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SECRETARY OF STATE

STATE OF TENNESSEE
Department of Intellectual and Developmental Disabilities

Frost Bldg., 4th Floor
161 Rosa L. Parks Blvd.
Nashville, Tennessee 37243

Phone: (615) 532-6530
Fax: (615) 253-4089

Public Meeting Notice Pursuant to Tennessee Code Annotated § 33-1-309

In accordance with §§ 33-1-309 of the *Tennessee Code Annotated* the Department of Intellectual and Developmental Disabilities (Department) giving notice through the Tennessee Administrative Register of the following Public Meeting:

General Description.

The Department will be changing its current Provider Manual. The Provider Manual is an operating guideline for DIDD Service Providers. There have been changes made within waiver services. Three (3) new waiver services were added and needed to be reflected in the Provider Manual.

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Public Meeting Notice Pursuant to Tennessee Code Annotated § 33-1-309 (Cont.)

Date, Time & Place of the Public Meeting and Opportunity to Comment.

This public meeting will take place on Tuesday, October 1st, 1 P.M. - 4 P.M. @ One Cannon Way Drive, Clover Bottom Development Center Campus 275 Stewart's Ferry Pike, Nashville, Tennessee 37217. Interested persons may provide written and/or oral comments to the changes made to the Provider Manual.

Name, Address and Telephone Number Contact Person.

Dr. Barbara Wilson, Administrative Assistant
Department of Intellectual and Developmental Disabilities
Frost Bldg., 161 Rosa L. Parks Blvd.
Nashville, TN 37243
(615) 741-9135

Department of Intellectual and Developmental Disabilities
Office of Policy & Innovation
Division of Policy

Summary of Revisions to the DIDD Provider Manual
August 29, 2013

Summary: The Department of Intellectual and Developmental Disabilities (DIDD) conducted an extensive review and revision of the DIDD Provider Manual, which has been condensed from 544 to 225 pages. The Department's approach to this process was to eliminate redundant information, clarify existing provider requirements, describe requirements associated with new waiver services, and describe new processes developed by the Department in order to support providers (e.g. New Provider Support Process). The primary purpose of this document is to present a high level overview of new requirements for providers. The document is organized by chapter, with annotations to the applicable section of the provider manual. This summary attempts to highlight as many of the changes as possible but cannot be all inclusive based on the size and complexity of the document and review.

Revisions throughout the Provider Manual

- Updated the Department name to reflect change from Division to Department
- Removed outdated terminology such as service recipient and mental retardation and replaced with current terminology such as person supported and intellectual disability
- Waiver service definitions are now separate from the Provider Manual and available on the Department's web site. It must be emphasized that providers are still required to comply with the requirements contained within the waiver services definitions.

Introduction

- Updated the Department's statements of Mission, Vision, and Values

Chapter 1: Eligibility, Enrollment, and Disenrollment

- No new requirements for providers

Chapter 2: Rights Applicable to All People with Intellectual Disabilities

- 2.7.b – Providers required to comply with Health Information Technology for Economic and Clinical Health Act (HITECH)
- 2.10.c – Provider Responsibilities Related to Court-Appointed Legal Representatives

Chapter 3: Individual Support Planning and Implementation

- Table 3.6.1 – Independent Support Coordinators (ISCs) and Case Managers (CMs) required to collect information on Third Party Payer Services and Community Supports
- 3.10.b – Residential, Day, and Personal Assistance Providers required to complete periodic reviews

Chapter 4: Support Coordination and Case Management

- 4.6.h - Independent Support Coordinators (ISCs) and Case Managers (CMs) are responsible for coordinating services with the person's Managed Care Organization
- 4.6.i - Independent Support Coordinators (ISCs) and Case Managers (CMs) are responsible for coordinating services prior to the person's 21st birthday

Chapter 5: General Provider Requirements

- 5.2.b – Providers required to confirm potential employees are not listed on the Office of Inspector General's List of Excluded Individuals/Entities
- 5.4 – Providers required to have an ongoing self-assessment process
- 5.6.4.b – Requirements for unannounced supervisory visits for Family Model Residential
- 5.5 – Providers required to have an Internal Quality Improvement (QI) Plan
- 5.12 – Providers required to notify DIDD of changes in provider information

Chapter 6: Staff Development

- 6.5.c – Requirements applicable to provider staff delivering employment supports. Phase III Training for Job Coaches

Chapter 7: Protection from Harm

- 7.1.c – Added categories of reportable incidents: Manual Restraint, Mechanical Restraint, Protective Equipment

Chapter 8: Health Care Management

- 8.3.a – Providers required to obtain consents and releases of information
- 8.4 – Providers required to integrate behavioral and therapeutic health supports
- 8.8 – Primary Provider has requirements related to hospitalizations
- 8.9 – ISCs required to address end of life issues with persons supported

Chapter 9: Quality Management

- 9.4 – New provider support process. This requirement impacts new providers, not existing providers

- 9.13 – Regional Provider Support Teams. This requirement impacts providers who are not performing according to Quality Management standards

Chapter 10: Creation and Maintenance of Provider Records

- 10.3 – Providers required to give person's supported and their legal representative, access to the person's records
- 10.8.b.6 – Behavior Service provider's requirements applicable to behavior service records. Contact Notes are validated by a co-signature line for staff at the service location that includes time in and out, or by the behaviorist's signature in the service location's visitor log that includes time in and out

Chapter 11: Residential and Day Services

- 11.1.e – Requirements applicable to Semi-Independent Living Services
- 11.1.f – Requirements applicable to Intensive Behavior Residential Services
- 11.1.g.1 – Requirements described in the following documents: Level Descriptions for Day Services, Level Descriptions for Family Model Residential Services, Level Descriptions for Residential Habilitation and Supported Living, Level Descriptions for Respite Services, Staffing Standards for Residential and Day Services

Chapter 12: Behavior Services

- 12.2 and 12.3 – Provider work product must meet standards described in Behavior Services Work Product Review
- 12.5 – Requirements applicable to Cross Systems Crisis Plans
- 12.5.a.4 – Requirements applicable to Behavior Safety Procedures
- 12.5.e – Requirements applicable to manual restraint, mechanical restraint, and protective equipment
- 12.8 – Requirements applicable to Self-Assessment and Internal QI
- 12.9 – Required provider policies

Chapter 13: Therapeutic and Therapy-Related Services

- 13.3 - Providers are responsible for assuring staff coverage for authorized services and must have a back-up plan for extended clinician illnesses, leave, or vacations
- 13.7 – Provider requirements for Self-Assessment and Internal QI

Chapter 14: Nursing, Vision and Dental Services

- No new requirements

Chapter 15: Other Waiver Services

- No new requirements

August 30, 2013

State of Tennessee

Department of Intellectual and
Developmental Disabilities

PROVIDER MANUAL

Effective November 1, 2013

TABLE OF CONTENTS

List of Tables and Illustrations

August 30, 2013

Memo from DIDD Commissioner

This page is a place holder.

INTRODUCTION

IN.1. Welcome.

Thank you for your participation as a provider in the Tennessee system of programs for persons with intellectual disabilities. An adequate network of providers with the ability to deliver quality services and supports is a primary asset in ensuring the ability to maintain the health, safety, welfare, and quality of life for people with intellectual disabilities who make the choice to pursue life in the community. We are glad that your agency has made the choice to participate as a provider in these programs. We look forward to working with your agency to assist people with intellectual disabilities in having a successful experience with community life.

IN.2. Development, Update and Distribution of the Provider Manual.

IN.2.a. Development. This manual was developed by staff of the Department of Intellectual and Developmental Disabilities (DIDD). Many stakeholders, including providers of all types, provider organizations, people who use DIDD services, family members and advocacy organizations, were involved in the development and review of this manual. We extend our sincere thanks for their patience and willingness to devote time and energy to the completion of the Provider Manual. This Provider Manual supersedes all previous provider manuals. Additional requirements not addressed in the provider manual can be found on the Provider Info page of the DIDD web site.[1] Any TennCare policies that have been distributed by DIDD pertaining to Medicaid Waiver programs continue to be applicable to waiver service providers.

[1] http://www.tn.gov/didd/provider_agencies/index.shtml

IN.2.b. Distribution. Primary responsibility for distribution of the manual and manual updates will rest with the Office of Policy and Innovation, Policy Division within DIDD. Printable copies will be available on the DIDD website in PDF format.[2]

IN.2.c. Updates. The provider manual will be updated as needed to communicate changes in policy and program requirements. Changes in provider requirements that result in manual updates will require public meeting of applicable manual sections as required by state law. Providers will be notified of updates through official written correspondence.

IN.3. Purpose of the Provider Manual.

IN.3.a. Basic Purpose. The purpose of this manual is to outline the basic principles and requirements for delivery of quality services to persons with intellectual disabilities. All providers who participate in state- and federally-funded service delivery programs must have an executed provider agreement which requires compliance with this manual. Some sections of the manual apply to all providers, whereas other sections refer to specific types of providers.

IN.3.b. Provider Resources. There is information throughout the manual which references additional provider resources such as state and federal statutes, rules and regulations; other tools and manuals; and websites. These types of materials are available to assist providers in the development of policies and practices that meet the requirements specified in this manual and promote a good system of service delivery.

IN.3.c. Relationships with People Using Services. For the purposes of this manual, people supported by DIDD programs may be referred to as people using services, person(s) supported, or person. These terms will be used in place of previously accepted terminology such as waiver participant, waiver enrollee, service recipient, client, member, consumer, or patient.

[2] WEB LINK

People using services are the most important stakeholders in the system. It is essential that providers have the ability to develop and maintain effective working relationships with the people using their services, their families, their legal representatives, and their advocates who may assist them in exercising their rights. Information in the manual outlines requirements and resources intended to promote respectful, effective relationships between the person (and those assisting or representing them) and the providers delivering the services.

IN.3.d. Relationships with Other Providers of Services and Supports. Information included in the manual is intended to assist providers in developing relationships with other types of providers, and in accessing and maximizing resources available through other programs available within the state. This information is intended to promote the ideal that people who participate in different programs must be treated in a holistic manner. In other words, the programs described in this manual will not meet all the social and health-care needs of persons with intellectual disabilities. It is essential that providers develop an understanding of how the services available through these programs fit within the broader system of state healthcare, educational, and social programs. Effective integration of services offered through the programs described in this manual with external services and natural supports is a goal that the state will continue to work toward.

IN.4. Organization of the Provider Manual.

IN.4.a. Organization of Content. A table of contents is followed by an introduction and fifteen (15) chapters, each of which describes expectations and requirements related to a particular component of service delivery. Following the body of the manual, appendices are provided which present information referenced in the manual. For example, **Appendix A** lists commonly used abbreviations. Additionally, a glossary is provided, which lists terms and phrases used throughout the manual. Terms, phrases, and abbreviations are listed in alphabetical order.

IN.4.b. Numbering System. A simple numbering system has been employed to ensure readability and ease in referencing sections and pages within chapters. The numbering system employed within the manual will be as follows:

1. "IN" is used to refer to sections within the Introduction.
2. Each chapter following the Introduction is numbered 1, 2, 3, etc.
3. Each chapter has sections numbered 1.1., 1.2., etc.
4. Subsections will be numbered 1.1.a., 1.1.b., etc.
5. Lists within sections and subsections will be numbered 1, 2, 3 or bulleted.
6. Appendices will be shown as **Appendix A**, **Appendix B**, etc.
7. Each page within a chapter will be numbered sequentially.
8. Tables and Illustrations will be numbered with the chapter number followed by the section number and subsection number if applicable.

IN.5. Description of DIDD Programs.

IN.5.a. Family Support. The Family Support program is a community-based, state-funded program that provides assistance to families with a family member who has a severe disability. Local Family Support Councils oversee the family support programs across the state. Services are provided by local agencies and providers who receive grant funds and technical assistance from DIDD. This manual will not address provider requirements for the Family Support Program. A basic description of the program and eligibility information will be provided. Any additional information needed about this program is available in the manual titled Tennessee Family Support Guidelines. This manual is available on the DIDD website.[3]

IN.5.b Medicaid Home and Community Based Waiver Services (HCBS) Programs. Medicaid HCBS waiver programs were developed as an alternative to services provided in an institutional setting, such as Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). HCBS waiver programs have been in

[3] http://www.tn.gov/didd/family_support/GUIDELINES20122013.pdf

existence since 1981. Tennessee's first HCBS waiver for persons with intellectual disabilities was approved in 1986. Currently, Tennessee has three waiver programs for persons with intellectual disabilities. The Section 1915(c) HCBS Waivers operated in Tennessee are:

1. HCBS Waiver for the Mentally Retarded and Developmentally Disabled (TN.0128), as amended, also known as the Statewide Waiver.[4]

2. HCBS Waiver for Persons with Mental Retardation (TN.0357), as amended, also known as the Arlington Waiver.[5]

3. Tennessee Self-Determination Waiver (TN.0427), as amended, also known as the Self-Determination Waiver.[6]

IN.5.c. State-Funded Services. Each year, the state legislature appropriates funding which allows DIDD to provide state-funded services to people who, for one reason or another, are not eligible or are otherwise not getting some or all of their needed services through the Medicaid waivers and other DIDD programs. The services provided are generally the same as those available through the Medicaid waiver programs and the same general requirements apply.

IN.6. State and Federal Laws, Rules, Regulations and Policies Governing Programs.

IN.6.a. Federal Laws, Regulations and Policy. The requirements of different programs are typically spelled out in state and federal laws, rules regulations and policies. Federal laws apply to DIDD programs that utilize federal funding, such as the Medicaid Waivers. At the federal level, laws and statutes are passed by Congress and are incorporated in the United States Code Annotated (U.S.C.A.). A federal agency is designated to develop regulations that implement the laws or statutes. Federal

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[4] http://www.tn.gov/didd/provider_agencies/resources/Application%20for%201915(c)%20HCBS%20Waiver%20TN_0128_R04_03%20-%20Jan%2001,%202013%20(as%20of%20Jan%2001,%202013)_jsp.htm

[5] http://www.tn.gov/didd/provider_agencies/resources/Application%20for%201915(c)%20HCBS%20Waiver%20TN_0357_R02_02%20-%20Jan%2001,%202013%20(as%20of%20Jan%2001,%202013)_jsp.htm

[6] http://www.tn.gov/didd/provider_agencies/resources/Application%20for%201915(c)%20HCBS%20Waiver%20TN_0427_R02_00%20-%20Jan%2001,%202013_jsp.htm

regulations are published in the Code of Federal Regulations (C.F.R.). Rules are state agency directives that implement, interpret, or describe the procedure or practice requirements of an agency. Policies are generally a more detailed interpretation of regulations that are easier and less time consuming to change because policies generally do not have to go through a promulgation process, which involves public hearings and legal reviews. An example of federal policy is the State Medicaid Manual.

IN.6.b. State Laws, Regulations, and Policy. State laws or statutes are passed by the state legislature. When laws are passed or amended, a particular state agency is responsible for developing or changing state rules to implement the law. Tennessee laws or statutes are published in the Tennessee Code Annotated (T.C.A.). State departments or agencies are responsible for developing rules to implement the law and developing any policies that are needed to interpret the state rules. Rules are promulgated or passed by publishing the proposed rule in the Tennessee Administrative Register (TAR) for thirty days prior to a rulemaking hearing. Public comments are accepted in writing after the proposed rule is published or interested parties may appear in person at the rulemaking hearing to support or voice any concerns about the proposed rule. If the proposed rule is necessary to public welfare, there are provisions that allow rules to be effective upon publication and promulgated within 90 days.

In Tennessee, a statute exists that requires any DIDD guidelines that are mandatory for providers to be promulgated similar to the way rules are promulgated. This manual is an example of mandatory DIDD guidelines.

IN.6.c. Court Orders. Court orders may contain programmatic and policy requirements with which the state must maintain compliance. There are several court orders that affect the operation of DIDD programs. The two major federal court orders can be found on the DIDD website.[7]

IN.6.d. Conflicts between Laws, Rules, Regulations, and Policies. The State attempts to ensure that there is consistency in all of the governing requirements for

[7] http://www.tn.gov/didd/compliance/litigation.shtml

programs. However, laws and regulations may be changed, resulting in temporary conflicts that have to be resolved all the way down to the policy level. When this occurs at the state and federal level, the language in the statute, rule or regulation governs. When the law and rules are consistent and the related policy is in conflict, the rule or regulation governs over the policy. If a federal law, rule or policy is in conflict with a state law, rule or policy, the federal standard governs. States are not typically considered to be in conflict with federal requirements if they establish standards that are more stringent than the federal minimum requirement.

IN.7. State and Federal Agencies Directly Involved in Administration, Operation, and Oversight of Medicaid-Funded Waiver Programs.

IN.7.a. Centers for Medicare and Medicaid Services. The Centers for Medicare and Medicaid Services[8] (CMS) is the federal agency within the Department of Health and Human Services (HHS) responsible for implementing federal regulations governing Medicare and Medicaid services. CMS provides funding to designated Single State Medicaid agencies for the administration of Medicaid programs in each state, including Medicaid HCBS Waiver Programs.[9] CMS reviews and approves waiver applications, develops federal Medicaid regulations and policy, provides technical assistance to states, and conducts periodic audits to ensure compliance with federal requirements. An approved waiver application serves as a contract between CMS and the State for operation of an HCBS waiver program.

IN.7.b. Bureau of TennCare. In Tennessee, the Bureau of TennCare[10] (TennCare) is the medical assistance unit within the Division of Healthcare Finance and Administration of the Department of Finance and Administration, the designated Single State Medicaid Agency. TennCare contracted with CMS to administer and oversee

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8 Additional information about CMS can be obtained by visiting the CMS web site at: http://www.cms.gov/.

9 Code of Federal Regulations Title 42 Part 441 Subpart G (42 C.F.R. § 441.300 *et seq*) – HCBS: Waiver Requirements. The Code is available online at: http://www.ecfr.gov/cgi-bin/ECFR?page=browse. Follow the directions on the page to locate the text.

10 Additional information about TennCare can be obtained by visiting the TennCare web site at: http://www.tn.gov/tenncare/index.shtml.

Medicaid HCBS waiver programs. The Division of Long-Term Services and Supports within the TennCare is directly responsible for administration and oversight of Medicaid HCBS waivers for persons with intellectual disabilities. The TennCare has established a contractual relationship with DIDD which makes DIDD responsible for daily operations of HCBS waiver programs for persons with intellectual disabilities. The TennCare/DIDD contract specifies administrative and oversight functions performed by TennCare including:

1. Development and promulgation of state rules for HCBS waiver programs.
2. Development and review and approval of HCBS waiver policies.
3. Provision of information to DIDD and HCBS waiver providers pertaining to changes in statute, regulation, policy, procedures or guidelines affecting the operation of HCBS waiver programs.
4. Execution of three-way provider agreement with HCBS waiver providers.
5. Submission of applications to CMS for waiver approval and renewal.
6. Payment of clean claims for services rendered.
7. Completion of monitoring activities to determine if DIDD is in compliance with the approved waiver application, state and federal rules, and TennCare regulations and policy.
8. Determination of medical eligibility for HCBS waiver programs.

In addition to ongoing informal communication processes, monthly meetings between TennCare and DIDD ensure adequate TennCare oversight. Monthly meetings include:

- **The Policy Meeting.** TennCare and DIDD staff review DIDD policies and stakeholder memorandums under development, including the status of those under review at TennCare; Provider Manual revisions; changes in TennCare rules and policy; and the status of waiver applications, as appropriate. This forum is also used as a mechanism for DIDD to obtain TennCare policy interpretations and for TennCare to assign responsibility for CMS deliverables.
- **The DIDD Statewide Continuous Quality Improvement (SCQI) Meeting.** DIDD and TennCare staff review DIDD quality assurance (QA) survey outcomes, identified data and reporting issues, as well as findings resulting from TennCare

QA activities (e.g., targeted Reviews, utilization reviews, fiscal audits) and discuss appropriate corrective actions.

- **The Abuse Registry Committee Meeting**. The Abuse Registry Committee is comprised of representatives from various government and private agencies. A TennCare representative serves on the Abuse Registry Committee and participates in the review of substantiated allegations of abuse, neglect, and exploitation. The committee decides when individuals will be referred for placement on the Tennessee Department of Health (DOH) Abuse Registry.
- **The Statewide and Regional Planning and Policy Council Meetings.** DIDD and TennCare staff participate in meetings with stakeholders including persons supported and family members, a variety of provider representatives enrolled as waiver service providers (e.g., clinical service providers, residential and day providers, support coordination providers, etc.), representatives from person and provider advocacy organizations, and other stakeholders. Planning and Policy Council members are routinely advised of the status of lawsuits; program expenditures and the state's budget situation; and expected changes in policy, provider requirements, and provider reimbursement; waiver application and amendment status; and other issues impacting service delivery and program operations.
- **The State Quality Management Committee (SQMC) Meeting**. DIDD management staff participates in the SQMC Meeting to discuss provider performance on QA surveys and actions taken as a result of survey findings such as technical assistance, moratoria, and terminations. Performance measure data and root causes for compliance issues are identified and discussed. Systemic issues are identified and appropriate systemic remedial actions are also discussed. Reports and recommendations from Regional Quality Management Committees (RQMCs) are reviewed. The DIDD Monthly Quality Management (QM) Report and TennCare discovery and remediation summary reports provide the data utilized for identification of issues. A report of SQMC activities is presented during the SCQI meeting referenced above.

IN.7.c. Department of Intellectual and Developmental Disabilities. The Department of Intellectual and Developmental Disabilities (DIDD/the Department) is the Operational Administrative Agency for Medicaid waiver programs for persons with intellectual disabilities. DIDD is also the state agency responsible for the administration of other programs that provide services to persons with intellectual disabilities. The Department is composed of a Central Office and three (3) Regional Offices (East,

Middle, and West). Administrative and operational functions performed by DIDD include:

1. Management of a qualified provider network sufficient to assure accessibility to services.
2. Development and implementation of approved policies and procedures.
3. Management of an intake process for people seeking services.
4. Enrollment of program participants.
5. Management of waiting lists for services.
6. Approval of individual support plans (ISPs) and pre-authorization of services.
7. Processing and adjudicating provider billing for services rendered.
8. Provision of training and technical assistance to providers.
9. Implementation of a QM program to ensure that services are provided in accordance with state and federal laws, regulations, rules and policies.
10. Completion of monitoring activities to determine provider compliance with the approved waiver application and with state and federal rules, regulations, and policies.
11. Implementation of grievance and appeals procedures applicable to program participants and providers.
12. Provision of informational materials to providers, people receiving services, and their families, potential applicants for services and other interested stakeholders.

IN.8. DIDD Vision, Mission and Values. DIDD is dedicated to serving people with intellectual disabilities in Tennessee and to supporting their families, caregivers, and providers who deliver the supports and services necessary to promote their personal quality of life.

IN.8.a. Vision Statement. The Department's vision is to support all Tennesseans with intellectual and developmental disabilities to live fulfilling and rewarding lives.

IN.8.b. Mission Statement. The Department's three-fold mission is as follows:

1. Through person-centered practices, persons with intellectual disabilities experience optimal health as a cornerstone for quality of life.
2. DIDD provides leadership and direction in a service delivery system that offers a continuum of services and supports so persons with intellectual disabilities will be

gainfully employed to their maximum ability, live in quality homes, develop meaningful relationships, and are part of the communities in which they live.

3. DIDD is purposefully and systematically structured so that people are supported, quality services are designed and managed, and evidence-based practice is used to continue to improve services provided to people with intellectual disabilities and their families.

IN.8.c. Values. Values are the principles that apply to all levels of the service delivery system. Values guide the day to day decisions that are made in service delivery, as well as the decisions that are made related to the system as a whole. The following values are to be recognized and utilized by all partners in service delivery:

1. **Honoring the individual rights of persons supported** is crucial and must be maintained at all levels of the system. The Department is committed to assuring that the rights of persons using services are protected and promoted, including rights afforded by the United States Constitution and the United Nation's Declaration of Human Rights.
2. **Focus on persons supported** must be maintained at all levels of the system. Persons supported are the most important participants in the system.
3. **Effective service and support planning and coordination** is crucial to the quality of life, health, and safety of persons supported.
4. **Individual choices** of persons are the foundation of service planning and delivery. It is incumbent on all individuals touching the lives of persons supported to ensure that they have the information needed to make informed decisions.
5. **Opportunities** to accomplish personal outcomes, live a meaningful life, and be included in the community are identified in the development and implementation of support plans.
6. **Safety and security** are essential to a person being able to achieve personal outcomes.
7. **Risk identification and planning** are essential to achieving a balance between allowing personal choice and protection from harm.
8. **Respect** of persons and the staff involved in direct delivery of their services is crucial at all levels of the system.
9. **Professionalism** of state and provider employees is essential to ensure the level of collaboration (guiding, coaching, modeling and supporting rather than supervising, controlling and care-taking) in the provision of services that will

result in achievement of personal outcomes. Expectations for achievement are high and it is expected that services are not intrusive or demeaning.

10. **Person- and family-friendly** information is necessary to promote understanding, choice, and ownership of the service delivery system. Training opportunities for persons supported and their families are needed to ensure understanding and appropriate utilization of services within the system.

11. **Reliable and valid data and information** must be easily accessible to all stakeholders to promote understanding of the system, identification of problems and issues and planning for effective ways of improving the system.

12. **Stakeholder input** is essential to developing and maintaining service delivery mechanisms that meet the needs of persons served from an operational standpoint and that ensure smooth implementation of changes in policy and operational procedure.

13. **Systems change and quality improvement (QI)** opportunities that benefit persons must be identified and implemented on an ongoing basis. Systemic issues, provider compliance issues, and individual problems must be identified, analyzed, and resolved in an organized, timely manner.

14. **Innovative approaches** that ensure the best use of available public funds must be employed to ensure that the maximum number of people have access to needed services.

15. **Compliance** with applicable state and federal statutes, rules, regulations and policies is necessary to ensure that adequate funding is available to provide access to services.

16. **Quality assurance** (QA) monitoring must be focused on achieving desired outcomes and ongoing compliance. Changes in quality monitoring must be accomplished in an organized manner that ensures stability of the system.

17. **Effective provider training and technical assistance** opportunities are necessary to ensure that providers achieve and maintain desired outcomes and programmatic compliance.

18. **Equity** must be achieved and maintained in the provision of services and treatment of providers.

19. **Provider payment rates** must be such that an adequate provider network is maintained and quality services are possible within available State appropriations.

CHAPTER 1

ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

1.1. Introduction.

This chapter describes the process of establishing eligibility for programs operated by the DIDD, as well as, requirements for establishing and maintaining eligibility for Medicaid-funded HCBS waiver programs.

1.2. Initial Contact and Referral.

Local providers are not involved in the initial determination of eligibility for services, but may be the first point of contact for people seeking to apply for services. When this occurs, provider staff must refer the person to the appropriate DIDD Regional Office so that prescreening and eligibility determination processes can be initiated. Contact numbers for Regional Offices are available on the DIDD website. The person may contact the local Regional Office directly or the contact may be made by anyone who has the person's permission, including employees of a local provider.

1.3. Eligibility for DIDD Services.

To be eligible for any DIDD program with the exception of Family Support, there must be documentation or evidence of a diagnosis of an intellectual disability with an overall Intelligence Quotient (IQ) Score of seventy (70) or below. The onset of the intellectual disability must have occurred prior to the age of eighteen (18).

For children under the age of five (5), IQ testing may be unreliable and services may be provided if there is presenting evidence of substantial developmental delay or if a condition is present that has a high probability of resulting in substantial developmental delay. If enrollment does occur prior to the age of five (5) due to a developmental disability, the person will be evaluated for a diagnosis of an intellectual disability when testing is considered to be reliable.

1.4. Additional Eligibility Criteria for Enrollment into DIDD Services and Programs.

1.4.a. Family Support. The eligibility criteria for this program are as follows:

1. The applying family must have a family member who has a severe disability.
2. The severe disability must be one that is attributable to a mental or physical impairment; is likely to continue indefinitely; and results in substantial functional limitations in three or more major life activities, such as self-care, receptive/expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency.

1.4.b. Arlington Waiver (0357). The eligibility criteria for this HCBS waiver is as follows:

1. Meet TennCare ICF/IID level of care criteria (TennCare Rule 1200-13-1-.15) and financial eligibility criteria and have a Pre-Admission Evaluation (PAE) approved by TennCare;
2. Have been assessed and found to have mental retardation (i.e., intellectual disability) manifested before eighteen (18) years of age, as specified in Tennessee State law (T.C. A. § 33-1-101); and
3. Are class members certified in United States vs. State of Tennessee, et al. (Arlington Developmental Center).

1.4.c. Self Determination Waiver Program (0427). The eligibility criteria for this HCBS waiver is as follows:

1. Meet TennCare ICF/IID level of care criteria (TennCare Rule 1200-13-1-.15) and financial eligibility criteria and have a PAE approved by TennCare.
2. Have been assessed and found to:
    a. Have mental retardation (i.e., intellectual disability) manifested before eighteen (18) years of age, as specified in Tennessee State law (T. C. A. § 33-1-101); or,

b. Have a developmental disability, which is defined as a condition of substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in mental retardation (i.e., intellectual disability) and be a child five (5) years of age or younger; and

c. Does not require residential habilitation, supported living, or family model residential services.

1.4.d. Statewide Waiver (0128). The eligibility criteria for this HCBS waiver is as follows:

1. Meet TennCare ICF/IID level of care criteria (TennCare Rule 1200-13-1-.15) and financial eligibility criteria and have a PAE approved by TennCare.
2. Have been assessed and found to:
   a. Have mental retardation (i.e., intellectual disability) manifested before eighteen (18) years of age, as specified in Tennessee State law (T. C.A. § 33-1-101); or,
   b. Have a developmental disability, which is defined as a condition of substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in mental retardation (i.e., intellectual disability) and be a child five (5) years of age or younger.

1.4.e. State-Funded Services. The amount of money available for state-funded services is limited. The Department's ability to offer state-funded services is dependent upon available funding. The eligibility criteria for this program are as follows:

1. The applicant may be financially ineligible for participation in the Medicaid waiver.
2. The applicant may be ineligible for the Medicaid waiver due to not meeting ICF/IID level of care criteria.
3. The applicant may need services that cannot be provided in a Medicaid waiver for other reasons.

1.5. Financial Eligibility for Medicaid Programs.

1.5.a. Responsibility for Financial Eligibility Determinations. TennCare contracts with the Department of Human Services (DHS)[11] to accept applications and determine financial eligibility for Medicaid/TennCare services. DIDD has made arrangements with DHS for specially trained staff persons to be designated to determine financial eligibility for the Medicaid waiver programs for persons with intellectual disabilities. Financial eligibility determinations may take up to forty-five (45) days, unless a disability determination is needed. When disability determinations are required, the process can take up to ninety (90) days.

1.5.b. Determination of the Amount the Person Supported Must Contribute to Cost of Care. After a person is determined to be financially eligible for Medicaid long-term care services, DHS then determines if the person is responsible for using some of his/her income to pay for the cost of care and establishes the amount he/she is responsible for paying. Federal law recognizes that persons who participate in Medicaid HCBS waivers may have to use part of their income to maintain a residence in the community. Consequently, CMS also requires states to specify how much of a person's available income can be set aside for living expenses and excluded from income when patient liability is established. Tennessee has specified that 200% of the SSI/FBR will be set aside for personal expenses for the Arlington and Statewide waivers. For the Self Determination Waiver, Tennessee has specified that 300% of the SSI/FBR will be set aside for personal expenses.

1.5.c. Resource Limits. In addition to income limits, there are also limits on the resources a person can have and still be eligible for Medicaid benefits. If a person has more than $2000 in resources, he/she may not be financially eligible for Medicaid. The following may be excluded from consideration as resources:

[11] Effective January 1, 2014, TennCare will make financial eligibility determinations.

1. The home of the person supported.
2. A car, if modified for handicapped accessibility, if used to travel to a place of employment, if used to access medical treatment or if necessary to perform essential daily activities.
3. Life insurance (face value not to exceed $1500 per owner).
4. Money set aside for burial expenses.

Things that are generally counted as resources include:

1. Bank accounts.
2. Cash on hand.
3. Stocks and bonds.
4. Life insurance with cash value exceeding $1500.
5. Second homes and second cars.

1.5.d. Denial of Financial Eligibility. When an applicant is denied eligibility for Medicaid, the DHS will notify the person in writing, including the reason for denial, right to request a fair hearing, and appeal procedures. If a person had been determined financially eligible and was later determined ineligible, involuntary disenrollment procedures would be followed. Discussion of involuntary disenrollment is provided later in this chapter.

1.5.e. Annual Redetermination and Reapplication and Ongoing Financial Eligibility. Unless the person is actively receiving SSI Benefits, sufficient information must be provided to the DHS for determination of continuing financial eligibility to be made. When the redetermination/reapplication is due, the DHS will mail a Form 1860 to the designated representative payee. Upon receipt, the representative payee must complete the required forms and contact the appropriate DHS staff by telephone to complete an interview, during which, the person's current income and resources will be verified. If the forms and interview are not completed in a timely manner, the DHS will determine the person to be ineligible for continuation of Medicaid. Providers who are involved with managing or assisting in management of personal funds must track resources and be aware of changes in the person's income that could affect his/her Medicaid eligibility. Providers serving as the representative payee for a person must

complete the required forms and interview for annual redetermination/reapplication within the specified time frames to avoid discontinuation of Medicaid-funded services.

1.6. Medical Eligibility for Medicaid Services.

1.6.a. Responsibility for Determination of Medical Eligibility. Medical eligibility determination is the responsibility of the TennCare, Division of Long-Term Services and Supports. To be medically eligible to receive services in a Medicaid HCBS Waiver for people with intellectual disabilities, level of care criteria for admission in an ICF/IID must be met in accordance with TennCare Rules.[12]

1.6.b. Ongoing Medical Eligibility for Medicaid Waiver services. DIDD must ensure that the independent support coordinator (ISC)/case manager (CM) reevaluates the person's need to continue to receive waiver services within twelve (12) calendar months of the person's enrollment and annually thereafter. See Chapter 4 for a description of support coordination

1.7. Enrollment into Medicaid Waiver Programs.

DIDD is responsible for enrolling persons into Medicaid Waiver programs. Services may begin when providers have been identified and services are authorized. For enrollment in the Statewide or Arlington Waivers, when individual circumstances permit, the first provider chosen may be the ISC in order to assist in selection of other service providers and to initiate the process of developing the ISP. However, in emergency or crisis situations, the Regional Intake CM assists the person and family in provider selection and all providers are authorized to begin at the same time. The ISC will initiate the development of the ISP and assist in coordination of any other services needed. If a person is enrolled in the Self-Determination Waiver or otherwise receiving DIDD case management, the DIDD CM will provide information for the person/family to make an informed choice of providers, in establishing program eligibility and in developing the ISP. The PAE, which includes a listing of initial services to be provided, serves as the initial plan of care until the ISP is developed.

[12] TennCare rules can be accessed online by visiting: http://www.tn.gov/sos/rules/1200/1200-13/1200-13.htm

1.8. Disenrollment from Medicaid Waiver Programs.

1.8.a. Voluntary Disenrollment. Waiver participation is voluntary. A person who is enrolled in a Medicaid Waiver may decide to disenroll at any time. To disenroll from the waiver program, written notice must be provided to the appropriate DIDD Regional Office by the person or the person's legal representative. DIDD staff will assist the person as needed or requested in arranging alternative placement or services.

1.8.b. Involuntary Disenrollment. DIDD may initiate involuntary disenrollment procedures in accordance with TennCare Rules with prior approval from TennCare if:

1. The HCBS Waiver is terminated.
2. A person becomes ineligible for Medicaid or is found to be erroneously enrolled in the Waiver.
3. A person moves out of the State of Tennessee.
4. The condition of the person improves such that the person no longer requires the level of care provided by the Waiver.
5. The person's medical or behavioral needs become such that the health, safety, and welfare of the person cannot be assured through the provision of Waiver Services.
6. The home or home environment of the person becomes unsafe to the extent that it would reasonably be expected that waiver services could not be provided without significant risk of harm or injury to the person or to individuals who provide covered services to the person.
7. The person or the person's guardian or conservator refuses to abide by the Plan of Care or related Waiver policies, resulting in the inability of the Operational Administrative Agency to ensure quality care or the health and safety of the person.
8. The health, safety and welfare of the person cannot be assured due to the lack of an approved Safety Plan.
9. The person was transferred to a hospital, NF, ICF/IID, Assisted Living Facility, and/or Home for the Aged and has resided there for a continuous period exceeding ninety (90) days.
10. The cost for all covered waiver services, including Emergency Assistive services, for an individual enrolled in the Tennessee Self Determination Waiver Program

has reached the waiver limit and the Operational Administrative Agency cannot assure the health and safety of the person.

DIDD must provide written notice to the person and offer assistance with making arrangements for alternative services. Appeal rights must be described within the written notice. The provider is responsible for continuation of services, as directed by DIDD or TennCare, until appeal rights are exhausted.

CHAPTER 2

RIGHTS APPLICABLE TO ALL PEOPLE WITH INTELLECTUAL DISABILITIES

2.1 Introduction.

People with intellectual disabilities have the same rights as other people unless their rights have been limited by court order or law. People do not give up their rights when they accept services from the DIDD or other state programs. There are basic human and civil rights that are protected by the United States Constitution, and state and federal laws. Many of these laws take the form of protecting people from discrimination. People with intellectual disabilities must be treated fairly and equally when services are being developed and provided. People with intellectual disabilities are entitled to the same human rights as those of individuals who do not have intellectual disabilities.[13] DIDD providers must adhere to 45 C.F.R. §84 and Title 33 of the T.C.A. as the primary laws governing the methods employed in service delivery to people with intellectual disabilities.

2.1.a. Individual Rights. Individuals receiving DIDD services shall be entitled to the following rights included but not limited to:

1. To be treated with respect and dignity as a human being.
2. To have the same legal rights and responsibilities as any other person unless otherwise limited by law.
3. To receive services regardless of gender, race, creed, marital status, national origin, disability or age.
4. To be free from abuse, neglect and exploitation.
5. To receive appropriate, quality services and supports in accordance with an ISP.

[13] United Nations Declaration of Human Rights http://www.un.org/en/documents/udhr/index.shtml

6. To receive services and supports in the most integrated and least restrictive setting that is appropriate based on the particular needs of the person supported.
7. To have access to DIDD rules, policies and procedures pertaining to services and supports.
8. To have access to personal records and to have services, supports and personal records explained so that they are easily understood.
9. To have personal records maintained confidentially.
10. To own and have control over personal property, including personal funds.
11. To have access to information and records pertaining to expenditures of funds for services provided.
12. To have choices and make decisions.
13. To have privacy.
14. To receive mail that has not been opened by provider staff or others unless the person or family has requested assistance in opening and understanding the contents of incoming mail.
15. To be able to associate, publicly or privately, with friends, family and others.
16. To have intimate relationships with other people of their own choosing.
17. To practice the religion or faith of one's choosing.
18. To be free from inappropriate use of physical or chemical restraint.
19. To have access to transportation and environments used by the general public.
20. To be fairly compensated for employment.
21. To seek resolution of rights violations or quality of care issues without retaliation.

