Massachusetts DDS
Q A B
Quality Assurance Brief

Information about the
Quality of DDS Services
FY 2008
Vol I No. I

ISSUED MAY 2009

A NEW FORMAT for the DDS Annual QA Report!

Welcome to the first DDS **Quality Assurance Brief**.
In an effort to enhance the usefulness and readability of the DDS Quality Assurance Report a new format has been developed. The new report will be broken up into **topic-based briefs** that will be issued throughout the year. Beginning in July of 2009 the Briefs will be published on the web in a special DDS site entitled "***Exploring Quality***." By changing the format of the QA Report we hope to make it easier for readers to target the information of most interest to them. Over the course of the year seven (7) Briefs will be published, each focusing on a specific area of quality,

Topic 1: Health
Topic 2: Protection and Safety
Topic 3: Rights
Topic 4: Community Membership and Relationships
Topic 5: Choice and Achievement of Goals
Topic 6: Work
Topic 7: Qualified Providers

The use of a web-based approach will facilitate the reader's ability to "move around" within each Brief through the use of links. It will also provide an easy mechanism for keeping information up-to-date and providing links to additional information and resources that some readers may find of interest.

This first Brief focuses on **HEALTH.** Because the web site is still under construction, this preliminary Brief is being issued in hard copy. Once the DDS Quality internet site is established, it will be published on the web.

QA Briefs are Developed in Partnership with the
University of Massachusetts Medical School ~ Commonwealth Medicine
Center **for** **D**evelopmental **Di**sabilities **E**valuation & **R**esearch (CDDER)

A FEW REMINDERS
ON HOW TO LOOK AT THE DATA:

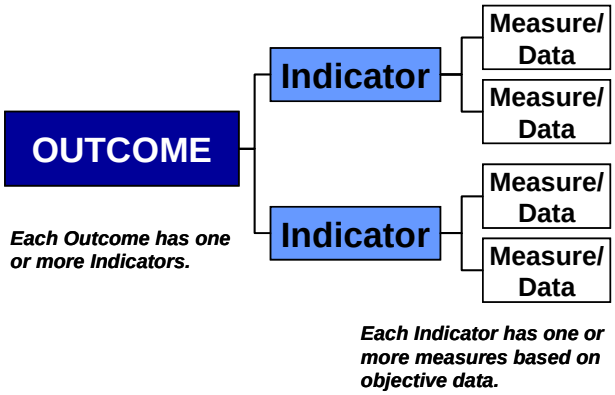
The data that forms the basis for the QA Briefs is drawn from a wide variety of quality assurance processes in which DDS is routinely engaged. These quality assurance processes allow for continuous review, intervention and follow-up on issues of concern in a timely manner. The information from these processes is integrated to provide a more complete or "holistic" picture of the quality of supports within the DDS system and to help identify areas that may become the focus for quality improvement initiatives and activities. In years past, and with the guidance of stakeholders, DDS established a set of **OUTCOMES** that represent system expectations and that form the basis for evaluating service quality.

The DDS QUALITY OUTCOMES:

- **Health:** People are supported to have the best possible health.
- **Protection from Harm:** People are protected from harm.
- **Safe Environments:** People live and work in safe environments.
- **Practice Rights:** People understand and practice their human and civil rights.
- **Rights Protected:** People's rights are protected.
- **Choice and Decision Making:** People are supported to make their own decisions.
- **Community Integration:** People use integrated community resources and participate in everyday community activities, and, people are connected to and are valued members of their community.
- **Relationships/Family Connections:** People gain/maintain friendships and relationships.
- **Achievement of Goals:** People are supported to develop and achieve goals.
- **Work:** People are supported to obtain work.
- **Qualified Providers:** People receive services from qualified providers.

A Few Reminders *(continued)*

To help evaluate each of the **OUTCOMES**, DDS has established a series of related **INDICATORS** as a way to know if the outcome is being achieved. Each indicator has a set of **MEASURES**, or specific **DATA** that is used to evaluate progress and trends over time. The relationship between outcomes, indicators and measures is illustrated below:



Much of the data that is included in the Briefs has been tracked over the past four to five years and therefore allows a direct comparison of the current report year with prior years. To help understand these trends, summary data tables for each major indicator include **COLORED ARROWS**. Arrows pointing up indicate an increase. 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 (i.e., desired or "good") or negative (i.e., not desired or "bad").

For purposes of standardization, positive and negative trends are only identified when the year to year change is at least 10%.

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

HEALTH & WELLNESS

OUTCOME 1

People are supported to have the best possible health.

Maintaining good health and physical and mental wellness is one of the most basic outcomes for evaluating the quality of services and supports provided by DDS. Achieving this outcome is dependent upon a number of factors including the following:

- ☐ Helping people to develop a **HEALTHY LIFESTYLE** including good nutrition, physical activity and exercise, maintaining a healthy weight and avoiding the use of tobacco products.
- ☐ Assisting people to access and receive preventive health-related care and services, including recommended **PHYSICAL and DENTAL EXAMS.**
- ☐ Assuring that people receive their **MEDICATION** in an appropriate and safe manner.
- ☐ Identifying and correcting problems with medications and the receipt of timely and **proper MEDICAL CARE.**
- ☐ Establishing accurate **electronic HEALTH CARE RECORDS** to assure up-to-date information regarding health is readily available

Some KEY Findings

- **Over 98% of DDS consumers surveyed through licensure and certification receive annual physical exams, a much higher rate than the average of 21% for adults in the U.S. general population.**
- **Licensure and certification findings for FY 2008 found that 97% of the individuals reviewed had had at least an annual dental exam.**
- **The number and rate of MORs and "hotlines" increased in FY 2008.**
- **There was an increase in the number of Action Required Reports for Health/Med issues in FY 2008 compared to prior years.**

OUTCOME 1
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.
6. Health information is accurate and up-to-date and available in **electronic health care records**.

Summary of Trends for Health Indicators and Measures
FY 2008

OUTCOME	Indicator	Measure	Change FY2007-FY2008
HEALTH - *people are supported to have the best possible health.*	**1. Healthy Lifestyle**	Percent Receive Support	⇔
	2. Physical Exams	Percent Receive Annual Exams	⇔
	3. Dental Exams	Percent Receive Annual Exams	⇔
	4. Safe Medication	MOR No. and Rate	↑ -
		Percent/No. Hotlines	↑ -
	5. Issues Identified and Addressed	No. Health/Med Action Required Reports	↑ -
		No. Substantiated Medication Investigations	**NA**
		No. Substantiated Denial of Treatment Investigations	**NA**
	6. Electronic Health Care Records	Percent Individuals with electronic HCRs	***New Measure***

More detailed information can be reviewed on each of these indicators in the following sections and by selecting the LINKS contained in each section in the web version of this Brief.

