly Earnings for
Massachusetts DMR and a National Benchmark (ICI)



WHAT DOES THIS MEAN? *Massachusetts DMR consumers who are reported as working in individual employment in DMR employment supports contracts earn more per hour than the national average. However, they work fewer hours on a monthly basis. Those working in group employment earn less per hour and work less than half the hours per month when compared to the national average. The difference in hours worked results in a substantial difference in average estimated monthly earnings for persons served by DMR compared to their counterparts in other parts of the country. Individuals in facility-based employment in Massachusetts earn much less than their peers in individual or group employment.*

QUALIFIED PROVIDERS

OUTCOME: People receive services from qualified providers.

Indicators:
1. Providers maintain their license/certification to operate.
2. Quality of life citations.

RESULTS:

Trends in the certification and licensure status of DMR providers and the number and types of citations resulting from the survey process are summarized below in Figure 50. During 2005 the percentage of providers that attained a 2-year certification with distinction increased slightly from 2004 levels. No change was noted for the percentage of providers with a 2-year certification. A slight decrease was observed for the relative percentage that attained either a 1-year or 1-year with conditions status.

In addition, the percentage of providers with citations increased from 2004. However, the average number of citations per provider (those with citations) decreased, continuing the positive trend noted in the last report.

It is important to note that the licensing and certification process underwent significant change during FY04-FY05 that compromises the ability to draw direct comparisons year to year for some of the measures.

Figure 50
Summary of Trends for Qualified Providers Indicators and Measures
2004 - 2005

OUTCOME	Indicator	Measure	Change FY03-FY04	Change FY04-FY05*
Qualified Providers - *People receive services from qualified providers.*	1. Maintain licensure/certification	Percent - 2 yr with distinction	↑ +	⇧
		Percent - 2 year	↓	⇔
		Percent - 1 year	⇔	↓
		Percent - 1 yr with conditions	⇔	↓
	2. Quality of life citations	Percent Providers with Citations	⇔	↑ -
		Total No. Citations	FY 04 data only for 3 quarters - direct comparison not appropriate	
		Average No. Citations per Provider	↓ +	↓ +
		Percent Citations by Type	Licensing & Cert System CHANGED	

** Changes to the system for licensing/certification do not allow a direct comparison with prior year findings for certain measures. See narrative for an explanation*

Direction of Arrow = increase, decrease, stable

Green = positive trend (+)

Red = negative trend (-)

White = slight change/neutral trend

OUTCOME: People receive services from qualified providers.

Indicator 1: Providers maintain their certification/licensure to operate

Measures: Percent of Providers by Level of Certification

Data Source: Survey and Certification database

FINDINGS:

It is important to note that in April of 2004 the licensure and certification system was revised. Up until that time providers were both licensed and certified through the use of one combined process that was based upon how their services impacted the quality of life of individuals in six important domains. Beginning in April, 2004, the process of licensure was separated from the process of certification. From that point forward, **licensure** was based upon the provider's ability to assure essential safeguards in the areas of health, safety, and rights. These licensing standards are considered essential and "non-negotiable." The **certification** level obtained by a provider became focused on a determination of how outcomes in people's lives, in additional to health and safety, were achieved. These outcomes include relationships, community connections, individual control and growth and accomplishments. Hence, commencing in April 2004, a review of provider agencies resulted in both a **level of licensure** and a **certification status**.

New System for DMR Licensure and Certification Effective April 2004	
LICENSURE	*Assurance of Safeguards in the areas of:* • Health • Safety • Rights • Organizational Safeguards
CERTIFICATION	*Achievement of Outcomes in the areas of:* • Relationships • Community Connections • Individual Control • Growth and Accomplishments • Organizational outcomes relating to staff development and strategic planning

Since the licensure and certification process occurs on a "rolling basis", the data included in this report (2005) reflects a combination of providers that were licensed and certified under the new process (100 providers) and those providers that had a level of certification based upon the old system (83 providers) as of June 30, 2005 (end of FY05).

For purposes of comparison of like processes, the tables below separate the two provider groupings. Table 57 compares the 83 providers reviewed under the previous ("old") system to data from prior years. Table 58 presents data on the 100 providers reviewed under the current ("new") process. Since this newer process has only been in place since April 2004, data for only one year is presented. Future reports will allow for analysis of trends (year to year comparisons).