2.2. Licensure Rules Pertaining to the Rights of Persons Supported.

The subject of rights pertaining to persons supported is addressed in several different sections of promulgated licensure rules, which are available online.[14]

2.3. The Rights of Individuals Receiving DIDD Services.

DIDD is committed to taking an active part in assuring that individuals receiving services understand their rights. DIDD is also committed to ensuring that providers train their staff to understand individual rights and focus on assisting people in exercising their rights. Individuals

[14] http://www.state.tn.us/sos/rules/0940/0940-05/0940-05.htm

receiving services must also be assisted in understanding the responsibilities associated with having certain rights. DIDD requires providers to implement policies and procedures that promote people's rights. Provider policy should:

1. Define how the organization will protect and promote rights of people using services.
2. Describe the organization's due process procedures.
3. Prohibit standing policies and practices that restrict rights.

Organizations should support people to exercise their rights and responsibilities. This should be done by knowing what rights are important to people using services and supporting them to exercise those rights such as voting, managing money, moving freely, having privacy, using the telephone and other electronic communication avenues, visiting and being visited by whomever they choose, access personal possessions, etc.

2.4. Provider Responsibilities Related to Individual Rights.

When a provider establishes a provider agreement with DIDD, the provider is agreeing to accept the responsibility of providing quality services to people as authorized in the Plan of Care (i.e., ISP) and to meet program requirements. When a provider agrees to render services to a person, the provider is in essence making a promise to honor the individual's rights and provide services in a way that is in the best interests of that individual. The Department wants to call attention to the fact as well as emphasize that people living with disabilities have all of the same rights as everyone else has. All staff employed by the provider to directly provide or oversee services, including the executive director or chief executive officer, management and administrative staff, contracted staff entities, direct support staff and volunteers have a role in contributing to the overall quality of services and in assuring that people are treated fairly and respectfully. This includes respecting the rights, lifestyle and/or personal beliefs of the person supported and not making comments or engaging in behavior that is meant to express an opinion or persuade change.

2.4.a. Staff Training. Providers must ensure that their staff have a basic understanding of individual rights and how to honor those rights while providing services. This is generally accomplished through a combination of training, mentoring

and providing adequate staff oversight and guided by provider policy. Staff should be trained to recognize and respect people's rights, to recognize and honor preferences in regard to how people choose to exercise their rights, and trained in due process procedures for placing a limitation of restriction on a person's rights.

2.4.b. Facilitating Understanding of Rights and Responsibilities. In addition to honoring individual rights and assisting people to exercise their rights, providers have a responsibility to help people understand that along with rights come responsibilities. To fully participate in community life, people must be assisted in learning what is expected of them when certain choices are made.

For instance, a person who wants to own their own home must be helped in understanding to the extent practicable that home ownership results in certain obligations, such as employment, mortgage payments, maintaining insurance, keeping the yard mowed, making repairs to things that break, etc. Providers are encouraged to assist persons supported and their informal support networks in accessing opportunities to learn about rights and responsibilities.

Providers are also encouraged to distribute available information to persons supported, families and legal representatives through self-advocacy training courses, focus groups, DIDD and TennCare individual and family meetings and other opportunities to learn about rights and responsibilities.

2.4.c. Intimate Relationships. Individuals supported have the right to have intimate relationships with other people of their own choosing, unless such rights have been specifically restricted by a court order. Intimacy is defined as sharing oneself with another person in a way one would not share with others. Intimate relationships include intellectual, social, emotional and physical components.

2.5. Title VI of the Civil Rights Act of 1964.

Title VI of the Civil Rights Act of 1964 prohibits certain types of discrimination in programs that utilize federal funds. Medicaid waivers are examples of programs that are partially funded with federal dollars. DIDD as well as DIDD providers must comply with Title VI requirements. The Department and DIDD providers must not exclude, deny benefits to or otherwise discriminate against any applicant for services or person supported based on race, color or national origin in the admission to or participation in any of its programs and activities. Prohibited practices include, but are not limited to, the following:

1. Denying any service, opportunity or other benefit for which an applicant or person supported is otherwise qualified.
2. Providing any applicant or person supported with any service or other benefit which is different or is provided in a different manner from that which is provided to others in the same program.
3. Subjecting any person supported to segregated or separate treatment in any manner related to the receipt of a service.
4. Restricting any person supported in any way in the enjoyment of services, facilities or any other advantage, privilege or benefit provided to others in the same program.
5. Adopting methods of administration that would limit participation or subject any group of applicants or persons supported to discrimination.
6. Addressing an applicant or person supported in a manner that denotes inferiority because of race, color, or national origin.
7. Subjecting any applicant or person supported to racial or ethnic harassment, to a hostile racial or ethnic environment or to a disproportionate burden of environmental health risks.

2.5.a Provider Requirements. All providers must ensure that applicants and persons supported receive equal treatment, equal access, equal rights and equal opportunities without regard to race, color, national origin or limited English proficiency (LEP). Providers must meet the following requirements:

1. Service providers, ISCs, and CMs must document that persons receiving services or persons on the waiting list for services are informed of Title VI protections and remedies for Title VI violations on an annual basis.
2. All providers must designate a Title VI Local Coordinator.

3. All providers must ensure that persons supported know who the Local Coordinator is and how to contact him/her.

4. All providers must develop and implement written policies and procedures addressing:

   a. Employee training to ensure Title VI compliance during service provision.

   b. Employee training to ensure recognition of and appropriate response to Title VI violations.

   c. Complaint procedures and appeal rights pertaining to alleged Title VI violations for persons supported.

   d. Personnel practices governing responses to employees who do not maintain Title VI compliance in interacting with persons supported.

5. All providers must provide or arrange language assistance (i.e., interpreters and/or language appropriate written materials) to LEP persons at no cost to the person.

6. All providers must provide meaningful access to services to LEP persons.

7. All providers must have a mechanism for advising persons regarding the options for filing a Title VI complaint.

8. All providers must display Title VI materials in conspicuous places accessible to persons (Materials are available from Local Coordinators, DIDD Regional Office Title VI Coordinators or the DIDD Central Office Title VI Coordinator.).

9. Residential providers must ensure that room assignments and transfers are made without regard to race, color, or national origin.

10. All providers must complete and submit an annual Title VI self-survey in the format designated by DIDD and in accordance with Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons ("Revised HHS LEP Guidance").

11. All providers must orient employees to their Title VI responsibilities and the penalties for noncompliance.

12. All providers must ensure that vendors, subcontractors and other contracted entities are clearly informed of Title VI responsibilities and are required to maintain Title VI compliance.

2.5.b. Failure to Maintain Title VI Compliance. Any service provider found to be in non-compliance with Title VI will be provided written notice. Failure to eliminate further discrimination within ninety (90) days of receipt of notice will be considered a violation of the terms of the provider agreement and basis for contract suspension, termination, or rejection.

2.6. Complaint Resolution.

Providers are required to establish a complaint resolution process to address complaints submitted by persons and families. Providers are also required to have an identified complaints contact person and to maintain documentation of all complaints filed. The Department has coordinators in the regions of the state who assist with complaint resolution. Complaints are monitored via the DIDD database to ensure timely and satisfactory resolution.

2.6.a Provider Responsibilities for Complaint Resolution. By virtue of being a licensee under T.C.A. § 33-2-402 and in accordance with the DIDD provider agreement, providers are required to adhere to Section 84.7 of the Rehabilitation Act of 1973 and develop written policies that describe how service providers will resolve complaints and other issues relative to the provision of services.

Providers are required to ensure that information about such policies has been provided to persons supported and/or their legal representatives. Providers are required to implement complaint resolution processes to ensure that complaints are recorded, action is taken for resolution and is documented. The provider's complaint resolution system must include but is not limited to:

1. Designation of a staff member as the complaint contact person.
2. Maintenance of a complaint contact log.
3. Documentation and trending of complaint activity.

Upon admission providers must notify each person, family members and/or legal representative of their complaint resolution system, its purpose and the steps involved to access it. Providers must attempt to resolve all complaints within 30 days of the date that the complaint was filed.

Providers shall inform persons supported or their legal representative that filing a complaint does not void their right to request a fair hearing, nor is it a prerequisite for a fair hearing.

In the event that persons supported, family members and/or legal representatives do not agree with a provider's proposed solution to a complaint, they may contact the DIDD Regional Complaint Resolution Coordinator for assistance. The DIDD Regional Complaint Resolution Coordinator will subsequently contact the provider(s) and/or other party(ies) involved to discuss potential resolutions to the complaint. These could include formal mediation or intervention meetings. The timeline for resolving the complaint is within 30 days of the date that the complaint was filed with the DIDD Regional Complaint Resolution Coordinator. The DIDD Regional Complaint Resolution Coordinator notifies, in writing, the provider(s) and/or other party(ies) involved of the outcome of the complaint within two (2) business days.

2.6.b. Retaliation for Involvement in a Complaint Process. Retaliation against a person supported or other party as a result of filing a complaint or involvement in a complaint process is specifically prohibited by 45 C.F.R. § 80.7(e) and will not be tolerated by DIDD. If such retaliation is found to have occurred, appropriate action against the provider will be initiated up to and including termination of the provider agreement.

2.7. Privacy and Confidentiality of Records.

2.7.a. Confidentiality. Providers shall create an individual record for each person supported that contains documentation of services provided. All records and information obtained and/or created by the provider, regardless of whether the information is kept and/or shared as a paper document, as an electronic record, as a verbal report or by any other means shall be kept confidential in accordance with applicable state and federal laws, rules, regulations, policy and ethical standards.

2.7.b. HIPAA and HITECH Compliance. Providers shall implement policies and procedures that comply with the Health Insurance Portability and Accountability Act

(HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH), the provider agreement, and as follows:

1. Designate a Privacy Officer, responsible for development and implementation of HIPAA-compliant policies and procedures and for responding to HIPAA-related complaints.
2. Identify the level of access to protected health information (PHI) necessary for each staff person to complete designated job responsibilities.
3. Obtain signed confidentiality statements from all staff.
4. Establish disciplinary actions for staff who do not adhere to HIPAA-related policies.
5. Assure that PHI is not left unattended or visible in public areas.

2.7.c. HIPAA and Individual Rights. Providers shall honor individual rights as specified in HIPAA and in accordance with the following:

1. Allow persons to see their records.
2. Provide copies of personal records to persons upon request. Additionally, providers are expected to educate people using services about their record and its contents.
3. Provide information to persons about how information is used and shared.
4. Respond to requests from persons to restrict the use and/or disclosure of personal information.
5. Respond to requests from persons to change incorrect information in records.
6. Provide persons with a list of people or entities who have obtained information from their records.
7. Honor requests from persons that certain health information not be shared.
8. Honor requests to rescind consents to share information.

2.8 Appeals.

2.8.a. Medicaid/TennCare Appeals. Federal Medicaid laws and regulations provide certain protections to people who apply for or receive services funded by Medicaid.

2.8.b. Fair Hearings (42 C.F.R. § 431.200). There are several situations when a person can appeal a determination made by the State and have the right to a fair hearing.

2.8.c. Provider Responsibilities Related to Eligibility Appeals. ISCs and CMs are required to assist applicants/people supported in appealing eligibility denials or terminations of eligibility as necessary. This may involve explaining any denial notices received, explaining the appeals process, assisting the applicant/person supported in submission of a timely appeal request, assisting the applicant/person supported in preparing for the appeal hearing, assisting in making arrangements for a telephone or "in-person" hearing, assisting the applicant/person supported in obtaining legal representation and/or providing testimony regarding needs and capabilities during an appeal hearing. Other providers may be required to provide records, information or hearing testimony that allows the judge to determine if eligibility criteria or requirements are met.

2.8.d. Service Appeals. Service appeals are related to the ability to receive a particular service within a program that may offer a variety of different service options.

The Grier Revised Consent Decree (Grier order) is a court-ordered settlement which was the result of a class action lawsuit called *Grier vs. Wadley.* The Grier order outlines requirements which ensure adequate notice and procedural protection upon the denial of Medicaid services to an eligible person. The Grier order is also available on the TennCare web site.[15]

2.8.e. Denials of Waiver Benefits or Services. The Grier order applies when a person enrolled in the waiver program experiences an "adverse action" regarding Medicaid benefits or services. An "adverse action" refers to a delay, denial, reduction, suspension or termination of Medicaid benefits or services, as well as, any acts or omissions which impair the quality, timeliness or availability of such benefits or services.

The Grier order contains specific appeal rights, notice requirements, procedural guidelines and compliance requirements to ensure that every denial of a Medicaid benefit or service is processed in the same manner.

[15] http://www.tn.gov/tenncare/forms/grier020508.pdf

2.8.f. Provider Responsibilities in Maintaining Grier Compliance. Providers have the responsibility to maintain compliance requirements as defined in the Grier order. Provider responsibilities include, but are not limited to:

1. Ensuring that services are provided in full as authorized in the Plan of Care (i.e., ISP).
2. Services must be provided consistently and timely, ensuring that there are no gaps in service delivery. There must not be any act or omission which would impair the quality, timeliness or availability of authorized services. Failure to provide services in accordance with these requirements may result in sanctions or recoupment of funds by the DIDD.
3. Providing all relevant information with service requests and responding promptly to Regional Office requests for clarification or additional information regarding service requests.
4. Providing documentation and information as necessary to the DIDD or TennCare staff to ensure timely resolution of appeals.
5. Ensuring that appropriate staff are educated on the Grier order, specifically on its compliance requirements in relation to the Medicaid waiver. At a minimum, appropriate staff are those who are directly or indirectly involved in ensuring that services are provided consistently and timely, are responsible for scheduling and employing direct care staff, are responsible for health care management and oversight or involved in obtaining service authorizations.

2.9 Human Rights Committees.

Human rights are innate rights and freedoms to which all humans are entitled. These rights include the right to life, liberty, equality, and the pursuit of happiness. Human rights also refer to basic respect and dignity that must be afforded to each individual. Regional and Local Human Rights Committees (HRCs) serve as advisory committees to the DIDD regional director, executive director or chief executive officer, and ensure that human and civil rights of persons receiving services through the DIDD are not violated.

2.9.a. Local HRCs. Local HRCs may conduct HRC business for a single provider or a group of providers. Local HRCs must be authorized to perform HRC functions by the DIDD Regional Director. For Local HRCs, the provider executive director(s)/chief executive officer(s) is responsible for appointment of HRC members.

Local HRC members shall be individuals who are familiar with people with disabilities and have relevant professional or personal experience which contributes to their role as an HRC member. Provider(s) involved with a Local HRC are responsible for providing adequate staff to administratively support the committee. If a Local HRC has been formed by a single provider, the provider executive director/chief executive officer is responsible for operational oversight and administrative support of the HRC. If multiple providers jointly form a Local HRC, the executive directors/chief executive officers shall determine which of the executive directors/chief executive officers are responsible for operational oversight and administrative support of the HRC.

2.9.b. Regional HRCs. Regional HRCs perform the same function as local HRCs, but they also serve to resolve human rights issues that cannot be resolved at the local level and provide oversight to the local HRCs. Members of Regional HRCs are appointed by the DIDD regional director. Like Local HRC members, Regional HRC members shall be individuals who are familiar with people with disabilities and have relevant professional or personal experience which contributes to their role as an HRC member. Regional office staff are responsible for the operational oversight and administrative support of the HRC.

2.9.c. Provider Responsibilities for Maintaining Authorization as a Local HRC. To continue authorization to perform HRC functions, the HRC must:

1. Ensure that the provider executive director/chief executive officer responsible for operational oversight of the HRC provides an annual roster of HRC membership to the DIDD regional director, within thirty (30) days of the beginning of each calendar year.
2. Ensure that the provider executive director/chief executive officer responsible for operational oversight of the HRC notifies the regional director of any changes in membership, change of chairperson or change of entity responsible for operational oversight that occurs throughout the year, within thirty (30) calendar days of the change occurring.
3. Ensure that the HRC is duly constituted at all times.
4. Ensure that meeting minutes are provided to DIDD regional director.
5. Ensure that all HRC performance standards and requirements are met.

2.9.d. Composition of a HRC. All HRCs will be composed of, at a minimum, four (4) members. HRC membership shall include:

1. A community representative who serves as the chairperson. The chairperson can serve for no more than three (3) consecutive years per term, and there must be at least three (3) years between terms.
2. A minimum of one (1) not to exceed a maximum of three (3) community representatives from relevant professions (e.g., clergy, law, psychology, psychiatry, behavior analysis, pharmacy, social work, counseling or medical), at least one of whom has experience with human rights issues.
3. A minimum of one (1) family member of a person with a disability.
4. A minimum of one (1) person with a disability.

2.9.e. Functions of the Local and Regional HRC. In addition to its advisory role concerning the rights of the people served, in those limited situations where HRCs have the authority to approve restrictions, HRCs function is to ensure that rights limitations are temporary in nature and that they occur in very specifically defined situations.

Except where noted all HRC reviews and/or approvals are valid for a period of time to be specified by the committee but for no longer than twelve (12) months. The functions of a HRC are:

1. Review behavior support plans (BSPs) that include restrictive interventions for potential human rights violations and informed consent.
2. Review any proposed or emergency right restrictions and restraints not contained in a BSP for potential human rights violations and informed consent.
3. Review of psychotropic medications.
4. Review and make recommendations regarding complaints received pertaining to potential human rights violations.
5. Provide technical assistance to providers regarding policies or procedures affecting the rights of an individual or the ability of an individual to exercise their rights.
6. Review and make recommendations regarding research proposals or academic projects involving individuals receiving services through DIDD to ensure that

implementation of the proposal or project will not result in human rights violations.

7. Ensure that proposed restriction is the least restrictive viable alternative and is not excessive.

8. Ensure that proposed restriction is not for staff convenience.

2.9.f. Conflict of Interest. Any HRC member who is involved in a matter under review or consideration by the HRC shall not participate in decision-making processes pertaining to that matter. If a conflict of interest involves the chairperson of the HRC, another HRC member must be designated to serve as chairperson while such matter is under review or consideration. Staff employed or contracted by providers shall not be involved in decision making or review of matters concerning individuals provided services by their employer or concerning other employees of the same agency. Behavior analysts who developed a BSP or who will be responsible for ensuring implementation of a BSP shall not be involved in decision making regarding approval of that BSP.

2.9.g. Local HRC Disposition Requirements. The HRC must address all business issues brought before the committee in a timely fashion. Final determinations must be provided no later than thirty (30) business days following presentation of the issue. Local HRC decisions may be appealed to the Regional HRC.

2.9.h. Confidentiality/HIPAA. HRC members have a responsibility to keep information discussed during meetings confidential. All individuals attending an HRC meeting must sign a confidentiality agreement. Aside from HRC members, only those individuals directly involved with the issue being presented to the committee or speaking on behalf of the individual may attend the HRC meeting. Arrangements must be made to ensure that individuals attending for issues involving other individuals do not have inappropriate access to confidential information. All HRCs maintain minutes of the meetings; all confidential reports disseminated to committee members must be shredded after the meeting.

2.10. Options for Individuals Determined Unable to Make Decisions.

A person under Tennessee law is deemed to have capacity unless otherwise adjudicated by a court. It is DIDD's position that a person's rights be preserved to the fullest extent possible. Conservators shall render decisions regarding only those rights explicitly removed from the person in the court order and all other rights shall remain with the person.

2.10.a. Conservator. A conservator is appointed by a court as its agent to act as a decision maker on behalf of a person with disability(ies) whom the court has formally determined to be a 'disabled person' as found in T.C.A. § 34-1-101 and T.C.A. § 34-1-126.

Any party having knowledge of circumstances necessitating appointment of a conservator can file a petition for appointment of a conservator under T.C.A. § 34-3-102. When a conservator is appointed, the court order will specify the powers removed from the individual and vested to the conservator T.C.A. § 34-3-107(2). The conservator's decision making authority is limited to that contained in the Order.

2.10.b. Providers and Family Members Serving as Conservators or Representing an Individual under a Durable Power of Attorney. A conservatorship establishes a legal, court-ordered association between the person or entity appointed in the conservatorship order to act in the *best interest* of the individual with disability(s). This relationship is 'fiduciary' in nature; as a fiduciary the Conservator has a legal duty to carry out his/her responsibilities under the highest standard of care required by law; therefore, situations that could be construed as a conflict of interest must be avoided. It is improper for an individual or entity acting as a conservator to be in a position to profit (receive gain) from decisions made on behalf of the person with disability(s). To this end:

1. Management or a person in a decision making capacity for a provider agency cannot serve as the conservator for a person supported by that agency(this is not applicable to agencies established to serve only one person); and

2. Family members or entities will not be paid for providing direct services to an individual for whom they are also a fiduciary, unless a court order is obtained expressly allowing them to do so. Even then, the Department must not be required to pay more than DIDD's appropriate and applicable rate or amount for the services supplied.

A power of attorney (POA) establishes a legal relationship in a signed agreement between a person and another person who is named in the agreement to carry out specific duties assigned by the person naming him/her in the instrument. It is not a court-ordered document and therefore can be misused more easily, especially when a suspected vulnerable person may be the one signing over important legal duties to another person. Therefore, the same restrictions and requirements found in **Section 2.10.b.**, subsections 1. and 2. above must be followed.

2.10.c. Provider Responsibilities Related to Court-Appointed Legal Representatives. Providers are expected to work cooperatively with POAs and/or conservators. Providers must have a copy readily available of the POA or conservatorship order under which the fiduciary is exercising his/her authority to make decisions on behalf of the person with disability(ies). Providers are expected to ensure that appropriate staff:

1. Provide basic information to individuals about options for assistance with decision-making.
2. Assist in accessing resources available to help individuals in establishing a POA, conservatorship or other options for decision-making.
3. Understand the roles and responsibilities of POA/conservator.
4. Obtain copies of the court documents pertaining to the appointment of the POA/conservator.
5. Determine the scope of authority of the POA/conservator for decision making.
6. Provide appropriate information and individual records to the POA/conservator in a timely manner when required or requested.
7. Collaborate and consult with the POA/conservator as needed to ensure service provision in accordance with the ISP.
8. Resolve issues of concern with service provision presented by POA/conservator in a timely manner.

9. Advise the POA/conservator if unable to provide services in a manner that is consistent with a decision made.

2.10.d. Health Care Surrogates. Providers should be aware that Tennessee law authorizes health care decision making by a surrogate under some circumstances. Under T.C.A. § 68-11-1806, a competent adult may designate a surrogate to make health care decisions in the event of subsequent incapacity. If a person lacks capacity, does not have a guardian or conservator and has not previously designated a surrogate or an agent (or if those persons are unavailable), the supervising health care provider may designate a surrogate. Relatives of the person supported, such as spouse, adult child, parent or sibling have preference under the statute. Availability, regular contact and demonstrated care and concern for the person supported are important considerations in selection. A surrogate must make decisions in accordance with the instructions and wishes of the person supported, if known, or based on the surrogate's determination of the best interest of the person supported. T.C.A. § 33-3-220 sets forth who may serve as a surrogate decision maker.

For routine medical, dental or mental health treatment of a person with a developmental disability that is not based solely on a diagnosis of mental illness or serious emotional disturbance who does not have a conservator, if the health care professional determines that the person lacks capacity using the assessment process prescribed by rule and there is an eligible adult who is determined to be capable of making such decisions, he or she may do so under T.C.A. § 33-3-219, provided that the person does not reject the proposed surrogate and adequate information is provided on which to make an informed decision.

CHAPTER 3

INDIVIDUAL SUPPORT PLANNING AND IMPLEMENTATION

3.1. The Individual Support Plan.

In accordance with 42 C.F.R. § 441.540, a person-centered service plan of care is developed for each person enrolled in waiver services. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the person, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the person. The ISP serves as Tennessee's required person-centered service plan.

3.2. Individual Support Planning.

The ISP is Tennessee's format for the federally required plan of care. The ISP is a person-centered document that provides an individualized, comprehensive description of the person. This document must provide guidance assisting the person in achieving quality and person-centered outcomes important to and for the person to develop and maintain a good quality of life. The ISP clearly describes the needs of the person and the services and supports required to meet those needs to include third party payer services that are utilized. The ISP also serves as the vehicle for justifying the person's need for services so that services can be authorized.

3.3. Person-Centered Planning Principles.

CMS refers to person-centered planning as "underpinning all aspects of successful HCBS." Successful person-centered planning is a process that focuses on:

1. Who the person is.
2. What the person wants from life, what a person may want to learn.

3. How to accomplish the person's desired outcomes.

4. What is important to the person including things that help a person feel happy, satisfied, and content and fulfilled.

5. What is important for the person which includes health and safety.

Person-centered planning is the process that is used to develop the ISP. The person receiving services and supports owns the ISP. Consequently, the person receiving services and supports is encouraged and supported to lead the person-centered planning process. The Circle of Support (COS) assists the person receiving services and supports with the planning process.

3.4. The Circle of Support.

The person supported and his/her legal representative, if applicable, directs the COS. The person supported and/or the person's legal representative determines who participates in the COS. Because the mission of the COS is to support the person in developing an ISP that will guide the achievement of the person's outcomes, the person may change the membership of the group at any time. At a minimum, the COS includes the person supported, his/her legal representative, the person's family member(s), ISC or CM, and any providers of supports and services the person receives. Friends, advocates, and all other non-paid supports are included at the invitation of the person supported.

During a ISP meeting, the COS works with the person to determine how to incorporate the details of what is important to and for the person's life into the ISP.

A COS meeting may occur at any time the person and legal representative requests a meeting. The ISC/CM as the primary facilitator of the person-centered planning process, is responsible for assisting the person and legal representative in understanding principles of person-centered planning, as well as the purpose of the COS, and state and federal rules and policies applicable to the ISP. The ISC/CM assists the person supported and legal representative, if applicable, in distributing meeting announcements and other materials to COS members.

3.5. The Role of Person-Centered Thinking Skills and Tools in the ISP Planning Process.

Person-Centered Thinking is what underlies and guides the respectful listening that leads to actions that result in people:

1. Having positive control over the life they desire and find satisfying;
2. Being recognized and valued for their contributions (current and potential) to their communities; and
3. Being supported in a web of relationships, both natural and paid, within their communities.

Person-Centered Thinking techniques provide structured ways to teach the value-based behaviors that result in discovering, understanding, and clearly describing the unique characteristics of each person. These techniques support and guide the actions that have the outcomes described above.

Person-Centered Thinking tools and techniques must be used in the development of an ISP. Each tool can stand alone as a way to discover important information or they can be used together. There are a number of Person-Centered Thinking tools available.[16] Use of one or more of the tools can assist in the development of an ISP These tools include but are not limited to those listed below.

1. Donut
2. 4 + 1 Questions
3. Good Day/ Bad Day
4. Important To/Important For
5. Learning Log
6. Matching Profile
7. The Relationship Map
8. What's Working/What's Not Working

[16] http://www.tn.gov/didd/provider_agencies/index.shtml

More information regarding these tools and how they can be effectively implemented is available on the DIDD website.[17]

Information learned when applying these tools assist in determining the foundation of a person-centered ISP – what's important to a person, what's important for a person and the balance between the two. This provides information as to what people need to know and do to support a person having these things in their lives. All providers who deliver services have a responsibility to participate in the information gathering and planning of services and supports.

3.6. The Role of Assessment in the Person-Centered Planning Process.

Assessments are necessary to assist the person supported and legal representative, if applicable, and other members of the COS in identifying the person's strengths, interests and desired outcomes. Assessments also aid in determining how to best assist in meeting the person's desired outcomes.

In support of DIDD's Employment First initiative[18], each ISP must address the person's desire for employment. The ISP should describe what efforts have been made to arrive at the decision regarding employment. There must be evidence that the person has had opportunity to be educated about employment opportunities available to them in their community. There must be evidence that the person has explored a wide array of employment opportunities available in their community.[19] Additionally, there must be evidence of experience related to employment. If there is no evidence that this has occurred, an outcome regarding employment would be expected. Additional information is provided in **Section 11.2**.

Several different assessment processes, performed by various individuals (i.e., a clinical assessment performed by an occupational therapist or nurse), contribute to the development of the ISP including but not limited to those that appear in **Table 3.6-1** below.

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[17] http://www.tn.gov/didd/provider_agencies/resources/PersonCenteredThinking/SKILLSReflectionForm.pdf

[18] U.S. Department of Labor's Employment First website: http://www.dol.gov/odep/topics/EmploymentFirst.htm

[19] DIDD considers an array to mean more than two (2) options based on a person's interest, education, and background.

TABLE 3.6-1. ASSESSMENT PROCESSES	
Assessment	**Information Provided**
Third Party Payer Services and Community Supports	Information about the services a person is receiving through resources outside DIDD programs such as the Managed Care Organization, Medicare or other organization.
Informal Conversation with the person, family, friends and/or legal representative.	Ideas and suggestions about what things the person can and cannot do, what things are important to the person and what things are liked and disliked by the person.
Uniform Assessments (e.g., ICAP or SIS)	Information about a person's capabilities and support needs. Assists in identifying needed services and supports and the activities for which a person may need assistance.
Risk Assessments	Identify potential risks in a variety of areas, as well as, risks associated with the personal choices of the person supported.
Clinical Assessments	Identify needs for clinical services and treatment.
Medical Assessments	Dental, health, and mental health records as applicable, as well as physician orders and physical examinations.
Vocational Assessments	Assist the person in determining strengths and interests and preferences in paid work.

3.7. Timelines for Completion and Review of the ISP.

When a person is enrolled in services, the initial ISP must be developed within sixty (60) calendar days from the date of enrollment. The date of enrollment for people enrolled in a Medicaid waiver is the date that services initially began as shown on the DHS Form 2362 or as otherwise determined by TennCare. The ISP must be reviewed at least monthly, as specified in TennCare rules. The initial ISP can be used for a period of twelve (12) months from the anniversary of the effective date of the ISP. During that time period, changes in the ISP may be accomplished through ISP amendments. The ISP is considered expired after a one (1) year period and must be updated before it expires.

3.8. Effective Date of the ISP.

The initial ISP effective date is the date the plan is to be implemented. The ISP will be developed within sixty (60) days from the date of enrollment listed on the DHS Form 2362 or as otherwise determined by TennCare. When services are state-funded, the initial ISP is due thirty (30) days from the date of enrollment in services. The effective date is used to determine when annual updates are due. The effective date of a new plan can be no more than one (1) year from the effective date of the previous plan.

3.9. ISP Amendments.

The ISP must be amended when any of the following occur:

1. The action steps and outcomes change.
2. Services or service providers change.
3. There is a significant change in overall service and support needs.
4. The person has made major changes to his/her preferred lifestyle.

3.10. Provider Responsibilities for Implementing the ISP.

Providers are required to implement the ISP and to provide staff training necessary to ensure proper implementation. Providers who employ direct support staff are required to ensure that staff instructions necessary to the completion of ISP action steps or achievement of ISP outcomes are carried out. This includes instructions written by other providers (i.e., therapists or behavior service providers). It is expected that when new staff instructions become necessary, providers will collaborate and cooperate in developing the instructions and providing training and support to ensure that the instructions are followed. Providers are required to document implementation of the ISP, including progress in completing action steps and achieving outcomes.

Providers are expected to take advantage of "teachable moments" that occur during the course of daily life. Teachable moments are opportunities to include the person supported in meaningful activities that occur throughout the day that may or may not be detailed in the ISP. Examples of such activities may include the person supported assisting staff to prepare meals or

plan menus, or assisting staff with household duties such as washing clothes or helping to schedule activities.

3.10.a. Residential, Day and Personal Assistance Provider Responsibilities. Residential, day and personal assistance providers who employ direct support staff are required to cooperate with therapists and other clinical service providers in developing and implementing staff instructions related to therapy services, when such staff instructions are necessary to complete therapy related ISP action steps.

3.10.b. Periodic Reviews. Periodic reviews, which are due monthly, are to be kept in the provider record and a copy is to be submitted to the ISC/CM by the twentieth (20^{th}) day of the month following the month for which the review was completed. Providers are responsible for completing and documenting periodic reviews, which provide a summary of the progress in meeting action steps and outcomes. Each provider is responsible for submitting periodic reviews describing progress related to the services they are responsible for providing. For example, providers are responsible for reporting progress made towards completion of any therapy-related ISP action steps or outcomes that direct support staff are responsible for carrying out, but are not responsible for reporting progress related to therapy services directly provided by the therapist or therapy assistant. Evaluation of risk management strategies is to be incorporated into the periodic review process.

3.10.c. Basic Requirements for Contents of Periodic Reviews. Reviews must include:

1. The name of the person supported.
2. The dates of services provided.
3. The person's response to services.
4. Any new or updated staff instructions.
5. Any recommendations for changes to the ISP.
6. Any significant health-related or medical events occurring since the last review.
7. The signature and title of the person completing the periodic review, with the date the periodic review was completed.

CHAPTER 4

SUPPORT COORDINATION AND CASE MANAGEMENT

4.1. Responsibility for Support Coordination and Case Management.

For people enrolled in the "Arlington" HCBS Waiver for Persons with Mental Retardation (control #0357) or the "Statewide" HCBS Waiver for the Mentally Retarded and Developmentally Disabled (control #0128), an ISC will perform the functions specified in the service definition.[20] For persons enrolled in the Tennessee Self Determination Waiver Program (control #0427), a DIDD case manager will perform the case management functions.

4.2. Independent Functioning of Support Coordination Agencies.

The intent of providing an independent support coordination option in the Arlington and Statewide Waivers is to ensure that planning and coordination of services is not unduly influenced by other entities providing or funding services.

4.2.a. Prohibition Against Provision of Direct Services by Support Coordination Providers. Based upon the intent indicated above, providers of independent support coordination services are prohibited from providing both support coordination and direct services. Support coordination involves determining what services are needed, developing a plan to outline the services that will be provided, and monitoring to ensure that services are provided according to the ISP. Support coordination does not involve actually providing direct services, such as transporting a person or finding a home or job for a person. Independent support coordinators shall not

[20] Service descriptions are available online:
http://www.tn.gov/didd/provider_agencies/ServiceDefinitions/WaiverSrvcDefinitions.shtml

perform functions that are included as a part of the service definition for any other services.

4.2.b. Support Coordination Agency Staff and Board Member Affiliations. Independent support coordinators are prohibited from being on the staff or serving on the board of agencies providing waiver services.

4.3. Qualifications of Individuals Employed as ISCs.

Individuals employed as ISCs must meet at least one of the following educational and professional experience requirements:

1. A Bachelor's degree from an accredited college or university in a human services field.
2. A Bachelor's degree from an accredited college or university in a non-related field plus one (1) year of relevant experience.
3. An Associate degree plus two (2) years of relevant experience.
4. High school diploma or general educational development (GED) certificate plus four (4) years of relevant experience.

Relevant experience is defined as professional experience in working directly with persons with intellectual disabilities or other developmental disabilities. All ISCs must receive ongoing supervision by someone who has a Bachelor's degree in a human services field.

Support coordination providers are required to ensure that persons employed to render support coordination services receive effective guidance, mentoring, and training, including all training required by DIDD. Effective training must include opportunities to practice support coordination duties in a manner that promotes development and mastery of essential job skills.

4.4. Accessibility to Support Coordination Services.

Support coordination services are most effective when locally based. Consequently, support coordination providers must maintain an office in each grand region where services are provided. Support coordination services are to be available to the person receiving services twenty-four (24) hours a day, seven (7) days a week. Support coordination providers must implement policies and procedures that ensure a staff member is available to people receiving services at all times, including evenings, nights, weekends, and holidays when provider offices

are generally closed. Providers should contact the administrator on duty (AOD) if they are working with someone in the SD Waiver.

4.5. Caseload Assignments to ISCs.

Support coordination providers will arrange individual caseloads within the maximums and under the conditions established below as needed to meet the needs of persons supported on those caseloads.

4.5.a. Maximum Caseloads for ISCs. An ISC shall not be assigned a total caseload of more than thirty (30) people, except in cases of the following situations below.

4.5.b. Exceeding Maximum Caseloads. Support coordination caseload maximums may be exceeded due to staff illness, vacation, or attrition if:

1. The situation is temporary (The support coordination provider must be actively seeking to resolve the staff shortage as evidenced by current advertisements to fill positions, current job interviews, etc. for the situation to be considered temporary.).
2. There is sufficient staff to ensure that support coordination responsibilities are met; and each person's needs in regard to support coordination services are satisfactorily met.

4.6. Providing Support Coordination as a Service.

Support coordination must be provided in accordance with the waiver service definition. Ongoing responsibilities pertaining to the provision of services as defined in the approved waiver documents are indicated in this section.

4.6.a. Ongoing Assessment of Individual Needs. Assessment refers to the process that precedes development of the ISP that includes gathering information from the person and from a variety of sources. Assessment also refers to the ongoing process of reevaluating the person's support needs by considering new circumstances that arise and new information that becomes available. The role of assessment in development and

revision of the ISP and the types of assessments that may be performed are discussed in **Chapter 3**.

4.6.b. Provision of General Information About Participating in Service Programs. The ISC is required to provide information and education to the person, guardian/conservator, and/or family regarding:

1. The types of services and programs available in the DIDD system.
2. Rights and responsibilities of people using services.
3. Resolution processes, including reporting abuse/neglect/exploitation, provider conflict resolution, DIDD and TennCare complaint resolution processes, and appeals processes.

The provision of this information is verified during the individual record review (IRR) performed by DIDD quality assurance surveyors. Therefore, providers should ensure that this information is documented and observable to DIDD surveyors.

4.6.c. Freedom of Choice and Assistance with Selection of Service Providers. Freedom of Choice is a phrase used in federal regulations pertaining to Medicaid waiver programs. "Freedom of Choice" refers to the person's right to choose services provided in an ICF/IID or in a Medicaid HCBS waiver. Federal Medicaid law requires that this choice be given initially when a person seeks services. The person's choice between ICF/IID and waiver services is to be documented on the Freedom of Choice Form, and this form needs to be available for inspection

Freedom of Choice also means that a person has the right to select any qualified provider that is available, willing, and able to provide the services needed. If a person chooses ICF/IID services, the ISC/CM is required to provide the person with a list of licensed ICF/IID facilities and assist in selection of an ICF/IID provider. Assisting in selection of a provider may include facilitating visits to facilities, helping to gather information about different facilities, helping the person to complete pre-admission forms, etc.

If the person chooses waiver services, the ISC/CM must assist in selection of providers. The ISC/CM is required to make the person aware of all options for providers of the services identified in the ISP. The ISC/CM must assist the person as needed/requested in determining what provider characteristics are desirable. The ISC/CM must also assist the person as necessary/requested in obtaining information about the different providers that are available in an unbiased and objective manner. This may be accomplished by:

1. Assisting the person, family members and guardian/conservator to collect brochures or other information available from the providers under consideration.
2. Assisting the person, family members, and guardian/conservator to collect information regarding licensure or QA surveys.
3. Offering to connect the person, family or conservator to other individuals or families receiving services from the providers under consideration and who would be willing to give consent to share their experiences about those providers.
4. Arranging for meetings between the person, family members, and guardian/conservator and provider management staff to discuss provider practices in delivering services.
5. Informing the family of the availability of mediation through DIDD.

In the event that a person requests to change any provider of a direct Waiver service, the ISC/CM must advise the person of all available providers and assist in selection of a new provider as specified above.