INDICATOR 1:
Healthy Lifestyle

Overview

This indicator is focused on how well individuals served by DDS receive support to live and maintain a healthy lifestyle, including support to eat healthy and nutritious foods and engage in physical activity and exercise on a regular basis. Data is from the Survey and Certification database, consequently this measure applies only to those individuals who live/work in programs that licensed/certified.

Did you know…

- Individuals with an intellectual or developmental disability tend to be less physically active than their peers in the general population. For example, NCI data for 3 New England states[1] shows an inactivity rate of 21%. This compares to only 10% for the general population.[2]
- Research suggests that about 35% of individuals who have an intellectual disability are overweight/obese.[3] In the general population about 34% of adults are considered overweight/obese.[4]
- Results from the 2007 NCI for 3 New England states indicates that only 9% of the population served by the DD state systems smoke or use tobacco products.[1] This compares to about 19% of the general population in the U.S.[5]

[1] NCI (2008) National Core Indicators: New England State Results (2006-2007). Special report prepared by HSRI, September 12, 2008.
[2] Barnes, P. (2007) Physical activity among adults: U.S. 2000 and 2005. National Center for Health Statistics (NCHS), January, 2007
[3] Yamaki, K. (2005) Body weight status among adults with intellectual disability in the community. Mental Retardation, 43(1): 1-10.
[4] National Center for Health Statistics (2007) Health: United States 2007 with chartbook on trends in the health of Americans. NCHS: Hyattsville, MD.
[5] CDC (2008) Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System Survey Data.

INDICATOR 1:
Healthy Lifestyle

Percent Receiving Support for Healthy Lifestyle
FY 2004 - FY 2008

Healthy Lifestyles	2004	2005	2006	2007	2008	Change 2007 - 2008	Type of Change
No. People Reviewed	1118	1314	1621	1397	968		
Percent with Support for Healthy Lifestyle	98%	98%	99%	99%	99%	0%	⇔

WHAT DOES THIS MEAN?

Over the past five years almost all individuals reviewed during Survey and Certification reviews have been found to be receiving necessary support to promote a healthier lifestyle. These findings have remained remarkably consistent, with 99% performance on this measure for FY 2006 through FY 2008.

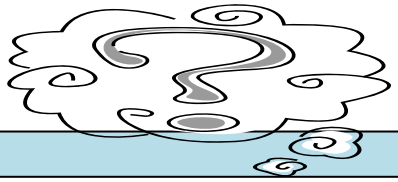
It is important to note that these findings are for individuals who are supported in licensed/certified programs and cannot be generalized to the entire population of persons served by DDS.

INDICATORS 2 and 3:

Physical and Dental Exams

Overview

The extent to which individuals receive an annual physical exam by their health care provider and at least an annual dental exam/visit are two very basic measures of access to and receipt of health care that are evaluated by DDS during the Survey and Certification process. [Results from these reviews can only be generalized to persons in licensed/certified programs.]



Did you know…

- Individuals with an intellectual or developmental disability appear to have better access to and engagement with their health care providers than their peers in the general population. For example, NCI results for 4 New England states shows that approximately 86% of the individuals surveyed had an annual physical exam in 2006/2007.[1] This compares to only 21% for the general population.[2]
- Research however suggests the opposite for dental care. For example, the CDC projects that only about 35% of U.S. adults who have a disability have seen a dentist within the past year[3] whereas about 60% of the adult general population have.[4] The percentage is **much higher within MA DDS** programs that are licensed/certified.

[1] NCI (2008) National Core Indicators: New England State Results (2006-2007). Special report prepared by HSRI, September 12, 2008.
[2] Barnes, P. (2007) Physical activity among adults: U.S. 2000 and 2005. National Center for Health Statistics (NCHS), January, 2007
[3] CDC (2008) Healthy People 2010 Database: Objective 21-10. Centers for Disease Control and Prevention, May 2008 edition
[4] CDC (2007) National Center for Health Statistics: Trends in Oral Health Status in the United States – 1999-2004. Series 11, No. 248. (PHS) 2007-1698, April 30, 2007.

INDICATORS 2 and 3:

Physical and Dental Exams

Percent with Annual Physical and Dental Exams
FY 2004 - FY 2008

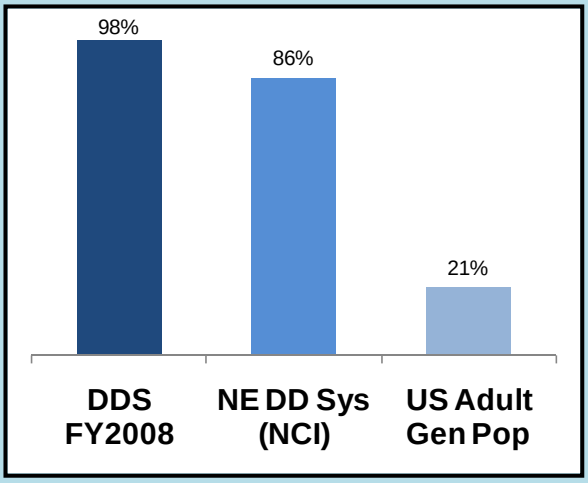
Medical and Dental Exams	2004	2005	2006	2007	2008	Change 2007-2008	Type of Change
Medical (Physical) Exams	92%	88%	96%	96%	98%	2%	⇔
Dental Exams	87%	86%	95%	93%	97%	4%	⇔

WHAT DOES THIS MEAN?

Data suggests an improving trend in the percentage of people who have had annual physical and dental exams. A very high percentage (98%) of individuals reviewed during FY 2008 and who are supported in programs that are licensed and/or certified by DDS had an annual medical/physical exam. This is slightly higher than FY 2006 and FY 2007 and substantially higher than the percentage in FY 2005. About 97% of the individuals reviewed also had evidence of an annual dental exam during this same time period. This percentage is also higher than that found in previous years. These results are illustrated on the next page.