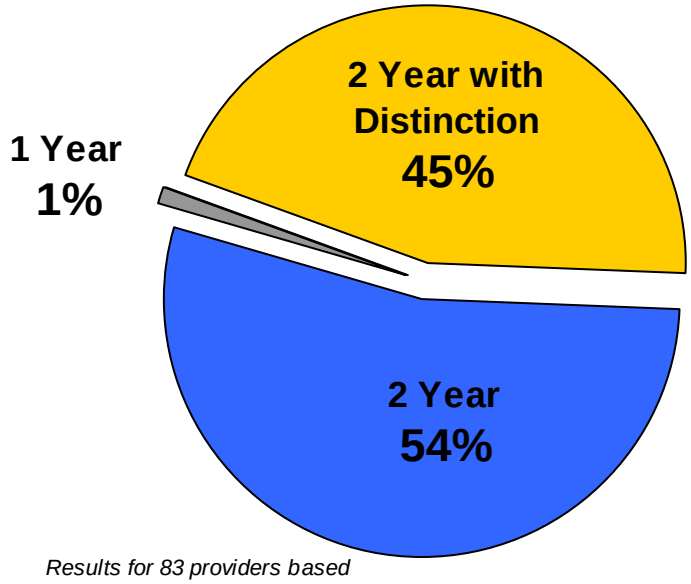
As can be seen in Table 57 and Figure 51 below, during FY05 approximately 45% of all providers evaluated using the older licensing/certification process had a 2-year certification with distinction. This was a slight increase over levels in FY04 and a rather substantial increase from levels attained in FY02 and FY03. No providers were given a 1-year certification with conditions, and there was a slight decrease in the overall number of providers who were only able to attain a 1- year level of certification in 2005. All of these findings are positive.

Table 57
Trends in Level of Provider Certification Based on the Old System
FY02-FY05

Level of Certification: Old System	*Year*				Change FY04-FY05
	2002	2003	2004	2005	
2-Year with Distinction	27%	30%	39%	45%	⇧
2-Year	50%	57%	51%	54%	⇔
1 Year	15%	7%	6%	1%	⇩
1 Year with Conditions	8%	6%	4%	0%	⇩

83 providers had certification status in FY05 using the "older" licensing and certification system. This table only compares results using the old system.

Figure 51
Percentage of Providers by Level of Certification: Old System
for 2005



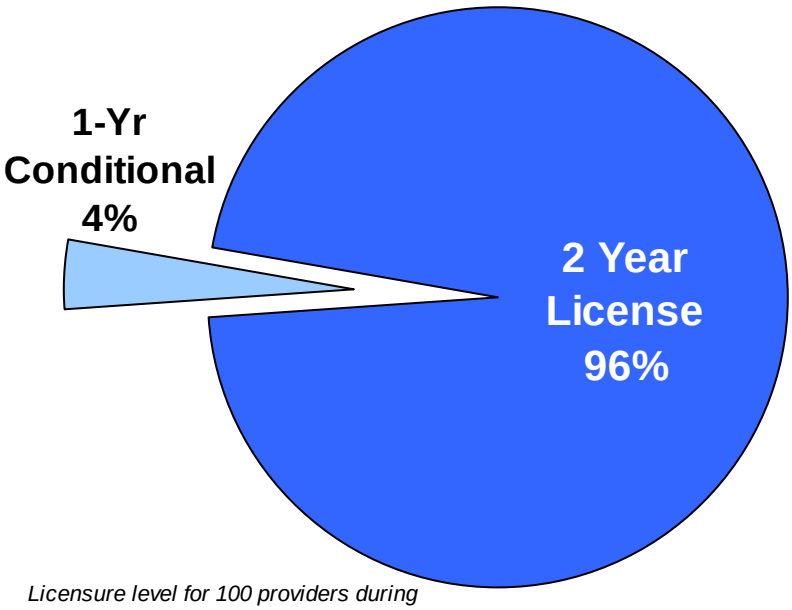
Results for 83 providers based on the "older" licensing/certification system during FY05.

Licensure. As noted above, the new system of licensure/certification bases licensure on the ability of a provider to meet requirements associated with basic safeguards in health, safety and rights. Table 58 and Figure 52 summarize the results of licensure for 100 providers evaluated in 2005 using this new system. Of these providers, almost all (96%) attained a 2-year license. Four were assigned a conditional 1-year license, and none were prevented from attaining a license to operate services.