4.6.d. Assistance with Obtaining and Coordinating Services. The ISC/CM is required to arrange and secure all services and supports described in the ISP (see **Section 3.1**). This includes providing information to potential and actual providers, completion of service authorization requests, assistance with appeals and monitoring and following-up to ensure that issues and problems are resolved so that the ISP can be implemented as written or amended as necessary. Coordination of services is critical when a person's life circumstances change. In arranging for services in the development of the ISP, the ISC should come to understand all of the services that may be currently provided to the person to ensure that there is no duplication of services, no supplanting of natural supports, or MCO services.

The ISC shall:

1. Provide assistance with identifying, locating and accessing providers of services and supports and arranging services and supports in a cost-effective manner.
2. Facilitate the development of the ISP with the COS.
3. Monitor to ensure that services are being delivered in accordance with the ISP.
4. Review the delivery of services and supports to determine the extent to which the needs of the person are being met.

The ISC/CM must arrange for services to follow the person when:

1. The person moves from school to adult services.
2. The person turns 21 years of age and there is a reduction in MCO services
3. The person moves from an ICF/IID to the community.
4. The person changes providers.
5. The person changes from one kind of service setting to another (such as changing from personal assistance in a family home to supported living or from the community system to a hospital).
6. The person moves from one area of the state to another..

4.6.e. Development, Evaluation, and Revision of the ISP. The ISC/CM is responsible for developing and amending/updating the ISP as needed in accordance with policy 80.3.4 Authorization of Services[21].

4.6.f. Monitoring Implementation of the ISP. Routine monthly review of the ISP and provider documentation, including review and summary of Provider Periodic Reviews, is one way that ISCs/CMs determine if the ISP is being implemented. Regular contact with the person, the person's family, the person's guardian/conservator, and the different provider staff who support the person is required as one of the primary mechanisms through which ISCs/CMs monitor implementation of the ISP. Regular contact allows the ISC/CM to:

1. Assess satisfaction with services and supports.
2. Ensure that services and supports are delivered in accordance with the ISP.

[21] http://www.tn.gov/didd/provider_agencies/policies/80%203%204%20Authorization%20of%20Services%203-13-11.pdf

3. Identify the need for ISP amendments and/or other actions to address a change in the person's condition or situation.

4.6.g. Contact Requirements. Requirements pertaining to support coordination contacts with persons include:

1. One (1) face-to-face visit is required each calendar month. Face-to-face visits are to occur across all environments in which services are received.
2. If a person receives residential services, one (1) face-to-face visit per quarter must be conducted in the place of residence.
3. If the person is a class member of the Settlement Agreement (Clover Bottom, Greene Valley or Nat T. Winston)[22], more frequent contact is required after moving from the developmental center to the community as described below:
    a. Face-to-face visits are required on the day of the move, within five (5) days of the move and within twenty-one (21) days of the move.
    b. Following these initial three (3) post-transition visits, face-to-face contact is required across all service environments every twenty-one (21) days.
    c. The ISC is required to develop a visitation schedule reflective of these requirements when a developmental center to community transition occurs involving a Settlement Agreement class member. The visitation schedule must also reflect unannounced visits for a period of three (3) months following the move, including those performed by Regional Office staff.

4.6.h. Coordination of Services with the Managed Care Organization (MCO). The ISC/CM is responsible for coordinating services with the person's MCO.[23]

1. It is the responsibility of the ISC/CM to be aware of any MCO services the person supported may be receiving as described in section 4.6.d.
2. If the person supported is unable to inform the ISC/CM of their assigned MCO, the ISC/CM may contact the TennCare Director of IDS for assistance in obtaining this information.

4.6.i. Care Coordination prior to person's 21st birthday. Coordination of services must occur prior to the person's 21st birthday to ensure continuity of care. The

[22]Information is available online, click on the pertinent link: http://www.tn.gov/didd/compliance/index.shtml

[23] WEB LINK: TennCare Protocol

ISC/CM shall contact the MCO no less than thirty (30) days prior to the date of the person's 21st birthday to discover if there will be any expected reduction in MCO services. To ensure continuity of care, the ISC/CM and MCO shall coordinate together for the review and assessment process as appropriate.

4.6.j. Initiating Corrective Actions. The ISC/CM is responsible for monitoring, reporting, and follow-up sufficient to ensure that resolution is achieved when there are problems with implementation of the ISP. Resolution may involve a change in the types of services/supports, a change in the provider of a particular service/support, or a change in the way a particular service/support is provided. Support coordination/case management responsibilities include:

1. Working with other providers and if necessary, the DIDD Regional and Central Offices, to ensure that dissatisfaction or concerns with services expressed by the person, the person's guardian/conservator, and/or the person's family are addressed promptly.
2. Ensuring that immediate action, including contacting the appropriate provider and submission of an incident report, is taken to protect the person's health, safety, and well-being when the ISC observes, discovers or suspects that abuse, neglect or exploitation has occurred.
3. Reporting service delivery or ISP implementation issues that are outside the scope of support coordination/case management responsibility to the appropriate providers and to DIDD as necessary to achieve resolution.
4. Assisting the person or the person's guardian/conservator or family to file eligibility and service appeals.

4.7. Documentation of Support Coordination & Case Management Services.

The ISC/CM are responsible for documenting assessment, planning, coordination, and monitoring activities that are relevant to the development, amendment, update or monitoring of implementation of the ISP. All documentation is to be maintained in the support coordination and case management record for each person receiving support coordination and case management services.

Documentation of contacts with the person and the person's guardian or conservator, family members and providers must be recorded in the appropriate format. Standardized formats available for documenting support coordination and case management services include the following:

1. The ***ISC/CM Monthly Documentation*** form is used to summarize information gathered from the monthly face-to-face visit; interviews with the person, family members and conservators or guardians; interviews with provider staff; and other information and documentation relevant to the implementation of the ISP that is received during the month. The ISC must complete this form at least monthly to document review of ISP implementation status, including progress in completing action steps and achieving outcomes. Contact with the person's guardian/conservator or an involved family member may be required to complete the form, particularly if the person is unable to communicate responses to interview questions.
2. The ***Annual ISP Review and Update Preparation*** form is to be completed prior to the annual ISP planning meeting, generally in the ninth month of the ISP year. The purpose of the form is to document ISP pre-planning and planning activities.

Completion of all applicable standardized forms meets monthly documentation requirements for ISCs/CMs.

4.8. Changing ISCs/CMs.

Persons receiving support coordination services or their guardian or conservator may request a change in the assignment of their ISC at any time. Persons receiving state case management services or their legal representative can request a change in the assignment of their individual CM at any time. To initiate selection of a new provider, either the current ISC or the DIDD Regional Office may be notified of the request to change providers. A change in ISC provider must be in the interests of the person and in accordance with policy 80.4.7 Community Transition.[24] If a change is to occur, a list of all available support coordination providers will be made available. When a selection is made, the new support coordination provider will be notified. The change in providers will be effective on the first day of the next calendar month. The new provider will amend the ISP to reflect the new provider of support coordination services. The transferring support coordination provider must make arrangements to forward

[24] http://www.tn.gov/didd/provider_agencies/policies/Community%20Transition%20Policy%2005%2031%202012%20changes%20accepted.pdf

essential information to the receiving support coordination provider in accordance with transfer of records policies indicated in policy 80.4.7 Community Transition.[25]

4.9. Changing from Case Management to Support Coordination or from Support Coordination to Case Management.

As people move from the waiting list to waiver programs or from one waiver program to another, transition from case management services to support coordination services or from support coordination services to case management services may be necessary, depending on which option is available within the program in which the person will be enrolled. The same basic procedures will be followed regarding transfer of records as that followed when support coordination providers are changed.

4.10. Annual Re-Evaluation and Re-Determination.

The ISC/CM is responsible for ensuring completion of processes required for a person to remain medically eligible for Medicaid benefits. This includes annual re-evaluation of the need for ICF/IID services.

[25] http://www.tn.gov/didd/provider_agencies/policies/Community%20Transition%20Policy%2005%2031%202012%20changes%20accepted.pdf

CHAPTER 5

GENERAL PROVIDER REQUIREMENTS

5.1. Licensure Requirements.

All providers who require licensure must obtain the appropriate license prior to establishing a provider agreement with DIDD. It is required that providers maintain licensure for services offered at all times while services are being rendered within the DIDD system. Providers who have allowed licensure to lapse will not be reimbursed for services provided during the lapsed period. Providers will be required to show proof of current licensure during DIDD annual QA surveys and during TennCare QA surveys. Proof of licensure may be required during other reviews or surveys, such as those conducted by CMS, the Tennessee Office of the Comptroller, or the Tennessee DOH.

5.2. Personnel Requirements.

5.2.a. Required Personnel Policies. Personnel policies are required if staff are employed by a provider. Personnel policies are not required of independent providers or when services are provided only by subcontractor's staff in accordance with a DIDD approved subcontract. Personnel policies must be updated, maintained, and implemented while a DIDD provider agreement remains in effect. Required personnel policies must address:

1. Procedures for hiring staff, including minimum qualifications for each staff position.
2. Job descriptions for each staff position.
3. Procedures for initiating and resolving employee complaints or grievances.
4. Requirements pertaining to use of employee-owned vehicles to transport people receiving services, if applicable.

5. Procedures for progressive employee disciplinary actions, including, but not limited to sanctions for Title VI non-compliance, drug-free workplace violations, and substantiation for abuse, neglect or exploitation of people using services.

6. Procedures for tuberculosis testing in accordance with current DOH policy.[26]

7. Procedures for maintaining a drug-free workplace.

5.2.b. Staff Requirements. The approved waiver documents list general requirements that are applicable to all provider staff, subcontractors and their staff, or independent providers. DIDD utilizes the same requirements for providers and staff and subcontractors rendering state-funded services. The general requirements are:

1. Staff must be at least eighteen (18) years of age.

2. Staff who have direct contact with or direct responsibility for people using services must be able to effectively read, write and communicate verbally in English and read and understand instructions, perform record-keeping duties and write reports.

3. Staff responsible for transporting a person using services must have a valid driver's license and automobile liability insurance of the appropriate type and minimum coverage limits for Tennessee, as established by the Department of Safety and Homeland Security.

4. Staff who will have direct contact with or direct responsibility for people using services must pass a criminal background check performed in accordance with T.C.A. § 33-2-1202.

5. Staff who have direct contact with or direct responsibility for people using services must not be listed on the Tennessee Abuse Registry, the Tennessee Sexual Offender Registry, the Tennessee Felony Offender Registry, and the Office of Inspector General's List of Excluded Individuals/Entities.

6. Family members who are paid to provide services must meet the same standards as providers who are unrelated to the person.

7. All providers must comply with DIDD and TennCare policies, procedures, and rules for waiver service providers, and quality monitoring requirements.

[26] For additional information visit the DOH web site: http://www.tn.gov/didd/provider_agencies/ProviderManual/Appendix%20I%20-%20Tuberculin%20Skin%20Testing%20Policy.pdf

5.2.c. Requirements for Background Checks. In accordance with requirements established in both Title 33 of the T.C.A. and the approved waiver, each provider must have a process for ensuring that statewide criminal background checks are performed for each employee, volunteer or subcontractor (or subcontractor employee) prior to employing a person who will have direct contact with or direct responsibility for people using services. Background checks must be completed prior to, but no more than 30 days in advance of, employment or reassignment to direct service. The individual must be told that a criminal background check will be conducted. The requirements for background checks are as follows:

1. A complete work history with a continuous description of activities for the past five (5) years.
2. At least three (3) personal references, including at least one who has known the individual for at least five (5) years.
3. A signed release authorizing information from the background check to be disclosed to the provider.
4. Either fingerprint samples for a criminal history background check conducted by the Tennessee Bureau of Investigation (TBI) or the Federal Bureau of Investigation (FBI), or information for a necessary criminal background investigation to be conducted by a Tennessee-licensed private investigation company.

5.2.d. Additional DIDD Requirements Pertaining to Background Checks. For an individual who has lived in Tennessee for one (1) year or less, a nationwide background check is required. Such nationwide background checks may be limited to those states where the person has lived during the past seven (7) years or since the age of eighteen (18) years, whichever is fewer.

5.2.e. Reimbursement for Criminal Background Checks. Reimbursement for criminal background checks will be made as follows:

1. The provider requesting the background check will pay the TBI, the FBI or the Tennessee licensed private investigation company.
2. DIDD will reimburse the provider for the cost of the criminal background check if the following conditions are met:

a. The provider is properly licensed and has a current provider agreement with DIDD.

b. The background checks have been completed by the TBI, FBI, or a Tennessee licensed private investigation company.

c. Funding is available for DIDD to make such reimbursement payments.

5.2.f. T.C.A. Title 33 Requirements for Employee Reference Checks. Work and personal references must be checked by the provider prior to employment of an applicant. Requirements for reference checks under T.C.A. § 33-2-1202 are as follows:

1. At a minimum, the provider must directly communicate with the most recent employer and any employer who employed the applicant for more than six (6) months within the past five (5) years.
2. At a minimum, the provider must directly communicate or provide documentation of attempts to directly communicate with at least two (2) of the personal references provided by the applicant.

5.2.g. Requirements Pertaining to the Continued Employment of Provider Staff. Requirements include:

1. The provider must have in place a process for periodically evaluating the performance of staff.
2. The provider must implement a written policy that ensures that employees do not continue to provide direct services or have direct responsibility for persons supported when the employee is convicted of criminal activity during employment or if the employee is placed on the Tennessee Abuse Registry.

5.3. Required Provider Policies.

In addition to the personnel policies described above, while a provider agreement with DIDD is in effect, the provider must have in place written policies covering these subjects:

1. Showing respect to people using services at all times.
2. Protecting and promoting the rights of people using services.
3. Using positive behavior approaches with people using services, including prohibited interventions.
4. Facilitating and supporting natural support systems.

5. Obtaining necessary emergency and/or urgent health care for people using services.

6. Addressing the health care needs of people using services, as specified in the individual transition plan (ITP) or ISP.

7. Advocacy for the person supported and arranging for external advocacy services as needed.

8. Taking appropriate action in emergency situations to ensure the safety of persons supported.

9. Maintaining a sanitary and safe environment, including fire safety precautions in provider offices, individual homes and other sites where services are delivered.

10. Managing and accounting for personal funds of people using services.

11. Maintaining a well-trained workforce.

12. Managing and reporting incidents.

13. Maintaining Title VI compliance.

14. Providing services to individuals with LEP.

15. Maintaining and monitoring of client records, including compliance with confidentiality requirements set forth in T.C.A. § 33-3-103 and HIPAA standards.

16. Quality assessment, assurance and improvement.

17. Protection from and prevention of harm.

18. Maintaining personnel records for staff and sub-contractors, including evidence of timely completion of required checks that are listed in **Section 10.13.a. Employee Records:** e.g., background checks, DOH's Tennessee Elderly and Vulnerable Abuse Registry, the Sexual Offender Registry, and the Office of Inspector General's List of Excluded Individuals/Entities.

5.4. Provider Self-Assessment.

All providers must have an ongoing self-assessment process. The specific requirements for clinical providers in this area are described elsewhere in this manual. All long-term (day, personal assistant (PA), residential) and support coordination providers are required to maintain an ongoing self-assessment. A provider's self-assessment ensures that an internal mechanism exists for ongoing review of the effectiveness of services provided. Self-assessment allows a provider to identify systemic issues and initiate corrective actions. The process also allows the

provider to incorporate results of external monitoring reports into its self-assessment processes. Each provider is responsible for completion of self-assessment activities and for evaluation and revision of self-assessment processes. To fulfill this requirement providers may use the Council for Quality and Leadership (CQL) Basic Assurances ® Self-Assessment[27] or at least the following components must be included in self-assessment activities.

1. Review of all documentation regarding the implementation of a person's plan and his or her progress toward meeting outcomes.
2. Review of trends related to persons supported and family satisfaction with services provided.
3. Review of incident trends, including those related to medication variances and errors and other health and safety factors.
4. Review of external monitoring reports for the previous twelve (12) month period.
5. Review of any sanctions imposed during the previous twelve (12) month period.
6. Review of personnel practices, including staff recruitment and hiring, staff training, and staff retention and turnover.
7. Review of processes intended to ensure timely access to health-related interventions, such as health care appointments and follow-up activities.
8. Review of policies to ensure continuing alignment with DIDD current requirements.
9. Application of the current DIDD QA Survey Tool to a sample of persons supported.

5.5. Provider Internal QI Plans.

The (QI) Plan is the mechanism for addressing the issues identified during the self-assessment process. The QI plan is to be focused on resolution of systemic issues at the provider level. Systemic issues are those that affect or have the potential to affect a number of persons supported. All provider staff should have access to the QI plan. The QI plan specifies how any necessary systemic improvements will be made through a process which includes:

1. Analysis of the cause of any serious issues and problems identified. Serious issues and problems are those that impact multiple persons supported or those that have health and safety consequences requiring medical treatment of one or more persons supported.
2. Development of observable and measurable quality outcomes related to resolving the causal factors.

[27] http://www.tn.gov/didd/accreditation/docs/2012%20BA_SelfAssess.doc

3. Establishment of reasonable timeframes for implementation of quality initiatives.

4. Assignment of staff responsible for completion of actions and achievement of quality outcomes.

5. Modification of policies, procedures, and/or the management plan (potentially including the QI plan) to prevent recurrence of issues and problems that were resolved.

5.6. Supervision Plans.

A written supervision plan is required when a provider employs or contracts with staff who are responsible for direct supervision of persons supported. Providers are required to evaluate the effectiveness of the supervision plan and revise as necessary. Supervision plans address how the provider accomplishes major supervisory functions, including:

1. Ensuring that staff understands their job duties and performance expectations.

2. Ensuring that staff acquires the knowledge and skills needed to complete job duties and meet performance expectations.

3. Monitoring staff performance to ensure that performance issues are promptly identified and rectified by requiring or providing additional training, increased supervision, counseling, and/or appropriate disciplinary action.

4. Ensuring that unannounced supervisory visits are conducted when both staff and the person using services are present as follows:

   a. Residential (excluding Family Model) – a minimum of three (3) visits each calendar month, including sleep hours, on weekends and on holidays.

   b. Family Model - a minimum of two (2) visits each calendar month, including weekends and on holidays.

   c. Day Services site (excluding Employment Services) – a minimum of one (1) visit each calendar month.

5. Developing and implementing policies that effectively control the incidence of employees having visitors, including family members, in a person's home that are not present based on the wishes of the person.

6. Developing and implementing policies that prevents employees from conducting personal business, such as running errands or attending to their children or other family members while on duty.

5.7. The Provider Management Plan.

All long-term (day, PA, residential) and support coordination providers are required to have a management plan. The management plan describes how the provider conducts business to ensure successful operation and compliance with applicable program requirements. The plan describes how the provider implements policies and procedures to assure the health, safety, and welfare of persons using services. The provider management plan includes:

1. The provider's mission statement and philosophy of service delivery.
2. An organizational chart.
3. A description of service(s) offered by the provider.
4. Complaint resolution procedures for persons supported, family members, and legal representatives.
5. Required policies as noted in **Section 5.3**.
6. For providers of transportation services or providers of services that include transportation as a component of the service, a description of the provider's transportation system, including the person's access to transportation (e.g., a description of how people will be provided adequate access to transportation for medical appointments and other activities that may be specified in the ISP).

5.8. Provider Governance.

The Department has requirements for both not-for-profit and for-profit providers.

5.8.a. Requirements for Not-For-Profit Provider Boards of Directors. An appointed Board of Directors is expected to follow all applicable state and federal laws pertaining to not-for-profit corporations as well as the following:

1. If members of the Board of Directors are not all residents of Tennessee, a local advisory group must be established that is comprised solely of Tennessee residents.
2. Minutes of all Board meetings will be taken and maintained.
3. Board meetings will be held at least quarterly and more frequently if necessary to effectively discharge Board duties.

4. Board members will be required to sign confidentiality agreements and the provider will be responsible for maintaining the confidentiality of people using services.

5. Board members will be provided with current information pertaining to:

   a. Provider fiscal status.

   b. Development and revision of operational policies, procedures, and plans.

   c. Results of provider self-assessment activities.

   d. Reports of compliance reviews conducted by external monitoring entities.

6. The Board will be composed of individuals representing different community interest groups, including persons with disabilities and/or family members of people with disabilities.

7. Existing board members must orient new board members within ninety (90) calendar days of their appointment to include:

   a. The duties and responsibilities of Board members.

   b. An introduction to the provider agency, including services provided and an overview of the provider's mission, purpose, and operational goals and objectives.

8. The Board chairperson and the chief executive officer/executive director are required to attend a DIDD new provider orientation within ninety (90) calendar days of assuming office or complete the online equivalent.[28]

9. Board minutes will reflect that board members are provided with a copy of T.C.A. § 48-58-302 pertaining to conflicts of interest.

10. Policies will be developed and implemented to address conflicts of interest between board members and the provider.

11. The Board will review and approve the provider's charter, bylaws, purpose, mission statement, goals and objectives, and operational policies and procedures as needed.

12. The Board will review the provider's financial statements at least quarterly and take action to resolve in a timely manner any fiscal issues identified.

13. The Board will review and take action to address any unresolved serious issues identified through the provider's self-assessment or through external compliance or quality monitoring. This review shall occur as often as necessary and at least annually.

[28] http://www.tn.gov/didd/provider_agencies/ProviderOrientationTraining/index.shtml

14. The Board will appoint a chief executive officer/executive director to whom the Board will delegate the responsibility and authority to implement Board-approved actions, direct provider day-to-day operations and to ensure compliance with the provider's obligations under its provider agreement with DIDD.

5.8.b. Requirements for For-Profit Provider Local Advisory Groups. For-profit providers of residential, day, personal assistance and support coordination services must have a local advisory group. Requirements include:

1. Minutes of all advisory group meetings will be taken and maintained.
2. Advisory group meetings will be held at least quarterly and more frequently if deemed necessary to fulfill its responsibilities.
3. The advisory group will be composed of individuals representing different community interest groups, including persons with disabilities and/or family members of people with disabilities.
4. Advisory group members will be required to sign confidentiality agreements and the provider will be responsible for maintaining the confidentiality of people using services.
5. Within ninety (90) calendar days of being appointed or beginning contracted services with DIDD, the executive director is required to attend a DIDD new provider orientation or complete the online equivalent.[29]
6. Advisory members are encouraged to attend an orientation, to be arranged by the provider, that includes an overview of provider operations and a description of the duties and responsibilities of advisory group members.
7. Advisory group members will be advised of the proposed changes to operational policies, procedures, and plans and asked to provide input.
8. Providers are expected to respond to advisory group recommendations by either incorporating recommendations into operational policies, procedures, or plans or by documenting the reasons that recommendations were not acted upon.

5.9. Assuring Adequate Staff to Provide Services and Adhering to Service Schedules.

Any provider who agrees to provide direct services such as residential services, day services, or personal assistance services must ensure sufficient qualified and trained staff to provide all authorized services in accordance with the staffing plan. Providers of clinical

[29] http://www.tn.gov/didd/provider_agencies/ProviderOrientationTraining/index.shtml

services must also ensure sufficient qualified and trained staff are available to provide all authorized services.

Arrangements must be made for coverage of services and supervision of staff as required when providers or employees take periods of extended leave, when staff resign or are terminated from employment or when staff are sick or otherwise unable to work due to unexpected events or circumstances. Schedules may unexpectedly change for a number of reasons. Service providers must ensure that the provider's direct support staff and/or family caregivers at the home or day service site are notified if an appointment is to be rescheduled for a different time or date. Likewise, direct support staff and/or family caregivers must notify service providers if an appointment needs to be rescheduled.

5.10. Provider Subcontracts.

An approved subcontract is required when any part or requirement of a service as defined by the service definition and provider agreement is to be rendered by individuals who are not directly employed (either as paid or volunteer staff) by the provider. The provider must hold any subcontractor(s) to the same terms and conditions specified in the DIDD provider agreement.

Providers relying upon subcontracted persons or entities for the provision of services are fully responsible for any services provided by or with the assistance of the subcontractor. Provider subcontracts are to be submitted to the DIDD Central Office for approval and are subject to TennCare approval. Services shall not be provided until approval is received.

5.11. General Requirements for Waiver Services.

The following list of requirements are applicable to providers of Medicaid funded HCBS waiver services[30] and state funded services, unless otherwise specified.

1. All waiver services must be pre-authorized.
2. Authorization of services shall be subject to medical necessity guidelines.
3. The provision of services shall be documented in sufficient detail to support the provider's billing.

[30] http://www.tn.gov/didd/provider_agencies/ServiceDefinitions/WaiverSrvcDefinitions.shtml

4. Providers shall document in writing the in/start time and out/stop time for all services billed (commensurate with the unit of reimbursement) with the provider's signature and credentials, and the date services were rendered.

5. Services shall be provided in accordance with the approved ISP.

6. Providers shall justify in writing (in the individual record) any discrepancy between the amount, frequency, and duration of services actually delivered in comparison to the amount, frequency, and duration of services authorized.[31] Should services be provided in excess of what is authorized, providers will only be paid for what is authorized.

7. Individuals enrolled in the Self-Determination Waiver may elect to self-direct the following services: day services (excluding facility-based), personal assistance, respite (single-person agencies only), and individual transportation services.

8. Providers are required to abide by regulations of the Occupational Safety and Health Administration (OSHA) regarding blood borne pathogens and hazard communications.[32]

9. Providers who serve as representative payees or have any role in managing personal funds are required to comply with policy, 80.4.3 Personal Funds Management.[33]

5.12. Notification to DIDD of Changes in Provider Information.

Providers are required to notify DIDD Central Office and the respective regional licensure office of the following changes in provider information using the **Disclosure Form for Provider Entities**, unless otherwise noted[34]:

1. Change in provider name.

2. Change in provider ownership.

3. Change in provider legal structure such as change from sole proprietor to corporation.

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31 http://www.tn.gov/didd/provider_agencies/DCMemos/2011/Memo%200155%20Yes,%20but%20Revised%205.27.11.pdf

32 For a free Power Point on the blood borne pathogen standard visit: https://www.osha.gov/dte/library/bloodborne/revised_bbp_standard/; For information regarding Hazard Communication visit: https://www.osha.gov/dsg/hazcom/

33 http://www.tn.gov/didd/provider_agencies/policies/80%204%203%20Personal%20Funds%20Management%209%2011%202012%20FINAL.pdf

34 For DIDD Central Office, email Provider.changes@tn.gov; For Licensure Office contact information visit, http://www.tn.gov/didd/Licensure/Licensure.shtml; For TennCare forms visit, http://www.tn.gov/tenncare/pro-misc.shtml

4. Change in provider information required for billing purposes such as federal tax identification number (e.g., Employer ID Number).
5. Change in provider office address or telephone. **(Group Provider Address Change Form)**
6. Change in provider fax number or email address. **(Submit via email).**
7. Change of provider chief executive officer or Board chair.
8. Changes in services offered. **(Submit via email)**
9. Change of address of the person supported (regional office only). **(Submit via email)**
10. Change in emergency contact information. **(Submit via email)**

5.13. Electronic and Computer Capability Requirements and Considerations.

5.13.a. Provider Requirements. It is the Department's intention to conduct business with providers through electronic means to the extent possible. Consequently, providers are required to:

1. Maintain e-mail accounts that permit DIDD access to the executive director or chief executive officer and Board Chairperson (if applicable).
2. Maintain access to the Internet by the provider's administrative office(s) and management personnel.
3. Provide basic computer skills training to any staff who will be expected to communicate electronically or to provide or access electronic information from DIDD.
4. Submit required reports, data, forms, billing documents and other information electronically through business applications or systems provided by DIDD.
5. Maintain an electronically secure environment in compliance with HIPAA Security Standards.[35]

5.13.b. Electronic Signatures. Providers are required to abide by policy 80.4.4 Electronic Records and Signatures.[36]

[35] http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/securityrulepdf.pdf

[36] http://www.tn.gov/didd/provider_agencies/policies/80%204%204%20%20Electronic%20Records%20and%20Signature%20Policy%207%2024%2012.pdf

CHAPTER 6

STAFF DEVELOPMENT

6.1. Introduction.

All providers who contract with DIDD must have adequate and suitable training to ensure they are able to provide safe and effective support for people with intellectual disabilities. The Department offers training to develop basic core competencies in provider staff. The Department has developed standardized training requirements and specified curricula for all staff providing supports based on the expectations of their job duties. The training requirements specified in this chapter apply to all providers, including those that provide services to individuals who self-direct services and Family Support Program directors and coordinators.

Dental services providers, audiology services providers and vision services providers are not considered clinical services staff for purposes of training and are excluded from meeting DIDD training requirements. Additionally, also excluded from DIDD training requirements are staff from agencies providing the following: environmental modifications, specialized medical equipment supplies and assistive technology (SMESAT), or personal emergency response systems (PERS).

6.2. Competency-Based Training Courses.

Most of the Department's training program is "competency-based." This means that a staff person completing the training, via the web-based program or classroom instruction, is required to obtain a score of 80% or better on the post test. Some trainings (e.g., *CPR, First Aid, Medication Administration, Information and Training Specific to the Person*) have a hands-on skills component and proficiency on those skills must be demonstrated for the trainer.

6.3. Staff Categories Training Requirements.

Staff will be described in terms of functional responsibilities for purposes of describing training requirements. Staff will be considered to fall within one of the categories described in the sections that follow. Specific courses are identified by staff category on the DIDD web site.[37]

6.3.a. Family Support Program Directors and Coordinators. Agencies that contract with DIDD to administer the Family Support Program must follow the Family Support Guidelines. Family support coordinators and/or directors are to be trained on Individual Rights, Title VI, The Americans with Disabilities Act (ADA), and Protection from Harm and Incident Reporting within 60 days of date of hire. Training is available as classroom or web based training.

6.3.b. Waiver Service Providers.

6.3.b.1. Direct Support Professionals and Supervisory Staff. Staff who provide direct support and assistance to persons supported by the agency have a variety of job titles including, but not limited to, direct support professionals (DSPs), residential support staff, day staff, PA, job coach, Certified Nursing Assistant (CNA), Certified Nursing Technician (CNT), respite care staff, or van driver. Supervisors may have job titles such as, but not limited to, residential, house, or group home manager. In any instance where direct support services are provided, the following DSP training must be completed.

6.3.b.2. Program Staff. Program staff are those who do not routinely provide direct, hands-on services but do perform functions essential to agency coordination of care. Program staff may include, but is not limited to, staff with the following job titles: social worker, agency case manager, qualified intellectual and developmental disabilities professional (QIDDP), residential coordinator, incident management coordinator (IMC), or program coordinator. Staff with these titles who do provide hands-on direct supports must follow the training requirements for DSPs and DSP supervisory staff. IMCs are

[37] http://www.tn.gov/didd/training/index.shtml

required as part of their job to take the classroom "train-the-trainer" advanced version of the Protection From Harm and Incident Management course from their regional office staff.

6.3.b.3. Day and Residential Managerial Staff. Managerial Staff are staff whose responsibilities include management of all aspects of a business entity providing day, residential, respite, behavioral respite, and/or personal assistance services. Managerial Staff may include staff with job titles including, but not limited to the following: executive director, chief executive officer, principal administrator, assistant director, or chief financial officer. Staff with these titles who do provide hands-on direct supports must follow the training requirements for DSPs and DSP supervisory staff.

6.3.b.4. Administrative and Operational Support Staff. Administrative and operational support staff are staff who perform tasks that do not routinely involve direct contact with people supported, but are necessary for the business to function. Administrative and operational support staff may have job titles including, but not limited to the following: cook or dietary staff, building maintenance staff, personnel director, bookkeeper, accountant, secretary, or administrative assistant. Staff with these titles who do provide hands-on direct supports must follow the training requirements for DSPs and DSP supervisory staff.

6.3.b.5. Clinical Services Staff. Clinical services staff may include, but are not limited to, physical and occupational therapists, speech and language pathologists, physical therapy (PT) and occupational therapy (OT) assistants, dietitians, orientation and mobility (O&M) specialists, behavior analysts or specialists, registered nurses (RNs), and licensed practical nurses (LPNs).

6.3.b.6. Subcontractors. Provider agencies are responsible for ensuring that subcontractors have been trained as required.[38] *Information and Training Specific to the Individual* shall only be provided by the entity holding the provider agreement with

[38] See **Section 6.4.b.**

DIDD. The provider must maintain evidence of the subcontractor's successful completion of all required training.

6.3.b.7. Providers of Self-Directed Services. Staff employed by a person choosing to self-direct services must also complete required trainings based on their staff category.[39]

6.3.b.8. Agency Trainers for Continuation of Staff Instructions. Providers (e.g., residential, day, personal assistance) must work with clinicians to designate, at a minimum, one trainer to carry out ongoing training of staff on individual specific staff instructions. If a clinician deems it to be appropriate, he or she can train a designated trainer to train another designated trainer as necessary. Providers (e.g., residential, day, personal assistance) are responsible for monitoring designated trainers as well as staff to assure they are training and carrying out staff instructions appropriately.

Copies of sign-in sheets with a clear description of the training, trainer name, training date, competency date and signature of staff are acceptable proof of training provided. All training on staff instructions must be competency-based. Designated trainer training must also be competency-based. If, at any time, staff suspect the instructions are no longer meeting the needs of the person receiving supports, they shall communicate this to the clinician or, if the person was discharged from the service, request a new referral to a clinician. Staff instructions may not be changed by anyone except a clinician in the appropriate discipline. The COS shall review staff instructions that remain in place after a clinician discharges the person at least annually to assure they continue to meet the person's needs.

6.3.c. ISCs and ISC Managerial Staff. Support coordination agencies employ ISCs. If managerial staff also provide ISC services, the ISC training requirements listed below will also be required for those persons. New hires shall be registered for the next available ISC training course and complete all the required training within 120 days of employment.

[39] http://www.tn.gov/didd/training/index.shtml

ISCs who were previously trained by DIDD shall not be required to complete all of the eight modules listed below. However, ISCs may be required to attend the new *ISP* training and *Person-Centered Thinking* training with certified trainers.

6.3.d. Developmental Center Staff Employed by Providers in the Community. Staff who are employed or were previously employed by a State developmental center, hired by a community provider may request that the developmental center issue a training history summary report. The summary report will be issued to the provider by the Staff Development Director at the developmental center and will include the person's name, the name of the training courses completed, the course evaluation score and the date the course was taken. No copy of the test or evaluation form will be provided. This transcript may be accepted by community agencies as documentation that training was completed.

For these documents to be accepted, training must have occurred within the timeframes outlined in **Section 6.5**. A full view copy of the unexpired card issued for CPR and First Aid also must be maintained in the provider agency's training file. Former or current employees of a state-operated developmental center in Tennessee who have not completed the appropriate training, must do so.

6.3.e. Rehires. A staff person rehired, who has been employed out of the field of intellectual disabilities for a year or more, will be required to be trained within the time frames set for new employees outlined for their job responsibilities per the various sections in this chapter.

6.3.f. Volunteers. Volunteers are persons who choose to perform a service for or to support a person receiving services. Providers have an obligation to provide appropriate information and skills training to volunteers as necessary to protect the health and safety of the person served and the volunteer. The provider is required to provide volunteers with *Information and Training Specific to the Person.* Agency policies on volunteers may vary but under no circumstances will a volunteer be left alone with a person served or assigned responsibility to perform the duties of a trained and paid staff.

Consent must be obtained from the person served or their legal representative before any personal information is shared.

6.3.g. Students and Interns. A student or intern is someone pursuing a degree in an area of human services or clinical therapies and performing a practicum or internship to gain experience and education in the chosen field as part of an academic program. The provider is required to provide students and interns with *Information and Training Specific to the Person.* The provider must ensure that the student has the necessary information and skills to provide the supports safely and effectively. Students are not to be left alone with a person served nor assigned responsibility to perform the duties of trained and paid direct support staff. Consent must be obtained from the person served or their legal representative before any personal information is shared.

6.3.h. Natural Supports. Natural supports are family members and close life-long friends of the person using services. Natural supports are not paid by DIDD or by contracted providers. Natural supports are often developed through connections and relationships with other people or organizations in the community such as churches, neighborhoods or clubs. The provider responsible for the person served is required to supply information and skills training as necessary to provide safe and effective natural supports. The information and training may be based on the time they are spending together with the person. Consent must be obtained from the person served or their legal representative in writing before any personal information is shared.

6.4. Course Requirements.

6.4.a. Protection from Harm Training. DIDD is committed to ensuring that all participants in the service delivery system understand the commitment to protecting people served from harm. To ensure that training on this topic is effective, completion of the web-based training and/or classroom training dealing with abuse, neglect and exploitation of adults and children as well as the DIDD incident reporting training, is required. Agencies desiring to supplement web training may contact the regional office IMC of the Protection from Harm Unit for additional classroom training.

6.4.b. Information and Training Specific to the Person. Prior to working alone with a person supported, individual specific training is required. Providers are responsible for ensuring that information and training specific to each person is current and accurate. Additional individual specific training is required when a staff person is assigned to a new person or when the person's needs change resulting in a modification of supports and/or services. The method of instruction includes not only written information, but also interactive instruction and demonstration on how to correctly perform the skill(s) required to support the person.

The ISP is the plan of care for the individual and provides critical information regarding what is important **to** the person as well as what is important for him or her. What the staff needs to know to support the person is addressed along with what services and supports are needed. Training specific to the person expands on information in the ISP to ensure that the DSP supports the individual appropriately on a day-to-day basis. *Information and Training Specific to the Person* compliments the ISP.

The focus of this training is specific information about the person served. The trainer shall be thoroughly familiar with the person served to ensure the provision of safe and effective supports. It is crucial that trainers provide staff with specific information about the person, such as his/her communication style and what makes a good day or a bad day for him or her.

In addition, the trainer should make sure that the staff acquires the skills necessary to assist with the person's activities of daily living (ADL). Such skills training may include how to provide person specific services relevant to dining, positioning, toileting and other ADLs as well as how to implement the person's ISP.

Staff must be trained on how to keep the individual safe at all times and across all environments where he or she lives, works, and relaxes. Training must address mobility for emergencies and evacuations due to fires, storms, natural disasters, accidents and acts of terrorism in all settings.

Information and Training Specific to the Person shall also include relevant information about the person's overall health status and diagnosed medical conditions. Staff shall be familiar with medical orders and treatment plans. For persons taking medications, staff training shall include an explanation of why the medication is prescribed, a basic description of how the medication works, common side effects to look for, when side effects or reactions are most likely to occur in relation to administration time, and the potential for interaction with other medications. Staff training shall also include information regarding how the person may express symptoms of side effects that are not observable, such as nausea or headache, and be trained to respond appropriately in reporting side effects and addressing emergency situations relevant to behavior.

The method of instruction includes written information by interactive instruction and demonstration on how to correctly perform the skills required to support the person. Staff must also be thoroughly trained on a person's behavioral history as documented in the ISP and if applicable, a BSP. This instruction should include information on events or circumstances which may trigger behaviors, preventive measures that may be taken, and what actions or steps are recommended in the event that a behavioral event does occur, for de-escalation and protection of both the individual and staff from harm.

A DIDD sample format, Personal Training Profile, can be found on the DIDD website[40], but agencies may document information and training specific to the person in a variety of formats, all of which shall include documentation of when and by whom staff were trained.