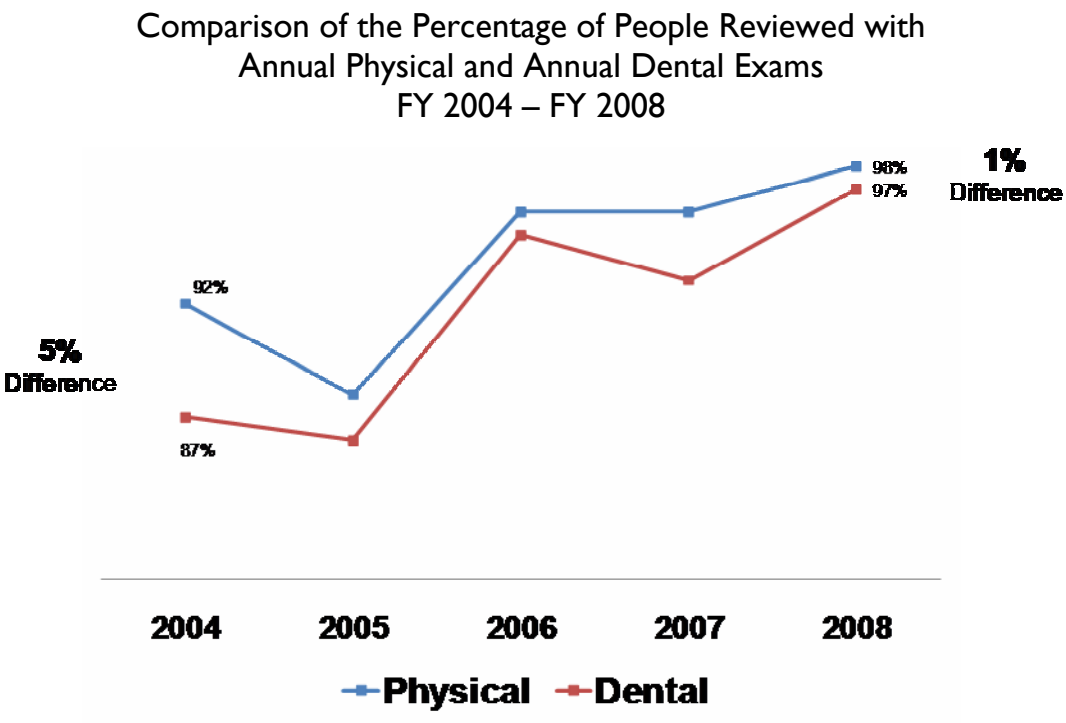
BENCHMARK

National Core Indicators (NCI, 2008) survey results for 4 New England states in 2007 found that 86% of the people with DD who were reviewed had had a medical/physical exam within the past year. A study by Mehrotra (2007) on adults in the U.S. found that only 21% had an annual preventive physical exam. This compares to the 98% of DDS consumers in licensed/certified programs during 2008 noted above.



Mehrota, A, Zaslavsky, A and Ayanian, J. (2007) Preventive health examinations and preventive gynecological examinations in the United States. *Arch of Intern Med*, 167(17), 1876-1883.
NCI (2008) *National Core Indicators: New England State Results (2006-2007).* Special report prepared by HSRI, September 12, 2008.

INDICATORS 2 and 3:
Physical and Dental Exams



WHAT DOES THIS MEAN?

Not only has there been apparent improvement in the percentage of people with both annual physical (medical) exams and dental exams over time, but the disparity seen in earlier years between dental and medical exams has been substantially reduced. In FY 2008 there was only a 1% difference between physical exams and dental exams, compared to a 5% difference in FY 2004. This suggests that individuals in programs licensed/certified by DDS are able to access basic dental and medical care at about the same level.

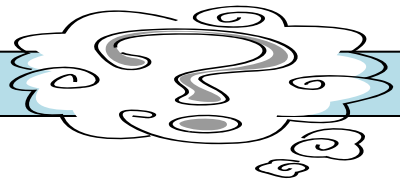
INDICATORS 4:
Safe Medication Use

Overview

This indicator concerns the extent to which individuals served by DDS receive medications in a safe and appropriate fashion by MAP (Medication Administration Program) Certified personnel who work within public and private provider organizations.

It is measured using findings from the Medication Occurrence Reporting (MOR) system, including:

- MOR number and rate
- Type of MOR
- No. and percent of Hotlines



DID YOU KNOW….

- Of the 6,700 individuals with completed DDS Health Care Records, an estimated 95% were receiving at least one prescription medication during FY 2008.
- On any given day there are an estimated 72,300 doses of medication being administered in DDS programs by Certified staff. This is equal to over 36 million doses each year!
- DDS has made a number of upgrades to the MAP training curriculum and testing procedure within the past two years in order to improve the skills of Certified staff.

For information on BENCHMARKS related to Safe Medication Use go to APPENDIX A

INDICATOR 4: Safe Medication Use

Medication Occurrence Report (MOR)

What is an "MOR?" MOR stands for Medication Occurrence Report. [In hospitals and other healthcare settings these are sometimes called "medication error reports" or, if there is an injury, "adverse drug events."] Whenever a DDS MAP Certified staff member fails to administer a medication according to the Health Care Professional's (HCP) instructions a MOR is required to be completed and submitted to DDS even if there were no untoward effects as a result of the occurrence. MAP Certified staff are required to report even those occurrences that they had no control over, for example, error in dosage or medication by the pharmacy, failure to deliver refills or incorrect orders written by HCPs. There are 5 categories or types of occurrences that must be reported: (1) the wrong medication is given, (2) the wrong dose is given (3) the wrong individual received the medication, (4) the medication is given via the wrong route and (5) the medication is given at the wrong time. This includes an omission, *i.e.*, failure to administer the medication.

No. and Rate of Medication Occurrence Reports
5 Year Trend: FY2004 to FY2008

Medication Occurrence Reports	2004	2005	2006	2007	2008	2007-2008 Change	Type of Change
No. MORs	3,599	3,667	3,612	3,823	4,440	617	↑
Est. No. Doses Adm	34,461,676	36,716,007	36,532,485	35,727,295	36,685,054	957,759	⇔
Occurrence Rate (per 1000)	0.104	0.100	0.099	0.107	0.121	0.01	↑

WHAT DOES THIS MEAN?

Data indicates that the actual number of Medication Occurrence Reports (MOR) increased by approximately 16% in Fiscal Year 2008 compared to Fiscal Year 2007, representing a statistically significant difference between these two years.[1] Although the estimated number of medication doses administered during FY 2008 also increased from the prior year, the actual occurrence rate (the number of MORs per 1,000 doses of medication) increased by approximately 13%.

[1] Chi-square test, chi-square statistic = 31.2, d.f. = 1, $p < 0.001$

INDICATOR 4: Safe Medication Use

Medication Occurrence Report (MOR)

What does this mean (continued)

A review of this data indicates that a greater number of occurrences (medication errors) took place in FY 2008 than in FY 2007. Data also shows that FY 2008 experienced the highest MOR rate in the past five years.

New MOR Reporting System. Within the past two years DDS has instituted an electronic MOR reporting system. The previous process was a paper one. It is unknown at this time if the new reporting mechanism has assured a more complete reporting of MORs. This indicator will be closely monitored to see if this increase levels off over the next two years.

PERSPECTIVE

How do DDS programs compare to nursing homes with regard to serious medication occurrences?

Research in Massachusetts[1] indicates that every month **one out of every 10** nursing home residents suffers from a medication related injury.