Table 58
No. and Percentage of Providers by Level of Licensure
Based on the New System
2005

Level of Licensure: New System	No.	Percent
2-Yr License	96	96%
Conditional 1-Yr License	4	4%
Non-Licensure	0	0%

Figure 52
Percentage of Providers by Level of Licensure: New System
2005



Licensure level for 100 providers during FY05 based on the "New" system (effective April 2004.)

Certification. In addition to a level of licensure, the new system also assigns a level of certification that is associated with the extent to which providers are able to meet both the licensure quality of life areas as well as quality of life areas related to individual choice/control, relationships and community connections, and growth and accomplishments. There is a combined total of six quality of life areas. Table 59 presents the results of certification using the new system. As can be seen, 75% of the providers that were reviewed received an "achieved" status in all six quality of life areas, with 35% achieving a level of certification with distinction. Thirteen percent (13%) achieved five of the quality of life areas. Only 4% met fewer than five.

Table 59
Level of Certification based on the New System
2005

Certification Status: New System	Percent in FY05
Certification with Distinction	35%
Certification: 6/6 Q of L	40%
Certification: 5/6 Q of L	13%
Certification: 4/6 Q of L	3%
Certification: 3/6 Q of L	1%
Certification: 2/6 Q of L	0%
Certification: 1/6 Q of L	0%
3 yr CARF	8%

WHAT DOES THIS MEAN? *A very large percentage of the community services system is achieving high levels of licensure. In FY05, 96% of providers attained a full 2-year license. Only 4% were assigned a 1-year license with conditions. About 75% achieved all six quality of life areas for certification. This suggests that the provider system is meeting basic standards of health, safety and rights with few exceptions and about 3 out of every 4 providers are meeting all six quality of life areas.*

Indicator 2: Quality of Life citations

Measures: Percent of Providers with citations

Average No. of citations per Provider

Type of citations

Data Source: Survey and Certification database

FINDINGS: Table 60 and Figures 53 and 54 below illustrate findings regarding the number of citations and the percentage of providers with citations for the four year time period between 2002 and 2005.

There were a total of 89 citations during FY05. However, due to the change-over in the certification process during FY04 when data from only three quarters was presented in the 2004 report, a direct comparison of the total number of citations in FY05 with FY04 findings is not appropriate. As can be seen, during FY05 the percentage of providers that received a citation increased from FY04. This percentage was higher than any other year over the four year time period between 2002 and 2005.

Table 60
Summary of Citations
2002-2005

Citations	2002	2003	2004	2005	Type of Change 2004-2005
No. Citations	111	83	63	89	FY04 data only for 3 quarters
Ave No. Citations per Provider	2.6	3.3	2.3	1.8	+
Percent Providers with Citations	22%	13%	14%	27%	-