6.4.c. Medication Administration for Unlicensed Personnel. The Nurse Practice Act generally prohibits administration of medication by unlicensed individuals. However, in the DIDD service delivery system, the shortage of nurses and other factors created a need for a statutory exemption codified at T.C.A. § 68-1-904(c). The exemption allows unlicensed trained and certified staff to administer certain medications upon passing DIDD's *Medication Administration for Unlicensed Personnel* course. The

[40] http://www.tn.gov/didd/training/index.shtml

training curriculum was developed by DIDD and must be taught in a classroom setting by RNs who are trained and certified by DIDD. No unlicensed staff of any level can administer medications until they have completed the training and certification process.

Agencies must have a copy of current signed participant record in staff training or personnel files. Agencies are required to verify current certification with the Regional Office Nurse Educator on all new hires and re-hires before allowing them to administer medications.

The State of Tennessee rules specifies criteria that must be met in order for unlicensed personnel to be certified to administer medications. Provider agencies cannot allow or require natural supports or volunteers to administer medication to supplant appropriately trained provider staff.

Re-certification is required every two years. Agencies shall contact the Regional Office Nurse Educator for documentation verification of all new staff and rehires.

6.4.d. Certification Requirements. Certification and re-certification is required for the following courses:

6.4.d.1. CPR with Abdominal Thrust. Certification and re-certification is required on a schedule determined by the certifying entity and a full view copy of the current certification issued shall be acceptable documentation. All Cardiopulmonary Resuscitation (CPR) courses must include training in use of the abdominal thrust maneuver (sometimes called the Heimlich Maneuver). If certification is for automated external defibrillator (AED), training must include hands-on CPR training with demonstrated competency as a class requirement.

6.4.d.2. First Aid. Certification and re-certification is required on a schedule determined by the certifying entity and a full view copy of the current certification issued shall be acceptable documentation. DIDD will not accept web-based CPR and First Aid training nor will it accept training without the hands-on

skills test showing competency and a written test, both administered by a certified trainer.

For staff employed as DSPs, respite providers or PAs, First Aid training provided in the CNA, CNT, Emergency Medical Technician (EMT), RN or LPN certification process is sufficient to meet DIDD First Aid training requirements. A current CNA, CNT, EMT, RN or LPN license and certification issued maintained in the employee's personnel file will be accepted as documentation.

6.4.e. Fire Safety and Emergency Evacuations. Fire safety and emergency evacuations should be taught as part of *Information and Training Specific to the Person* across all environments including where the persons work and relax. Fire and emergency staff training records shall include what was trained, by whom and when, and be signed by the trainee and instructor(s).

When personal assistance services are provided in a family home, fire safety and emergency evacuation training may be provided by either appropriate agency trainers or by family members who serve as primary caregivers. Fire and emergency staff training records shall include what was trained, by whom, where and when, and be signed by trainee and instructor.

6.4.f. Federally Mandated Trainings. In addition to the required training mandated by DIDD, there are three (3) training courses mandated as part of participation in the federally funded waiver program. These topics are to be trained annually. In order to help agencies meet these federal requirements, DIDD has created curricula available for web-based training or classroom instruction. Electronic transcript for web instruction or a copy of the test or certificate of completion for classroom instruction can be used as acceptable proof of training.

6.4.f.1. Universal Precautions Training. This training is required OSHA (29 C.F.R. § 1910.1030) to protect employees from exposure to human blood borne pathogens.

6.4.f.2. Title VI training. This training is required by the Federal Civil Rights Act (Title VI, 42 U.S.C. § 2000d et seq.) to prohibit discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance. This covers LEP and other federal civil rights laws.

6.4.f.3. Health Information Portability and Accountability Act (HIPAA). This training is to assure that a person's private information is protected.

6.5 Completing Training within Required Time Frames.

It is essential that training is completed within specified timeframes. For quality monitoring purposes, timeframes are calculated from the employee's date of hire or appointment date, as designated by the agency.

6.5.a. Phase I or Pre-Service Training. Staff must complete this initial training before working alone with a person served. This training must be completed within thirty (30) days from date of hire. Prior to completion of Phase I Training, new staff must be accompanied by a fully trained staff person who assumes the responsibility for providing direct services while mentoring the new employee.

6.5.b. Phase II or Core Training. This training is to be completed within sixty (60) days of date of hire. Staff may work alone with persons served while completing Phase II courses. However, medications shall not be administered by unlicensed staff until successful completion of the course *Medication Administration for Unlicensed Personnel.*

6.5.c. Phase III for Job Coaches. This training is to be completed within 90 days of date of hire. Staff may work alone with persons served while completing Phase III courses.

6.5.d. Phase IV Training for ISCs. This training is to be completed within 120 days of date of hire. Staff may work alone with persons served while completing Phase IV courses.

6.6. Training Documentation.

Agencies may utilize web-based training or choose to complete training using the web-based training materials in a classroom setting. However, agencies shall do all testing in the web-based training portal site so that all training is recorded in the electronic learning management (ELM) system. For courses included in the web-based training program, post test scores are maintained permanently on the employee's electronic transcript. A hard copy of staff electronic transcripts may be placed in the personnel file. The ELM system provides agencies with the means to enter and track classroom training (e.g., *CPR, First Aid, Medication Administration for Unlicensed Personnel*) with certification documentation and staff test scores. Certificates issued by DIDD may be presented as proof of completion of required training, with the exception of *Medication Administration for Unlicensed Personnel*, which needs to be verified with the nursing department of the appropriate regional office. For DIDD web-based training course names and the documentation requirements, see the job specific information in this chapter and on the DIDD website.

For training on *Information and Training Specific to the Person*, where there is not a written test, competency shall be demonstration of the knowledge and skills required to provide the services or supports with documentation of type of training, date, trainer name and staff signature.

Providers must maintain documentation of training completed by the volunteer, student, or natural support. Documentation must include the name of the volunteer, student or natural support; the name of the person or entity providing the training; a brief description or explanation of the training provided; and the date the training was provided.

The documentation for Individual Specific Training can be completed by using the DIDD Personal Training Profile[41] available on the DIDD web site or a provider specific format containing the same elements. For any additional training using the web-based venue the training transcript is acceptable documentation. Training documentation is to be followed as outlined in this chapter according to the course and/or entity being used.

[41] http://www.tn.gov/didd/training/index.shtml

6.7. Training Resources.

DIDD is committed to offering contracted providers a wide array of staff development opportunities intended to achieve a balance among person-centered practices, ensuring the health and safety of people, and effective utilization of resources to meet core competencies.

Staff development opportunities are offered utilizing web-based learning and classroom instruction. Employer mentoring and support ensure a workforce with the basic competencies to support persons with intellectual disabilities in achieving life goals based on what is important to them within the context of what is important for them. To complement this chapter and provide additional resources, refer to the training requirements on the Department's web site.[42] This plan includes course and documentation requirements for web-based vendors, as well as other courses provided by DIDD.

In addition to web-based training, DIDD offers training on important content on *Person-Centered Thinking, ISP Planning and Implementation* and skill-based trainings such as *Challenges of Physical Management* and *Mealtime Challenges*. Some of these classes, along with the classes taught by the regional nurse educators are listed as available upon request, while some are offered each month. The regional training calendars can be found on the DIDD web site.[43] To help providers develop the resources needed to deliver and enhance training for their staff and assist in developing training skills for agency staff called upon to be trainers, DIDD offers a course called *Effective Training Techniques* as a first step. Essential Learning courses are available to be utilized as classroom training, one-on-one or in small groups. If classroom training is utilized, learners have the option of testing on the web learning platform or completing paper tests. Using the web platform for testing ensures all training is reflected on one transcript. If paper testing is used, trainers must enter classroom training as an event with roster and test scores on the Essential Learning platform. Copies of sign-in sheets with course and instructor name, date, and signature of staff are accepted proof of agency training provided to staff and shall be maintained in a training file. The Regional Nurse Educator will maintain the database of all certified RN trainers for *Medication Administration for Unlicensed Personnel* course.

[42] http://www.tn.gov/didd/training/index.shtml
[43] http://www.tn.gov/didd/regional_offices/training.shtml

CHAPTER 7

PROTECTION FROM HARM

7.1. Overview.

7.1.a. Introduction. Assuring the safety, protection, and personal freedom of people supported by DIDD is a primary responsibility of the Department and all DIDD providers. To ensure that this responsibility is fulfilled, DIDD has developed a comprehensive Protection from Harm system. The Protection from Harm system includes an Incidents Management Unit and Investigations Unit. This chapter identifies specific requirements intended to achieve and maintain the safety and protection of all people supported by the DIDD provider network.

The Incident Management Unit tracks reportable incidents for persons supported and providers. The data is analyzed to determine trends that may demonstrate a need for adjustments in the system. In addition to reported incidents, DIDD also requires the timely reporting of allegations of abuse, neglect and exploitation, which are investigated by the Investigations Unit, as listed below in **Table 7.1-1**.

TABLE 7.1-1 TIME FRAMES APPLICABLE TO REPORTING INCIDENTS			
TYPE OF INCIDENT / EVENT	**NOTIFY AS SOON AS POSSIBLE AND NO LATER THAN FOUR HOURS**	**NOTIFY AS SOON AS POSSIBLE AND NO LATER THAN TWENTY-FOUR HOURS**	**NEXT BUSINESS DAY**
Death	Regional Office AOD for all deaths DIDD Investigations Hotline (If death is suspicious, (abuse or neglect involved), or if unexpected or unexplained)	Legal Representative (document all attempts)	Reportable Incident Form (RIF) to DIDD Central Office Notice of Death Form and RIF to Regional Director RIF to ISC Agency/ISC
Alleged or suspected abuse, neglect, or exploitation	DIDD Investigations Hotline Department of Human Services (DHS) Adult Protective Services or Department of Children's Services (DCS) Child Protective Services If criminal activity: Law Enforcement	Legal Representative (document all attempts)	RIF to DIDD Central Office RIF to ISC Agency/ISC
Serious Injury of Known/Unknown Cause	If unknown, DIDD Investigations Hotline DHS Adult Protective Services or DCS Child Protective Services	Legal Representative (document all attempts)	RIF to DIDD Central Office RIF to ISC Agency/ISC
Suspicious Injury (i.e., suspicious as caused by abuse or neglect)	DIDD Investigations Hotline DHS Adult Protective Services or DCS Child Protective Services	Legal Representative (document all attempts)	RIF to DIDD Central Office RIF to ISC Agency/ISC

TABLE 7.1-1 TIME FRAMES APPLICABLE TO REPORTING INCIDENTS			
TYPE OF INCIDENT / EVENT	**NOTIFY AS SOON AS POSSIBLE AND NO LATER THAN FOUR HOURS**	**NOTIFY AS SOON AS POSSIBLE AND NO LATER THAN TWENTY-FOUR HOURS**	**NEXT BUSINESS DAY**
Reportable Medical Incident	Regional AOD if: Unplanned Hospitalization	As specified by Legal Representative	RIF to DIDD Central Office RIF to ISC Agency/ISC
Reportable Behavioral Incident Missing Person Sexual Aggression Criminal Conduct	Regional AOD for: Any hospitalization resulting from a behavior or psychiatric incident, or any behavioral incident with Law Enforcement or Mental Health Mobile Crisis Team involvement at the scene or in person Any incarceration	As specified by Legal Representative	RIF to DIDD Central Office RIF to ISC Agency/ISC
Reportable Staff Misconduct Incident		As specified by Legal Representative	RIF to DIDD Central Office RIF to ISC Agency/ISC
Request for Emergency Service Approval outside of regular DIDD business hours	Regional AOD		

All reportable incidents must be submitted to the Department, within required timelines, on the DIDD RIF, which can be found on the DIDD web site under the heading Forms & Tools, Reportable Incident Forms.[44] Instructions for completing the RIF can be found on the DIDD web site under the same heading.[45]

[44] Click on the link for the RIF for the appropriate region http://www.tn.gov/didd/provider_agencies/index.shtml
[45] http://www.tn.gov/didd/provider_agencies/index.shtml

7.1.b. Categories of Incidents. The following categories of incidents shall be reported to the DIDD Investigations Hotline as well as to the Incident Management Unit using a RIF:

1. **Allegations of abuse, neglect and exploitation** in accordance with the definitions below:

   a. **Abuse:** [defined in T.C.A. § 33-2-402 (1)] the knowing infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. DIDD recognizes three subcategories of abuse:

      i. **Physical Abuse:** actions including, but not limited to, any physical motion or action by which physical harm, pain or mental anguish is inflicted or caused. The use of any unauthorized restrictive or intrusive procedure to control behavior or punish. Takedowns, prone and supine restraints are prohibited and considered abuse.

      ii. **Sexual Abuse:** any type of sexual activity or contact with sexual intent or motivation between a person and anyone affiliated with DIDD as a staff person, contracted entity or volunteer. This includes but is not limited to actions by which a person is coerced into sexual activity (forced, tricked, induced or threatened) or exposed to sexually explicit material or language. Sexual battery by an authority figure as defined in T.C.A. § 39-13-527 is also considered sexual abuse. Sexual abuse occurs whether or not a person is able to give consent to such activities.

      iii. **Emotional/Psychological Abuse:** actions including but not limited to humiliation, harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures) directed to or within eyesight or audible range of the person.

   b. **Neglect:** [T.C.A. § 33-2-402 (9)] failure to provide goods or services necessary to avoid physical harm, mental anguish or mental illness, which results in injury or probable risk of serious harm.[46]

   c. **Exploitation:** [T.C.A. § 33-2-402 (8)] actions including but not limited to the deliberate misplacement, misappropriation or wrongful temporary or

[46] Neglect towards a person includes being on duty while impaired or under the influence of alcohol or illegal substances. If a staff person has a valid current prescription for a drug and is impaired while on duty from the prescription drug, this may be considered neglect.

permanent use of belongings or money[47] with or without the consent of a person using services. The illegal or improper use of a person's resources or status for another's benefit or advantage is considered exploitation.

2. **Serious Injury of Unknown Cause:** an injury that requires assessment and treatment beyond basic first aid that can be administered by a lay person, the cause of which is unknown.
3. **Suspicious Injury:** an injury that may have been the result of abuse or neglect or is not consistent with the explanation provided. There must be a reason to suspect the injury was the result of abuse or neglect.
4. **Death:** a fatality occurring under circumstances that are unexpected or unexplained.

7.1.c. Other Incidents and Interventions. The following categories of incidents and interventions must also be reported to the Incident Management Unit using the RIF[48]:

1. **Death**: a fatality regardless of cause or location.
2. **Serious Injury:** any injury to a person supported that requires assessment and treatment beyond basic first aid that can be administered by a lay person.
3. **Person Missing Longer Than 15 Minutes:** any person receiving services, unless the absence is specified in a plan, whose whereabouts are unknown for longer than 15 minutes.
4. **Criminal Conduct or Probable Criminal Conduct:** acts which lead to or can reasonably be expected to lead to police involvement, arrest, or incarceration of a person using services.
5. **Sexual Aggression:** relating to potentially violent behavior of a person supported, focused on gratification of sexual drives regardless of the desire for participation on the part of the other person.
6. **Hospitalization:** a medical or psychiatric admission whether planned or unplanned.
7. **Use of CPR or AED.**

[47] The loss of $50.00 or more within a sixty (60) calendar day period.

[48] Go to Forms & Tools, Reportable Incident Forms. Click on the link for the RIF for the appropriate region. http://www.tn.gov/didd/provider_agencies/index.shtml

8. **X-ray to Rule Out a Fracture:** use of any imaging technique to determine whether a person using services has a fracture. This does not include imaging techniques used to diagnose illness.

9. **Use of Abdominal Thrust or Heimlich Maneuver:** techniques used for dislodging food or foreign objects from the windpipe.

10. **Any Use of Crisis Services:** including 911 Call, emergency room visit, mobile crisis services, EMT, fire or police on scene, or the use of an urgent care facility for emergency services.

11. **Serious Injury to Another by a Person Using Services:** any injury to another person by a person using services that requires assessment and treatment beyond basic first aid and was the result of a challenging behavior.

12. **Manual Restraint:** holding the limbs or body of a person supported in response to an imminently harmful behavior using an approved manual restraint procedure so that movement is restricted or prevented.

13. **Protective Equipment**: applying a device to any part of the body of a person supported that prevents tissue damage or other physical harm due to a person's behavior.

14. **Mechanical Restraint:** applying a device to any part of a person's body that restricts or prevents movement or normal use/functioning of the body or body part to which it is applied because of an ongoing risk of harm.

15. **PRN Administration of Psychotropic Medication:** psychotropic medications administered on an as needed (PRN) basis.

16. **Property Destruction Exceeding $100 in Value.**

17. **Reportable Staff Misconduct:** actions or inactions by staff of contracted agencies, contracted employees, volunteers or others affiliated with persons supported by DIDD that are contrary to sound judgment and/or training and that are related to the provision of services and/or the safeguarding of the person's health, safety, general welfare and/or individual rights. Staff misconduct includes incidents that do not rise to the level of abuse, neglect, or exploitation[49] and do not result in injury or adverse effect, and the risk for harm is minimal.

18. **Medication Variances and Omissions:** the submission of categories E to I on the Medication Variance Form shall require a RIF, with a copy of the DIDD

[49] The loss of fewer than $50.00 within a sixty (60) calendar day period.

Medication Variance Report.[50] In all cases, medication administration by someone who was not certified or was unlicensed requires notification to the DIDD Investigations Hotline.

7.2. Notification.

When any of the above listed types of incidents occur, the provider's Incident Management Coordinator (IMC) must complete and electronically submit the front page of the RIF[51] to DIDD and to the ISC within one (1) business day. If the primary provider is not the submitting party, the initial reporter will also send a copy to the primary provider within one (1) business day.

In the event that two or more providers are aware of or involved in an incident, a RIF must be completed and submitted to DIDD by the provider responsible at the time of the incident.

If an incident involves suspected abuse, neglect or exploitation, serious injury of unknown cause, suspicious injury, or death that is unexplained, unexpected, or the possible result of abuse or neglect; the provider shall also report the incident by telephone to the DIDD Investigations Hotline in the region where the incident occurred[52, 53, 54] as soon as possible and no later than four (4) hours after the incident or discovery of the incident. If provider staff is uncertain whether an incident qualifies for telephoned notification or other reporting requirement, it is recommended that the reporter consult with the on-call investigator for his or her respective region.

50DIDD Medication Variance Report: http://www.tn.gov/didd/provider_agencies/resources/Medication%20Variance%20Report_Form%20Field_Revised%205%202013.doc

51 Go to Forms & Tools, Reportable Incident Forms. Click on the link for the RIF for the appropriate region. http://www.tn.gov/didd/provider_agencies/index.shtml

52 East Tennessee Hotline poster: http://www.tn.gov/didd/protection/ProtectionFromHarmPosters_East.pdf

53 Middle Tennessee Hotline poster: http://www.tn.gov/didd/protection/ProtectionFromHarmPosters_Middle.pdf

54 West Tennessee Hotline poster: http://www.tn.gov/didd/protection/ProtectionFromHarmPosters_West.pdf

Providers are held accountable for any delay beyond the specified time frame. Providers must also be aware that state law requires reporting of certain injuries to or abuse of children to the DCS, Child Abuse Hotline and if an adult is the victim, to DHS, Adult Protective Services Division. For specific reporting requirements, see T.C.A. §§37-1-403, T.C.A.37-1-605, T.C.A. 71-6-103 (b) (1), and T.C.A. 71-6-103 (b) (2)(c).

7.3. Incident Management Requirements.

Each contracted provider is responsible for the designation of an IMC and each contracted provider of day, residential and personal assistance services is responsible for the designation of an Incident Review Committee (IRC). The IMC shall be a management level staff person within the agency. The IMC shall have primary responsibility for ensuring compliance with all safety requirements and fulfilling all of the incident management responsibilities discussed herein. Specific responsibilities of the IMC include:

1. Review of all incidents for timely and appropriate action.
2. Ensure that all reportable incidents have been reported as required, including reports to the DIDD Investigations Hotline.
3. Ensure that RIFs are typed, complete and electronically submitted to DIDD, the ISC and primary provider of the person.
4. Ensure that documentation of the submission is maintained for ten (10) years.
5. Ensure that DIDD recommendations associated with reportable incidents and/or resulting from DIDD investigations are addressed and implemented.
6. Serve as the chair of the IRC.
7. Conduct trend studies of reportable incidents and submit reports, analyses and recommendations to agency management.
8. Ensure that all incidents of reportable staff misconduct that are not directly investigated by DIDD are reviewed and addressed by agency management.

Day, residential, and personal assistance providers must establish an IRC with a defined membership and meeting schedule. The IRC is responsible for review of all incidents and investigations and the development of corrective/preventive action plans. The IRC is required to meet at least every two weeks. Smaller providers may elect to share an IRC with another

provider if appropriate steps are taken to ensure confidentiality of information regarding the person supported.

Membership of the IRC must include at least two provider management personnel. The membership shall also include at least one of each of the following: supervisory staff, direct support supervisory staff and direct support staff. Providers must consider including as members of the IRC persons supported and/or family members. Functions of the IRC include:

1. Monitoring of reporting of incidents including timely notification to entities other than DIDD.
2. Addressing recommendations relating to incidents and Final Investigation Reports and provider incident reviews, including reviews of Reportable Staff Misconduct incidents.
3. Identifying individual risk issues for prevention of harm and increasing safety of person supported.
4. Identifying incident trends and making recommendations as necessary.
5. Conducting reviews and/or assessments of particular homes, persons, programs, conditions or other factors which can be reasonably identified as presenting risks to the persons served.

The IRC is also responsible for completion of an annual written analysis of trends and patterns related to reported incidents. The annual written analysis must be completed each year and shall be made available to DIDD within two business days of the request for the written analysis.

The report must include, at a minimum, the following information:

1. An assessment of increasing or decreasing rates of specific types of reported incidents including abuse, neglect, exploitation and serious injuries.
2. An assessment of persons served who have a higher than average number of reported incidents.
3. An assessment of programs and/or homes with a higher than average number of reported incidents or substantiated investigations.
4. An assessment of direct support staff or supervisors who have been involved in a higher than average number of reported incidents or substantiated investigations.
5. Recommendations from these analyses.

Minutes of IRC meetings must be documented and kept on file by the provider. The minutes must reflect the date and time of the meeting, an agenda and identify the members present. The minutes must also include documentation of discussion and actions concerning reported incidents and investigations, their causes, corrective actions taken and recommendations made by the committee.

7.4. Investigation Requirements.

1. When there is a suspicion that abuse, neglect and/or exploitation has occurred, a suspicious injury or serious injury of unknown cause is discovered or an unexpected or unexplained death has occurred, a DIDD investigation shall be conducted. DIDD reserves the right to conduct an investigation into any incident.
2. When notified that an investigation will be initiated, providers are expected to cooperate fully with the investigator and respect the investigative process.
3. DIDD may conduct investigations of allegations involving DIDD employees, management or staff of contracted agencies, volunteers or other persons subject to DIDD oversight.
4. In cases where DIDD investigates the provider's director or chief executive officer, the Final Investigation Report will be sent to the board chairperson of a non-profit provider and to the owner or chief corporate executive of a for-profit provider. The recipient of the Final Investigation Report will be required to respond if allegations are substantiated.
5. In cases where DIDD investigates an independent clinical provider, the Final Investigation Report will be sent to the Regional Director and appropriate Central Office Clinical Director for follow up as indicated.
6. When an employee of a provider or its agent or volunteer is implicated in allegations of physical or sexual abuse, the provider is required to place that person on administrative leave or in a position that does not involve direct contact with or supervision of any person served or supervision of other staff who provide direct care, pending the completion of the investigation.
    a. If the provider contends that any of the staff involved in physical or sexual abuse investigations must not be placed on administrative leave or reassigned, the provider may file a written request for an exemption [55] to this requirement with the DIDD Protection from Harm Director or designee.

[55] Exemption Request Form:
http://www.tn.gov/didd/provider_agencies/policies/Exemption%20Request%20Form_BLANK.pdf

b. In such circumstances, the subject must be placed on administrative leave or reassigned pending approval or denial of the request.

7. Providers shall develop and implement a policy concerning appropriate action for staff who are the subject of a DIDD investigation.

   a. The provider is expected to ensure that adequate steps are taken for the protection and safety of the victim and other persons supported.

   b. The provider's policy and administrative staffing actions will be reviewed during the investigation.

   c. The provider shall instruct all staff that the facts and circumstances being investigated are not to be discussed with anyone except the DIDD investigator or law enforcement officer.

8. DIDD will be responsible for the distribution of the Final Investigation Report to the provider and the notification of the ISC of the investigative conclusions. Upon receipt of the report, the provider shall take the following actions:

   a. Within fifteen (15) days of the receipt of the Final Investigation Report, the provider shall notify the alleged perpetrator(s), in writing, of the outcome of the investigation.

   b. Within fifteen (15) days of receipt of the Final Investigation Report, the provider shall discuss the outcome of the investigation with the person(s) supported, and invite the person's legal representative if any, to participate in this discussion. This meeting shall be documented by the provider.

   c. Address late reporting (if applicable).

   d. Respond to any incidental information contained in the Final Investigation Report.

9. In instances where allegations are substantiated, the provider is required to submit a written Plan of Correction (POC) within fourteen (14) days of receipt of the Final Investigation Report. The response shall include the following information:

   a. What procedures have been implemented for protecting the person(s) using services from risk of further abuse, neglect, or exploitation?

   b. What has or will be done to address late reporting (if applicable)?

   c. Verification that the substantiated perpetrator(s) was notified of the outcome of the investigation.

   d. A statement of what, if any, disciplinary action was issued as a result of the findings of the investigation.

   e. A response to any incidental information contained in the report.

10. DIDD will notify the provider when the POC is accepted.

11. If allegations were not substantiated, a POC is not required.

12. For both substantiated and unsubstantiated investigations, providers must ensure that recommendations made by DIDD are acted upon in a timely manner. Documentation must be maintained that describes recommendations for corrective and preventative actions made by the provider staff or committees and actions taken to address such recommendations and those made by DIDD. Providers shall make available for DIDD review documentation of compliance with these obligations. DIDD staff may conduct reviews to ensure that all appropriate actions have been taken.

7.5. Requesting a Review of a DIDD Final Investigation Report.

Providers, ISCs/CMs, persons supported, and their legal representatives may request review of a DIDD Final Investigation Report within fifteen (15) days of receipt by submitting via mail or email, a written request, using the DIDD Request for Investigation Review Form[56] to the Office of the Director of Protection from Harm.

Such requests must be based on new or additional information or evidence not considered during the investigation or a matter which raises a question as to the integrity of the investigative process. DIDD will respond to such requests within thirty (30) days of receipt of the request to review the investigation. If further investigation is warranted, or additional information needed, an interim response will be issued to the requesting party.

7.6. Protection from Harm Policy Requirements.

All providers are expected to develop and maintain a Protection from Harm Policy for the safety and welfare of the persons they support.

This policy shall include:

1. A description of any disciplinary actions for personnel substantiated for abuse, neglect, exploitation, or Reportable Staff Misconduct.

2. A description of procedures for addressing such incidents promptly and appropriately to minimize the future risk of similar incidents or events.

56 Go to Protection from Harm, Forms, and select Request for Investigation Review
http://www.tn.gov/didd/protection/index.shtml

3. A procedure to develop and utilize trend studies of reportable incidents and substantiations of abuse, neglect, and exploitation for the purpose of identifying and reducing risks to persons using services.

4. A procedure for conducting risk assessments of persons using services identified as presenting higher risks to the safety of themselves or others.

5. Procedures to ensure immediate response to safety and health risks associated with reportable incidents to include:

   a. Obtaining medical attention for persons using services and provider staff.

   b. Immediate correction of hazards contributing to the incident.

   c. Attention to staff conduct that may have contributed to the incident.

   d. Notifying the ISC/CM of incidents.

6. Measures to ensure the reporting of incidents timely and accurately; cooperation with DIDD investigators; and furnishing requested information and documentation promptly upon request.

7. Sanctions for falsification of incident reports; the making of false allegations; providing false or misleading information during an investigation; or the withholding of information during an investigation by any employee. The provider is expected to adopt a zero tolerance policy for such infractions.

8. Measures to prevent intimidation of or retaliation against any person and to bring information about attempts to do so to the attention of management.

   The provider's policy must include this statement: "Any person subject to this policy who retaliates against another person for his or her involvement as a reporter, witness, or in any other capacity related to incident management and/or investigations of abuse, neglect, or exploitation shall be subject to disciplinary action, including possible termination. Such actions may also result in legal or other administrative measures as appropriate."

9. All providers are required to develop and implement a policy that addresses how staffing actions are handled with regard to investigations.

10. Measures to ensure that the provider's management and staff do not interfere with nor compromise the investigative process and that matters under investigation shall not be discussed except with the DIDD investigator and law enforcement officer(s).

11. Measures to ensure that the RIF and DIDD Final Investigation Report are kept confidential and that file copies of these documents are maintained in a location separate from the record of the person.

CHAPTER 8

HEALTH CARE MANAGEMENT

8.1. Introduction.

Maintenance of optimal health is one of the most basic supports provided by DIDD. This is a shared responsibility among all entities who work with each person. The level of active involvement with health care practitioners depends on recognition of the risk factors of each person. Achievement of optimal health is based upon these principles:

1. People make person-centered decisions about healthy lifestyle, such as food choices, and activity.
2. People participate in decisions about their health.
3. People have adequate contact with health practitioners regarding their physical and mental health.
4. People receive preventive health care and services, including recommended physical and dental exams.
5. People receive timely assessment, treatment, and follow up for acute and chronic health issues.
6. People are supported to follow their prescribed treatment plans (e.g., medications, special diets, mealtime instructions, BSPs).
7. People's health related information, both current and historical, is documented accurately and available when needed.
8. People shall have some form of identification which includes emergency contact information with them at all times.

8.2. Overview of Health Care Supervision.

Each person shall receive the level of health care necessary to ensure optimal health. All providers are required to incorporate health management policies into overall agency operations. These policies shall include how management, supervision and documentation of health care for persons supported occur.

Health care requires an ongoing systematic process for surveillance and review of the health care needs of each person. This process includes activities such as:

1. Preparing the person for all health care appointments and/or health care encounters.
2. Follow-up of all appointments and/or health care encounters to ensure recommendations are completed.
3. Obtaining informed consent from the person and or legal representative.
4. Supervision of medication administration and prompt action when variances, omissions or other problems are discovered.
5. Signs and symptom recognition and management of urgent and emergent medical problems.
6. Continuity and coordination of care before, during and after health care encounters, appointments, and/or emergency room treatment or hospitalization.
7. Ensuring individualized supports such as special diets, staff instructions for health and safety, BSPs, and adaptive equipment and supplies are provided as ordered and/or as referred to in the person's ISP/Plan of Care.
8. Ensuring health care supervision and management are performed by trained qualified staff.

8.3. Responsibilities of Service Providers.

Providers must support persons to be involved in their health care management. Providers, as appropriate, are expected to develop and maintain health care management policies, and implement practices that ensure the following outcomes:

8.3.a. Informed Consent and Release of Information.

1. Informed consent for treatment shall be obtained from the person and/or legal representative prior to the provision of services, treatments, and medications.
2. Consents must be current. Renewal shall occur no later than one (1) year from the date the consent was originally obtained. A new informed consent is required if specifications are not included and changes occur after the consent was signed.
3. Release of information obtained to share health related information is in accordance with HIPAA and Title 33 of the T.C.A.

8.3.b. Health Care Coordination. The primary provider, as determined in **Section 10.5.a,** subsections 1, 2 and 3, shall make and/or coordinate necessary health care encounters, medical, dental, and other appointments. Because of their extensive responsibility for the person, they shall document the following outcomes as related to health care management and supervision.

1. All appointments and health care encounters including follow-up recommendations by the treating practitioner are arranged and attended in a timely manner.
2. Accessible transportation is available for all health care encounters, medical, dental and other appointments.
3. The person is adequately supported to attend the health care encounter and/or appointment by:
    a. Arriving at the health care encounter and/or appointment on time.
    b. All necessary preparation for any health care encounter and/or appointment has been completed.
    c. Staff who accompany a person to health care encounters and/or appointments are familiar with the person and able to provide current health information including documentation of allergies, medications and physical or behavioral health concerns.
4. Health care encounters and/or appointments and all recommendations are appropriately documented.
5. Outcomes from health care encounters and/or appointments are communicated to the legal representative, if applicable, and the ISC/CM.
6. Document all supports provided to assist the person and or legal representative to obtain the examination if the person and or legal representative refuses.

8.3.c. Primary Care Practitioner and Dental Services. Persons supported shall have access to primary care services as needed. Regular contact with the Primary Care Provider (PCP) for physical examination, appropriate medical screenings and medical care of acute and chronic conditions is essential to maintenance of best possible health.

Each person supported must receive a medical examination according to TennCare Rules.[57] **Table 8.3-1** describes TennCare, CMS, and DIDD minimum requirements for medical examination by the physician.

Table 8.3-1 **Schedule for Medical Examinations per TennCare Rule**	
Age	**Minimum Frequency**
Up to age 21	In accordance with TennCare Early Periodic Screening, Diagnosis and Treatment (ESPDT) standards.
Ages 21-64	Every one (1) to three (3) years as determined and documented by the PCP.
Ages 65 and older	Annually

Note: *TennCare rules indicate physical exams must be annual unless otherwise noted by exception by the attending primary care practitioner.*

Persons supported shall have access to dental services as needed. Regular contact with the dentist is essential to maintenance of best possible health.

8.4. Integrating Behavioral and Therapeutic Health Supports and Services.

1. Provider assures the person is available and is supported to participate in scheduled behavioral and therapeutic services appointments.
2. Providers and clinicians are mutually responsible for contacting one another when an appointment must be rescheduled by either party.
3. Providers assure staff are trained to carry out staff instructions and BSPs designed to support health and safety during daily activities. DIDD Regional Clinicians offer a variety of classes for provider staff on a wide range of topics such as falls, mealtime safety, menu planning, etc.
4. Providers monitor the implementation of staff instructions and BSPs designed to support health and safety during daily activities and notify the clinician if issues with implementation arise.
5. Medically necessary assistive and adaptive equipment is obtained, available for use, utilized appropriately, and maintained in good working order for the person (once funding is approved).

[57] TennCare Rules 1200-13-01-.25, 1200-13-01-.28, 1200-13-01-.29: http://www.tn.gov/sos/rules/1200/1200-13/1200-13-01.20121225.pdf

6. Providers work with clinicians to designate a trainer to carry out ongoing training of staff on individual specific instructions and plans.

7. Providers shall continue the implementation of individual specific instructions, as recommended, after the person is discharged from a therapeutic service. These are to be reviewed at least annually by the COS to assure they continue to meet the person's needs. Any changes to the instructions require a new referral to the appropriate clinician. Staff instructions are filed in the person's comprehensive record and appropriate record set as defined in **Chapter 10.**

8.5. Medication Safety.

8.5.a. Medication Administration by Unlicensed Personnel. A statutory exemption allows unlicensed staff to administer certain medications to persons supported in DIDD's waiver programs. Providers who employ staff to administer medication are responsible for compliance under DIDD (presently DOH) rules.[58] Providers shall ensure that all unlicensed staff who administers medication has successfully completed the DIDD Medication Administration for Unlicensed Personnel competency based training and that current certification is maintained.

1. Providers shall have a medication safety policy (formerly known as medication administration policy) that is accepted by DIDD. Required elements of a medication safety policy are specified in the DIDD (presently DOH) rules.[59]

2. The medication safety policy shall also contain elements which address self-administration of medications.

3. The medication safety policy shall also contain elements which address the safe administration of psychotropic medications, including appropriate screening for medication-induced movement disorders every six months.

4. A separate Medication Administration Record (MAR) must be maintained for each individual receiving medications. MAR required elements are specified in the DIDD (presently DOH) rules.[60]

5. PRN psychotropic medications may only be administered by a licensed nurse after an RN or prescribing practitioner has determined less restrictive measures have been taken and failed to stabilize the situation. Informed consent is required

[58] Rulemaking Hearing Rules of Tennessee DOH, Division of Health Services Administration Chapter 1200-20-12 http://www.tn.gov/sos/rules/1200/1200-history.pdf
[59] Ibid.
[60] Ibid.

before the doctor's order is implemented, and HRC review is required within 30 days.

6. Medication variances and omissions can occur during transcribing, preparing, administering or in the documentation of a medication. A medication variance occurs at any times that a medication is given in a way that is inconsistent with how it was ordered by the prescribing practitioner and in accordance with the "Eight Rights" (i.e., right dose, right drug, right route, right time, right position, right texture, right person, and right documentation).

8.5.b. Administration and Supervision of Psychotropic Medications. Psychotropic medications are appropriate as part of the treatment plan for people who have been diagnosed with a psychiatric illness. Provider agencies must ensure individuals receiving psychotropic medications have a minimum of quarterly appointments with their treating practitioner. Therefore providers must ensure training is provided on administration of any prescribed psychotropic medications and recognition of side effects, including potentially life threatening side effects; e.g., neuroleptic malignant syndrome, serotonin syndrome. Involuntary administration of psychotropic medications by provider agency staff is strictly prohibited.

8.6. Recognition and Response to Urgent and Emergent Health Problems.

Providers shall have written policy and procedures that communicate the actions that must be taken for urgent and emergent health conditions (including behavioral and mental health issues) and ensure staff are trained to recognize a medical emergency or behavioral crisis and respond appropriately. The policy shall include the following elements:

1. Instruction that 911 call must not be delayed.
2. Information regarding initiation of first aid procedures.
3. Requirements for provision of information to emergency medical staff.
4. Requirements for notification of designated provider supervisory staff.
5. Ensuring that each person identified as prone to a behavioral crisis has an appropriate cross-systems crisis plan.

8.7. First Aid Kits.

Providers shall have a written policy and procedures regarding appropriate first aid kits, including the following:

1. Accessibility.
2. Locations.
3. Contents.
4. Security.
5. Periodic review and restocking.

8.8. Primary Provider Responsibilities for Hospitalizations.[61]

1. Remain current with changes to health status and support needs of the person to ensure necessary supports are in place to adequately meet the needs of the person upon discharge.
2. Provide the hospital with contact numbers for the ISC/case manager, including after-hours contact information.
3. Provide communication links between the person and or legal representative, residential service provider and hospital staff.
4. Collaborates with the legal representative and or the residential provider to ensure the person has adequate supports while receiving in-patient hospital care.
5. Collaborates with hospital discharge planning staff, the legal representative, the person's MCO, the residential provider and, if the person is also Medicare eligible, his/her Medicare provider to identify and obtain any alternative supports and services needed by the person upon discharge.
6. Update the ISP as needed but no later than within 14 calendar days from date of discharge to ensure the person's needs are met.
7. Identification of individuals and/or medical professionals to be contacted and informed when discharge is imminent and/or when alternative placement is needed following discharge.
8. Arrangements to resume or change previous professional services as appropriate and/or arrangements for providers of any new services and supports needed post-discharge.

[61] Refer to **Section 10.5.a,** subsections 1, 2, and 3.