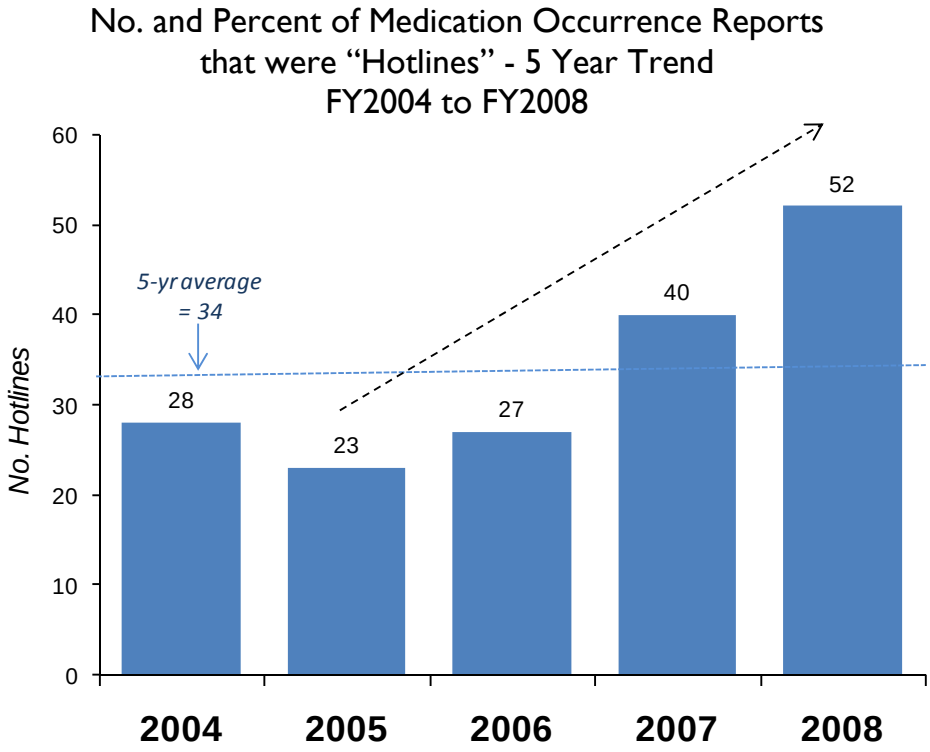
Within DDS programs MOR data suggest that about **one out of every 1,400** people receiving medication experience a serious occurrence per month. **Very few** of those result in an actual injury.

[1] Dembner, A. Medication errors plague nursing home residents. *Boston Globe*, February 24, 2005.

INDICATOR 4: Safe Medication Use

Medication Hotlines

What is a "Hotline?" Whenever there is a medication occurrence that results in any type of medical intervention (e.g., lab test, hospital emergency room visit, visit to the doctor) it is categorized as a "Hotline" and requires immediate notification to DPH. Consequently, "hotlines" represent potentially more serious medication occurrences. All hotlines are investigated by the DDS Regional MAP Coordinator and the DPH MAP Consultant and corrective action is taken when necessary.



WHAT DOES THIS MEAN?

This graph shows the number of "hotlines" that were called in for serious medication occurrences (i.e., medication errors) for each fiscal year between FY2004 and FY2008. The data suggests that there has been a somewhat steady **increase in "hotlines" from FY 2005 forward.** The difference between FY 2008 and FY 2005 is statistically signficant.[2] As can be seen in the graph above, over the five year time period between FY 2004 and FY 2008 there were an average

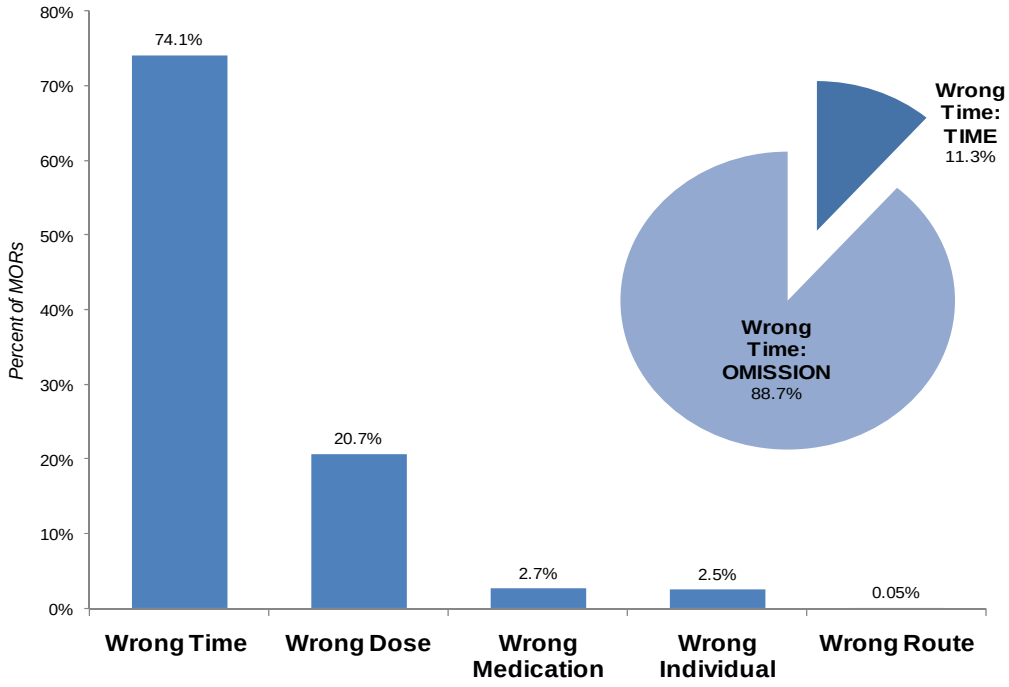
[1] Chi-square test, chi-square statistic = 11.2, d.f. = 1, p < 0.001

What does this mean?
of 34 "hotlines" per year. In both FY 2007 and FY 2008 that average was exceeded. Of the 52 hotlines reported in FY08, 10 resulted in illness and 1 caused an injury.

INDICATOR 4: Safe Medication Use

Causes for MORs

Percentage of Medication Occurrence Reports
by Cause (Type) during FY 2008



WHAT DOES THIS MEAN? This graph shows the percentage of medication occurrence reports by cause for FY 2008. As can be seen, almost 3 out of every 4 MORs were due to a medication being administered at the wrong time (within and hour before or an hour after the scheduled time). The pie chart shows that most of these "wrong time" occurrences were related to an omission (i.e., the medication was not administered). About 20% of all MORs in FY 2008 were due to an error in dosage. Very few occurrences were related to the wrong medication being given, or a medication being given to the wrong person. During FY 2008 only two (2) reports were filed for a medication being administered via the wrong route. Data for FY 2008 are very similar to prior years with regard to the type of occurrence or error.

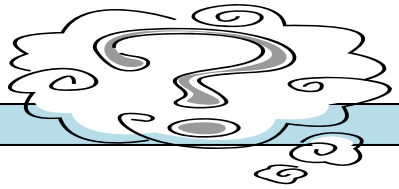
INDICATOR 5:
Health Issues are Identified and Addressed

Overview

This indicator is concerned the extent to which the DDS system identifies, responds to and corrects serious medication and health care related issues that may be affecting the safety of individuals.