Figure 53
Percent of Providers with Citations
2002 - 2005

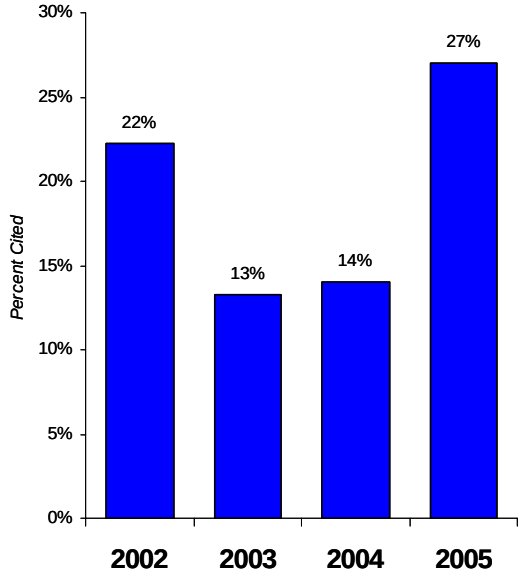


Figure 54
Total No. of Citations
2002 - 2005

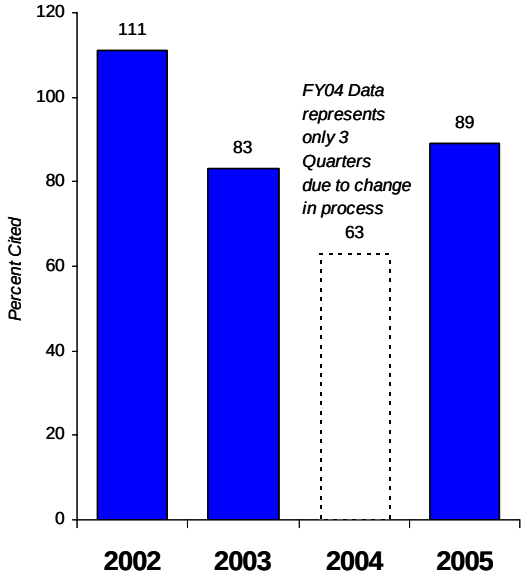


Figure 55 illustrates the average number of citations per provider (of those with one or more citations). During FY05 there were, on average, 1.8 citations per provider, the lowest level over the four year time period from 2002 to 2005. The reduction in FY05 in the average would appear to be primarily due to the increase in the number of providers that did receive a citation. Nonetheless, this reduction does appear to represent a continuing trend of fewer citations for those providers that receive any type of citation.

Figure 55
Average No. Citations per Provider with Citations
2002 - 2005

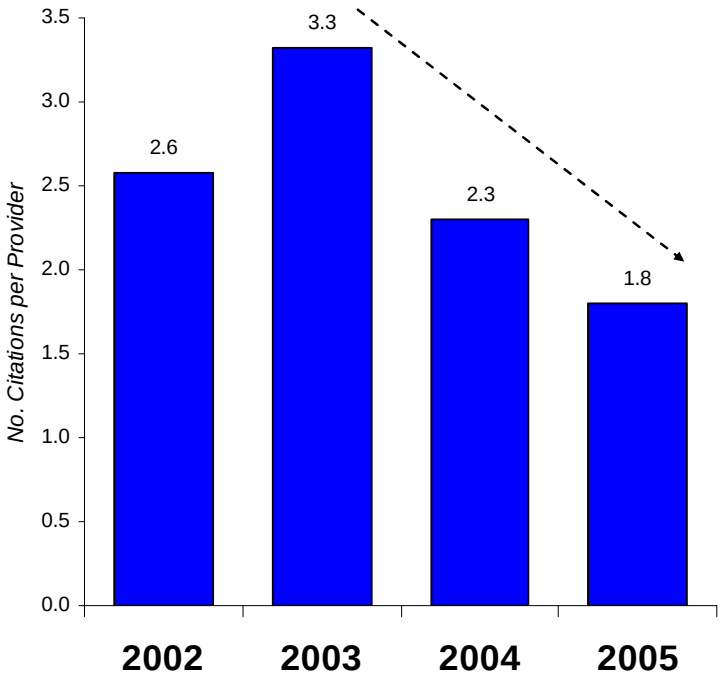


Table 61 provides an overview of the percentage of citations by type. Changes to the review process may have contributed to some "shifts" between citation categories during FY05, resulting in the increase in citations associated with organizational outcomes and personal well-being. Such changes may also be partially responsible for the noted decrease in citations in the areas of rights and dignity and community/social connections. Therefore, caution should be exercised in reviewing the information contained in Table 61, as it may be more reflective of process changes rather than actual or real changes to outcomes.

Table 61
Percentage of Citations by Type
2002 - 2005

Citations by Type	2002	2003	2004	2005	Type of Change 2004-2005
Rights/Dignity	28%	29%	30%	25%	⇩
Comm/Soc Conn	21%	20%	22%	9%	⇩ +
Pers Wellbeing	22%	19%	20%	31%	⇧ -
Organiz Outcomes	15%	20%	18%	33%	⇧ -
Indiv Control	9%	7%	6%	1%	⇩
Growth & Accomp	5%	4%	4%	1%	⇔

Percentages are rounded and may not equal 100

WHAT DOES THIS MEAN? *A higher percentage of providers received citations during FY05 compared to prior years. The average number of citations per provider (cited) decreased, continuing a 3-year trend in such reductions. However, caution should be exercised in reviewing this data as well as the data on type of citation due to the changes in the licensing and certification process that were initiated in the last quarter of FY04. More meaningful analysis of trends regarding citations will be available in the FY06 report (when all providers will be reviewed using the same set of standards and the same licensing/certification process).*

APPENDICES

A Summary of the Outcomes and Indicators

B Summary of Data Sources

C Summary of Findings: Statewide Quality Outcomes

APPENDIX A

SUMMARY OF THE OUTCOMES AND INDICATORS

The chart that follows summarizes the key outcomes and indicators that appear in this report. The data for this report draws its information from a variety of quality assurance processes in which the Department is routinely engaged. While the quality assurance processes allow for continuous review, intervention and follow-up on issues of concern, aggregation of data in this report allows for the analysis of patterns and trends in overall performance.