9. Arrangements for any environmental modifications, new equipment or supplies needed post discharge.

8.9. End of Life Issues.

1. Every person has the right to make Advance Medical Directives in accordance with Tennessee and Federal law.
2. The ISC must ascertain the person's wishes concerning life-sustaining treatment as a part of the preparation processes carried out around the time of the annual ISP process.
3. The ISC will address end of life decisions, including autopsy, Physician's Orders for Scope of Treatment (POST), which includes do not resuscitate (DNR) orders and advance directives for all individuals served.

8.10. Death Reporting and Death Reviews.

Entities serving persons with intellectual disabilities who are supported by HCBS waiver or other community programs funded through DIDD are responsible for reporting the death of such persons supported to DIDD and for complying with the 90.1.2 Death Reporting and Review Policy.[62]

8.11. Autopsies.

The Department requires an autopsy for deaths that are unexpected and unexplained. These autopsies will be performed without cost to the family or legal representative. In the event the family or legal representative objects to the autopsy, the Department will respect their wishes and not request an autopsy be performed.

[62] http://www.tn.gov/didd/provider_agencies/policies/Death%20Review%20Policy%205-31-2012.pdf

CHAPTER 9

QUALITY MANAGEMENT

9.1. Introduction.

Ensuring quality in the provision of services and supports is the responsibility of all partners in the service delivery system. State and federal governments are responsible for oversight of such programs to ensure that the services funded are meeting the needs of persons.

Providers who establish contracts with the state are required to provide services in accordance with program standards and other requirements and in accordance with individualized plans created for each person. Providers must have a process for conducting self-assessments. Self-assessment is the process by which the provider identifies issues affecting the quality of services provided, as well as areas of operation resulting in non-compliance. Providers must react to self-assessment findings by determining the causative factors and taking action to improve quality or compliance.

Persons and their families, legal representatives, and advocates have a role in assuring quality by participating in the service planning process, ensuring that their needs are met, and taking advantage of available options for recourse when services and supports do not meet a person's needs or when unintended events or incidents occur.

9.2. Quality Management Activities External to DIDD.

9.2.a. Federal QM. CMS, within the United States HHS, is responsible for ensuring the quality of Medicaid waiver programs. CMS approves waiver applications submitted by the state. Approved waivers define the services the state will provide and specify provider qualifications and state administrative responsibilities. The approved waiver requires the state to make a number of assurances to CMS, including an assurance

to protect the health, safety, and welfare of persons. Once approved, the waiver application serves as a contract between CMS and the state. CMS approves new waivers for a period of three (3) years and waiver renewals for a period of five (5) years.

CMS monitors the state for compliance with federal assurances on an ongoing basis. Monitoring focuses on ensuring that the state has the capacity to identify and remediate performance issues related to individual persons, providers, and the system as a whole. CMS relies upon data provided by the state to document compliance with each of the federally-required waiver assurances. For each waiver assurance, the state has developed CMS-approved performance measures for which data must be collected, analyzed and reported each month via specified monitoring processes. Federally mandated waiver assurances are:

1. **Administrative Authority**

   The Single State Medicaid Agency must exercise administrative authority over all waiver programs operating within the state.

2. **Level of Care**

   The state must have effective processes for determining that individuals are medically and categorically eligible for services prior to enrollment and remain eligible thereafter.

3. **Qualified Providers**

   The state must ensure access to services provided by a network of service providers that meet qualifications specified in the approved waiver document as well as state-specific licensure, certification, and other programmatic requirements.

4. **Service Planning**

   The state must have processes in place to effectively identify person needs and plan for delivery of services and supports to meet identified needs.

5. **Health and Welfare**

   The state must assure that waiver services, combined with other available services and supports for which the person may be eligible, result in ongoing maintenance of the person's health, safety and welfare.

6. **Fiscal Accountability**

The state must ensure that federal funds expended are utilized to provide payment for necessary services rendered in accordance with an approved service plan. Federal audits or investigations may be triggered for reasons unrelated to routine waiver monitoring.

9.2.b. TennCare QM. The contract for federal funding of waiver programs (the approved waiver application) is between CMS and TennCare. TennCare is responsible for administrative oversight of all Medicaid waiver programs.

TennCare contracts with DIDD to manage the day-to-day operations involved in making quality waiver services available to eligible persons. TennCare performs a number of administrative oversight activities to evaluate DIDD's performance as the operational lead agency and to evaluate DIDD and provider agency compliance with state and federal rules, regulations, and policies.

When DIDD requests documentation to support a response to a TennCare finding, providers are required to provide such documentation to DIDD for TennCare review within ten (10) calendar days. Providers will be required to provide documentation validating that adequate remediation activity has occurred and that corrective actions have been implemented to prevent subsequent related findings. TennCare findings may result in sanctions or recoupments.

9.2.c. Quality Monitoring Activities Conducted by Other External Entities. Monitoring activities conducted by other state agencies that may involve DIDD providers or require the cooperation of DIDD providers include:

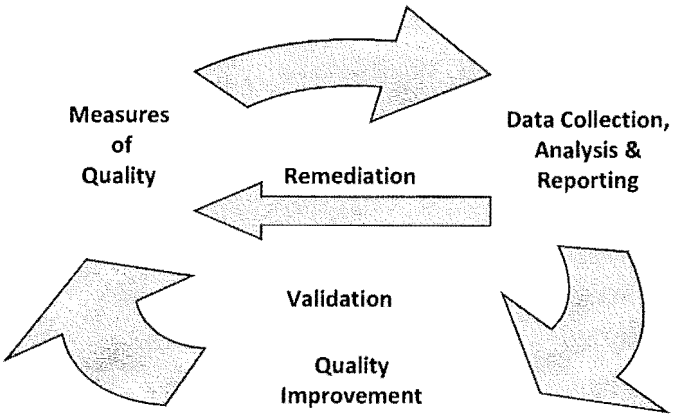
1. TennCare utilization reviews and audits of services.
2. Licensure surveys and complaint investigations of home care organizations and professional support services providers conducted by DOH.
3. Audits conducted by the Tennessee Office of the Comptroller to evaluate TennCare's performance in administering the waiver program.
4. Abuse, neglect, and exploitation investigations conducted by DCS, Division of Child Protective Services or DHS, Division of Adult Protective Services.
5. Regional Financial Reviews conducted by CMS.

6. Court-appointed monitoring entities responsible for measuring compliance with federal court-ordered requirements.

9.3. Overview of the DIDD Quality Management System (QMS).

The QMS measures quality in terms of achieving outcomes that are important to and important for persons. The primary purpose of the QMS is to provide a mechanism for achieving continuous improvement in both the quality of services and the performance of the service delivery system. In addition, the QMS measures compliance with state and federal requirements to ensure ongoing availability of federal funding, assists in documenting compliance with federal court orders, and provides information that contributes to effective utilization of resources. Quality management is not a static process; there is no beginning or end point. Rather, it is an ongoing circle of measurement, discovery, action/implementation, and re-measurement to determine the effectiveness of strategies employed for improvement of the system.

Figure 9.3-1.
THE QUALITY MANAGEMENT SYSTEM CIRCLE



9.3.a. QMS Principles. The following principles guide the QMS:

1. The system must produce improvement(s) in the delivery of services.
2. All tools, processes, and protocols developed must be implemented statewide.
3. All tools, processes, and protocols developed must be applicable to and effective for **all** persons receiving Medicaid waiver-funded services.
4. The system must include the least amount of duplicative processes as possible.
5. The system must include a database capable of collecting and producing reliable information for analysis and reporting purposes.
6. Reports describing QM activities and trend analysis must be widely available.
7. The QMS must identify deficiencies and opportunities for improvement.
8. The QMS must highlight positive practices.
9. The QMS must employ targeted interventions and strategies designed to address the causes of identified issues and concerns.
10. The QMS must include effective sanctioning options for serious health and safety issues identified and failure to correct quality and compliance issues in a timely and sustainable way.

9.3.b. QMS Activities and Data Sources. Efficient and effective technology systems are essential to the timely collection and production of performance measure data used to evaluate the system or services and supports. Ongoing analysis of systemic performance is an essential component to continuous QI. In addition, QM data allows DIDD to assess satisfaction with services, document compliance with federal court orders, monitor the effectiveness of policy and training initiatives, and ensure adequate fiscal management. Data sources available to the QMS include:

1. New Provider Support Process.
2. Provider Performance Surveys.
3. Individual Waiver-Specific Record Reviews.
4. Fiscal Accountability Review (FAR).
5. Person Satisfaction Surveys.
6. Incident and Investigation (I&I) Data Analysis.

7. Complaint Resolution Tracking.

8. Death Reviews.

More detailed descriptions of QMS activities are provided in the subsequent sections of this chapter.

9.3.c. QMS Remediation of Findings. Remediation must occur at all levels of the system. Individual person findings will require provider and/or DIDD remediation actions. The requirement is to achieve remediation of individual findings within 30 days of discovery. DIDD will perform follow-up validation reviews involving a sample of individual remediation actions. In addition, TennCare reviews and validates individual remediation of findings.

Provider-level findings will typically require development or revision of a provider QI plan which specifies strategies for achieving adequate remediation of findings and preventing subsequent related findings. Depending on the nature of the findings, implementation of the provider QI plan may be monitored through follow-up or focused reviews, reassessment during the next scheduled Provider Performance Survey, Regional Provider Support Team (RPST) monitoring and technical assistance, or provider submission of documentation supporting QI plan implementation.

Systemic findings will typically require longer time periods to determine the cause of the systemic finding and develop system-wide remediation strategies. Systemic improvement strategies will be proposed by DIDD and discussed with TennCare during monthly QM meetings (if applicable to waiver providers and/or persons). TennCare will monitor implementation of DIDD systemic improvement strategies via review of supporting documentation and data, status updates during interagency meetings, and/or focused surveys.

9.4. New Provider Support Process.

It is the provider's responsibility to develop and implement policies, procedures and systems congruent with DIDD, TennCare and CMS regulations. To assist a new provider with these responsibilities, once a newly approved provider has a fully executed provider agreement, a

member of the RPST will begin to make periodic contacts with the new provider. The primary purpose of this process is to assist a new provider with administrative areas or program implementation applicable to HCBS regulations, Tennessee State law, federal/state court orders, and DIDD policies and procedures. RPST involvement in this process will continue at least until the initial QA consultative survey and thereafter as determined by the RQMC.

As part of the process, the RPST will document its contacts using the New Provider Checklist. For new clinical service providers, the Regional Office clinicians and their Central Office counterparts are available to provide assistance and support as needed.

9.5. DIDD Provider Performance Surveys.

Provider Performance Surveys are conducted to determine provider outcomes related to Quality Domain indicators, determine provider compliance with the provider agreement, and determine compliance with federally-mandated waiver assurances and related performance measures.

9.5.a. Quality Domains. Provider performance is evaluated via the Provider Performance Survey process, through outcome measurement in ten (10) quality domains which are as follows:

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

9.5.b. Survey Tools. Outcomes and indicators related to each quality domain have been incorporated into DIDD Provider Performance Survey Tools. Individual survey tools have been developed for different provider types. Copies of current QA survey tools[63] applicable to specific provider types are available on the DIDD web site.

Tools include two areas of focus: 1) Evaluation of services and supports received by a sample of individual persons; and 2) Assessment of the provider's ability to ensure an adequately trained workforce, develop an effective management structure including a self-assessment process and a QI strategy, and develop and implement policies and practices that are person-centered and quality focused. Survey results highlight both exemplary performance and opportunities for improved compliance and/or quality of service.

9.5.c. Frequency of Surveys. DIDD QA staffs conduct annual surveys of all providers. Less frequent surveys may be conducted for provider agencies demonstrating ongoing proficient or exceptional performance in overall operation. There are specific criteria for making decisions about the frequency of monitoring. DIDD may determine that more frequent surveys are necessary to evaluate provider performance in ensuring health, safety and welfare of people using services or to determine resolution of serious compliance issues.

9.5.d. Consultative Surveys. DIDD QA staff conducts initial consultative surveys for new agencies that have initiated service provision but have not previously participated in a Provider Performance Survey. A consultative survey is considered an "informal" survey process intended to give the new provider experience with the survey process and knowledge of compliance issues and needed improvements.

The provider will be required to correct any serious health and safety issues identified during a consultation survey. After the consultation survey is completed, the provider will participate in annual DIDD Provider Performance surveys. Consultative surveys are generally scheduled between ninety (90) days and six (6) months.

[63] http://www.tn.gov/didd/quality_management/survey_inst.shtml

9.5.e. Sampling Methodology. A ten percent (10%) representative sample of persons will be selected for onsite review during each Provider Performance Survey, with a minimum of four (4) and a maximum of fifteen (15) persons selected. The provider will be given a list of persons selected for the initial sample on the first day of the survey. Sample size may be increased if issues are identified within the sample population and more information is needed to determine the scope of the issue.

9.5.f. Preparing for a Provider Performance Survey. A Provider Performance Survey schedule is developed prior to the beginning of each survey year. Providers will be notified at that time of the approximate date that DIDD plans to begin the agency's Provider Performance Survey. For providers serving in more than one region with only one statewide office, QA staff will make arrangements, when possible, to coordinate these reviews. Approximately sixty (60) days before the start of the survey, DIDD will send written notice to the provider of the actual date the survey will begin. The provider must complete the following activities prior to the survey:

1. Submit required pre-survey information in the required format to DIDD at least thirty (30) days prior to the survey start date.
2. Identify a staff member as DIDD's contact during the survey process.
3. Notify all persons, involved family members, and legal representatives, as applicable, of the upcoming survey.
4. Notify all persons, involved family members, and legal representatives, as applicable, of the survey team's availability to discuss the survey processes or services received during the course of the survey.

Providers shall be allowed to determine the best method of distributing information about the survey. Examples of acceptable methods for information distribution include individual correspondence, articles in provider newsletters, announcements posted at service sites, and email announcements.

9.5.g. On-site Provider Performance Survey Procedures. Surveys begin with a meeting between key provider staff and the survey team. During the initial meeting, participants will discuss the logistics of the survey. The provider may utilize the initial meeting to provide general information about the organization, including management

and QI strategies that have been implemented since the last survey. Following the initial meeting, survey activities will begin. Throughout the survey, survey team members will interact with provider staff to ask questions and request needed information. Surveyors will act in accordance with the following during the survey:

1. Initial observations will be considered in light of additional relevant information that is presented or discovered during the course of the survey.
2. Identified issues that are corrected prior to the end of the survey will be included in survey results, with notation of expedient corrective action.
3. Immediate jeopardy issues (that have caused or have potential to imminently cause harm to the person) identified during a survey will require expedient provider corrective action (**Section 9.7** describes immediate jeopardy situations and protocols in greater detail.).
4. Reporting protocols will be followed if unreported incidents are discovered, including notification of DIDD investigators as appropriate.

When survey activities are completed, survey team members will participate in a conciliation process to determine the provider's level of performance based on all information collected and reviewed during the survey. The survey will conclude with an exit conference. During the exit conference, the survey team will review major findings. Under most circumstances, the written survey report will be made available during the exit conference. When circumstances require further review of specific issues, the survey report will be issued when review is completed. A copy of the final report will be sent to the provider agency's board chair or chief officer.

9.5.h. Provider Response to Provider Performance Surveys. The provider agency executive director shall be held responsible for ensuring that the internal QI plan is revised to address survey findings, as appropriate. In addition, the provider must evaluate self-assessment capabilities and develop QI strategies that allow prompt identification and correction of compliance issues.

9.5.i. Provider Requested Reviews of Provider Performance Survey Results. Providers may request review of findings cited during a survey and included in the written survey report. Review requests may be submitted to the appropriate DIDD Regional Director of QA.

If the provider is dissatisfied with the results of the review, a second review may be initiated by submitting a written request to the DIDD Commissioner stating the reason a second level review is being requested. The Commissioner or designee will respond to the request as expeditiously as possible, in most cases, within 30 days. Response times will vary depending upon the number and complexity of issues presented with the review request.

All review requests must specify findings to be reviewed and must be accompanied by any documentation available to support requested changes in survey findings. For each step, the provider will have ten (10) days from the date of receiving the survey report or written notification of a determination to initiate or continue the review process.

9.6. Individual Waiver-Specific Record Reviews.

Individual Record Reviews are conducted during each waiver year to collect data demonstrating compliance for three (3) of the six (6) federally-mandated waiver assurances: Level of Care, Service Plan and Health and Welfare. Individual Record Reviews are conducted by DIDD QA staff. DIDD is required to conduct these reviews annually.

9.6.a. Sampling Methodology. During each waiver year, a statistically valid random sample of individual persons will be selected for review from each waiver program. Sampling methodology will be available on the DIDD website.

9.6.b. Review Process. For each person selected, a record review will be conducted by DIDD QA staff utilizing a data collection instrument design based on federally-mandated waiver assurances and CMS-approved performance measures. The current data collection instrument is available on the DIDD website.

9.6.c. Remediation of Findings. Designated DIDD Regional Office staff will report findings to the appropriate remediation entities (designated DIDD staff and/or appropriate provider management staff). Appropriate remediation strategies will be implemented. DIDD Regional and Central Office Compliance staff will report findings, remediation activities and remediation timeframes. Remediation actions will be validated by designated DIDD Regional Office staff and by TennCare Quality and Administration staff to ensure successful and timely remediation of findings.

9.7. Immediate Jeopardy.

Immediate jeopardy issues are those that have caused or have the potential to imminently cause harm to a person. These issues require expedient provider corrective action.

9.7.a. Issues Warranting Initiation of Immediate Jeopardy Procedures. Immediate jeopardy issues include, but are not limited to:

1. Serious medication errors not previously detected or corrected.
2. Lack of follow-up for major medical issues.
3. Failure to follow mealtime staff instructions resulting in choking or imminent risk of choking.
4. Little or no food in the home or little or no food appropriate to a person's special diet.
5. Serious mismanagement of personal funds.
6. Identification of major risk factors in absence of a plan to address the risk.
7. Serious environmental hazards.

9.7.b. Immediate Jeopardy Procedures. When immediate jeopardy is identified, the following actions shall occur:

1. The DIDD employee identifying the immediate jeopardy situation will contact the agency director or designee to provide verbal notice of the immediate jeopardy situation.
2. DIDD staff will remain on-site as necessary until the immediate jeopardy situation has been resolved sufficiently to ensure the person's health and safety.

3. The DIDD employee identifying the immediate jeopardy situation or other DIDD staff available will notify the DIDD Regional Director or designee of the immediate jeopardy situation and forward a copy of the immediate jeopardy notice when completed.

4. The DIDD employee will issue a written immediate jeopardy notice to the provider describing the situation and time frame by which actions must be taken to ensure the person's health and safety.

5. The DIDD employee will send a copy of the immediate jeopardy notice to the person's ISC/CM.

6. The DIDD employee will assure that a RIF[64] is completed and the Investigations Unit is notified of the situation.

7. The provider will notify the person's legal representatives and/or involved family members.

8. If necessary, designated DIDD staff will validate and document corrective actions taken.

9. Survey scores and ratings will be affected by immediate jeopardy findings during a survey, even when timely corrections are implemented.

9.8. Other Components of the QMS.

9.8.a. Satisfaction Surveys. Person satisfaction surveys provide information about the quality of services and supports directly from the people who receive them. The person perspective is a valued and essential component of the QMS. Person and/or family member interviews are utilized to obtain information about the impact of services and supports on quality of life during Provider Performance surveys and/or other monitoring processes.

9.8.b. Provider Initiated Satisfaction Surveys. Provider agencies are required to conduct person surveys and use the information obtained to improve the quality of services and supports. For support coordination agencies, evaluation of person satisfaction with independent support coordination services occurs with completion of required service documentation forms described elsewhere in this manual. Other provider agencies are required to conduct an annual survey, the results of which are

[64] Go to Forms & Tools, Reportable Incident Forms. Click on the link for the RIF for the appropriate region. http://www.tn.gov/didd/provider_agencies/index.shtml

reviewed during DIDD Provider Performance Surveys.

9.8.c. People Talking to People Survey. DIDD contracts with an external entity to administer the annual People Talking to People (PTP) Survey. The current PTP survey format is available on the DIDD website. The PTP survey involves face-to-face interviews with persons and/or family members conducted by an independent evaluator employed by the contractor.

The contractor works with the DIDD PTP Director to collect and analyze survey data, and produce an annual PTP Survey Report. Trends are reported statewide, by region, and by waiver program. PTP Survey data is utilized to document compliance with CMS-approved performance measures related to the Service Planning and Health and Welfare federally-mandated waiver assurances. PTP data is also used to identify systemic issues and develop systemic QI strategies.

9.9. Incident Management and Customer-Focused Services.

Both complaint and I&I data are utilized to monitor compliance with the federally mandated health and welfare assurance and related CMS-approved performance measures. The I&I database also provides information relevant to court compliance and provider performance. Information on incidents and investigations is used to determine if more frequent provider monitoring or provider technical assistance is warranted.

9.9.a. Customer-Focused Services Data. Complaints are handled by the Customer Focused Service Coordinators in the regions of the state. The Assistant Statewide Director of Customer Focused Services monitors all complaints via the DIDD database to ensure timely and satisfactory resolution. Providers are required to establish a complaint resolution process to address complaints submitted by persons using services and families. Providers are also required to have an identified complaints contact person and to maintain documentation of all complaints filed.

9.9.b. Incident and Investigations Data. Incident and Investigation data is maintained by the DIDD Protection from Harm Unit, utilizing the I&I database. The database produces the following data:

1. Types and numbers of incidents statewide, by region, by waiver and by provider.
2. Number of investigations completed statewide, by region, by waiver and by provider.
3. Rates of substantiated investigations statewide, by region, by waiver and by provider.

9.10. Death Reviews.

Death reviews are conducted by DIDD Regional Death Review Committees for all unexpected and unexplained deaths. The 90.1.2 Death Review Policy is available on the DIDD web site.[65]

9.11. FAR and Licensing.

Annual FAR reviews provide information and data used to evaluate the overall financial status of the provider network, including provider competency in adequately documenting the provision of services to support claims submitted. Data pertaining to CMS-required performance measures is collected, analyzed and acted upon when there are findings during FAR reviews. In addition, information regarding licensure may be obtained by visiting the DIDD web site.[66]

9.12. Regional and State Quality Management Committees.

9.12.a. Regional Quality Management Committee. Each region maintains an RQMC comprised of management level staff of all units within the region. This group meets on a regular basis, at least monthly, to review provider performance and determine the need and frequency of Provider Support Team Follow up. Results of each QA Provider Performance survey are reviewed along with information from other components of the QMS such as complaint information, I&I information, provider

[65] http://www.tn.gov/didd/provider_agencies/policies/Death%20Review%20Policy%205-31-2012.pdf

[66] http://www.tn.gov/didd/Licensure/Licensure.shtml

support team follow up information, etc. Based on review of provider performance or other issues, follow up actions are planned if warranted.

9.12.b. Statewide Quality Management Committee. The SQMC is comprised of management level staff of all units within the Central Office and includes representation from each Regional Office. This group reviews statewide data to determine trends and initiate follow up actions if warranted. Additionally, information as to actions taken by the RQMC in response to specific provider performance or other issues is reported to the SQMC, which ensures statewide consistency and maintains oversight of regional QM activities.

9.13. Regional Provider Support Teams.

The RPST consist of Regional Office Staff persons within the Operations Unit of each region. A primary focus of the RPST is to support new contractors with DIDD or existing day, residential, and personal assistance providers performing below acceptable standards in QA Domain 3 (Safety and Security), Domain 5 (Health) and/or Domain 9 (Provider Capabilities and Qualifications). New providers will be assisted in all domains. Where applicable, assistance to providers of Clinical Services and Independent Support Coordination Services in Domain 2 may be included. Activities of the RPST are reported regularly to the RQMC.

9.13.a. Technical Assistance. Technical assistance may be requested by the provider or mandated by DIDD. DIDD technical assistance is provided by RPST members or by ad hoc teams formed to provide specialized technical assistance.

As previously stated, it is the provider's responsibility to develop and implement policies, procedures and systems congruent with DIDD, TennCare and CMS regulations. The primary focus of regional office involvement with this process is to assist the provider in understanding the interpretations and expectations of the Department. Technical assistance may involve help with identifying causative factors, identifying resources available to the provider, developing internal strategies for correction of systemic issues, and/or measuring improvements achieved with implementation of corrective actions.

9.13.b. Requested Technical Assistance. Requests for technical assistance may be submitted to the Regional Office Director of Operations for providers of day/residential/PA or ISC services; or to the Regional Clinical Director for the appropriate clinical discipline. Every effort will be made to respond to requests for technical assistance in a timely manner.

9.13.c. Mandated Technical Assistance. Mandated technical assistance (MTA) may be required when there is a pattern of failure to assure the health, safety and welfare of people receiving services. Situations that may result in MTA include, but are not limited to:

1. Identification of immediate jeopardy issues that are significant in terms of scope, frequency or severity.
2. An overall performance rating of "Serious Deficiencies" or "Significant Concerns" as determined through a QA Provider Performance Survey.
3. QA Provider Performance Surveys identifying minimal or non-compliance in areas related to safety and security (Domain 3), health (Domain 5) or Provider Capabilities/Qualifications (Domain 9); and/or for Clinical and Support Coordination agencies, Individual Planning and Implementation (Domain 2).
4. QA Provider Performance surveys identifying repeat findings that have not been adequately resolved or have not been adequately addressed through ongoing QI strategies.
5. A Provisional license is issued by DIDD, DOH or any other licensure entity.
6. Financial issues are identified that threaten the continued financial viability of the agency.
7. Other serious issues identified through any monitoring activity that are equivalent to those listed above in terms of effect on persons served or ability to operate as a provider agency.

9.13.d. Notification. The Provider Executive Director shall be notified in writing by the Regional Director or designee of the performance issues for which MTA is being imposed. A copy of the letter shall be sent to the Board Chair (if a non-profit organization) and to the corporate office if out of state. The notification will include information about the provider's right to appeal a sanction as required by Title 33 of the T.C.A.

9.13.e. Selection of an Entity to Provide Technical Assistance. The provider may accept MTA from DIDD at no cost. The provider also may choose to contract with an outside entity that is approved by DIDD, at the provider's expense.

1. Within 10 calendar days of notification of MTA, providers must notify the Regional Office of their choice to accept MTA from DIDD or the external entity chosen.
2. If the provider selected is presently contracted with DIDD they must have performed in the substantial compliance range in the Domains for which they are providing the technical assistance.
3. Information as to the provider's selection will be reported to the SQMC at the next regularly scheduled meeting of the SQMC.
4. When a provider chooses an external technical assistance provider, the RPST will continue to make monitoring visits to assess the progress of a provider on a schedule determined by the RQMC.
5. RQMC reserves the right to require that a provider choose an external source for technical assistance if the provider has previously had MTA and not maintained improvements; or if sufficient progress has not been made over time.
6. RQMC reserves the right to rescind approval of the external technical assistance provider based on lack of progress over time or change in performance of the external technical assistance provider.

9.13.f. External Technical Assistance.

1. An initial meeting will occur with both of the providers prior to the start of the technical assistance. Whenever possible, a member of the RPST will be in attendance. A written Technical Assistance agreement as well as a business agreement addressing HIPAA requirements will be signed.
2. The provider will submit to the RPST Coordinator the external technical assistance provider's plan for assisting the agency to achieve compliance and the indicators or measures the provider will use to track progress in achieving compliance.
3. The RQMC may accept or reject all or part of the technical assistance plan developed by the external technical assistance provider. If all or part of the plan is rejected, the provider will be notified of revisions needed for the plan to be acceptable.

4. The provider will report data monthly to the RPST Coordinator to demonstrate its ongoing efforts and progress toward achieving compliance.

9.13.g. DIDD Technical Assistance.

1. If DIDD is chosen to provide the technical assistance, the provider shall be contacted by RPST staff to schedule the initial meeting. A written Technical Assistance agreement will be signed at the initial meeting.
2. A period of 30 days will be allowed for the RPST and provider to work together to identify the cause(s) of noncompliance issue(s), develop and finalize a measureable QI plan, set timeframes for completion, and submit the plan to the RQMC.
3. According to timeframes established in the Provider Support Plan, the provider will submit data to the RPST specific to progress toward compliance on the QI plan.
4. During the next 90 days the provider will continue to work in collaboration with the RPST on MTA. The RPST will utilize various technical assistance techniques such as process mapping, side-by-side assessment, etc.
5. A validation review will be scheduled to assess the provider's progress as determined by the RQMC. A validation tool will be utilized and consist of a subset of essential quality elements from the QA Survey Tool; and will be customized to the provider based on the performance issues which have resulted in MTA.
6. If the provider is making progress but needs additional time to achieve compliance, the RQMC may make a recommendation to the SQMC for an extension of 60 days. Upon approval by the SQMC for the extension, the provider will be notified in writing.
7. If the provider is not making progress, the RQMC shall recommend to the SQMC that the provider be placed on benchmarks which must be achieved within specified timeframes to avoid further administrative actions, up to and including termination of provider agreement.

9.13.h. Conclusion of Technical Assistance. Technical assistance will be concluded when the provider has achieved compliance and SQMC has given approval. Progress in meeting technical assistance goals will be evaluated based on provider performance presented to the RQMC. A letter will be sent to the Executive Director and

Board Chair (if applicable) to notify them of the conclusion of MTA. An evaluation of the MTA process will be attached for feedback to be sent to the Regional Director.

9.14. Provider Recoupments and Sanctions.

DIDD may directly recoup funds or impose sanctions based on findings identified through DIDD, TennCare and/or other external monitoring processes, in accordance with the terms of the provider agreement. DIDD may also advise other state licensing entities, as appropriate, of findings directly identified through DIDD monitoring processes. The Recoupments and Sanctions policies are available on the DIDD web site.[67]

[67] Recoupment Policy: http://www.tn.gov/didd/provider_agencies/policies/P-003%20Recoupment%20and%20Sanctions%2010-9-06%20SCANNED.pdf

Sanctions Policy: http://www.tn.gov/didd/provider_agencies/policies/80%204%206%20Sanction%20Policy%203-11-13.pdf

CHAPTER 10

CREATION AND MAINTENANCE OF PROVIDER RECORDS

10.1. Introduction.

The purpose of this chapter is to outline requirements for a functional method of creating and maintaining records pertinent to the provision of services provided to persons supported by the DIDD waiver programs.

10.2 General Records Requirements.

10.2.a. Requirements Applicable to Creation of Records. Requirements applicable to all providers creating records for persons supported include:

1. Each provider must create a record containing documentation of services provided for each person.
2. Information must be clear, concise, complete, and current.
3. Information must be factual and absent of any fabricated or falsified names, dates, data or narratives.
4. Information and documents must be organized in a systematic and chronological format.
5. Information must be written in ink, recorded in a typed/printed format or must be in an electronic file with appropriate provisions for back-up.
6. Correction fluid, correction tape or similar appliances must not be used to correct errors in the record.
7. Errors are to be corrected by marking through the incorrect entry with a single line and recording the date and initials of the person correcting the entry.
8. Information must be legible.

9. Information must be dated and authenticated by the signature and title of the person recording each entry.

10. Abbreviations, acronyms and symbols other than those listed as acceptable standard abbreviations (see **Appendix A***)* either must not be used, or if used, must be spelled out in complete form followed with the abbreviation, acronym or symbol in parenthesis.

11. Information entered into the record must be recorded in a timely manner, as soon as possible following the completion of the event or activity described by the entry.

10.2.b. Requirements Applicable to Maintenance of Records. Requirements applicable to all providers maintaining persons' records include:

1. Providers must implement written policies pertaining to records maintenance, including the location of required components and staff responsible for records maintenance.

2. Records must be stored in a manner that maintains the confidentiality of the information.

3. Records must be maintained for a period of ten (10) years from date of death or discharge.

4. Professional support services licensure rules require maintenance of records for people with developmental disabilities for ten (10) plus one (1) years from date of death or discharge.

5. Records maintained in the home of the person supported must be regularly purged to ensure usability of the record and to protect the confidentiality of the records.

6. Providers must maintain original (e.g., paper or electronic) documents for the services provided by their employed staff.

7. Providers must maintain copies of required documentation obtained from contracted staff and other providers.

8. Records must be maintained in a manner that ensures that the records are accessible and retrievable within two (2) hours.

10.2.c. Requirements Applicable to Maintenance of Incident Reports. Providers must maintain RIFs relative to the service(s) provided for a period of ten (10) years from date of death or discharge. RIFs are to be maintained in an administrative file

separate from the person's records. Copies of the RIF for each region can be found on the DIDD web site under the heading Forms & Tools, Reportable Incident Forms.[68]

10.3. Access to Records.

Persons' records are to be made available, upon verification of identity of the person requesting access, to:

1. The person supported.
2. The person's legal representative(s).
3. Family members or other individuals who have obtained appropriate consent for access to the record or parts of the record from the person or the person's legal representative.
4. Service providers involved in the provision of services specified in the ISP, including those who may not be employed or contracted with the provider responsible for maintaining a particular record, such as ISCs/CMs or clinical service providers.
5. DIDD and TennCare staff or designees conducting monitoring or other related activities.
6. Staff of other state and federal agencies with authority to conduct monitoring or other related activities, such as the Tennessee Office of the Comptroller, CMS, the Office of the Inspector General (OIG) and the Office of Civil Rights.

10.4. Record Sets.

A record set is a compilation of documents and recorded information pertaining to the provision of a group of services or a particular service. Different record sets are maintained by different types of providers. The following record sets will be discussed in this chapter:

1. The Comprehensive Record.
2. The Residential Record.
3. The Day Services Record.
4. The PA Record.
5. The Support Coordination Record.
6. The Clinical Service Record.
7. The Ancillary Provider Record.

[68] http://www.tn.gov/didd/provider_agencies/index.shtml

8. Provider Personnel Records.

9. Provider Administrative Records.

10.5. The Comprehensive Record.

A Comprehensive Record will be maintained for each person supported. Multiple providers may contribute information to the Comprehensive Record. The Comprehensive Record contains all information relevant to planning, implementing and evaluating the provision of services and supports specified in the ISP. The contents of the Comprehensive Record will vary, depending upon the types of services that are required to support the person in the community setting. Portions of the Comprehensive Record may be kept at different locations, including provider administrative offices or the person's home, depending on the nature and age of the documentation/information contained in the record. This is a comprehensive list of documents that are filed in records for people using services:

1. MARs.
2. Medication Profile Sheets.
3. Elimination, weight, menstrual, seizure and/or sleep records.
4. Clinical service assessment reports.
5. The Uniform Assessment.
6. The Physician Ordered Treatment Log.
7. The current ISP.
8. The current BSP.
9. HRC and Behavior Support Committee approvals.
10. Staff communication notes.
11. Staff instructions.
12. Cross-systems crisis plan.
13. The Emergency Disaster Plan.
14. Plan(s) of Care.
15. Training documentation.
16. Required ISC documentation/ISP and BSP implementation data.

17. Monthly reviews/progress notes.
18. Date of admission/enrollment.
19. DHS Form 2350 and 2362 for a three-year period.
20. The PAE packet.
21. The Freedom of Choice form.
22. The annual Medical and Assessment plan.
23. The Health Care Oversight form.
24. The Physical Status Review.
25. A current photograph of the person.
26. Emergency contact information.
27. Court orders pertaining to guardianship/conservatorship.
28. Health care surrogates, POAs, and order of conservatorship.
29. Critical health and safety information.
30. Insurance cards, including TennCare information.
31. Authorization for release of information.
32. Signed consents for treatment.
33. All current physicians' orders.
34. The Individual Transition Plan.
35. The Individual Education Plan.
36. The annual physical.
37. The annual dental examination.
38. Correspondence.
39. Discharge summaries.

10.5.a. Responsibility for Maintaining Persons' Comprehensive Records. The primary provider is responsible for maintaining the Comprehensive Record. Responsibility for maintaining the person's Comprehensive Record is distributed as follows:

1. If the person receives residential services, the residential provider is the primary provider.
2. If residential services are not required, and the person receives day services, the day service provider is the primary provider responsible for maintaining the Comprehensive Record.
3. If the person requires neither residential nor day services, but receives personal assistance services, the personal assistance provider is the primary provider responsible for maintaining the Comprehensive Record.
4. If the person receives neither residential, day nor personal assistance services, the support coordination provider is the primary provider.
5. If the person has neither a residential, day nor support coordination provider, the DIDD Regional Office will maintain the comprehensive individual record.

The primary provider is responsible for maintaining the original portion of the record that is created for the provision of all of the services that provider is responsible for providing. The primary provider is also responsible for maintaining copies of all documentation created by other sources that is obtained by the provider and essential to the provision of the services the provider is rendering. For components of the comprehensive record that other service providers are responsible for maintaining, the primary provider must maintain information regarding the location of that information and how to access such information within a two (2) hour time period. The primary provider is not required to maintain copies of all documents contained in the comprehensive record. Other service providers are expected to cooperate with requests made for comprehensive records and make them available for audit, survey, or other monitoring purposes. The primary provider's responsibility in obtaining requested information for auditors/surveyors from other service providers is generally limited to being able to provide correct information to the individual requesting the documentation so that person may initiate contact with the provider responsible for maintaining the portion of the record being requested.

10.5.b. Comprehensive Record Active and Archived Files. A person's Comprehensive Record must be maintained for a period of ten (10) years from date of

death or discharge. The previous twelve (12) months is considered to be the active file. Records relevant to services provided during the past two (2) to ten (10) years may be kept in archived files. There are two exceptions to the one-year rule for maintaining records as active vs. archived files. The first pertains to documents that are more than one (1) year old that continue to be relevant to the services currently provided. Such records are to be kept in the active file. Examples of such documents may include:

1. A physician's history and physical that was performed two (2) years ago, but is the most current history and physical available.
2. A therapy evaluation or discharge summary for a person who needs to be monitored for specific indications of deterioration in condition that could warrant initiation of a new period of therapy services.
3. Physician's orders that are more than one (1) year old, but continue to be in effect.

The second exception pertains to staff communication notes. For some persons supported, staff communication notes may become quite voluminous. To ensure that staff communication notes are usable, they may be archived after a period of six (6) months. Whether records are in active or archived files, they must be accessible within two (2) hours.

10.5.c. Staff Communication Notes. "Staff Communication Notes" is the portion of the Comprehensive Record that contains direct support staff entries describing what occurred with the person during a staff member's scheduled work periods. Staff Communication Notes are useful in the provision of services to the extent that they are utilized by direct support staff to communicate and share information with other direct support staff involved in service provision. Staff Communication Notes can ensure timely awareness of acute factors that may affect the person and impact the supports provided.

Providers must ensure ongoing supervision and feedback to direct support staff to ensure that only relevant entries are recorded. Entries such as "slept well" or "had a good night" provide little useful information. Staff Communication Notes are to include information relevant to the implementation of staff instructions, the completion of ISP

action steps and/or the progress made toward achieving ISP outcomes. Routine events or data that must be documented on a daily basis can be concisely documented utilizing a checklist format. Staff Communication Notes are to contain narrative descriptions of :

1. Significant achievements realized by the person supported.
2. Significant health-related events and staff response.
3. Unusual behaviors and staff response.
4. Unusual activities or contacts and the person's response.
5. Atypical responses to implementation of staff instructions or ISP action steps.
6. Other unusual or significant events that vary from the person's normal activities or responses.
7. Clinician presence in the home or at the day service site.