It is measured using findings the Survey and Certification review process and the DPPC/DDS investigations systems, including:

- **Action Required Reports**
- **Medication Investigations**
- **Denial of Medical Treatment Investigations**



DID YOU KNOW….

- DDS has instituted a special Triggers Review process to identify people who may be at heightened risk and assure they are reviewed for possible risk mitigation intervention. Three (3) of the triggers focus on health care related incidents (unplanned hospitalizations).

INDICATOR 5: Issues are Identified and Addressed

Health & Medication Action Reports

What are "Action Required Reports?" During reviews and surveys of service and support programs that are licensed/certified an **Action Required Report** (ARR) is completed whenever more serious issues are identified that can jeopardize or compromise the health, safety or rights of an individual being supported within the program. Providers are required to correct these issues. More serious concerns are labeled immediate jeopardy and require immediate correction. Less serious issues (require correction within 30 to 60 days.

Overview

This measure assesses the extent to which issues are identified that could affect the health and safety of individuals served by DDS. **Action Required Reports (ARR)** are completed for the following types of issues:

- Health and Medication
- Human Rights
- Safe Evacuation
- Safe Environment
- Consumer Funds

Data reflecting the number of ARRs and the relative proportion of ARRs for Health and Medication issues as a percentage of all ARRs for each fiscal year are used to help evaluate the integrity and quality of health related care and service. [Note: ARRs for the other categories will be reviewed in later Topic Briefs that address those types of issues.]

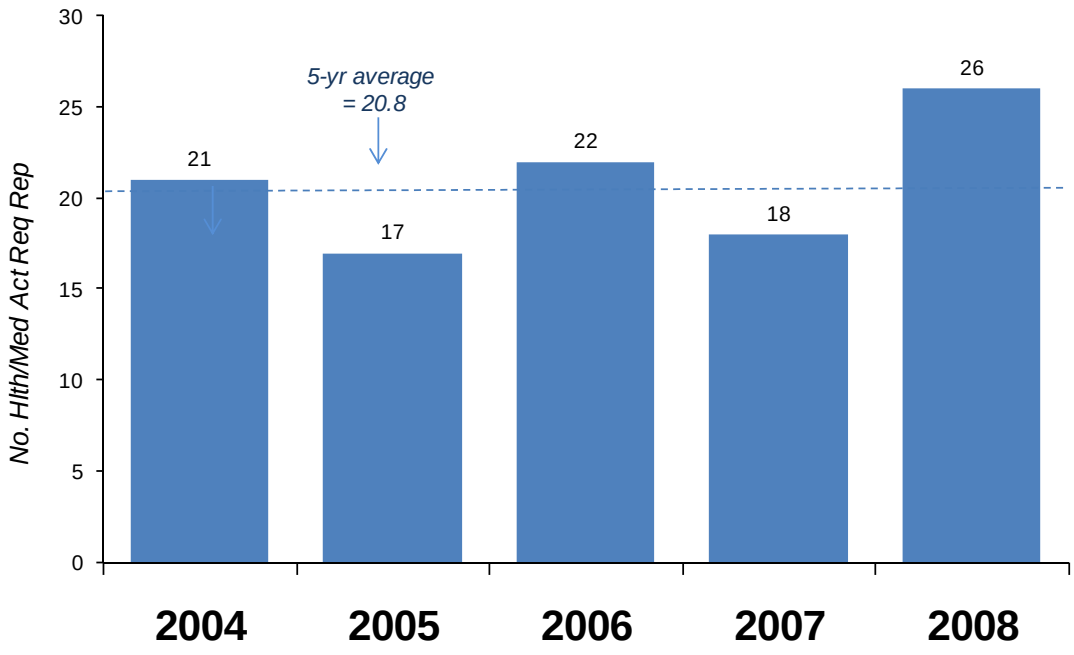
INDICATOR 5: Issues are Identified and Addressed

Health & Medication Action Reports

Action Required Reports for Health and Medication Issues
5-Yr Trend

Type of Action Required Report	2004	2005	2006	2007	2008	Change FY07-08	Percent Change	Type of Change
Health/Medication	21	17	22	18	26	8	44%	-
All Other Categories of ARR	163	88	98	116	91	-25	-22%	+
Total	184	105	120	134	117	-17	-13%	+

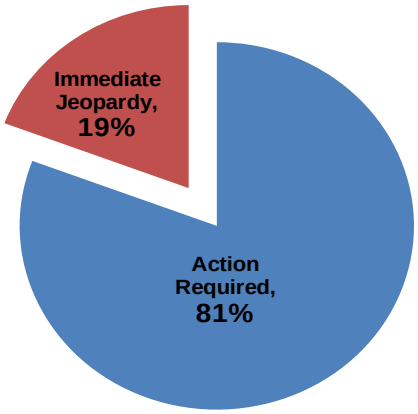
Action Required Reports for Health and Medication Issues
5-Yr Trend



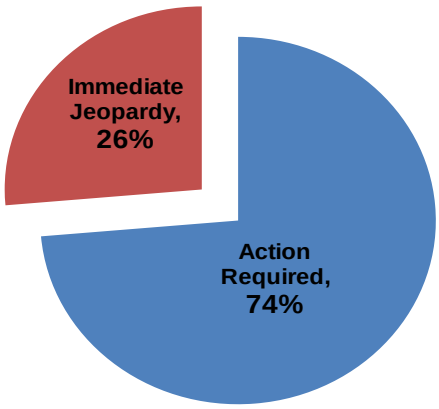
INDICATOR 5: Issues are Identified and Addressed

Health & Medication Action Reports

Percentage of
Health & Medication ARRs
by Category
FY 2008



Percentage of
All Other ARRs
by Category
FY 2008



WHAT DOES THIS MEAN?

Although the number of Action Required Reports for health and medication issues remains very low, the data suggest that more issues/concerns related to health and medication took place during FY 2008 than in prior years. More specifically, in Fiscal Year 2008 there were a total of 117 Action Required Reports issued by DDS during licensure and certification surveys. Of these, 26 were related to health and medication concerns. This represents a **44% increase** over Fiscal Year 2007 and was higher than any of the preceding four years.

However, compared to other types of ARRs, a smaller percentage of health and medication concerns were considered very serious (immediate jeopardy). During Fiscal Year 2008, 19% of Action Required Reports related to Health and Medication were categorized as "immediate jeopardy" (very serious) compared to 26% for all the other types of Action Required Reports. This suggests that a smaller percentage of issues related to health and medication compared to other reasons were seen as threatening the immediate health and safety of the persons being reviewed.

INDICATOR 5: Issues are Identified and Addressed

Medication Investigations

What are "Medication Investigations?" Whenever there is a concern that a problem with administration of medication could be considered mistreatment, illegal, dangerous or inhumane, staff are required to report to the Disabled Person Protection Commission (DPPC). DPPC screens the allegation and makes a determination as to whether or not it meets the criteria for an investigation. Investigations will usually result in an allegation being either substantiated (findings indicate there was abuse or neglect) or not substantiated (there is not sufficient evidence to verify that neglect or abuse took place).