People are supported to have the best possible health	1. Individuals are supported to have a healthy lifestyle	1. Survey & Certification Outcome 5.3A
	2. Individuals get annual physicals	2. Survey & Certification Outcome 5.3C - National Core Indicators Project
	3. Individuals get dental exams	3. Survey & Certification Outcome 5.3C - National Core Indicators Project
	4. Individual's medications are safely administered	4. Survey & Certification Outcome 5.3E - Medication Occurrence database
	5. Serious health and medication issues are identified and addressed	5. Survey & Certification/Action Required - Investigations data - Risk Management data
People are protected from harm	1. Individuals are protected when there are allegations of abuse, neglect or mistreatment	1. Survey & Certification Outcome 5.2C,D - Investigations database
	2. CORI checks are completed for staff and volunteers working directly with individuals	2. CORI audit database
	3. Safeguards are in place For individuals who are at risk	3. Survey & Certification Outcome 5.2A - Critical incident data - Risk Management data

People live and work in safe environments	1. Homes and work places are safe, secure and in good repair 2. People can safely evacuate in an emergency 3. People and supporters Know what to do in an emergency	1. Survey & Certification/Action Required Outcome 5.1A 2. Survey & Certification/Action Required Outcome 5.1C 3. Survey & Certification Outcome 5.1B
People understand and practice their human and civil rights	1. People exercise their Rights in their everyday lives 2. People receive the same Treatment as other employees 3. People experience respectful interactions	1. Survey & Certification Outcome 1.2B - National Core Indicators Project 2. Survey & Certification Outcome 1.2C 3. Survey & Certification Outcome 1.1A
People's rights are protected	1. % of instances where less intrusive interventions are used before implementing a restrictive intervention 2. People or guardians give consent to restrictive interventions 3. People and supporters know how and where to file a complaint 4. % of restraints and type of restraint	1. Survey & Certification Outcome 1.3A 2. Survey & Certification Outcome 1.3C 3. Survey & Certification Outcome 5.2E 4. Restraint database
People are supported to make their own decisions	1. People make choices about their everyday routine and schedules 2. People control important decisions about their home and home life 3. People choose where they work 4. People influence who providers their supports	1. Survey & Certification Outcome 2.2A - National Core Indicators Project 2. Survey & Certification Outcome 2.3C - National Core Indicators Project 3. Survey & Certification Outcome 2.3D - National Core Indicators Project 4. Survey & Certification Outcome 3.1B

		- National Core Indicators Project
People use integrated community resources and participate in everyday community activities	1. People use the same community resources as others on a frequent and on-going basis	1. Survey & Certification Outcome 3.1B - National Core Indicators Project
People are connected to and valued members of their community	1. People are involved in activities that connect them to other people in the community	1. Survey & Certification Outcome 3.2B - National Core Indicators Project
People gain/maintain friendships and relationships	1. People are supported to maintain relationships 2. People are supported to develop new friendships 3. Individuals have education and support to understand and safely express their sexuality	1. Survey & Certification Outcome 3.3A National Core Indicators 2. Survey & Certification Outcome 3.3B 3. Survey & Certification Outcome 3.3C
People are supported to develop and achieve goals	1. People are supported to develop an individualized plan that identifies needs and desires 2. People have support to Accomplish goals	1. Survey & Certification Outcome 2.3A 2. Survey & Certification Outcome 4.1C
Individuals are supported to obtain work	1. Average hourly wage of people who receive work supports 2. Average number of hours worked per/month	1. Employment supports performance outcome data 2. Employment supports performance outcome data
People receive services from qualified providers	1. Providers maintain their license/certification to operate 2. Quality of Life citations	1. Survey & Certification database 2. Survey & Certification database

Appendix B

SUMMARY OF DATA SOURCES

The Quality Assurance Annual Report derives its information from a variety of different data sources. One of the strengths of the quality assurance system lies in the fact that no one process or data set is used to arrive at conclusions. Rather, most outcomes reported on draw from a diverse array of departmental information systems and evaluation processes. Following is a brief description of the databases and the parameters of the information collected.