Learning logs are a person-centered practice tool. Learning logs may be used in place of Staff Communication Notes. There is no current requirement to use Learning Logs. However, if they are used in place of Staff Communication Notes, they must be included in the comprehensive record.

10.5.d. Emergency Contact Information. Emergency contact information shall include:

1. The name, address, and telephone number of the contact(s).
2. The name, address, and telephone number of the person's primary care physician.
3. The names, addresses, and telephone numbers of any other medical, mental health or behavior service providers that may need to be contacted in an emergency situation.
4. The name and telephone number of the person's legal representative(s), if applicable;
5. The name and telephone numbers of any family members (who are not legal representatives) that are to be notified in event of an emergency.
6. The name of the person's residential provider, if applicable, and the name of a contact person and that person's telephone number;

7. The name of the person's ISC/CM, the name of the provider who employs the ISC/CM, a telephone number that is accessible twenty-four (24) hours per day and seven (7) days per week for contacting the ISC/CM in case of emergency.

10.6. The Residential Record.

When a person receives residential services, the portion of the Comprehensive Record that is kept in the home is called the Residential Record. The residential record is to contain documentation necessary for provision of those services that occur in the residential or home environment, primarily those provided by direct support staff. The residential record is to be utilized by direct support staff to document services provided and to communicate significant events to other staff. In order for the Residential Record to be used in accordance with intended purposes, it must be organized, compact, and contain relevant information. The Residential Record shall contain:

1. MARs, if applicable.
2. Medication Profile Sheets, if applicable.
3. Elimination, weight, menstrual, seizure and/or sleep records, if applicable.
4. The Physician Ordered Treatment Log, if applicable.
5. All current physicians' orders.
6. Health Care Surrogates, POA, and Order of Conservatorship.
7. Emergency contact information.
8. A current photograph of the person supported.
9. Consents for treatment.
10. Insurance cards, including TennCare information.
11. The current ISP.
12. The BSP, if applicable.
13. ISP and BSP implementation data.
14. The Emergency Disaster Plan.
15. Any necessary, written staff instructions.
16. Staff communication notes.

10.7. The Support Coordination Record.

The Support Coordination Record includes all documents and information pertaining to developing and monitoring implementation of the ISP. Support Coordination Records are kept in the support coordination provider's business office. The Support Coordination Record shall contain:

1. The Uniform Assessment.
2. Reports from medical and other consultants (e.g., therapy consultation reports, specialty physician consult report, psychiatric consult report, etc.).
3. Clinical service assessment reports.
4. DHS Form 2350 and DHS Form 2362 for a three (3) year period.
5. Medicaid medical eligibility documentation (the PAE packet).
6. The annual dental examination.
7. The Annual Medical and Assessment Plan, as applicable.
8. The annual physical (for developmental center transitions).
9. Court orders pertaining to guardianship/conservatorship, if applicable.
10. The Freedom of Choice Form.
11. Critical health and safety information.
12. Emergency contact information.
13. The current ISP.
14. The current BSP, if applicable.
15. The ITP (for developmental center transitions).
16. The Individual Education Plan, if applicable.
17. Support coordination monthly reviews.
18. Correspondence, as applicable.
19. Discharge summaries, if applicable.
20. Plans of care or treatment for nursing, therapeutic, therapy-related, or dental services.
21. Required ISC documentation forms.

22. Provider monthly reviews and other monthly reports as applicable to the needs of the person.

23. Health Care Surrogates, POA, and Order of Conservatorship.

10.8. Clinical Service Records.

A Clinical Service Record is maintained by each clinical services provider involved in implementation of the ISP. Clinical service providers include physical, occupational and speech/language therapists, nutritionists, behavior analysts/specialists, O&M specialists and nurses. Individual clinical service records are described below. Clinical service providers are not required to maintain copies of all documentation reviewed during assessments or evaluation of ongoing services.

10.8.a. The Nursing Record. Nursing records shall contain:

1. Nursing assessment reports.
2. Physician orders for nursing services.
3. Authorization(s) for release of information.
4. Signed consents for nursing treatment(s).
5. The current ISP.
6. The ITP, if applicable.
7. Nursing Contact Notes.
8. Nursing Monthly Reviews.
9. Correspondence as applicable.
10. A discharge summary, if applicable.

10.8.b. Behavior Service Records. Behavior service records shall contain:

1. Consents for treatment.
2. The current ISP and BSP.
3. The ITP, if applicable.
4. Cross System Crisis Plan
5. Monthly reviews for behavior services.

6. Behavior Service Contact Notes (which are validated by a co-signature line for staff at the service location that includes time in and out, or by the behaviorist's signature in the service location's visitor log that includes time in and out).
7. Human Rights and Behavior Support Committee approvals.
8. Correspondence, as applicable.
9. A discharge summary, if applicable.

10.8.c. Therapeutic Services Records. Therapeutic services records shall contain:

1. Identifying information.
2. Physician orders (if applicable).
3. Assessment report.
4. Plan(s) of Care.
5. Authorization for release of information.
6. Signed consent for treatment.
7. Current ISP.
8. Therapy contact notes.
9. Monthly summary.
10. Staff instructions.
11. Training documentation as applicable.
12. Correspondence as applicable.
13. Discharge summary as applicable.

Record retention is ten (10) years plus one (1) for services requiring a Professional Services Support License (PSSL) and ten (10) years for other clinical services providers.

10.9. The Day Services Record.

When Residential and Day services are rendered by the same provider, one record set may be maintained to avoid duplication. The Day Services Record shall contain:

1. MARs pertaining to time periods day services are provided, if applicable.
2. Medication Profile Sheets, if applicable.
3. Elimination, menstrual, and seizure records pertaining to time periods during which day services are provided.
4. Physician-Ordered Treatment Log for treatments provided during day service hours, if applicable.
5. All current physicians' orders.
6. Health Care Surrogates, POA, and Order of Conservatorship.
7. Critical health and safety information.
8. Individual emergency contact information.
9. A current photograph of the person.
10. Consents for treatment as applicable.
11. The current ISP.
12. The current BSP, if applicable.
13. ISP and BSP Implementation Data.
14. Any necessary, written staff instructions.
15. Staff communication notes.

10.10. The Personal Assistance Record.

Records maintained by personal assistance providers shall contain:

1. MARs pertaining to time periods personal assistance services are provided, if applicable.
2. Medication Profile Sheets, if applicable.
3. Elimination, menstrual, sleep, and seizure records.
4. Physician Ordered Treatment Log for treatments provided during personal assistance service hours, if applicable.
5. All current physicians' orders.
6. Health Care Surrogates, POA, and Order of Conservatorship.
7. Critical health and safety information.
8. Individual emergency contact information.

9. A current photograph of the person supported.
10. Insurance cards.
11. The current ISP.
12. The current BSP, if applicable.
13. ISP and BSP implementation data.
14. Any necessary, written staff instructions.
15. The Emergency Disaster Plan, if applicable.
16. Monthly reviews for personal assistance services.
17. Staff communication notes.

10.11 Respite Records.

Records maintained by respite and behavioral respite providers shall contain:

1. MARs pertaining to time periods respite services are provided, if applicable.
2. Medication Profile Sheets, if applicable.
3. Elimination, menstrual, sleep and seizure records pertaining to time periods during which respite services are provided, if applicable.
4. Physician Ordered Treatment Log for treatments provided during respite service hours, if applicable.
5. All current physicians' orders.
6. Health Care Surrogates, POA, and Order of Conservatorship.
7. Critical health and safety information.
8. Emergency contact information.
9. A current photograph of the person supported.
10. The current ISP.
11. The current BSP, if applicable.
12. ISP and BSP implementation data, if applicable.
13. Any necessary, written staff instructions.
14. The Emergency Disaster Plan, if applicable.
15. Staff communication notes.

10.12. Ancillary Provider Records.

Ancillary provider records are the records kept by dental or vision providers when services are funded by DIDD programs. Ancillary records also refer to providers of intermittent services such as equipment providers, home modification contractors or stand-alone transportation providers.

10.12.a. Dental and Vision Provider Record Requirements. Dental and vision must maintain the person's records in accordance with professional licensure standards for the service being provided. For purposes of reimbursement of services through a DIDD program, documentation must be available describing:

1. The type of services provided.
2. The person's response to the service provided.
3. The date and time services were provided, inclusive of the total time required to provide the service.
4. Any follow-up instructions or actions to be taken related to the service provided.
5. The cost of the service provided, inclusive of an itemized account of all charges.

10.12.b. Other Ancillary Providers. Providers of equipment, home modifications, transportation, or supplies must document:

1. The type of service or equipment provided.
2. The date the service was rendered or the equipment was delivered.
3. Any staff or primary caregiver training or instruction provided regarding use of equipment or supplies.
4. The cost of the service, supplies or equipment provided.

10.13. Personnel Records.

Providers who employ one (1) or more staff must maintain personnel records. Providers must ensure that such records sufficiently document staff qualifications, training and supervision.

10.13.a. Employee Records. The following documentation must be maintained in the personnel records for each individual employed:

1. An employment application.
2. Any resumes provided that document education and experience with transcripts/diplomas that verify the educational information provided (required for professional/clinical staff).
3. Results of the background check performed.
4. Reference checks.
5. Results obtained from checking the DOH's Tennessee Elderly and Vulnerable Abuse Registry, the Sexual Offender Registry, and the Office of Inspector General's List of Excluded Individuals/Entities.
6. A signed confidentiality agreement.
7. Current licensure and/or certification as applicable, including renewal number.
8. Documentation of required training.
9. Documentation of any disciplinary actions taken.
10. Perpetrator history (i.e., criminal history and history pertaining to substantiation as the perpetrator of abuse, neglect, or exploitation).
11. Consent forms signed by the employee to allow the provider to perform background checks or access other employment related information.

For newly employed or reassigned direct support staff, providers are required to obtain background and registry checks prior to but no more than 30 days in advance of the employee's employment or change in assignment to providing direct supports. Additional requirements regarding background and registry checks are described in the provider agreement.

10.13.b. Contract Staff Records. The following documentation must be available for contracted staff:

1. A copy of resume(s) with transcripts/diplomas to verify educational information provided for staff providing or supervising direct care services to persons under the terms of the contract.

2. A copy of the contract specifying performance terms and conditions.

3. The provider's evaluation performed for the purpose of determining whether the contract staff met performance expectations specified in the contract.

4. A copy of current applicable professional licenses or certifications for licensed/certified staff.

5. Evidence of required DIDD training and background and registry checks.

6. A copy of the current DIDD approved sub-contract(s).

For newly employed or reassigned contracted direct support staff, providers are required to obtain background and registry checks prior to but no more than 30 days in advance of the contractor's employment or change in assignment to providing direct supports. Additional requirements regarding background and registry checks are described in the provider agreement.

10.14. Provider Administrative Records.

Providers are required to maintain administrative records for a period of ten (10) years. Administrative records include financial records, written policies and procedures, board or advisory group appointments, committee members and/or documentation of other administrative functions specified in applicable state or federal law, rule or regulation.

10.15. Distribution and Transfer of Records Between Providers.

To ensure integration of services, communication must occur between providers. Sharing documents and the records of the person supported is one of the ways that communication occurs between multiple providers who may be involved with providing services and supports to the same person.

10.15.a. General Requirements Pertaining to Distribution of Records. The following requirements are applicable to distribution of records between providers:

1. The legal standard for mailing documents and records is first class mail, return receipt requested.

2. Any documents or records that must be distributed to another provider are to be mailed to the provider's primary business office.

3. If a provider has the technological abilities to send the records by secure email that is also an acceptable method of distribution.

4. Original documents or records created by a provider are to be maintained in that provider's file with copies of the document or record distributed as necessary.

10.15.b. Transfer of Records When a Change in Providers Occurs. When a person changes providers for any reason, it is essential that sufficient records be transferred to allow service provision to continue uninterrupted and to allow the overall health, safety, and welfare of the person to be assured. Records may be transferred in the following manner:

1. Records may be provided to the person, the person's ISC, or the person's legal representative to be delivered to the receiving provider.

2. Consent may be obtained from the person or legal representative to release records directly to the receiving provider.

3. It is acceptable to transfer copies of original records rather than transfer the original.

4. Records need to be transferred on or before the date the receiving provider assumes service responsibility.

5. The transferring provider(s) shall send the Comprehensive Record to the receiving provider(s) as long as required consents are obtained.

10.15.c. Transfer of Records When a Change in Primary Provider Occurs. The primary provider is responsible for maintaining the Comprehensive Record. If the person supported is receiving residential services, the Comprehensive Record will include the Residential Record that is maintained in the home. The transferring primary provider is responsible for:

1. Ensuring that copies of information from the Comprehensive Record for at least one (1) year prior to change in providers is made available to the receiving provider.

2. Maintaining a copy of all records for persons supported who transfer or are otherwise no longer receiving services for a period of ten (10) years.

3. Obtaining permission to transfer the Comprehensive Record to the new provider from the person or the person's legal representative.

4. Ensuring that the transfer of the person's Comprehensive Record occurs on or prior to the effective date of transfer when the receiving provider becomes responsible for the provision of services.

5. Documenting the transfer of records along with other pertinent information in the transfer summary.

The receiving primary provider is responsible for:

1. Accepting and documenting receipt of the transferred records.

2. Ensuring that required records are appropriately filed.

10.15.d. Transfer Summaries. Transfer summaries are to be used by ISCs when a person supported is transferring from one ISC to another. The summary is prepared and sent by the relinquishing agency to the receiving agency. Transfer summaries are intended to describe the person's current condition, situation and/or service needs, as well as any outstanding issues at the time a transition between two providers occurs. Transfer summaries shall include:

1. Due dates that are essential to the service for which the provider change is occurring, such as:
   - ISP due dates.
   - Due dates for level of care reevaluations or financial eligibility determinations.
   - Dates of any medical or other appointments already scheduled.
   - Due dates for annual medical, dental or other appointments that have not been scheduled.

2. Pending or outstanding issues, such as:
   - Pending ISP updates or amendments that need to be submitted or have been submitted to the DIDD Regional Office.

- Pending referrals.
- Outstanding health or mental health-related recommendations.
- Outstanding medical equipment or equipment repairs.
- Issues that otherwise require follow-up by the receiving provider.

3. Progress toward achieving ISP action steps or outcomes.
4. The person's status as of last contact and/or anticipated dates of discharge for clinical services as applicable.
5. Other significant issues affecting the person as of the effective date of transfer to the receiving provider.

10.15.e. Transfer of Records When Provider Agreements are Voluntarily or Involuntarily Terminated. In the event that a provider goes out of business or otherwise voluntarily terminates a provider agreement with DIDD or in the event that DIDD terminates a provider agreement for convenience or cause, sufficient measures must be taken to ensure that records are available to ensure continuity of services. All requirements for transfer of records to receiving providers as described in this chapter will apply. In the event that the transferring provider demonstrates unwillingness to transfer essential records, the DIDD Regional Office will implement measures to obtain and transfer essential records as necessary.

CHAPTER 11

RESIDENTIAL AND DAY SERVICES

11.1. Residential Services Requirements.

There are a variety of residential service options available to persons who are not able to live in a home with family members. The residential service option selected must be one that meets the person's needs and that is able to ensure the person's health and safety. Residential service options include intensive behavior residential supports, residential habilitation, family model residential support, medical residential services, and supported living. In addition, the Self Determination Waiver has a residential option – Semi-Independent Living – for people who live on their own in a home under their own control and only need a limited amount of supports to continue to live safely in their community.

1. All residential services must be appropriately licensed prior to the provision of services.
2. Licensure is not required for agencies that serve only one (1) person.
3. All residential service providers are required to maintain a minimum 48-hour food supply in each home that meets the needs of the persons supported.

11.1.a. Requirements Applicable to Residential Habilitation Providers. With the exception of agencies that serve only one (1) person, a residential habilitation home cannot be owned by:

1. Staff members.
2. Board members.
3. Family members of staff or board members.

11.1.b. Requirements Applicable to Family Model Residential Support Providers. Mobile homes may be utilized as family model residential support homes

only if the home was manufactured after 1974 and meets standards specified by the Tennessee State Fire Marshal for the use of mobile homes to support persons with intellectual disabilities.

Prior to placement of a person in a family model residential home, the provider must complete a DIDD-compliant home study and the DIDD Family Model Residential Supports Initial Site Survey to ensure that the home meets the person's needs and that the family and person are compatible and well matched. Requirements 1-9 listed below pertain to the provider agency, not the sub-contracted provider (if applicable).

1. Following placement of a person, the provider is required to perform a supervisory visit to the home twice a month and complete the DIDD Family Model Residential Supports Monitoring Tool on an annual basis.
2. The provider must maintain a personnel file for each individual providing services in the home, including documentation of required training.
3. The provider must ensure that the person has opportunities to participate in family and community activities in accordance with outcomes specified in the ISP.
4. The provider must ensure that the person has access to a telephone and all common living areas within the home with due regard to privacy and personal possessions.
5. The provider must assure that the person is offered choice in selection of religious and other activities.
6. The provider must assure that the person is afforded the freedom to associate with those of his/her choosing and have visitors at reasonable hours.
7. The provider may serve as the representative payee for the person supported. Individuals residing in the home may not serve as the representative payee or conservator.
8. The provider may serve as the day services provider for the person supported. Individuals residing in the home may not serve as the day services provider.
9. The person may be assigned reasonable responsibilities, commensurate with expressed interests and abilities, in the home environment.

11.1.c. Requirements Applicable to Medical Residential Support Services. Medical residential support services rates allow the provision of health care supports. Requirements that must be met for this service include:

1. The provision of RN supervision to assure that individual person health care needs and medication safety policies and procedures are addressed.
2. Supervision of and/or attendance during health-related appointments and follow-up.
3. Interaction by a licensed nurse with physicians, pharmacists, therapists and other medical providers as needed to assure coordination of health-related services.
4. Documentation by RNs of monthly face-to-face visits with the person(s) supported for the purpose of providing health-related oversight.
5. Supervision of LPNs by RNs.
6. Provision of health-related training by RNs as necessary to direct support staff.
7. The provision of direct nursing services in accordance with the PCP's (i.e., physician, nurse practitioner, physician assistant, dentist) orders for activities that can only be performed by a licensed nurse in accordance with the Tennessee Nurse Practice Act.
8. The documentation of nursing services provided by a licensed nurse to enhance basic residential services.

11.1.d. Requirements Applicable to Supported Living Services. Supported living services are provided in a home owned or leased by the person(s) supported. The amount and type of supports required for the person to enjoy the benefits and accept the responsibilities associated with home ownership or individual lease arrangements are variable, depending upon each person's unique abilities and needs. Supported Living services provides a residential option which allows greater involvement and control in the operation of the home. Involvement and control in operation of the home may include, but is not limited to:

1. Participation in determining the support services needed.
2. Involvement in the hiring and evaluation of direct support staff, including the opportunity to meet direct support staff prior to hire, and to the degree possible, approving the termination of employment of direct support staff.
3. Participation in developing the roles and responsibilities of direct support staff, including the opportunity to direct day to day activities.
4. Involvement in the selection of housemates with whom to live.

Supported living focuses on the person, rather than the provider having primary control and responsibility regarding operation of the home and support services. Supported living services are available to persons regardless of disability level and continue to be an option for persons and families seeking involvement, control and exercise of self-determination.

11.1.d.1. Lease Requirements Applicable to Supported Living Services. The following requirements are applicable regarding lease arrangements for persons receiving supported living services:

1. The preferred lease option is for the home lease to be signed by the person supported or legal representative.
2. A provider may co-sign a lease with a person supported in order to increase the selection of housing options available to the person, but may not be the sole lease holder. A provider would not be expected to co-sign the lease with the person supported if the provider owns the home.
3. If a provider does co-sign a lease with a person supported, the provider must also sign a written agreement with the person supported stating that the person will not be required to move or pay an increased lease payment due to a change of supported living providers.
4. If a provider owns a supported living home leased to a person supported, the provider shall not require as a condition of the lease agreement that the person move if a different supported living provider is chosen. The lease agreement shall specify that the person supported will not be forced to move should the person choose to be supported by a different provider agency.
5. A provider may not be affiliated with the owner of a supported living home leased to a person supported if the entity owning the home requires that the person move as a condition of the lease if a different supported living provider is chosen.
6. A change in provider shall not require the person to change residences. Should the person supported wish to change residential sites, residential services, or provider agencies, such transition shall proceed in accordance with person-centered transition planning processes set forth in the policy 80.4.7 Community Transition.[69] This process requires that the wishes and desires of the person supported be considered by the COS and incorporated into the planning process.

[69] http://www.tn.gov/didd/provider_agencies/policies/Community%20Transition%20Policy%2005%2031%202012%20changes%20accepted.pdf

The person and legal representative, if applicable, in conjunction with the COS shall determine if the proposed transition is in the person's best interests. Logistics of the transition, including disposition of co-signed leases, will be worked out during the transition process.

7. The owner of a supported living home may not be an employee or board member employed or appointed by the supported living provider.
8. The lease must provide for a sixty (60) day notice to the person supported prior to termination of the lease agreement or increase in the rent or lease amount.
9. The rental payment or lease amounts shall not exceed fair market value for similar property in the same general location.
10. The term of the rental or lease agreement shall not exceed one (1) year unless specified in the ISP and in the best interests of the person supported for purposes of obtaining a home with accessibility modifications.
11. In the event that a multi-year agreement is desired and meets the aforementioned standards, an annual increase of no more than the current Fair Market Rents as defined by the Department of Housing and Urban Development (HUD) be contained within the lease agreement.
12. No more than one month's rent may be charged as a security deposit.
13. All notices related to termination of or changes in the lease agreement must be provided to the person supported, and/or legal representative or other person designated by the person.

11.1.d.2. Availability of Mortgage and Lease Documentation. Individual leases and mortgage documentation must be accessible to auditors and surveyors representing CMS, TennCare, DIDD and other state and federal agencies responsible for regulation and oversight of DIDD programs. Lease/mortgage payment information must also be available for review if the provider is involved with assisting the person in managing financial resources.

11.1.e. Requirements Applicable to Semi-Independent Living Services. Semi-Independent Living Services is the only residential service offered in the Self Determination Waiver. The distinguishing factor that separates this service from Personal Assistance services is 24/7 access to direct support staff in the event of an emergency. Lease requirements described in **Section 11.1.d.1** are applicable to Semi-Independent Living Services.

1. Training for the person to assure that he/she is able to readily access direct support staff in an emergency.
2. A minimum of two (2) face-to-face contacts in the person's home per week is required for each person receiving semi-independent living services.

11.1.f. Intensive Behavior Residential Services. The Intensive Behavioral Residential Service is a clinical treatment model designed to meet the specific needs of each person supported by the program. The target population for this program is adults with intellectual disabilities who have exhibited high risk behavior, placing themselves and or others in danger of harm. This program is designed to be flexible enough to respond to the changing levels of need (LON) of the person supported and the level of risk (or lack thereof) presented by the person's current behavior. It is not an indefinite, long term, residential support service. A person with high risk behavior who is involved in this program will have opportunities to develop a lifestyle which includes developing healthy and meaningful relationships with others.

Factors that differentiate this service from others offered are that program leadership is provided by a licensed Clinical Director, who is responsible for ensuring service quality and providing clinical oversight of clinical and direct support staff. Additional requirements include increased training for management staff and other persons involved in supporting program participants. Specifically this will include ensuring that Direct Support Professionals involved in supporting program participants (e.g., assistance with meal preparation, attending appointments, and other activities of daily living) will participate in a rigorous program of staff training and development which is in addition to training currently required for all DSP's (e.g., CPR, fraud and abuse reporting). The Clinical Director and/or other Managers will receive the same training as direct support professionals and additional training as outlined in the IBRS application.

Agency providers seeking to deliver this service should submit the IBRS application and required materials to the DIDD Director of Behavioral and Psychological Services for review. Upon review, the DIDD Director of Behavioral and Psychological

Services will present the expansion application and required materials, with recommendation, to the Department's Provider Development Committee. This committee will review the provider's qualifications and performance history to determine eligibility to contract with the Department and the Medicaid agency to deliver this service. Additional requirements for this service are described in the service definition which is available on the DIDD web site.[70]

11.1.g. Staffing Plans. Providers of residential habilitation services, intensive behavior residential services, family model residential supports, medical residential services and supported living services must develop a staffing plan (i.e., schedule) that addresses staffing needs for each person.

11.1.g.1. Staffing Plan Requirements. The staffing plan must reflect:

1. Compliance with staffing standards specified in licensure regulations.
2. Adequate numbers of trained staff to implement the ISP, including implementation of any staff instructions that are determined necessary, and ensure the health and safety of persons.
3. Sufficient staff to cover the staffing requirements as described in the documents, Level Descriptions for Day Services, Level Descriptions for Family Model Residential Services, Level Descriptions for Residential Habilitation and Supported Living, Level Descriptions for Respite Services, Staffing Standards for Residential and Day Services.[71]
4. Availability of back-up and emergency staff when scheduled staff cannot report to work.
5. Presence of at least one staff person when the person is in the home, unless the ISP allows less than 24-hour supervision.

11.1.g.2. Monitoring Staffing Plan Compliance. The staffing plan must be available in the home to provide direct support staff information regarding who is to be responsible for service provision for each staffing period or shift.

[70] http://www.tn.gov/didd/provider_agencies/ServiceDefinitions/WaiverSrvcDefinitions.shtml

[71] WEB LINKS

11.1.h. Home Inspection Requirement. All supported living residences and semi-independent residences will be inspected by DIDD prior to the date of initial occupancy. Thereafter, an inspection will be performed by DIDD approximately every twenty-four (24) to thirty (30) months. Inspections will be conducted by a certified life safety codes inspector employed or contracted by DIDD. Inspections will be conducted utilizing the DIDD Home Inspection Form for Supported Living provided on the DIDD web site.

11.1.i. Requirements for Services Provided Out-of-State. Waiver services may only be provided out-of-state as outlined in TennCare Rule 1200-13-01-.25-2(w) and the waiver service definition.[72] Waiver services outside of the country will not be reimbursed by Medicaid funds.

11.2. Day Services.

Tennessee is an Employment First state.[73] This means DIDD requires that Supported Employment be considered as the first option for each individual enrolling in day service and for each person over the age of fifteen (15) who receives either Day Services and or Personal Assistance Services. The cornerstones to successful work opportunities reside within the essential components of informed choice. In order to make informed choice about employment, there should be effort to ensure that the person supported has had *education*, *experience* and *exposure* to the same array of jobs as other people in their community.[74]

Day services shall occur in the least restrictive setting possible as appropriate to the person. Therapeutic objectives and action steps are outlined in the ISP during the person-centered planning process. Types of Day Services include, Community Based Day Services, Employment Services, Facility Based Day Services and In-Home Day Services.

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[72] Service descriptions are available online:
http://www.tn.gov/didd/provider_agencies/ServiceDefinitions/WaiverSrvcDefinitions.shtml

[73] U.S. Department of Labor's Employment First website: http://www.dol.gov/odep/topics/EmploymentFirst.htm

[74] DIDD considers an array to mean more than two (2) options based on a person's interest, education, and background.

The guiding strategy in pursuit of effective Day Services employs the principles of productivity, inclusion and independence. Day Services must be structured so each person has the opportunity to discover his or her skills, interests, and talents in his or her community.

Some examples of the implementation of effective Day Services objectives are:

1. Exploring Supported Employment.
2. Job shadowing.
3. Exploring volunteering opportunities or volunteering in their community.
4. Being an active member of their community (examples are being a member of a garden club, neighborhood organization, local gym, etc.).
5. Taking a class in the community to learn a new skill.
6. Participating in experiences that coincide with their interests.
7. Training in a specific skill.

In-Home Day Services, while available to meet specific and well documented needs, are to be used only in exceptional circumstances. These circumstances may include limited provision of these supports due to behavioral or psychiatric destabilization, medical concerns/necessity, or other infrequent and exceptional circumstances. Extended in-home services related to medical concerns shall require a physician's order and accompanying documentation in the ISP supporting the provision of in-home services as the most appropriate and viable option. The BSP for a person with extended in-home services related to behavioral concerns should be time limited and include a plan to fade out in-home services with increasing community services. Retirement may be chosen and should be based on Social Security age eligibility standards when the COS feels it appropriate.

11.2.a. Utilizing Natural Supports in the Provision of Day Services. The use of natural, or unpaid, supports in the workplace is encouraged. The use of natural supports can be beneficial to the person supported. Benefits to the person supported may include increased inclusion in the work environment, development of positive relationships with co-workers and improved job performance.

11.2.b. Requirements and Limitations of Natural Supports. When natural supports are utilized, the following requirements and limitations will apply:

1. The type and amounts of assistance provided by natural supports must be described in the ISP and updated as needed during the monthly review process.
2. Applicable federal and state confidentiality guidelines for sharing information with natural supports will apply (i.e., the person supported or legal representative will need to consent if PHI needs to be shared with co-workers who are not employed by the day service provider).
3. Work-related natural supports are to be utilized only to provide on-the-job training and support that would be provided to any person hired in a similar position.
4. Day service providers are prohibited from contracting with the employer of the person supported to allow natural supports within the work environment to be substituted for support that must be provided by trained job coaches.
5. State-funded day service providers are permitted to bill at the DIDD published rates for times during which natural supports are utilized if service provision and documentation requirements are met; however, providers are prohibited from billing the Medicaid waiver programs for times when services are provided by natural supports.
6. Natural supports are to be included in the provider's staffing plan; however, the day service provider retains responsibility for safety and other requirements associated with the service being provided.
7. A job coach employed by the day service provider must be available on call if needed to come to work the site immediately upon request from the person supported or the employer of the person supported.

CHAPTER 12

BEHAVIOR SERVICES

12.1. Introduction.

Behavior is the final common pathway for a host of neurological, psychological, medical/physical, and environmental influences. These influences merge together to create the observable behavior that we see in a particular individual. Knowing that a person displays challenging behavior is not particularly helpful in designing treatment to overcome that behavior. It is far more important to understand factors that bring about that behavior.

Applied Behavior Analysis (ABA) is a way of understanding how experiential and biological factors affect behavior. Behavior analysts attempt to assess these factors and come to an understanding of what circumstances precede and immediately follow the behavior. The initial goal of ABA is to determine the goal or function of the behavior. Once the function is determined, behavior analysts seek to identify and strengthen an alternative adaptive behavior that helps the person achieve her goals.

DIDD supports the practice of ABA so that individuals have the opportunity to experience greater independence and an improved quality of life, free of challenging behavior. Behavior analysts enlist the help of members of the person's network of support to accomplish these aims. Working with family members and support staff, behavior analysts provide strategies and training to change the way others interact with the person. Behavior analysts also work in an interdisciplinary fashion with other professionals such as therapists, primary care physicians, nurses, psychiatrists, and psychologists to ensure that the person receives comprehensive and integrated services.

12.2. Behavior Services Assessment Reports.

1. A Behavior Services Assessment Report is a clinical service assessment completed by a behavior analyst. Behavior Services Assessment Reports shall include all information relevant to a functional behavior assessment completed by a behavior analyst. The behavior assessment is a functional assessment of challenging behavior(s) relevant to the reason for referral and recommended behavior interventions, as applicable.

2. The Behavior Services Assessment Report shall include an analysis of potential vulnerabilities, contributing and triggering conditions, and functional consequences of target behaviors. Such analysis shall include a review of medical, psychological/ psychiatric, sensory, social environment, physical environment, staff behavior, and quality of life issues that might be important in influencing the behaviors of interest. A reinforcer assessment shall also be included.

3. A variety of information sources must be collected/reviewed, including direct observations by the behavior service provider, staff interview, behavioral data of direct observations by staff, previous and current interventions and treatment, and assessment reports of relevant professionals. All assessments shall contain an analysis of data collected during direct observation of the target behavior.

4. Behavior Services Assessment Reports shall include a set of recommendations regarding behavior analyst services and behavior specialist services, as determined by the level of behavioral need, and including justification for the scope, amount, duration, and frequency of the recommended services.

5. Recommendations may also include suggestions to the COS regarding the consideration of referrals to other professionals.

6. Behavior analysts shall write the report in clear and concise language.

7. Behavior Services Assessment Reports shall meet quality criteria outlined for the assessment section of the Behavior Services Work Product Review.[75]

8. All Behavior Services Assessment Reports shall include the following information:

    a. The date the assessment was completed and the reason for referral.

    b. A topographical definition of each targeted behavior under assessment in objective and measurable terms.

    c. Reinforcer assessment.

    d. Review of medical, psychiatric, or psychosocial conditions which may contribute to target behaviors.

[75] Forms & Tools: http://www.tn.gov/didd/provider_agencies/index.shtml

e. Documentation of information and findings from interviews with the person served, family, legal representatives, the ISC/CM, and support staff, as available and appropriate, regarding behavior related issues, concerns, capacity, and other information.

f. Documentation of assessment/evaluation and findings related to applicable clinical parameters (for behavior assessments this would include direct observation of the behaviors of interest, data collection and analysis/evaluation, analysis of staff interviews, functional analysis as appropriate, behavior rating scales as appropriate, and reinforcement assessment).

g. Documentation of relevant information and findings from review of a person's records.

h. An analysis of contextual and ecological factors that may interfere with successful intervention(s) regarding the target behavior(s).

i. Appropriately constructed graphic representations of baseline and/or comparison data measures of behaviors targeted for reduction and other responses of interest.

j. Identification of the function for each targeted problem behavior.

k. Identification of at least one replacement behavior for each function identified or an explanation of why replacement behaviors are not provided.

l. Presentation of the comprehensive clinical analysis of the information compiled to justify the scope, amount, frequency, and duration of the services recommended.

m. Time-limited and measurable behavioral objectives for target and replacement behaviors (one replacement behavior for each identified function).

n. Proposed ISP outcome for replacement behaviors.

o. Recommendations for the COS to consider, including a list of all proposed behavior interventions if assessment shows a need for behavior services.

p. A description of the risk of the person's behavior and an analysis of the risks and benefits, possible side effects and potential contraindications for the recommended behavioral approach.

q. The signature of the clinical service practitioner and credentials with the date the assessment was completed.

12.3. Behavior Support Plans.

1. Behavior Support Plans are written and monitored by behavior analysts to address health and safety risks to the person served or other behaviors that significantly interfere with home or community activities. The BSP will be based on the following:
   a. A Behavior Services Assessment Report that meets quality criteria outlined in the Assessment section of the Behavior Services Work Product Review.[76]
   b. The frequency, intensity, and duration of target behaviors.
   c. Level of risk of the target behaviors to self and others.
   d. Input from the person served, DSPs, and the planning team regarding the functions of target behaviors and alternative ways to achieve these functions.
   e. The efficacy of the proposed plan.
   f. The practicality of the proposed plan for implementation.
2. The BSP shall be written by a behavior analyst or a behavior analyst in conjunction with a behavior specialist. The behavior specialist may implement the BSP and train others on the BSP, however, the behavior analyst retains overall responsibility and clinical oversight for the BSP and its implementation.
3. The BSP shall meet quality criteria outlined for the Planning section of the Work Product Review.
4. The BSP will provide information in clear, user-friendly language and avoid technical jargon. The BSP will include sections to address the following:
   a. Strategies for prevention of problem behavior and increasing replacement behavior (list the replacement behavior and what to do).
   b. Interventions for decreasing challenging behavior (list the target behavior, and what to do).
   c. Interventions for responding to a crisis (i.e., what to do if the plan is not successful and results in a behavioral crisis).
   d. Instructions for data collection (specific instructions regarding what documentation/data recording needs to be done).
   e. Strategies for generalization and fading of behavioral intervention to assist the person in becoming independent of others, restraints, protective equipment, and other environmental controls. This portion of the plan shall also include a plan for decreasing dependency on behavioral services.

[76] Forms & Tools: http://www.tn.gov/didd/provider_agencies/index.shtml

5. Informed consents and approvals shall be obtained prior to implementation of the BSP. The behavior analyst shall sign the plan with credentials and the implementation date for the plan shall be clearly shown at the top of the first page of the plan (e.g., Implementation Date: 9/1/2014). Revisions to the plan should also be noted at the top of the first page (e.g., Revision Date: 11/15/2014). Any BSP to be implemented in a DIDD contracted agency shall receive appropriate consent and approval even if the plan is developed by an external provider.

6. Behavior Support Plans including unrestricted procedures shall be implemented within thirty (30) days of start date of the authorized BSP development. Plans involving restricted procedures shall be implemented within sixty (60) days of start date of the authorized BSP development. For a plan to be considered "implemented," DSPs shall be trained on carrying out the procedures required in the BSP. Document any barriers to meeting stated timeline in the clinical service monthly review.

7. Behavior analysts shall employ competency-based procedures when training DSPs to implement a BSP. Behavior analysts shall provide documentation of training within contact notes and report the training or that no training occurred in Clinical Service Reviews.

8. Requirements for BSP review by Regional Behavior Support Committee and HRC review are provided in the section entitled Classification of Procedures and Associated Requirements.

9. The BSP shall be overseen by a behavior analyst and may not remain in effect after the discontinuation of behavior services. When appropriate, behavior analysts may develop behavioral guidelines which may remain in effect after discharge. Behavioral guidelines shall only include unrestricted procedures that help the person served remain successful. Crisis plans may also remain in effect after the person served is discharged from behavioral services. The COS is responsible for managing and revising guidelines, ISP strategies, or crisis plan that remain after the person is discharged from behavioral services.

12.4. Clinical Services Reviews for Behavior Services.

1. This section provides information regarding the completion of a service note for behavior services. These Service Notes shall be referred to as Clinical Service Monthly Reviews and Clinical Service Quarterly Reviews.

2. Clinical Service Monthly Reviews provide a brief assessment of progress toward implementing the clinical service plan of care. Clinical Service Monthly Reviews are required from the outset of behavior services including periods of assessment and planning. A copy of the Clinical Service Monthly Review is to be submitted to the ISC/CM by the twentieth (20th) calendar day of the month for the preceding month of

service. The Regional Office Behavior Analyst Director (or designee) or Director of Behavioral and Psychological Services may request that a behavior provider forward a copy of the most recent review to the Regional or Central Office within two (2) business days. The Behavior Analyst (BA) must submit the requested document within two (2) business days.

3. Clinical Service Monthly Reviews include the following information:

   a. Name of person served.

   b. Dates of services provided.

   c. Properly constructed graph(s) displaying appropriate measures of target and replacement behaviors.

   d. Frequency and duration of Behavioral Safety, Restricted, or Special Individualized Procedures.

   e. Number of units:

      i. Approved

      ii. Used

      iii. Explanation of unused units

   f. Any noted barriers to services and steps the BA is taking to resolve them.

   g. Provider's signature, credentials, and date the review was completed.

4. Clinical Service Quarterly Reviews are a comprehensive assessment of progress toward implementing the clinical service plan of care for the foregoing three (3) months. A copy is to be submitted to the ISC/CM by the twentieth (20th) calendar day of every fourth (4^{th}) month for the preceding three (3) calendar months of service. The last CSQR before the annual ISP review shall include any recommended adjustments to ISP outcomes. The Regional Office Behavior Analyst Director (or designee) or DIDD Director of Behavioral and Psychological Services may request that a behavior provider forward a copy of the most recent quarterly review to the Regional or Central Office within two (2) business days for clinical review and QA. Quarterly review dates may be adjusted to coincide with the annual ISP dates so long as no more than three (3) months elapse between CSQRs.