It is important to note the difference between Medication Investigations and Medication Occurrence Reports. The latter simply reflect self-reported errors or problems in the administration of a medication. They do not imply abuse or neglect.

Overview

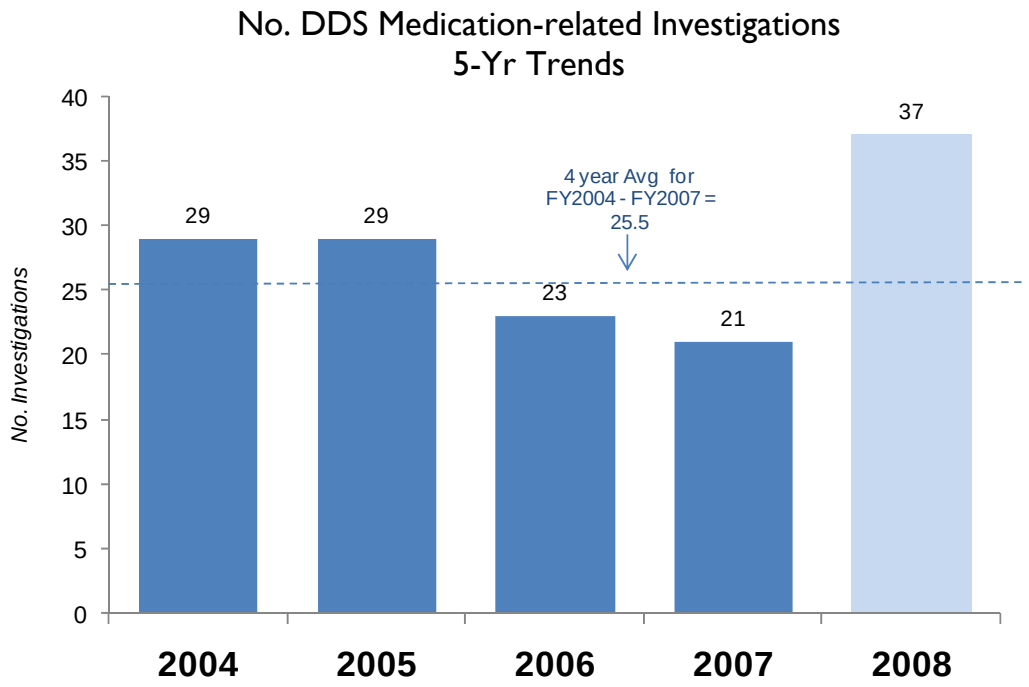
This set of measures assesses the relative extent of more serious actions when administering (or failing to administer) medications that could be deemed "abusive" or "neglectful." Data reflecting the number and percentage of medication investigations that are substantiated each year are used to help determine trends. A number of investigations initiated in FY 2008 remained "open" at the time of report preparation. Therefore, calculation of change is based on a comparison of FY 2006 to FY 2007 for this measure.

DDS Medication-related Investigations
5-Yr Trends

Medication Investigations	2004	2005	2006	2007	2008	Percent Change 2006-2007	Type of Change 2006-2007
No. Investigations re: Medication	29	29	23	21	37	-9%	⇩
No. Investigations Substantiated	17	19	15	15	13	0%	⇔
Percent Investigations Substantiated	59%	66%	65%	71%	Data not complete due to open cases		⇔

INDICATOR 5: Issues are Identified and Addressed

Medication Investigations



WHAT DOES THIS MEAN?

In Fiscal Year 2008 there were a total of 37 investigations conducted by DDS/DPPC regarding allegations that individuals may have experienced serious issues with their medication administration. This is higher than the number of investigations conducted in any year between FY 2004 and FY 2007. However, given the number of "open" investigations (i.e., not finalized), it is not possible to accurately determine the number of those investigations that were substantiated. A comparison of substantiated investigations between FY 2006 and FY 2007 shows no change.

Important Note: There is typically a delay in the finalization of investigation reports that can affect the substantiation rate for more recent time periods. Consequently, the percentage of substantiated investigations for FY 2008 could not be determined at the time of report preparation.

INDICATOR 5: Issues are Identified and Addressed

Denial of Medical Treatment Investigations

What are "Denial of Medical Treatment Investigations?"

Whenever there is a concern that a person has been denied prompt, timely and appropriate medical care and the DDS or the DPPC is notified, the allegation is reviewed and, if deemed appropriate, it is then investigated. There can be many different reasons for such an allegation, including:

- An important medical appointment is missed
- Critical signs and symptoms of an injury or serious illness are not identified in a timely fashion, leading to a delay in medical care
- The proper procedures during a medical emergency are not followed
- The designated protocol (process) for assessing an injury or illness does not take place
- There is a failure to provide required or proper medical care

Investigations will usually result in an allegation being either substantiated (findings indicate there was neglect) or not substantiated (there is not sufficient evidence to verify that neglect took place). Each investigation that results in "substantiation" can have a number of different findings (issues that represent the type of medical neglect that took place). When reviewing the data for medical neglect it is important to remember that the actual number of substantiated investigations in any given year will be different (smaller) than the number of investigation "findings."

Overview

This set of measures is designed to help evaluate the extent to which the DDS system (and its providers) safeguards the health of the individuals it support and provides basic and prompt medical care when required. Data reflecting the number and percentage of investigations that are substantiated each year are used to help determine trends along with trends associated with the types of findings that result from completed investigations.

INDICATOR 5: Issues are Identified and Addressed

Denial of Medical Treatment Investigations

Denial of Medical Treatment and Medical Neglect Investigations
FY2004– FY2008

INVESTIGATIONS: Denial of Treatment & Medical Neglect	2004	2005	2006	2007	2008	Percent Change 2006-2007	Type of Change
Total Investigations	73	73	58	60	75	3%	⇔
No. Substantiated	29	29	31	28	20	-10%	↓ +
Percent Investigations Substantiated	40%	40%	53%	47%	Data not complete due to open cases		

WHAT DOES THIS MEAN?

In Fiscal Year 2008 there were a total of 75 investigations conducted by DDS/DPPC regarding allegations that individuals were not receiving prompt and appropriate medical care. However, at the time of report preparation a number of these investigations remained open (i.e., investigations were continuing); consequently data was incomplete for the number and percent of investigations that were substantiated. For this reason, change is calculated only for the difference between FY 2007 and FY 2006 for this quality measure.

In FY 2007 60 investigations were conducted concerning denial of treatment and medical neglect. This compares to 58 in FY 2006 and over 70 in both FY 2004 and FY 2005. Of the 60 completed investigations, 28 were substantiated, a 10% reduction from FY 2006.

Important Note: There is typically a delay in the finalization of investigation reports that can affect the substantiation rate for more recent time periods. For this reason change for this measure uses the difference between FY 2006 and FY 2007.