Survey and Certification

The Survey and Certification system is the process by which DMR licenses and certifies all public and private providers of community residential, work/day, placement and site based respite services. The tool used to license/certify providers, known as the Quality Enhancement Survey Tool (QUEST) evaluates the impact of a provider's services on the quality of life of individuals in five key domains and one organizational domain. A random sample of individuals is selected in proportion to the number of individuals served by the provider in discrete service models.

The data presented in this report reflects the number of individual surveys conducted during each of the fiscal years 2002 - 2005. It includes individuals over the age of 18 served in the above-mentioned models. It does not include individuals living in State Developmental Centers or those getting family and individual support services.

National Core Indicators

The National Core Indicators project is a joint project of the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). States participate in collecting data on performance/outcome indicators that provide national benchmarks for quality. Massachusetts is a participating state. In 2005 DMR commissioned a special NCI study that resulted in a Massachusetts-specific report (External Evaluation Report, September 2006). NCI data referenced throughout the 2005 Quality Assurance Report includes information from both the national (Phase VI) report issued by HSRI and the National Association of State Directors of Developmental Disabilities Services (NASDDDS) in May of 2006 and the above referenced Massachusetts-specific report, available by contacting the DMR.

Medication Occurrence Reporting System

Providers are subject to the requirements of the Medication Administration Program (MAP) when non-licensed (non-RN) staff are trained and certified to

administer medications in community residential and day programs. The Medication Occurrence Reporting (MOR) system is the process whereby all public and private providers that come under the requirements of the MAP program report medication occurrences. A medication occurrence is defined as any time a medication is given at the wrong time, the wrong dose, the wrong route, or to the wrong person. A medication occurrence is defined as a "hotline" any time it results in a medical intervention of any kind.

The data presented in this report reflects the number of medication occurrence reports filed by providers in each of the fiscal years 2002 - 2004. This reflects information reported on 168 providers and 2,291 registered sites.

Investigations

Mandated reporters are required to notify the Disabled Persons Protection Commission (DPPC) whenever an individual with mental retardation is alleged to be the victim of abuse, neglect, mistreatment or omission. Complaints may be dismissed, resolved without investigation, referred for resolution or investigated.

The data presented in this report reflects the number of complaints filed and substantiated in each of fiscal years 2002 - 2005, for all individuals over the age of 18 regardless of where they reside.

Critical Incident Reporting System

The Critical Incident Reporting system is the mechanism for reporting incidents which rise to a certain threshold. The system is used to provide immediate communication to senior management of all major incidents involving individuals at serious risk and to bring prompt support to staff in responding to these incidents. The types of incidents reported include accidents, assaults, inappropriate behavior, fires, medical issues, those with police involvement or indication that a felony may have been committed, serious physical injury, likely media interest, and situations in which a protective order is being sought.

The data presented in this report reflects the number of critical incident reports filed in each of the fiscal years 2002 - 2005.

Restraint Reporting System

Providers and facilities are required to report any time an emergency restraint is utilized to prevent and individual from harming themselves or others. Data is reported on the number of individuals restrained, the number of restraints utilized, the number of times individuals are restrained, and the duration of the restraint.

Employment Supports Performance Outcome Information

Providers submit information for a designated four-week time period in April of each year. Information is collected on individual, group and facility employment for both hours worked and wages earned.

APPENDIX C

SUMMARY OF FINDINGS
STATEWIDE QUALITY OUTCOMES

Note: The column to the far right on the next two pages illustrates the type of change in each measure that occurred between 2004 and 2005. The second column from the right illustrates change that took place between 2003 and 2004 and is included to provide a context for better understanding current changes and possible trends.