5. Clinical Service Quarterly Reviews are completed after every third (3^{rd}) month of services and shall meet quality criteria outlined for the Follow-up section of the Work Product Review. Clinical Service Monthly Reviews are not required for months when a CSQR is completed.

6. Clinical Service Quarterly Reviews shall include the following information:

   a. Name of person served.

   b. Dates of services provided during the quarter.

   c. A list of behavior change objectives or behavior maintenance objectives assessed for the quarterly review. For each objective, there shall be a determination of progress, no change, or achieved.

   d. The response of the person served to the service as determined by data and graphical analysis assessed (include a copy of the graph(s) displaying baseline/comparison data and current levels of behavior).

   e. Frequency and duration of Behavioral Safety, Restricted, or Special Individualized Procedures.

   f. An assessment of data and plan implementation reliability.

   g. An analysis of data collected during the quarter, including contextual/ecological factors, motivating operations or contributing conditions, antecedents, and functional consequences of targeted behaviors.

   h. Properly constructed graph(s) displaying appropriate measures of target and replacement behaviors.

   i. An updated assessment of the function(s) of target behaviors.

   j. An assessment of the effectiveness of the plan of care.

   k. An assessment of any barriers to the effectiveness of the plan of care.

   l. Projected adjustments to replacement behaviors or procedures within the BSP or changes to the ISP based on the updated analysis.

   m. Projected adjustments to behavioral objectives and ISP outcomes based on the updated analysis.

   n. Documentation of staff training that has occurred or statement that training has not occurred during the quarter and additional training that is needed.

   o. A recommendation to continue the clinical service at its current quantity of units, increase or decrease the level of service, or discharge the person served from the service.

   p. Number of visits to person served that were:

      i. Scheduled

      ii. Carried Out

      iii. Explanation of missed visits

q. Number of units:

i. Approved

ii. Used

iii. Explanation of unused units

r. Provider's signature, credentials, date the review was completed

7. Discharge Notes shall be completed by the twentieth (20^{th}) day of the month following the discontinuation of services. Discharge notes shall include information required for the appropriate Clinical Services Review (monthly or quarterly) and the following additional information:

a. Date of discontinuation of behavior services;

b. Reason for discharge; and

c. Discharge plan including reference to behavioral guidelines or a crisis plan that will remain in effect when the BSP is discontinued.

12.5. Behavior Health Crisis.

1. A behavioral health crisis occurs when the crisis response results in the use of a Behavioral Safety Procedure, PRN Psychotropic Medication, or the involvement of crisis response entities outside the ordinary daily supports provided by the agency.

2. Behavioral Safety Procedures are listed in **Section 12.5.a.4.**

3. Procedures not identified in the foregoing list shall be approved by the DIDD Director of Behavioral and Psychological Services.

4. Special requirements applying to the use of manual restraint, mechanical restraint, and protective equipment are provided in **Section 12.5.e.**

5. All residential, day service, and personal assistance agencies are required to adopt and provide training for an approved method of personal safety and crisis intervention techniques (including physical interventions such as blocking and manual restraint) for DSPs who are in contact with persons served who engage in behaviors that place themselves or others at risk. Crisis management training is required prior to providing services for these individuals. Crisis intervention systems shall be approved by the DIDD Director of Behavioral and Psychological Services. Agencies that can demonstrate that they exclusively serve a population that is not prone to behavioral crises may request an exemption in accordance with policy 30.1.6 Exemption Process.[77]

[77] http://www.tn.gov/didd/provider_agencies/policies/Policy%20-3016%20Exemption%20Process%2005-07-2012.pdf

6. Persons served who have had a behavioral health crisis within the past two (2) years are identified as at-risk for crisis. Persons who have had more than three (3) applications of Behavioral Safety Procedures or PRN psychotropic medication within a six (6) month period shall receive behavior services unless an exemption of the need for these services has been provided by the DIDD Director of Behavioral and Psychological Services. An exemption of this requirement may also be obtained if it is determined that the person does not meet medical necessity criteria for behavior services. In these instances, agencies shall develop a Cross Systems Crisis Plan (see glossary for definition) to address concerns leading to the use of Behavioral Safety Procedures or PRN psychotropic medication. A Cross-Systems Crisis Plan may remain in effect without behavior services once the person served has gone six (6) months with fewer than three (3) applications of Behavioral Safety Procedures or PRN psychotropic medication.

7. Applications of staff protective equipment, safety delay, and supported recovery shall be reported in the Clinical Service Quarterly Reviews of behavior service providers. Manual and mechanical restraints, protective equipment, and PRN psychotropic medications shall be reported in Clinical Service Monthly and Quarterly Reviews and as required through the DIDD incident management system.

8. Persons at-risk for crisis shall have a Cross-Systems Crisis Plan developed jointly by day and residential provider agency personnel and other COS members as appropriate. When a person is receiving behavioral services, provider agencies shall consult with behavior analysts or the clinical providers in the development of the plan to ensure that the crisis plan is consistent with the person's behavioral treatment. In instances where behavior services are provided, the behavior analyst shall outline crisis procedure and/or refer the reader to the Cross-Systems Crisis Plan for further guidance in the crisis section of the BSP. Behavior Support Plans that contain Behavioral Safety Procedures and no other Restricted or Special Individualized Procedures may be implemented without approval by an HRC or Behavior Support Committee.

    a. Cross-Systems Crisis Plans shall contain instructions for how to identify an emerging crisis and a list of strategies for how to interact with the persons supported and define appropriate ways to de-escalate the crisis. Strategies shall be hierarchically arranged from least to most intrusive so that they show how to respond as the crisis escalates. Prevention strategies shall be consistent with treatment procedures included.

    b. When crisis plans involve external crisis response entities (mobile crisis, police, psychiatric hospitals, etc.), they shall include critical background information that will help external service provider understand the person. Medical and psychiatric diagnoses, behavior assessment information, and trauma and family history are examples of information that shall be included.

c. Crisis plans shall also contain contact information for any person or entity that may need to be contacted during a crisis. At a minimum, the plan shall include contact information for the person's legal representative, agency director(s), behavior analyst, ISC, mobile crisis services, respite services, and psychiatric hospitals.

d. The plan shall define the specific circumstance under which people or entities must be contacted and how to coordinate the necessary services during a crisis. The plan shall also define the responsibilities of staff during the process of placement in a respite facility, crisis stabilization unit, or psychiatric hospital. In the event of psychiatric hospitalization, agency provider staff shall remain with the person served until it is clear that the person has been admitted to the hospital.

e. The crisis plan shall be in a form that can be easily shared with external crisis personnel to inform their actions and facilitate the crisis response. To the extent possible, external entities shall have the opportunity to contribute content to the crisis plan. They must also have a copy of the crisis plan to keep on file in the event of a crisis involving the person served. Consent of the person or legal representative is required to share this information with external entities in advance of a crisis situation.

In conjunction with the annual ISP, the crisis plan shall be reviewed at least annually and revised as indicated based on the needs of the person receiving services.

12.5.a. Classification of Interventions and Associated Requirements.

1. DIDD adheres to person-centered principles and a model of positive behavior supports, with an understanding that individual needs may require the limited application of interventions designed to set appropriate limits for persons served to sustain their regard as a valued member of the community. Behavior Support Plans shall be developed using the least restrictive interventions that effectively produce a desired behavior change. The behavior provider is sensitive to each person's individualized clinical needs, and wherever possible, unrestricted procedures shall be used exclusively.

2. DIDD has designated three (3) classifications of approved behavior interventions, unrestricted interventions, restricted interventions, and special individualized interventions. Crisis interventions are not considered behavioral interventions and are classified separately as Behavioral Safety Procedures.

3. Unrestricted interventions shall be attempted prior to restricted interventions or special individualized interventions, unless delay of implementing the restricted intervention is likely to result in significant harm, or is otherwise contraindicated.

12.5.a.1. Unrestricted Behavior Intervention Procedures.

1. DIDD encourages COSs to engage in informal problem solving and unrestricted, non-restrictive intervention procedures when appropriate. Referrals for behavior services shall only be made when such informal processes are inadequate and the services of a behavior analyst are needed to help resolve the problem.

2. DIDD has classified these interventions as environmental strategies that teach, train, increase behavior, or maintain desired behaviors. In some cases, the procedures involve mild forms of negative feedback, such as social disapproval. These interventions are based upon scientifically and professionally derived knowledge. The definitions listed below are examples of unrestricted behavior interventions and terminology may be different depending upon sources. As needed, a behavior provider may consult with the Regional Behavior Services Director or the DIDD Director of Behavioral and Psychological Services regarding the categorization of a particular procedure.

3. A BSP that incorporates only unrestricted behavior interventions does not require an approval by a Behavior Support Committee or an HRC. When desired, the behavior provider may contact other behavior analysts for consultation or a peer review of the proposed plan. Review by the committees may be requested for technical assistance regarding the interventions or potential human rights concerns.

4. The following list contains examples of unrestricted behavior interventions that may be used without approval:

    a. Antecedent Modification: social and/or environmental changes that lessen the likelihood of the occurrence of challenging behavior.

    b. Backward Chaining, Forward Chaining, Total Task Training: using prompting and positive reinforcement to teach a sequence of behaviors.

    c. Behavioral Contracting: a written agreement between two parties in which one or both parties agree to engage in a specified level of a target behavior or behaviors (sometimes called a contingency contract). The contract states that the consequence will be administered contingent upon the occurrence (or nonoccurrence) of the behavior. The consequence to be administered by either presentation or withdrawal shall not involve the manipulation of any basic human rights.

    d. Behavioral Momentum: a procedure to produce higher rates of cooperative behavior. The procedure involves the presentation of a rapid sequence of high-probability (high-*p*) instructions immediately preceding a low-

probability (low-*p*) instruction with which the person has been noncompliant.

e. Differential Reinforcement of an Alternative Behavior (DRA): reinforcement for adaptive behavior that is an alternative to one or more inappropriate behaviors.

f. Differential Reinforcement of High Rate Behavior (DRH): reinforcement for exhibiting a behavior a specific number of times or more during a specified period of time.

g. Differential Reinforcement of Incompatible Behavior (DRI): reinforcement for exhibiting adaptive behavior that is functionally incompatible to one or more inappropriate behaviors.

h. Differential Reinforcement of Low Rate Behavior (DRL): reinforcement for exhibiting a behavior a specific number of times or less during a specified period of time.

i. Differential Reinforcement of Other Behavior (DRO): reinforcement for not exhibiting inappropriate behaviors during a specified period of time.

j. Environmental enhancement or modification: an antecedent modification involving the adjustment in the environment to include access to high quality attention, preferred items, and activities.

k. Escape Extinction without Physical Prompting: no longer allowing a challenging behavior to result in the escape or avoidance of task. Physical prompting, such as graduated guidance, is not used to prevent escape or avoidance.

l. Fading prompts or cues: gradually changing stimuli or reinforcement schedules so that a behavior occurring in the presence a contrived set of stimuli now occurs in the under more natural conditions.

m. Functional Communication Training: using discrete trial training that combines reinforcement and graduated guidance to teach an adaptive communicative behavior that replaces an inappropriate behavior used for communication.

n. Modeling and imitation: teaching adaptive behavior through demonstration.

o. Neutralizing Routine: Providing opportunities to reduce the evocative or increase the abative effects of motivating operations through alterations in the daily life routine.

p. Noncontingent Reinforcement: presentation of reinforcement independent of specific behavior.

q. Prompting: using vocal, gestural, demonstration, or physical cues, including graduated guidance, to teach adaptive behaviors.

r. Redirection: vocally, gesturally, or physically prompting or moving a person towards an activity, task, or area.

s. Role Playing: providing an individual with the opportunity to practice a behavior in a contrived interpersonal situation which is similar to the everyday circumstances under which the behavior occurs.

t. Self-Control/Monitoring/Instruction: Self-Control: Teaching an individual to control his/her own behavior through the systematic use of behavior technology. Self-Monitoring: Teaching the individual to observe, record, and evaluate his/her own behavior. Self-Instruction: Teaching the individual to interrupt inappropriate behavior and to engage in situation-appropriate behavior.

u. Shaping: reinforcing new approximations of an adaptive behavior, while placing previous approximations on extinction.

v. Simple Correction: Requiring the individual to restore the environment to its original state following the occurrence of destructive or disruptive behavior. Prompting, but no physical force, is used. Simple Correction shall not include restoration by way of monetary cost to the person served or any overcorrection.

w. Social Disapproval: telling an individual "no," "don't do that," or similar forms of feedback following each instance of inappropriate behavior.

x. Social Extinction: elimination of social reinforcement (e.g., attention) as a consequence for behavior that has been found to be maintained by social consequences.

y. Time-Out From Positive Reinforcement: the withdrawal of the opportunity to earn positive reinforcement or the loss of access to positive reinforcers for a specified period of time while remaining in the setting.

12.5.a.2. Restricted Behavior Intervention Procedures.

1. The following procedures require a BSP developed by a behavior analyst in conjunction with the person's COS. Approval from the Regional Behavior Support Committee and an HRC is required prior to implementation of restricted procedures. Informed consent from the individual or his/her legal representative

is also required prior to implementation. Any BSP to be implemented in a DIDD contracted agency shall receive appropriate consent and approval even if the plan is developed by an external provider.

2. The definitions listed below are examples of restricted behavior interventions and terminology may be different depending upon sources. As needed, a behavior provider may consult with the Regional Behavior Services Director or the DIDD Director of Behavioral and Psychological Services regarding the categorization of a particular procedure.

   a. Escape Extinction with Physical Prompting: no longer allowing a challenging behavior to result in the escape or avoidance of task. Physical prompting, such as graduated physical guidance, is used to prevent the escape or avoidance of the task.

   b. Exclusionary Time-Out: the removal of the person from the immediate area for a period of time to prevent access to positive reinforcers and to withdraw the opportunity to earn positive reinforcement contingent upon the occurrence of a challenging behavior. The person is returned to the setting after a required period of time. Attempts to return to the area prior to the required time period may be blocked, but locking the person in the area with no one else present is prohibited.

   c. Response Cost: removal of tokens, points, preferred items, scheduled events, and other reinforcers or restricting activities or outings following a behavior to decrease its occurrence. Activity delays of greater than two (2) hours shall be considered Response Cost.

   d. Sensory Extinction: removing the sensory consequences of behavior using devices such as helmets and gloves that do not restrict movement.

12.5.a.3. Special Individualized Interventions.

1. Special individualized interventions, as classified by DIDD, are interventions that involve the delivery of an aversive stimulus or event with the intent to decrease behaviors that pose a danger to self or others.

2. Any procedure not listed as an unrestricted or restricted intervention shall be considered a special individualized intervention.

3. These procedures shall be accompanied by procedures that teach the individual alternative responses to the behaviors that are targeted for these procedures.

4. These interventions can only be implemented through a BSP that has been approved by the Regional Behavior Support Committee, the Regional HRC, and the DIDD Director of Behavioral and Psychological Services.

5. Examples of special individualized interventions are listed below:

   a. Contingent Effort: physically guiding an individual to exhibit an effortful behavior for an established period of time contingent upon the occurrence of inappropriate behavior.

   b. Negative Practice: the individual is required to repeatedly perform a targeted undesirable behavior for a maximum of five minutes contingent upon emission of that behavior.

   c. Overcorrection: the individual is required to engage in effortful activity for a brief period following the targeted behavior. This activity includes positive practice in which the person is required to engage in correct forms of behavior for a number of times and correction, in which the individual is required to restore an environment to a condition better than that prior to the occurrence of a problem behavior.

   d. Required relaxation: requiring the individual to sit down or lie down on his/her back for a designated period of time after each instance of inappropriate behavior. Graduated physical guidance may be used as needed, however, takedowns are prohibited.

12.5.a.4 Behavioral Safety Procedures.

1. Behavioral safety procedures are physical interventions that prevent harm to the person or others that should only be used in case of an emergency or immediate threat. Use and frequency of these interventions will be monitored by the DIDD Director of Behavioral and Psychological Services to ensure that these interventions are being used appropriately and not excessively.

2. The focus on treatment procedures must be the prevention of the need for Behavioral Safety Procedures. The use of behavioral safety procedures represents a failure in the treatment that has been provided to the person served through other plans of care.

3. The use of behavioral safety procedures must be outlined in the Cross-Systems Crisis Plan or in the crisis section of the person's BSP.

4. Behavior Support Plans that contain Behavioral Safety Procedures and no other Restricted or Special Individualized Procedures may be implemented without approval by an HRC or Behavior Support Committee.

5. Response blocking and/or safety delay may be used as part of General Agency Crisis Plan for individuals who do not have a history of the use of behavioral safety procedures within the past two years.

   a. Response Blocking - blocking a movement of individual's limbs or body with a protective pad or with one's own limb, open hand, or body with minimal force so that the occurrence of inappropriate behavior is prevented.

   b. Manual Restraint: Holding the limbs or body of a person supported in response to an imminently harmful behavior using an approved manual restraint procedure so that movement is restricted or prevented, not to exceed fifteen (15) continuous minutes. Take downs and prone and supine restraints are prohibited. For the purposes of this manual, the following are **not** considered manual restraint:

      1. Holding the limbs or body of a person supported as a part of a specific medical, dental, or surgical procedure that has been authorized by an appropriate health care professional.

      2. Holding the limbs or body of a person supported to provide support for the achievement of functional body positions and equilibrium, such as supporting someone to walk, or achieving a sitting or standing position.

      3. Holding the limbs or body of a person supported to prevent him or her from falling.

      4. Use of response blocking in response to harmful behavior, or use of graduated physical guidance as part of an approved intervention.

6. The following procedures are specialized Behavioral Safety Procedures and shall require the approval of the DIDD Director of Behavioral and Psychological Services prior to implementation. The DIDD Director of Behavioral and Psychological Services shall establish reporting requirements for these procedures upon approval.

   a. Safety Delay: Restricting the person's freedom of movement and community access for a period of time after the occurrence of a harmful behavior to ensure that the person is calm and that the risk of engaging in unsafe behavior has decreased to an acceptable level. A safety delay may not exceed two hours following the last occurrence of unsafe behavior.

b. Supported Recovery: Use of a specific, safe, and physically secure location for DSPs to engage in de-escalation of crisis behavior responses not to exceed forty-five (45) minutes. Staff shall remain with the person at all times during the use of supported recovery.

c. Supported Recovery - Separation: Use of a specific, safe, and physically secure (i.e., door held closed with physical pressure) location that must allow for visibility into the room for DSPs to engage in de-escalation of crisis behavior responses not to exceed forty-five (45) minutes. At least one staff person shall remain in the room with the person and remain available to interact with the person at all times during the use of supported recovery - separation.

d. Mechanical Restraint: The application of a device to any part of a person's body that restricts or prevents movement or normal use/functioning of the body or body part to which it is applied because of an ongoing risk of harm, not to exceed forty-five (45) minutes. Mechanical restraint shall not impair or inhibit visual or auditory capabilities or prevent or impair speech or communication modalities.

e. Protective Equipment: The application of a device to any part of a person's body that prevents tissue damage or other physical harm due to a person's behavior. Protective equipment shall not restrict or prevent movement or the normal use/functioning of the body or body part to which it is applied because of an ongoing risk of harm, not to exceed forty-five (45) minutes. Protective equipment shall not impair or inhibit visual or auditory capabilities or prevent or impair speech or other communication modalities.

7. Supported Recovery – Separation, Mechanical Restraint, and Protective Equipment require review by an HRC. Behavior Support Plans that contain Behavioral Safety Procedures and no other Restricted or Special Individualized Procedures may be implemented without approval by an HRC or Behavior Support Committee.

8. Manual restraint may be used as part of General Agency Crisis Plan for individuals who do not have a history of the use of behavioral safety procedures within the past two years.

9. Some of the above procedures qualify as reportable incidents and interventions and should be reported in accordance with **Section 7.1.c.** Providers may request a reporting variance from the DIDD Director of Behavioral and Psychological Services. For more information on reporting variances, see **Section 12.6.**

12.5.b. Behavior Support Committees.

1. Regional Behavior Support Committees shall be available in each region for the purpose of reviewing BSPs with Restricted and Special Individualized Procedures. The Regional Behavior Services Director or designee shall serve as chair of the committee. The committee will be composed of at least two other behavior analysts. Reviews will include a Work Products Review and a review of the plan with regard to other relevant DIDD requirements. Decisions of the committee shall be determined by a simple majority. In case of a tie, the chair shall cast the deciding vote. Plans reviewed by the Regional Behavior Support Committee shall be approved, disapproved, or approved with changes.
2. Special Individualized Interventions and Variances to DIDD requirements shall also be reviewed by the Statewide Behavior Support Committee. The Statewide Behavior Support Committee is composed of the DIDD Director of Behavioral and Psychological Services and the three (3) Regional Behavior Services Directors. When the committee is convened, decisions are made by a simple majority. In case of a tie, the DIDD Director of Behavioral and Psychological Services shall make the deciding vote. Plans reviewed by the Regional Behavior Support Committee shall be approved, disapproved, or approved with changes.

12.5.c. Chemical Restraints. Chemical restraint is defined as a medication used to control behavior or to restrict the movement of the person supported for convenience or as a punishment and is not a standard treatment for a medical or psychological condition. Chemical restraint is prohibited.

12.5.d. Other Prohibited Interventions. The use of seclusion or seclusion time-out is prohibited. Seclusion shall mean placing a person in a room alone while holding or locking the door to prevent egress. Prone and supine restraints and takedowns are prohibited.

12.5.e. Safeguards for Restraint and Restrictive Interventions.

1. Restraint and Protective Equipment may only be used when necessary to protect the person served or others from an imminent risk of harm and when less intrusive methods have been ineffective. Restraints and protective equipment may not be used excessively, for a time period beyond that which is necessary to ensure safety, as treatment or punishment, for staff convenience, or as a substitute for other services. Take downs and prone and supine restraints are prohibited.

2. All agencies are required to adopt and provide training for an approved method of personal safety and crisis intervention techniques for DSPs who are in contact with persons served. Crisis intervention systems shall be approved by the DIDD Director of Behavioral and Psychological Services. Agencies that can demonstrate that they exclusively serve a population that is not prone to behavioral crises may request an exemption in accordance with policy 30.1.6 Exemption Process. Restraint or protective equipment shall not, under any circumstances, be applied by a person who has not been trained to safely apply such a procedure.

3. Restraint or protective equipment shall be implemented cautiously in a manner which ensures protection from harm and protection of the rights of the person served.

4. Direct support professionals shall also be trained to apply general proactive and reactive strategies for recognizing, preventing, and minimizing the frequency, intensity, and duration of individual behaviors and minimize the use of restraint and protective equipment. Response to challenging behavior must follow procedures, as applicable, specified in the Cross-Systems Crisis Plan, BSP, or the provider agency's General Crisis Plan.

12.5.e.1. Manual Restraint.

1. If an emergency situation places the person served or others at imminent risk of harm, and alternative strategies have been ineffective in reducing the risk, DSPs may apply manual restraint to minimize the risk of harm.

2. When a person served has had three (3) manual restraints within the past six (6) months, there shall be a plan for its use. The plan may be placed within a Cross Systems Crisis Plan or the crisis section of a BSP.

3. Cross-Systems Crisis Plans or crisis sections of BSPs involving the use of manual restraint shall specify criteria for use of restraint. Criteria in the plan shall clearly describe behaviors that pose an imminent risk of harm.

4. When a novel situation occurs where a person without a written plan displays behavior that poses an imminent risk of harm, DSPs may rely on an agency's General Crisis Plan to determine if restraint must be used.

5. Plans involving the use of manual restraint will include procedures for continuously monitoring the physical condition of the person being restrained throughout the restraint. Persons showing abnormalities of breathing or skin color shall be immediately released from restraint. Persons for whom manual restraint is contraindicated must not be restrained. Medical conditions which may contraindicate physical restraints are head or spinal injury, fracture and

pregnancy. Relative contraindications include: osteoporosis or history of fracture; asthma; seizures; heart disease, including hypertension; recent history of surgery; and a history of abuse. The risks and benefits of restraint in response to these contraindications must be evaluated by the person's COS in consultation with the primary care physician to determine an appropriate course of action. The results of the risk-benefits analysis shall be documented in a Cross-Systems Crisis Plan or BSP.

6. Individual-specific criteria for release from manual restraint shall be included in a Cross-Systems Crisis Plan or crisis section of a BSP. General release criteria shall be established in an Agency General Crisis Plan. The following shall guide the establishment of criteria for release from manual restraint.

   a. Behaviors that must be absent at the time of release shall be described.

   b. Manual restraint may be applied continuously for a maximum period of fifteen (15) minutes.

7. If the behavior which led to the application of restraint recurs after release, the agency director or designee shall be contacted to consider alternative interventions. Manual restraint may be reapplied as necessary to minimize the risk of harm.

8. Any use of manual restraint that does not conform to the rules stated above shall require approval as a variance. Procedures for the approval of variances are provided in **Section 12.6**.

12.5.e.2. Mechanical Restraint and Protective Equipment.

1. In unique circumstances where a person's behavior poses a persistent and ongoing risk of harm, mechanical restraint or protective equipment may be used to minimize the risk.

2. Mechanical restraints or protective equipment may only be used if their use is outlined in a Cross-Systems Crisis Plan or the crisis section of a BSP.

3. Devices used as mechanical restraint or protective equipment shall be commercially produced and in good repair.

4. The following shall guide the establishment of criteria for release from mechanical restraint or protective equipment.

   a. Behaviors that must be absent at the time of release shall be described.

   b. Mechanical restraint or protective equipment may be applied continuously for a maximum period of 45 minutes.

c. After forty-five (45) minutes of continuous mechanical restraint or protective equipment usage, the restraints must be removed for fifteen (15) minutes before they may be reapplied unless the behavior that led to the restraint recurs after release.

5. The physical condition of the person being restrained shall be evaluated continuously throughout the restraint. Persons showing abnormalities of breathing, skin color, or other abnormalities shall be immediately released from restraint. Mechanical Restraint or Protective Equipment shall not be used when its use is contraindicated. Medical conditions which would contraindicate Mechanical Restraint or Protective Equipment are head or spinal injury, fracture and pregnancy. Relative contraindications include: osteoporosis or history of fracture; asthma; seizures; heart disease, including hypertension; recent history of surgery; and a history of abuse. The risks and benefits of restraint in response to these relative contraindications must be evaluated by the person's COS in consultation with the primary care physician to determine an appropriate course of action. The results of the risk-benefits analysis shall be documented in a Cross-Systems Crisis Plan or BSP.

6. If the behavior which led to the application of mechanical restraint or protective equipment recurs after release, the agency director or designee shall be contacted to consider alternative interventions. Mechanical restraint or protective equipment may be reapplied as necessary to minimize the risk of harm.

7. Any use of mechanical restraint or protective equipment that does not conform to the rules stated above shall require approval as a variance. Procedures for the approval of variances are provided in **Section 12.6.**

8. Behavior analysts sometimes use protective equipment in a plan for the purpose of extinction procedures. Such use shall be outlined in the "What I Do to Decrease Behavior" section of a BSP and shall require approval as a special individualized intervention. Procedures for the approval of special individualized interventions are included in **Section 12.5.a.**

12.5.e.3. Monitoring of Manual and Mechanical Restraint and Protective Equipment.

1. All uses of manual or mechanical restraint or protective equipment shall be reported in accord with requirements of the DIDD Incident Management system. Incident reports involving restraint shall specify the frequency and duration of each use of manual or mechanical restraint or protective equipment.

2. Following each use of restraint or protective equipment, a designee of the agency IRC shall conduct a debriefing regarding the restraint with DSPs who applied the

restraint. The debriefing shall include a discussion of the appropriateness and effectiveness of the restraint or protective equipment, and whether procedures were carried out appropriately. In instances where problems are identified in the use of a restraint, the person conducting the debriefing shall make adjustments to the use of restraint that may be needed. A summary of the debriefing and recommended adjustments shall be included in the narrative of the incident report. If appropriate, adjustments shall be made to the Cross-Systems Crisis Plan or the crisis section of the BSP.

3. Behavior Analysts shall include information regarding the frequency and duration of use of Manual and Mechanical Restraints and Protective Equipment in Clinical Service Reviews.

4. Agency Incident Management Committees shall review the supports for any person who has three (3) or more incidents involving Manual or Mechanical Restraint or Protective Equipment within a six (6) month period. Consideration shall be given to additional services and supports that may be needed for the person to minimize the need for restraint and protective equipment.

5. Cross Systems Crisis Plans and BSPs for Persons receiving three (3) or more applications of Manual or Mechanical Restraint, PRN Psychotropic Medication, Psychiatric Hospitalization, or other Behavioral Safety Procedures (except Response Blocking) within a one (1) month period shall receive monitoring and consultation by the Regional Office Behavior Services unit. The Regional Behavior Services Director or designee will review the services and supports for persons meeting this criterion and will provide individual-specific recommendations to the person's COS. In cases where the person is receiving behavior services, behavioral documentation will be reviewed and recommendations will be made directly to the assigned behavior analyst. When behavior analysis strategies are ineffective in meeting the persons need, behavior services may be discontinued. In these cases, the COS will make referrals to appropriate alternative providers. The Regional Behavior Services Director may request that behavior services documentation be provided for review by the Regional Behavior Support Committee. In cases where the rate of restraint continues to be high, the Regional Behavior Services Director may refer the case to the Statewide Behavior Support Committee for review. Behavior services for individuals meeting this criterion shall continue to be monitored each month until the rate of restraint has fallen below three (3) restraints in a six-(6) month period.

6. Some persons with plans for mechanical restraint or protective equipment may have frequent or ongoing use of these devices. In cases where the baseline use of mechanical restraint or protective equipment exceeds ten (10) applications per month over a three (3) month period, a reporting variance may be requested.

Reporting variances may allow for the completion of one (1) monthly incident report for all instances of the use of mechanical restraint and protective equipment. Requests for reporting variances shall be made in writing to the DIDD Director of Behavioral and Psychological Services. Reporting variances shall only be approved when the person served is receiving behavior services.

7. When reporting variances are approved, the DIDD Director of Behavioral and Psychological Services shall monitor the use of these procedures. Behavior Analysts for persons with reporting variances shall send the monthly incident report to the DIDD Central Office Incident Management unit and the DIDD Director of Behavioral and Psychological Services. Behavior Analysts shall also send all behavior services documentation to the Director of Behavioral and Psychological Services when a variance has been approved. The behavior services for each person with a reporting variance shall be reviewed at least annually by the Statewide Behavior Support Committee.

12.6 Procedural and Reporting Variances.

Circumstances sometimes warrant that procedures or reporting requirements be modified to meet the particular needs of an individual or prevent onerous and unnecessary paperwork. Provisions for obtaining approval for variances are provided below. Such variances fall into two (2) categories.

- Procedural Variances are the use of a behavioral procedure that is either not included or varies from the description of the procedure in provider manual.
- Reporting Variances are different incident reporting requirements for unique situations where the frequency of a reportable event is too great for the standard incident reporting system.

1. Behavior analysts may request a Procedural Variance from DIDD policies when warranted by the unique needs of a person served. A Procedural Variance shall only be considered based on an individual's needs. No Procedural Variances shall be granted for an agency to apply the variance to general agency procedures.
2. The Procedural Variance shall be incorporated into a BSP for which an approved behavior analyst has oversight. Justification for the variance must be clearly stated. A behavior specialist may assist in the construction of the intervention plan, but an approved behavior analyst shall be required to maintain ultimate responsibility for the plan.

3. The written intervention plan containing the Procedural Variance shall be reviewed and approved by the COS, including the legal representative, as applicable. Signatures of the ISC and legal representative on a consent form referencing the plan shall serve as evidence of such approval.

4. The written intervention plan containing the Procedural Variance shall be reviewed and approved by the Regional Behavior Support Committee and Regional HRC.

5. The written intervention plan containing the Procedural Variance shall also be reviewed and approved by the DIDD Director of Behavioral and Psychological Services. The DIDD Director of Behavioral and Psychological Services may consult with the Statewide Behavior Support Committee in making the decision to approve the variance. The Statewide Behavior Support Committee is composed of the DIDD Director of Behavioral and Psychological Services and the three (3) Regional Behavior Services Directors. When the committee is convened, decisions are made by a simple majority. In case of a tie, the DIDD Director of Behavioral and Psychological Services shall make the deciding vote.

6. Procedural variances shall be reviewed and approved a minimum of annually by the Regional Behavior Support Committee, an HRC, and the Director of Behavioral and Psychological Services. Briefer review intervals may be prescribed by committees as necessary to ensure adequate ongoing review of the response to treatment. Variances recommended for approval shall be submitted through the policy exemption process, in accordance with the 30.1.6 Exemption Policy.

7. Behavior analyst may require Reporting Variance when appropriate. Some persons supported with plans for mechanical restraint or protective equipment may have frequent or ongoing use of these devices. In cases where the baseline use of mechanical restraint or protective equipment exceeds ten (10) applications per month over a three (3) month period, a reporting variance may be requested. Reporting variances may allow for the completion of one (1) monthly incident report for all instances of the use of mechanical restraint or protective equipment. Requests for reporting variances shall be made in writing to the DIDD Director of Behavioral and Psychological Services. Variances to reporting procedures shall be initially approved by the DIDD Director of Incident Management.

Reporting variances will only be approved when the person supported is receiving behavior services.

12.7 Behavioral Respite Services.

1. Behavioral Respite Services shall mean short-term behavior-oriented services for a waiver participant who is experiencing a behavioral crisis that requires removal from the current residential setting in order to resolve the behavioral crisis.

2. Clinicians for respite facilities may include behavior analysts, psychologists, senior psychological examiners, or nurses.

3. Upon admission to a behavioral respite site, the respite provider shall obtain all appropriate records for the individual including health records, ISP, and BSP.

4. For each person entering Behavioral Respite Services, a treatment plan shall be developed by a clinician within three (3) days of admission. The treatment plan shall include the following:

    a. Objectives for the respite stay, projected discharge criteria, and probable length of stay.

    b. Procedures for data collection on the issues of concern.

    c. Strategies for preventing and intervening in problem behavior.

5. Personnel from the originating agency shall have the opportunity to review and provide input for the treatment plan. The treatment plan shall be reviewed and revised as appropriate at least once every seven (7) days during the respite stay.

6. DSPs for the respite facility shall receive training on the treatment plan and implement it during the period of the respite stay.

7. During the respite stay, the individual shall be observed and data shall be collected regarding target symptoms/behaviors of concern.

8. An individual may be discharged from Behavioral Respite Services when the objectives outlined in the treatment plan have been accomplished. Typical lengths of stay in a behavioral respite facility are two (2) to four (4) weeks.

9. A discharge summary for the respite stay shall be completed by an appropriate clinician. The report shall include an objective report of data, changes in treatment that occurred during the stay, and recommendations for improving quality of life for the individual. The report shall also include recommendations for preventing a recurrence of behavior that led to the respite stay. An appropriate clinician shall conduct a discharge meeting and review the report for personnel with the originating agency on the day of discharge.

12.8. Self-Assessment and Internal QI.

Behavior services providers are required to complete self-assessment and internal QI activities that provide an ongoing review of the effectiveness of services provided, identify systemic issues, and initiate corrective actions in a timely manner and before such issues are identified by other monitoring entities. Providers need to document processes used and steps taken/changes made to address issues identified. This information should be made available to others working for the agency. Self-assessment and internal QI activities must be completed annually. Providers shall develop and implement a QI plan to address issues identified through self-assessment activities. The following components must be included in provider's self-assessment/internal QI activities:

1. Records management processes.
2. Trends in any incident reports completed or investigations involving clinical staff.
3. Review of external monitoring reports and identification of any trends.
4. Review of any personnel practices and any personnel issues.
5. Review of policies and procedures and any updates/revisions needed.
6. Review of a sample of services provided, including persons supported discharged from services, to identify documentation issues and service effectiveness.
7. Review of satisfaction survey processes and results.
8. Steps taken or changes made in response to internal and external review findings, including any sanctions and/or recoupments imposed.
9. Ways the information gained through self-assessment is communicated to other agency staff or those outside of the agency as appropriate.

Self-assessment and internal QI activities must be completed between DIDD QA surveys. Providers shall develop and implement a QI plan to address issues identified through self-assessment activities.

12.9. Policies.

Behavior services providers are required to develop agency policies prior to initiating any service provision. Additionally, they are required to develop and implement the following policies:

1. Drug free workplace requirements.
2. Showing respect to persons supported.
3. Serving as an advocate for persons supported and referring to external advocacy as needed.
4. Taking appropriate actions in emergency situations.
5. Managing and reporting incidents using DIDD procedures.
6. Maintaining Title VI compliance.
7. Protection and promoting people's rights.
8. Protection from and prevention of harm.
9. Complaint resolution.
10. Assuring staff coverage and service schedules.
11. Supervision plan (as applicable when using behavioral specialists).

CHAPTER 13

THERAPEUTIC AND THERAPY-RELATED SERVICES

13.1. Introduction.

Therapeutic services for adults with intellectual disabilities are geared towards chronic care supports designed to prevent or slow progression of chronic health related conditions, to improve or gain functional skills through adaptations necessary to overcome barriers and to assist in maintaining optimal health and function across time as people age. In addition, when acute health events happen, therapeutic services are often necessary to pick up where acute services end in order to help assure a person gets back to their prior functional level or as close to it as possible. Therapeutic services include OT, PT, speech language pathology (SLP), audiology, O&M, and nutrition. Therapy-related services include environmental accessibility modifications (EAM) and SMESAT.

Therapeutic services require an integrated approach with individuals and their families, PAs, agency staff, DSPs, and other health professionals to ensure success in meeting individualized goals. This is accomplished through the implementation of direct therapeutic interventions, training of caregivers on strategies to be implemented throughout an individual's day, and periodic monitoring of the ongoing implementation of written strategies by caregivers and the status of adaptive devices to assure the person remains healthy, safe and is able to function across environments.

13.2. Requirements.

The following requirements outlined for therapeutic services provision are set forth by DIDD. Agencies and or individual clinicians are responsible for adhering to requirements outlined in their Provider Agreement with the DIDD as well as additional or more restrictive

requirements set forth and surveyed or audited by DOH, national certification boards, or state practice boards. Descriptions of services are available online.[78]

13.2.a. Identifying the Need for Assessment. The need for a therapeutic service assessment may be identified in a variety of ways. Persons supported transitioning from a developmental center may have received therapeutic services and supports that need to be reassessed as they move into the community, adjust to their new environments, and establish new daily routines. For others who are currently living in the community, any provider may identify a need and make a referral for a therapeutic service assessment through the ISC/CM. In addition, various DIDD staff may assist in identifying needs.

An assessment must clearly identify how pertinent health-related issues are impacting function in order to justify the need for any recommended services. Assessment recommendations must identify supports and services needed to assist the person in accomplishing his or her outcomes and actions across environments (i.e., home, work, community) as appropriate. Assessments must also encompass a review of relevant assistive technology needs to identify equipment necessary to ensure health, safety, comfort and function.

13.2.b. Preauthorization of Services.