INDICATOR 5: Issues are Identified and Addressed

Denial of Medical Treatment Investigations

Findings re: Substantiation of
Denial of Medical Treatment and Medical Neglect
FY2004– FY2008

TYPE of FINDINGS: Denial of Treatment & Medical Neglect	2004	2005	2006	2007	2008	Difference 2006-2007	Percent Change 2006-2007	Type of Change
Signs & Symptoms	10	15	15	14	6	-1	-7%	⇩
Treatment Protocol	6	11	9	9	7	0	0%	⇔
Assessment Protocol	5	2	4	9	3	5	125%	⇑ -
Emergency Protocol	14	5	7	12	5	5	71%	⇑ -
All Other	9	8	11	13	13	2	18%	⇑ -
TOTAL	44	41	46	57	34	11	24%	⇑ -

*2008 not used to determine amount of change due to number of open cases at the time of report preparation.

WHAT DOES THIS MEAN?

In Fiscal Year 2008 there were 34 separate investigation findings for the 20 substantiated cases of denial of medical treatment/medical neglect. [Note: one investigation can result in multiple findings, therefore the number of findings usually is greater than the actual number of substantiated investigations in any given year.] However, as noted earlier, there were a number of open investigations at the time of report preparation. Therefore, change calculations are based on a comparison of FY 2006 and FY 2007 for this measure. As can be seen, there was a slight reduction in investigation findings related to signs and symptoms in FY 2007. A rather large increase took place for findings related to assessment and use of the proper emergency protocol. Overall, there was an increase in substantiated findings in FY 2007.

Important Note: The analysis presented above is based on data that is represented by a small number of cases and must therefore be viewed with caution. Small fluctuations year to year can result in relatively large percentage differences.

New Indicator:
Electronic Health Care Records

What are "Electronic Health Care Records?"

In order to promote more standardized access to more timely and up-to-date health information DDS has established an Electronic Health Care Record (EHCR). Current policy requires the use of this record for all individuals who receive residential support and encourages its use for all other service recipients.
Electronic Health Care Records are a new addition to the systems within DDS. Use of the records is tied into the annual service planning process. For this reason, historical data regarding Electronic Health Care Records does not exist. Beginning with this 2008 QA Brief a new quality indicator is being established. Data reported below should be used only as a "baseline" for evaluating future activity and performance.

Indicator 6:
Health Information is up-to-date and in an electronic health care record

Overview

This indicator is concerned with the extent to which individuals supported within the DDS system have an updated Electronic Health Care Record.
It is measured through an analysis of the HCSIS database for those persons who are receiving services in programs that require an EHRC. Measures include:

- **No. of Individuals with an EHCR** (in Programs Required to have an EHCR)
- **Percentage of Persons with an EHCR** (in Programs Required to have an EHCR)
- **Percentage of Persons with an EHCR that has been updated within the past 12 months** (in Programs Required to have an EHCR)

INDICATOR 6: Health Information is up-to-date and in an electronic health care record

Electronic Health Care Records

April 2009
Findings re: Use of Electronic Health Care
Baseline

Electronic Health Care Records	Baseline: April 2009
No. People in Services that Require an EHCR*	9,259
No. with an EHCR	8,066
Percent with an EHCR	87%
No. with EHCR Updated	6,846
Percent with EHCR Updated w/in 12 mo.	85%

WHAT DOES THIS MEAN?

As of April 2009 8,066 people or 87% of the individuals who receive residential services and/or supports (and who, by DDS policy, should have an EHCR) had health information in their electronic record. Of those with an EHCR, 6,855 or 85% had records that were updated within the past year. This data will be used to help evaluate future trends and agency performance.

* Residential Programs with a requirement for EHCR.s included in the April 2009 Baseline are: Individual Support & Community Habilitation (3286), Placement Services T1 (3288), Residential Supports (3153), Shared Living/Home Share (3150) and State Operated Residential (4157

WHAT'S HAPPENING? DDS Activities to Support Health Care Quality and Access

DDS is committed to improving the quality of health care individuals with intellectual disabilities experience. While much remains to be done, DDS has and continues to be involved in many activities and initiatives that have advanced the goal of improved quality and access. Review the highlights below to learn about some of these initiatives and other health-related activities. We look forward to continuing this important work and implementing new strategies to support the goal of quality health care.

HEALTH IMPROVEMENT INITIATIVES

1. Health Promotion and Coordination Initiative: This initiative has been in effect since December, 2003. Its primary goal is to enhance the quality of health care that individuals with disabilities receive through a focus on the important role that direct support professionals play in health care advocacy. The initiative includes:

- **Preventive health screening recommendations** adapted from the Massachusetts Health Quality Partnership that are now used by all providers of DDS services during the annual physical health care exam. When first published, they were mailed to over 7000 practicing physicians in Massachusetts. DDS providers are required to use these guidelines when accompanying an individual to his/her annual physical exam so that they and health care practitioners are aware of the preventive health screening procedures individuals should be getting. The recommendations provide valuable guidance to both direct support professionals and health care practitioners and serve as a valuable tool in assuring that individuals with intellectual disabilities receive age specific screenings. These guidelines are updated as screening recommendations change.

- **Health Review Checklist** which is completed by direct support professionals and taken to every primary care appointment to aid in communication and follow up. The health review checklist allows direct support professionals to respond to questions about easily observable indicators of health status. The health review checklist provides the primary health care provider with important information to allow for proper diagnosis and treatment.

DDS Activities to Support Health Care Quality and Access

The Health Promotion and Coordination Initiative (continued)

- **Electronic Health Care Record** for all individuals receiving residential supports from DDS. Providers utilize this health care record in a variety of settings including primary and specialty care visits as well as unanticipated visits to the emergency room. The health care record is required to be updated and submitted annually as part of the Individual Service Plan process.
- **Health Care Encounter Tools** to use to assure a successful visit with a health care provider including procedures for a medical appointment.
- A set of easy to use **Informational Sheets** posted on the DDS website for use by direct support professionals to assist them in observing and reporting signs and symptoms of illness. New informational sheets are added periodically.
- **Statewide Quarterly Training** offered to DDS providers in a Train-the-Trainer modality on common health related issues. Trainings already provided include those on seizures, nutrition, Medicare Part D, antibiotic resistant microorganisms, hospice service, scabies, recognizing behavioral symptoms of illness, dysphagia, sepsis, dental issues. Training materials are posted on the DDS website.

2. Falls Prevention Campaign

Entitled **S**creen –**T**rain – **O**bserve - **P**revent **Falls** or **S.T.O.P. Falls**, this initiative is currently underway to decrease the number of preventable falls for people with intellectual disabilities. As part of the campaign, DDS provided all 200 of our providers with a training CD and curriculum designed to decrease falls in individuals with ID. Training was provided across the state for over 300 provider staff in how to use the new materials to train additional staff. A pilot that will provide technical assistance and support to several providers is underway and will track the rate of <u>all</u> falls in residential and day programs over the next several months. Information from this pilot will be used to enhance the program for the entire DDS network of providers.