OUTCOME	Indicator	Measure	Change FY03-FY04	Change FY04-FY05
Health - *people are supported to have the best possible health.*	1. Healthy Lifestyle	Receive Support	⇔	⇔
	2. Physical Exams	Receive Annual Exams	⇔	⇔
	3. Dental Exams	Receive Annual Exams	⇔	⇔
	4. Safe Medication	MOR No. and Rate	↓+	⇔
		Percent/No. Hotlines	↓+	↓+
	5. Issues Identified and Addressed	Action Required Reports	↓+	↓+
		Medication Investigations	↓+	↑-
		Denial of Tx Investigations	↓+	⇔
Protection - *people are protected from harm.*	1. Investigations	No. & Percent Substantiated	↓+	⇔
		Trends: Most Common Types	NA	NA
	2. CORI checks	No. Without Violations	⇧	↑+
		Violations per Provider	↓+	⇔
		Percent Lack of Records	↓+	⇔
	3. Safeguards for Persons at Risk	Corrective Action	⇔	⇔
		Preventive Action	⇔	⇔
		CIR Rates	↑-	⇧
		CIR by Type	NA	NA
Safe Environments - *People live and work in safe environments.*	1. Safe homes and work places	Percent Safe Environment	⇔	⇔
		Action Required Reports	↓+	↑-
	2. Evacuate Safely	Percent - Safely Evacuate	⇔	⇔
		Action Required Reports	↓+	↓+
	3. Know what to do - Emergency	Percent - Know what to do	⇔	⇔
Practice Rights - *People understand and practice their human and civil rights.*	1. People exercise their rights	Percent Exercise Rights	⇔	⇔
		Percent Treated Same	⇔	⇔
		Percent Treated with Respect	⇔	⇔
Rights Protected - *People's rights are protected*	1. Less Intrusive Interventions	Percent - Less Intrusive Used	⇔	⇔
	2. Consent - Restrictive Interventions	Percent - with Consent	⇧	⇔
	3. File Complaints	Percent - Able to File Complaint	⇔	⇔
	4. Restraint Utilization	Facility: Percent Restrained	↓+	↑-
		Community: Percent Restrained	⇔	⇔
		Facility: Ave No. Restraints	⇧	↓+
		Community: Ave No. Restraints	⇧	⇔

OUTCOME	Indicator	Measure	Change FY03-FY04	Change FY04-FY05
Choice & Decision making - *People are supported to make their own decisions.*	1. Choices re: everyday routines	Percent - Choose schedule	⇔	⇔
		Comparison with NCI		
	2. Decisions re: home & home life	Percent - Control decisions	⇔	⇔
		Comparison with NCI		
	3. Choose where work	Percent - Choose where work	⇔	⇔
		Comparison with NCI		
	4. Influence who provides support	Percent - Influence who supports	⇔	⇔
		Comparison with NCI		
Community Integration - *People use integrated community resources and participate in everyday community activities.*	1. Use the same community resources as others	Percent Use Community Resources	⇔	⇔
		Comparison to NCI		
People are connected to and valued members of their community.	2. Involved in acitivities that connect to other people	Percent Involved in Community Activitie	⇔	⇔
		Comparison to NCI		
Relationships & Family Connections - *People maintain and gain relationships with family and friends.*	1. Support to maintain relationships	Percent Maintain Relationships	⇔	⇔
	2. Support to gain new relationships	Percent - New Relationships	↑	⇔
	3. Receive education about intimacy	Percent - Educated re: Intimacy	↑	⇔
Achievement of Goals - *People are supported to develop and achieve goals.*	1. Develop Personal Goals	Percent Develop Goals	⇔	⇔
	2. Support to Accomplish Goals	Percent - Access to Resources	⇔	⇔
Work - *People are supported to obtain work.*	1. Average Hourly Wage	Individual Job - Average Wage	↑	⇔
		Group Job - Average Wage	⇔	↑
		Facility Job - Average Wage	↓	↑ +
	2. Monlthy Hours Worked	Individual Job - Mo. Hrs. Worked	⇔	⇔
		Group Job - Mo. Hrs. Worked	↑ +	⇔
		Facility Job - Mo. Hrs. Worked	⇔	⇔
Qualified Providers - *People receive services from qualified providers.*	1. Maintain licensure/certification	Percent - 2 yr with distinction	↑ +	↑
		Percent - 2 year	↓	⇔
		Percent - 1 year	⇔	↓
		Percent - 1 yr with conditions	⇔	↓
	2. Quality of life citations	Percent Providers with Citations	⇔	↑ -
		Total No. Citations		
		Average No. Citations per Provider	↓ +	↓ +
		Percent Citations by Type		