DDS Activities to Support Health Care Quality and Access

HEALTH INFORMATION

In an on-going effort to distribute and share important health related information DDS creates a variety of informational materials in different formats including:

Living Well Newsletter. The *Living Well Newsletter* is published on a semi-annual basis and highlights seasonal health care concerns as well as specific topics of interest that impact the health status of individuals we support. It is mailed to every residential program site and is posted on the DDS webpage.

Protocols of specific interest to the DDS community are posted on the DDS webpage on a periodic basis. Examples include clinical protocols related to: Methicillin resistant staphylococcus aureus (MRSA), Vancomycin resistant staphylococcus aureus (VRSA), Vancomycin resistant enterococci (VRE), Clostridium Difficile (C. Diff,) Dysphagia, scabies, and seizures.

MAP Updates. Updated Medication Administration Program (MAP) policies are developed in collaboration with DPH and DMH to continue to meet the needs of the DDS community. Recent changes include a new section on MAP policies related to hospice services in order to eliminate obstacles to hospice services within the constraints of MAP; for example, an exception to how medications need to be labeled to better address the frequent order changes inherent within hospice services, how to store and count the emergency medication kit provided by hospice, allowing staff to use orders that contain dose ranges after conferring with the hospice nurse, requiring orientations to MAP for hospice providers and an orientation to hospice services for DDS provider staff when the services are instituted.

Mortality Report. On an annual basis the UMASS Medical School's Center for Developmental Disabilities Evaluation and Research (CDDER) prepares an independent report to help identify trends and patterns related to the death of individuals supported by DDS. The report includes an examination of the causes of death in order to better understand how some unexpected deaths may be prevented if health issues are identified earlier and treated appropriately.

Health Advisories. Special advisories are issued on an "as needed" basis to alert the DDS community to issues of concern related to health and wellness. Examples include:

DDS Activities to Support Health Care Quality and Access

COLLABORATION

DDS has engaged in several **collaborative training and service efforts** to increase the knowledge of health care practitioners and to improve access to specialty services including the following:

- **Alzheimer's Care.** Successful joint statewide conference with the Alzheimer's Association for families and practitioners designed to better support caregivers and individuals. Also created screening tools for direct care staff and clinicians as well as a resource list of practitioners with expertise in diagnosing A.D. in the ID population. DDS continues to work with the Alzheimer's Association, providers and other state and private entities to create regional dementia diagnostic clinics to help facilitate early diagnosis and treatment of dementia and Alzheimer's Disease by clinicians with expertise with the ID population.

- **Eye Care.** Ongoing work with ophthalmologists and optometrists to develop better eye examinations for individuals with intellectual disabilities and provision of a list of eye doctors willing and able to serve this population across the state.

- **ER Services.** Provision of training to ER staff in Northeast, Metro area and Central Massachusetts regarding interpreting behavior in order to diagnose acute health issues for individuals with intellectual disabilities when they arrive at the ER

- **Internships.** Provision of internship settings twice a year for fourth year nursing students from Simmons College in the care of people with intellectual disabilities in the community as part of their community nursing practicum.

- **Short-term Rehabilitation.** The use of Tewksbury Hospital for individuals requiring short term rehabilitation prior to returning home. The facility has developed specialized expertise in supporting and treating individuals with intellectual disabilities.

- **Dental Care.** A series of unique initiatives to improve access to quality dental services, including:

  - **Tufts:** Comprehensive dental services are offered through the Tufts Dental clinics around the state. The clinics with a cadre of specially trained dentists provide preventive and restorative services to the majority of individuals DDS supports.

  - **Dental loan repayment program** which assists in attracting and retaining dentists serving individuals with disabilities.

  - **BU:** Boston University School of Dental Medicine is in the final planning stages of beginning a special residency track to serve individuals with intellectual disabilities

DDS Activities to Support Health Care Quality and Access

COLLABORATION (continued)

- **Wellness.** Planning is currently underway for joint training with DPH for providers regarding exercise and nutrition using a special curriculum designed for individuals with intellectual disabilities.
- **Plymouth Outreach.** The Plymouth Area Office Provides outreach to doctors and hospitals to support better communication between DDS providers and community health providers.
- **SE Medical Safeguarding Project.** This initiative in the Southeast Region provides care coordination and health care advocacy for individuals living in the Region.
- **NE Regional Collaborative with Hospice Care Inc.** This collaborative in the Northeast Region has worked successfully to develop systems to overcome obstacles so that individuals with intellectual disabilities, their families and caregivers can receive the physical, social and spiritual support offered by hospice services.

SPECIAL TASK FORCES & COMMITTEES

DDS is actively sponsoring a variety of special workgroups, committees and formal Task Forces to study, develop resources for and advise DDS on best practice approaches to providing quality health services and enhancing the wellness of the people supported by the department. These special groups include the following:

- **DDS Quality Council.** Comprised of self advocates, family members, providers, DDS staff,,, and other stakeholders, this Council reviews data and information, including that related to health and wellness, and makes recommendations to DDS about what actions should be taken to enhance and improve the quality of services and supports. The Falls Prevention campaign was developed as a result of the Council's review of HCSIS incident data regarding unplanned hospitalizations that were related to injuries from falls.
- **Mortality Review Committee.** Mortality review committees exist at the Regional and Central level and reviews all deaths that meet the criteria for a full mortality review. This process enables DDS to identify patterns and trends relative to the causes and circumstances of individuals who have died in DDS programs and take action to decrease deaths in the future for possibly preventable conditions.

DDS Activities to Support Health Care Quality and Access

Task Forces & Committees (continued)

- **DDS Task Force on young adults in need of intensive community based medical supports.** This special task force has been working on identifying issues and making recommendations on how best to support young adults in a variety of settings, including those with special health care needs. To date the group has:
  - Defined the population and projected numbers of individuals who will require on-going intensive supports
  - Identified services and supports deemed a high priority for continuation into adulthood, particularly for adult children remaining at home
  - Made recommendations re: options for provisions of services and supports, including case management, day services, transportation, equipment and adaptations, in-home daily living and financial assistance, and
  - Served as the impetus for additional funding by DDS to provide medical case management and care coordination for individuals between the ages of 18-25 in each of the 5 medically complex programs that DDS purchases.

Western Massachusetts Complex Needs Task Force. This Task Force developed a manual for communicating with hospital staff during in-patient hospital stays as well as guidelines for supporting thorough discharge planning

CLINICAL RESOURCES

Many DDS providers have registered nurses who provide oversight and coordination of health care services within their service constellation. In addition every DDS Area Office has a full time nurse who consults and coordinates care with human service and health care providers.

Visit the DDS Website for more information about health-related initiatives, special advisories and reports. The site can be accessed at www.mass.gov/dds.