1. Assessments and services must be pre-authorized and are subject to medical necessity review prior to authorization.
2. An assessment must be completed prior to the provision of services, in order to establish/justify a need for a particular service.
3. Services cannot be authorized at the same time as an assessment.
4. Requests for more than 24 units a month or 288 total units per ISP year for OT, PT, or SLP services are subject to a concurrent review process and may be subject to a requirement to submit additional documentation for continued authorization.

[78] http://www.tn.gov/didd/provider_agencies/ServiceDefinitions/WaiverSrvcDefinitions.shtml

13.2.c. Therapeutic Services Plan of Care. The Plan of Care must contain person-centered goals that are functional and measureable along with interventions and timeframes. The goals in the Plan of Care must relate to/support an individual's outcomes and/or actions in his or her ISP. Services are to be provided in the natural environment relevant to the goal(s) being addressed.

13.2.d. Billing.

1. Services must be provided face-to-face with the person supported in order to be billed, with the exception of nutrition and O&M services. These two (2) services can be provided with only the support staff of the person supported for the purposes of training when necessary and appropriate.
2. Phone consultations in lieu of direct services cannot be billed.
3. Phone calls made during face-to-face service provision for the purpose of obtaining on-site technical assistance from a manufacturer's representative, durable medical equipment vendor, etc. in regards to programming devices, repairing, or operating equipment relevant to services is a billable part of service provision.
4. Reimbursement will not be made for different disciplines providing services to the same individual during the same time period unless there is documentation by both clinicians supporting medical necessity for co-treatment. Co-treatment is an intervention used to accomplish a goal, not a goal in and of itself.

13.2.e. Professional Support Services License (PSSL). Agencies providing OT, PT, or SLP services must apply for and obtain a Professional Support Services license through the Tennessee DOH, Health Facilities prior to establishing a provider agreement with the DIDD. This license must be renewed annually through the DOH and is subject to an annual DOH licensure survey. Services provided and reimbursed during any lapse in licensure are subject to recoupment. Providers will be required to show proof of current licensure during their DIDD QA surveys and any other external reviews, audits, etc.

13.2.f. Policies. Therapeutic services providers are required to develop agency policies prior to initiating any service provision. OT, PT, and SLP providers licensed through the DOH as a Professional Support Services Home Care Organization are

required to develop and implement the following policies in addition to those required through the PSSL:

1. Personnel procedures.
    a. Background checks including:
        1. A criminal background check through the TBI or the FBI (if the applicant has lived in Tennessee one year or less).
        2. Registry checks in accordance with T.C.A. § 63-1-149.
        3. Search of the OIG List of Excluded Individuals/Entities.
        4. Tennessee Felony Offender Information Lookup (FOIL).
    b. Initiating and employing progressive disciplinary actions (including warnings, suspension, termination, and reporting to the DOH Boards) including steps to be taken during any investigations of clinical staff; and
    c. Drug free workplace requirements.
2. Showing respect to persons supported.
3. Serving as an advocate for persons supported and referring to external advocacy as needed.
4. Taking appropriate actions in emergency situations.
5. Managing and reporting incidents using DIDD procedures.
6. Maintaining Title VI compliance.
7. Protection and promoting people's rights.
8. Protection from and prevention of harm.
9. Complaint resolution.
10. Assuring staff coverage and service schedules.
11. Supervision plan (as applicable when using therapy assistants).

Nutrition and O&M service providers must develop and implement the following policies and procedures in addition to 1-11 above:

1. Personnel Procedures.
    a. Background checks including:
        1. A criminal background check through the TBI or the FBI (if the applicant has lived in Tennessee one year or less).

2. Registry checks in accordance with T.C.A. § 63-1-149.
3. Search of the OIG List of Excluded Individuals/Entities.
4. Tennessee Felony Offender Information Lookup (FOIL).

b. Job descriptions, credentials, and verification of references.

c. Ensuring a well-trained workforce.

d. Procedures for tuberculosis testing.

e. Periodic performance evaluations for employed or contracted staff.

2. Maintenance and confidentiality of medical records.

3. Self-assessment and QA.

4. **For O&M providers only**: Requirements pertaining to the utilization of an employee-owned vehicle used for transportation of persons supported relevant to service provision.

13.2.g. Referrals for Assessment.

1. Providers need to assure they obtain a reason for referral.

2. Providers need to assure that they have adequate staff prior to taking new referrals. Providers should not take referrals for assessments if they will not have adequate staffing to provide services if recommended.

3. Recruitment of persons supported from another clinical services provider is prohibited.

13.3. Assuring Clinician Coverage.

Providers are responsible for assuring staff coverage for authorized services and must have a back-up plan for extended clinician illnesses, leave, or vacations.

13.4. Provider Subcontracts.

See **Section 5.10** of this manual.

13.5. Changes in Provider Information.

See **Section 5.12** of this manual.

13.6. Electronic Capability.

See **Section 5.13** of this manual.

13.7. Self-Assessment and Internal QI.

Therapeutic services providers are required to complete self-assessment and internal QI activities that provide an ongoing review of the effectiveness of services provided, identify systemic issues, and initiate corrective actions in a timely manner and before such issues are identified by other monitoring entities. Providers need to document processes used and steps taken/changes made to address issues identified. This information should be made available to others working for the agency. Self-assessment and internal QI activities must be completed annually. Providers shall develop and implement a QI plan to address issues identified through self-assessment activities. The following components must be included in provider's self-assessment/internal QI activities:

1. Records management processes.
2. Trends in any incident reports completed or investigations involving clinical staff.
3. Review of external monitoring reports and identification of any trends.
4. Review of any personnel practices and any personnel issues.
5. Review of policies and procedures and any updates/revisions needed.
6. Review of a sample of services provided, including persons supported discharged from services, to identify documentation issues and service effectiveness.
7. Review of satisfaction survey processes and results.
8. Steps taken or changes made in response to internal and external review findings, including any sanctions and/or recoupments imposed.
9. Ways the information gained through self-assessment is communicated to other agency staff or those outside of the agency as appropriate.

Self-assessment and internal QI activities must be completed between DIDD QA surveys and DOH license surveys (as applicable). Providers shall develop and implement a QI plan to address issues identified through self-assessment activities.

13.8. Approved Services.[79]

Services are to be provided in accordance with the approved ISP and clinician's Plan of Care. Providers must justify in writing any discrepancy between the amount, frequency and duration of services authorized and those utilized.[80]

13.9. Supervision Requirements.

Licensed OT assistants and licensed PT assistants must be supervised in accordance with the rules and regulations set forth by The Tennessee Board of Occupational Therapy and The Tennessee Board of Physical Therapy respectively The supervising OT or PT is responsible for each individual being treated by a therapy assistant under his or her supervision.

Supervising therapists must inspect the actual act of therapy service provision by the therapy assistant a minimum of every sixty (60) days per individual. Time required to supervise a therapy assistant has been addressed in the rates. Consequently, time spent supervising a therapy assistant is not separately billable. Both clinicians must sign the contact note or clinician's attendance log generated during the supervisory visit.

For persons receiving services once per month or less, services must be provided by a licensed therapist, not a therapy assistant. Documentation of supervision must be maintained in personnel files in accordance with licensure rules. Such documentation must not violate the confidentiality or privacy of the person receiving services.

13.10. Documentation.

Documentation is required to justify the need for skilled therapeutic services at the amount, frequency, and duration requested, to create a record of each visit, to show progress across visits, and to support billing. Clinicians must refer to their professional associations for additional guidance on documentation.

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[79] TennCare list of approved services: http://www.tn.gov/tenncare/forms/quickguide.pdf

[80] Memo 0155 Acceptable reasons for service recipients not receiving services in the amount, frequency, or duration specified in the ISP: http://www.tn.gov/didd/provider_agencies/DCMemos/2011/Memo%200155%20Yes,%20but%20Revised%205.27.11.pdf

Documentation must be legible. Errors are to be corrected with a single line though the error and initialing and dating the change.

Time spent documenting in isolation of direct service provision is not separately billable with the exception of development of the initial Plan of Care in conjunction with a per diem assessment. The following documentation is required:

13.10.a. Physician Orders.

1. Physician orders are required for all therapeutic services except Nutrition Assessment and O&M Assessment and Services.
2. Separate physician orders are required for assessment and subsequent services. Assess and treat orders are not allowed. However, if a physician provides an "assess and treat" order, it can be used to approve the assessment only.
3. A Plan of Care signed by the physician, physician's assistant or a nurse practitioner is acceptable as orders for services.
4. Verbal orders are allowed, however, the agency is responsible for assuring that written orders are obtained and filed following a verbal order.
5. Orders for doctor prescribed diets must be obtained by the primary provider and maintained in the primary provider's record.

13.10.b. Assessment.

1. Identifying information.
2. Reason for referral.
3. Individual concerns/desired goals (including any input from family, COS, etc.).
4. Relevant health history.
5. Relevant discipline specific data.
6. Relevant adaptive equipment/assistive technology needs.
7. Comprehensive analysis.
8. Recommendations.
9. Service provider's signature, credentials, and date.

If completing a therapeutic site assessment in order to provide EAM recommendations, the clinician must include detailed information about mobility status,

current assistive devices and equipment (with dimensions) relevant to the recommended modifications, details on areas of the home needing modified (measurements, etc.), an analysis of what modifications are needed and why, and recommendations including specific measurements when applicable (e.g. for widening doorways, modifying bathrooms, ramps, etc.).

13.10.c. Plan of Care (if services are recommended).

1. Information as specified in DOH rules, Standards for Home Care Organizations Providing Professional Support Services.
2. Functional and measurable goals, interventions, timeframes.
3. Amount, frequency and duration of services.
4. Service provider's signature, credentials, and date.

The Plan of Care must support needs and issues identified in the assessment as well as the individual's ISP.

13.10.d. Contact notes.

1. Identifying information.
2. Time in and time out.
3. Units utilized.
4. Goal(s)/interventions addressed during visit (including any training).
5. Objective measurement of individual response to intervention and status in relation to goals addressed.
6. Updated status of any equipment procurement.
7. Service provider's signature, credentials, and date.
8. Signature of the staff, family, and/or person supported and date either on the contact note or on the clinician's attendance log.

13.10.e. Staff instructions.

1. Identifying information.
2. Required equipment.

3. Any precautions relevant to implementing the instructions.
4. Steps for implementation.
5. Service provider's signature, credentials, and date created.
6. Review date (at least annually while services are being provided).
7. Revision date (as applicable).

Occupational therapists and physical therapists, not therapy assistants, are responsible for developing staff instructions. Therapy assistants may contribute information to the development of staff instructions and may make appropriate revisions in consultation with the supervising OT and PT.

Initial staff instructions for health and safety issues (e.g., mealtime, mobility, transfers, bathing, oral hygiene, etc.) must be in place within thirty (30) days of the start of services.

13.10.f. Monthly Progress Note. These notes are to be completed for any month in which services are authorized.

1. Identifying information
2. Objective measurement of status in relation to each Plan of Care goal
3. Updated status of any equipment procurement
4. Any barriers to service provision and steps taken to resolve them
5. Service provider's signature, credentials, and date
6. Monthly progress notes must be sent to the ISC by the twentieth (20^{th}) of the month following the month of service provision.

Therapy assistants can contribute to the completion of a progress note, however, it must be completed by the therapist. In cases where services are being provided once a month or less often, the therapist can combine the contact note information and monthly progress note information onto the same page and submit one (1) document.

13.10.g. Reassessment and update of the Plan of Care.

1. Required if recommending new services, changing existing services or preparing for discharge.

2. Assessment units will not be approved for this review.

13.10.h. Discharge Summary.

1. Identifying information
2. Reason for discharge and effective date of discharge
3. Analysis of the services provided and their benefit to the person using services.
4. Status at the time of discharge
5. Relevant indicators for re-referral (as applicable)
6. Service provider's signature, credentials, and date

Discharge summary must be completed within seven (7) days of discharge date.

Clinicians must notify the individual, conservator and the ISC of plans to discharge in advance. If the individual will continue to need services, the provider is responsible for giving sixty (60) days' notice, and for assuring another service provider is available prior to discharging the individual.

13.11. Record Requirements.

See **Section 10.8.c.** of this manual.

13.12. Distribution of Documentation.

1. Copies of therapeutic assessments, monthly progress notes, and discharge summaries are to be forwarded to the individual's ISC agency/ CM, and primary provider.
2. Documentation must be made available to relevant providers upon request, as reasonable.

13.13. Scheduling Visits.

Clinicians must work in a collaborative manner with the person supported and his/her staff or family to schedule appointments. It is expected that services be provided in the setting most relevant to the Plan of Care goals and/or ISP outcomes/actions. Clinicians should attempt to schedule appointments at a time that meets the needs of the person supported. Clinicians must communicate the need to cancel a scheduled appointment as soon as possible to the person

supported and his/her staff or family. Conversely, staff of the person supported must also notify the clinician in a timely manner when the person supported will not be available for a scheduled appointment.

13.14. Obtaining Adaptive Equipment and Assistive Technology.

Clinicians are responsible for completing the Letter of Medical Necessity and obtaining a physician's order for needed equipment, forwarding this to the ISC to be either processed through insurance or through the waiver as applicable. Clinicians are responsible for following up on the status of equipment being authorized and ordered. When the equipment is delivered, the clinician is responsible for assuring the equipment works and is adjusted etc. and for training the person supported and staff.

13.15. Required Training.

See **Chapter 6** of this manual.

13.16. Differential Rates for Travel.

Tiered rates have been established to support time spent traveling, when a clinician is seeing an individual in an outlying area where a local provider is unavailable for any reason. Pre-authorization is required for differential travel rates. The tiered rates are based on the average time required to travel within a defined mile radius. Mileage shall be calculated and verified using an approved mapping website such as MapQuest to determine the mileage between the treating therapist's location and the site where therapy services to an individual will be provided. If therapy services are provided to an individual in different locations on different days, mileage is to be calculated based on the location of the site where therapy services are most frequently provided.

13.17. Environmental Accessibility Modifications (EAM).

13.17.a. Establishing a Need for EAM. The need for EAM for an individual must be recommended by a qualified healthcare professional such as a physician, an occupational therapist, a physical therapist, O&M specialist, or a behavior analyst.

Documentation of recommendations must be submitted with the service request for modifications to the person's ISC/CM.

For individuals who may be eligible for EAM services and who require an assessment of their accessibility needs, an occupational therapist, physical therapist, or O&M specialist shall be contacted. If the needs include modifications to a bathroom, an occupational therapist may be the most appropriate if the assessment needs to include potential adaptive bathroom equipment.

For individuals who may be eligible for EAM services and who may require safety modifications for installation of non-breakable replacement windows in order to protect an individual who is at risk to injure his/herself by breaking glass windows, a behavior analyst or occupational therapist shall be contacted.

If an individual already receives therapy or behavior analyst services, the current provider shall be contacted to determine the needs. If not, a referral to an appropriate clinician must be made. Recommendations for modifications must be forwarded to the individual's ISC/CM,

13.17.b. EAM Requirements. Contractors and/or their approved subcontractors will be appropriately licensed according to state law (e.g. Limited Licensed Plumbers, Limited Licensed Electricians). Subcontractors cannot "work off of" another contractor's license.

Providers of EAM will be knowledgeable and comply with all applicable city, county, and state/international codes and laws and will pull all necessary permits for work being completed.

13.17.c. Determining EAM Scope of Work. Contractor scope of work must be based on the recommendations of the clinician. If a clinician assessment is not provided when the scope of work or bid is requested, the EAM provider must notify the Case Manager or ISC to request a copy of the assessment recommendations.

Contractors are expected to conduct an onsite visit to determine the scope of work to be completed before submitting a service request (when a bid is not required) or bid. All work must be pre-authorized. Work completed prior to authorization of funding cannot be reimbursed. Notwithstanding any use of approved licensed subcontractors, the DIDD contracted provider shall be the prime provider and will be held responsible for all work performed.

A statement signed and dated by the homeowner/landlord consenting to the recommended modifications must be included with the service request for funding.

Required forms and templates for required components are available on the DIDD web site.[81]

13.17.d. Obtaining Bids for EAM. Good faith efforts shall be made to obtain three (3) competitive bids for EAMs when the amount exceeds limits set forth by the State Purchasing Division. The ISC/CM is responsible for obtaining necessary bids from qualified EAM providers for the proposed work. Each DIDD contracted provider of EAM services, including residential providers, can submit only one (1) bid per job. Bids must:

1. Be based on a clinician's recommendations.
2. Be itemized in order for DIDD to separate out any excluded items without having to request a re-bid but also contain a total cost.
3. Contain diagrams of recommended modifications for ramps, and existing and recommended diagrams with dimensions for room modifications such as bathroom modifications.
4. Be in the name of the licensed contractor as indicated on their license.
5. Contain the license number of the contractor as well as the contractor's name, address, phone number, and signature of the contractor or other person authorized to submit the bid on behalf of the bidding entity and the date signed.
6. Include the name of the person and the address, and county of residence of the home being modified.
7. Contain a projected time frame for completion.

[81] Forms & Tools: http://www.tn.gov/didd/provider_agencies/index.shtml

8. Be inclusive of all costs including but not limited to, the costs of materials, parts, and labor for completion of the modifications and for permits, demolition, disposal of debris, and cleanup associated with the modifications.

9. Be based on least costly alternatives that meets the needs of the person supported.

10. Provide a description of any warranties, guarantees, or conditions.

The winning bid shall be determined using the lowest bid from a qualified provider for which the specifications meet the identified needs of the person.

An exception to the three (3) bid or the lowest bid requirement can be made under the following circumstances:

1. All qualified providers within a reasonable distance to the person were contacted but less than three (3) were willing or able to provide a bid.

2. There are not three (3) qualified providers within a reasonable distance to where the person lives.

3. The modifications to be provided require specialized skills or certifications and there are not three (3) qualified providers.

4. The modification to be provided require specialized skills or certifications and the qualified provider is not the lowest bidder.

5. When modifications are being done in conjunction with the ordering and installation of a ceiling track lift funded through insurance (e.g. an EAM provider who is also a durable medical equipment provider who can bill insurance).

13.17.e. Billing for EAM Services. The Department cannot provide down-payments before work begins or interim payments halfway through a job. No monies for reimbursement will be paid until all work is completed satisfactorily and to code based on required permit inspections, indication from the clinician who recommended the modifications that they are functional, a visual inspection by a DIDD employee (as deemed applicable) and sign-off by the homeowner.

13.18 SMESAT.

To establish a need for SMESAT, the following must be completed:

1. Documentation supporting the medical necessity of the item(s) being requested based on an assessment performed by an appropriately licensed/certified therapist (e.g., OT, PT, SLP, audiologist, physician) is required.
2. The medical necessity documentation must be provided along with the ISP or amended/updated ISP requesting approval of SMESAT.
3. Once recommended equipment, supplies or technology is delivered, the therapist who performed the assessment (or the current treating therapist) shall assure that the item(s) meet the needs of the person supported and that the person and his or her support staff have needed staff instructions and are trained on the use of the equipment.

CHAPTER 14

NURSING, VISION, AND DENTAL SERVICES

14.1 Introduction.

This chapter describes the remaining professional and clinical people available within the DIDD system but not covered in previous chapters.

14.2 Nursing Services.

14.2.a. Waiver Definition for Nursing Services. The waiver definition shall apply to all nursing services provided in a Medicaid waiver. The waiver definition shall also be used to define nursing services provided in other DIDD-funded programs.

14.2.b. Nursing Assessments. Requirements applicable to clinical service assessments are described in **Section 13.2.** Nursing assessment is not a separate billable service.

14.2.c. Planning Nursing Services. Nurses are required to develop a nursing Plan of Care which must be consistent with action steps and outcomes specified in the ISP. The nursing Plan of Care must be guided by the specific nursing activities ordered by the physician, including the amount, frequency and anticipated duration of services required. The nursing Plan of Care must be consistent with and reflective of the action steps and outcomes specified in the ISP.

14.2.d. Obtaining Approval for Nursing Services. The ISC/CM will submit the ISP requesting nursing services to the appropriate DIDD Regional Office. To obtain approval for nursing services, the following requirements must be met:

1. The ISP must be submitted with a physician's order.

2. The ISP must provide documentation of a chronic medical condition requiring the provision of nursing services.

3. The ISP must provide documentation to justify that the nursing service is medically necessary to ensure the health and safety of the person supported or to avoid a more costly and restrictive service.

4. The ISP must include a statement that nursing services are not available or were denied through Medicare, the TennCare managed care organization (MCO) program or private health insurance.

14.2.e. Self-Assessment and Internal QI. Nursing services providers are required to complete self-assessment and internal QI activities that provide an ongoing review of the effectiveness of services provided, identify systemic issues, and initiate corrective actions in a timely manner and before such issues are identified by other monitoring entities. Providers need to document processes used and steps taken/changes made to address issues identified. This information should be made available to others working for the agency. Self-assessment and internal QI activities must be completed annually. Providers shall develop and implement a QI plan to address issues identified through self-assessment activities. The following components must be included in provider's self-assessment/internal QI activities:

1. Records management processes.

2. Trends in any incident reports completed or investigations involving clinical staff.

3. Review of external monitoring reports and identification of any trends.

4. Review of any personnel practices and any personnel issues.

5. Review of policies and procedures and any updates/revisions needed.

6. Review of a sample of services provided, including persons supported discharged from services, to identify documentation issues and service effectiveness.

7. Review of satisfaction survey processes and results.

8. Steps taken or changes made in response to internal and external review findings, including any sanctions and/or recoupments imposed.

9. Ways the information gained through self-assessment is communicated to other agency staff or those outside of the agency as appropriate.

Self-assessment and internal QI activities must be completed between DIDD QA surveys and DOH license surveys (as applicable). Providers shall develop and implement a QI plan to address issues identified through self-assessment activities.

14.2.f. Provision of Nursing Services. The types of services performed by nurses are governed by the Tennessee Nurse Practice Act. The Nurse Practice Act allows nurses to perform a number of direct and non-direct functions, although not all of the functions allowed are separate billable services within the DIDD system. Services that are billable at the quarter-hourly unit rate are limited to direct face-to-face activities such as changing wound dressings, administering injectable medications and other medications that cannot be administered by direct support staff in accordance with state law or teaching direct support staff to perform a nursing-related function that the nurse intends to delegate to direct support staff.

14.2.g. Documentation of Nursing Services. General requirements pertaining to provider documentation and records maintenance are provided in **Chapter 10. Section 10.8.a.** describes records requirements applicable to nursing providers. Additionally, a billing calendar must be submitted each month showing the actual amount of time spent providing nursing services on the date(s) services are billed. The amount of nursing units billed must be consistent with the "in/out" times noted in contact notes. Nursing activities completed during visits and any contacts or follow-up activities completed between nursing visits must be documented in contact notes.

14.2.h. Reimbursement Considerations. Nursing oversight by an RN is reimbursed only as a part of the service rate for Medical Residential Services and Other Residential Services at a reimbursement level of four (4) or higher. The nursing services described in this section of the manual are direct face-to-face skilled services. Such nursing services are reimbursed based on the number of units billed. A unit is defined as one (1) hour. Consequently, nursing rates are paid as quarter-hourly rates. Reimbursement will not be provided for:

1. Services provided without a physician's order.
2. Services provided prior to authorization and approval.

3. Services provided that do not require the expertise of a skilled nurse and could be safely performed by direct support staff.

4. Assessment activities not considered a component of the direct nursing service being provided (e.g., If changing a wound dressing, assessment of the wound is a part of the physician ordered nursing activity; however, doing a comprehensive head to toe assessment would not be related.).

5. Services provided to a person supported in a nursing facility or ICF/IID or within a program operated by a local school system.

6. Time spent waiting for a person supported to arrive at a particular location.

7. Time spent traveling between service sites to locate the person supported.

8. Units of service billed, but not supported by required documentation.

9. Visits made for purposes other than the provision of direct, hands-on nursing services (e.g., to perform staff supervisory activities).

10. Time spent performing administrative activities such as documentation, attending meetings, etc.

14.3. Vision Services.

14.3.a. Waiver Definition for Vision Services. Vision services are available only to persons enrolled in the "Arlington" Waiver.

14.3.b. Obtaining Approval for Vision Services. A unit of vision services must be defined in the person's ISP. Vision services are paid in accordance with the current TennCare vision services rate schedule. The ISP, ISP amendment or ISP update establishing the need for vision services must be submitted to the Regional Office by the ISC for the person supported. Any alternative funding resources, such as the TennCare Managed Care Organization or private insurance must have been exhausted before waiver vision services may be accessed. The TennCare program does not cover routine eye examinations and refraction, eyeglass frames or contact lens for adults over the age of twenty-one (21). The ISP must be authorized in writing by the Regional Office prior to implementation.

14.4. Dental Services.

14.4.a. Waiver Definition for Adult Dental and Dental Services. The definitions for dental services differ in different waiver programs. The "Statewide" waiver definition for Adult Dental Services shall apply to the Tennessee Self Determination Waiver Program and to DIDD state-funded dental services. The waiver definition for Dental Services shall only apply to persons enrolled in the "Arlington" Waiver.

14.4.b. Obtaining Approval of Adult Dental or Dental Services. A unit of dental services must be defined in the ISP. Dental units are paid in accordance with the current TennCare dental rate schedule. Services will be approved only if alternative funding sources, such as a TennCare MCO or private insurance have been exhausted. Dental services must be recommended by a licensed dentist. A Dental Treatment Plan with itemized costs is required. If sedation is required, there must be written justification by a qualified professional. Routine dental care (e.g., preventive examinations, cleanings, etc.) is not covered through Statewide Waiver Adult Dental Services. Preventive dental care is covered under Dental Services in the Arlington Waiver. Dental procedures requiring hospitalization or out-patient surgery are not covered. The ISP, ISP amendment or ISP update documenting the need for the dental service being requested must be submitted to the Regional Office for approval. Approval must be obtained in writing from the Regional Office prior to provision of the dental service.

CHAPTER 15

OTHER SERVICES

15.1 Introduction.

This chapter provides waiver definitions and additional requirements applicable to respite services, personal assistance services, PERS and individual transportation services.

15.2 Respite Services.

15.2.a. Waiver Definition of Respite Services. The waiver definition shall apply to all respite services provided in a Medicaid waiver. The waiver definition shall also be used to define respite services provided in other DIDD-funded programs.

15.2.b. Additional Requirements Applicable to Respite Services.

1. The provider agency must have a respite license in the region in which the service is provided.
2. If this service occurs in a licensed residential setting, the respite person cannot exceed that home's licensed capacity. If this service is provided under an agency's supported living license, the home where the person is supported cannot exceed three (3) individuals.
3. If this service is provided under an agency's Family Model Residential Supports license, the home cannot exceed service to two (2) individuals.
4. The service provider must continue implementing ISP outcomes and must continue to ensure transportation to other necessary services.
5. The service provider must ensure management of health care needs including medical appointments and medication management.
6. General documentation requirements applicable to residential providers described in **Chapter 10** are also applicable to respite providers.

7. No more than eighty percent (80%) of the maximum Supplemental Security Income (SSI) benefit for the current calendar year may be charged to a person supported for room and board expenses by a respite provider.

8. Respite provided eight (8) or less hours a day will be billed hourly and the service will be documented by the hour.

9. For respite provided over eight (8) hours a day the appropriate daily respite rate will be billed and service documented.

15.3. Personal Assistance Services.

15.3.a. Waiver Definition for Personal Assistance Services. The waiver definition shall apply to all personal assistance services provided in a Medicaid waiver. The waiver definition shall also be used to define personal assistance services provided in other DIDD-funded programs.

15.3.b. Licensure Requirements. Personal assistance providers must obtain licensure as a home care organization from the DOH or licensure as a personal support services agency from DIDD unless they provide support to only one person.

15.3.c. Environmental Safety Requirements. Prior to initiation of personal assistance services that will be rendered in a private home, DIDD or a DIDD contractor will conduct an inspection of the home to ensure that the health, safety and welfare of the person supported can be maintained while receiving services within the designated environment. The inspection will be conducted utilizing the *Personal Assistance Environmental Checklist*. The results of the inspection will be shared with the person supported and legal representative (if applicable).

Independent support coordinators, CMs and personal assistance providers will work with the family to assist in the resolution of issues identified and the identification of resources to assist in making repairs or purchasing necessary items required to ensure that the home meets safety standards. The *DIDD Housing Resource Directory* may be helpful in identifying resources. This resource manual can be accessed on the DIDD website.

15.3.d. Additional Requirements Applicable to Personal Assistance Services.

1. Personal Assistance is to be used as an alternative to residential services to assist the natural family, including the person supported, to continue to live together within the family home and community.
2. Home Care Organizations licensed by DOH may provide personal assistance services, but must ensure that staff meets DIDD training requirements for personal assistance staff.
3. Personal assistance providers may receive reimbursement for individual transportation when the person supported is transported by personal assistance staff for the purpose of meeting ISP outcomes.
4. An individual may receive both personal assistance services and day services, but not concurrently during the same time period.
5. Children receiving residential services are not eligible to receive personal assistance for days when school is not in session, but may receive a day service rate for such days.
6. The personal assistance provider must meet general records requirements as described in **Chapter 10** and must document quarter-hourly services provided.
7. The personal assistance provider must complete monthly reviews as indicated in **Chapter 4**.

15.4. Personal Emergency Response Systems Waiver Definition for PERS.

The waiver definition shall apply to all PERS provided in a Medicaid waiver. The waiver definition shall also be used to define PERS provided in other DIDD-funded programs.

15.5. Individual Transportation Services.

15.5.a. Waiver Definition for Individual Transportation Services. The waiver definition shall apply to all individual transportation services provided in a Medicaid waiver. The waiver definition shall also be used to define individual transportation services provided in other DIDD-funded programs.

15.5.b. Additional Requirements Applicable to Individual Transportation Services.

1. All vehicles used to transport individuals must have operable seat belts.
2. Staff must ensure that people are transported using seat belts in the proper manner.
3. Any mobility support needs applicable to transportation must be met in accordance with the ISP or staff instructions (e.g., if the person supported uses a wheelchair, staff must be trained to properly use vehicle lifts and secure the wheelchair in the vehicle).
4. Providers must implement a written policy to ensure documentation that vehicles used to transport people are safe and that use of such vehicles meets all transportation service requirements, whether the vehicle is owned by the provider or by provider staff.
5. Providers must maintain a copy of the vehicle liability insurance certificate for vehicles used to transport people, whether the vehicles are owned by the provider or by provider staff.
6. Each vehicle used to transport people must have first aid supplies as required in **Chapter 8.**
7. Providers may not charge people supported or their families for the cost of routine maintenance or the cost of cleaning the interior or exterior of vehicles owned by the provider or the provider's staff.
8. Providers may not charge people or their families for the cost of providing a cellular phone intended for the use of staff involved in transporting people, unless specifically requested by the person supported or legal representative.

APPENDIX A

ACRONYMS

A

ABA	Applied Behavior Analysis
ADA	Americans With Disabilities Act
ADL	Activities of Daily Living
AED	Automated External Defibrillator
AOD	Administrator On Duty

B

BSP	Behavior Support Plan

C

CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CNA	Certified Nursing Assistant
CNT	Certified Nursing Technician
COS	Circle of Support
CPR	Cardiopulmonary Resuscitation
CQL	Council for Quality and Leadership

D

DCS	Department of Children's Services
DHS	Department of Human Services
DIDD	Department of Intellectual and Developmental Disabilities
DMHSAS	Department of Mental Health and Substance Abuse Services
DNR	Do Not Resuscitate

DOH	Department of Health
DRA	Differential Reinforcement of an Alternate Behavior
DRH	Differential Reinforcement of High Rate Behavior
DRI	Differential Reinforcement of Incompatible Behavior
DRL	Differential Reinforcement of Low Rate Behavior
DRO	Differential Reinforcement of Other Behavior
DSP	Direct Support Professional

E

EAM	Environmental Accessibility Modifications
ELM	Electronic Learning Management
EMT	Emergency Medical Technician

F

FAR	Fiscal Accountability Review
FBI	Federal Bureau of Investigation
FOIL	Felony Offender Information Lookup

G

GED	General Educational Development

H

HCBS	Home & Community Based Services (Medicaid Waiver)
HIPAA	Health Insurance Portability & Accountability Act
HITECH	Health Information Technology for Economic and Clinical Health Act
HHS	Department of Health & Human Services
HRC	Human Rights Committee

I

I&I	Incident and Investigations

ICAP	Inventory for Client & Agency Planning Assessment
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
IMC	Incident Management Coordinator
IQ	Intelligence Quotient
IRC	Incident Review Committee
ISC	Independent Support Coordinator
ISP	Individual Support Plan
ITP	Individual Transition Plan

J

K

L

LEP	Limited English Proficiency
LPN	Licensed Practical Nurse

M

MAR	Medication Administration Record
MCO	Managed Care Organization
MTA	Mandatory Technical Assistance

N

O

OIG	Office of the Inspector General
O&M	Orientation and Mobility
OSHA	Occupational Safety and Health Administration
OT	Occupational Therapy

P

PA	Personal Assistant

PAE	Pre-Admission Evaluation
PCP	Primary Care Provider
PERS	Personal Emergency Response Systems
PHI	Protected Health Information
POA	Power of Attorney
POC	Plan of Correction
PT	Physical Therapy
PRN	As needed or necessary
PSSL	Professional Services Support License
PTP	People Talking to People

Q

QA	Quality Assurance
QIDDP	Qualified Intellectual & Development Disabilities Professional
QI	Quality Improvement
QMS	Quality Management System

R

RIF	Reportable Incident Form
RN	Registered Nurse
RPST	Regional Provider Support Team
RQMC	Regional Quality Management Committee

S

SCQI	Statewide Continuous Quality Improvement
SIS	Supports Intensity Scale
SLP	Speech Language Pathology
SMESAT	Specialized Medical Equipment Supplies and Assistive Technology

SQMC	State Quality Management Committee
SSI	Supplemental Security Income
SSI/FBR	Supplemental Security Income Federal Benefit Rate

T

TAR	Tennessee Administrative Register
TBI	Tennessee Bureau of Investigation
TCA	Tennessee Code Annotated

U

USCA	United States Code Annotated

V

W

X

Y

Z

GLOSSARY

Administrator on Duty (AOD) shall mean a person designated by the Regional Director to be available to respond to emergency requests for services outside usual business hours (i.e., 8:00 a.m. to 4:30 p.m. Monday through Friday) and on holidays.

Adult Protective Services shall mean the unit within the Department of Human Services which has the statutory authority to receive and investigate reports of abuse, neglect, and exploitation of adults age eighteen (18) and over who are unable to protect themselves from abuse, neglect or exploitation.

Agency General Crisis Plan shall mean a generic plan for behavioral crisis intervention based on an agency's adopted form of crisis management training.

Approved Provider or Approved Waiver Services Provider shall mean a provider who has been approved by DIDD to provide one or more HCBS waiver services and may include state-funded services.

Assessment shall mean a systemic collection of data.

Behavior Support Plan (BSP) shall mean the document written by a Behavior Analyst which clearly defines the actions and steps that direct support professionals and other care givers will take to change the behavior of a person supported.

Center for Medicare and Medicaid Services (CMS) shall mean the United States federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program.

Chief Officer shall mean the chief executive officer of a Developmental Center operated by the Department of Intellectual and Developmental Disabilities.

Circle of Support (COS) shall mean a group of people who meet together on a regular basis to help a person supported plan for and accomplish his/her personal outcomes and actions. The person supported is the focus or the center of the COS. At a minimum, this includes the person supported, his/her family member(s) and/or conservator(s), case manager, and the providers of any supports and services that the person receives. Friends, advocates, and other non-paid supports are included at the invitation of the person.

Class Member shall mean an individual meeting the requirements in the definition of the class specified in People First of Tennessee, et. al. v. Clover Bottom Developmental Center; or United States of America v. State of Tennessee, et. al. (Arlington Developmental Center).

Cross-Systems Crisis Plan shall mean a planned prevention and intervention strategies for direct support professionals to implement during a behavioral health crisis including procedures for obtaining needed services from external crisis response entities.

Date of Hire or Appointment Date shall mean the date an individual officially became an employee or was appointed to a particular set of job responsibilities.

Developmental Center shall mean an Intermediate Care Facility for individuals with intellectual disabilities operated by the Department of Intellectual and Developmental Disabilities (ICF/IID).

Dietitian/Nutritionist shall mean a health professional licensed in the state of Tennessee who provides nutrition services within the scope of his/her license.

Direct Support Professionals (DSPs) shall mean staff who provide direct supports and assistance to the persons using services.

Electronic Learning Management (ELM) System shall mean software application for administration, documentation, tracking and reporting of training programs.

Electronic Signature shall mean an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record. (Examples of an electronic signature include a name at the end of an email or clicking a button or downloading content to indicate acceptance of a transaction or certain terms and conditions).

Emergency Disaster Plan- shall mean a plan to direct staff and persons supported as to what the procedures are for various emergencies (e.g., fire, flood, tornado, poison control, etc.).

External Provider shall mean Departments, agencies, or professional service providers whose services are not funded by DIDD (e.g., MCO-funded behavior analysts, DMHSAS, mental health centers, psychiatric hospitals, private physicians or psychiatrists, etc.).

Fiscal Accountability Review (FAR) shall mean the Fiscal Accountability Review Unit in the Office of Internal Audit in the Department of Intellectual and Developmental Disabilities.

Health Information Portability and Accountability Act (HIPAA) shall mean a Federal law enacted by the United States Congress in 1996 to address the security and privacy of health data.

Home and Community Based Services (HCBS) waiver shall mean a waiver approved for Tennessee by the Centers for Medicare and Medicaid Services to provide services to a specified number of Medicaid eligible individuals who have an intellectual disability and who meet criteria for Medicaid criteria of reimbursement in an Intermediate Care Facility for Individuals with Intellectual Disabilities. The HCBS waivers for Individuals with Intellectual Disabilities in Tennessee are operated by the Department of Intellectual and Developmental Disabilities with oversight from TennCare, the state Medicaid agency.

Home Manager shall mean the residential supervisor responsible for ensuring the efficient operation of the home, including the assignment of DSPs, to maintain adequate coverage to meet the needs of the persons residing in the home.

Human Rights Committee shall mean a group of appointed persons responsible for ensuring that appropriate mechanisms and safeguards are in place to promote and protect individual rights and that any limitation of rights will not occur without due process.

Immediate Jeopardy shall mean issues that have caused or have the potential to cause imminent harm to the person supported. These issues require expedient corrective action by the provider.

Incident Review Committee (IRC) shall mean a group of persons with a defined membership and meeting schedule assigned to monitor the quality of reportable incident reports, and to review and provide recommendations and identify trends regarding reportable incidents.

Independent Support Coordinator (ISC) or Case Manager (CM) shall mean a person who provides support coordination services to a person supported; who is responsible for developing, monitoring, and assuring the implementation of the Plan of Care; who assists the person supported in identifying, selecting, obtaining, coordinating, and using both paid services and natural supports to enhance the person's independence, integration in the community, and productivity as specified in the ISP.

Individual Support Plan (ISP) shall mean a person-centered document that provides an individualized, comprehensive description of the person supported as well as guidance for achieving unique outcomes that are important to the person in achieving a good quality of life in the setting in which they reside.

Informed Consent shall mean a voluntary agreement made by a well-advised and mentally competent person or legal representative (in the case of a person adjudicated as incompetent) to receive treatment after the person's health care provider has provided full disclosure of information regarding the material risks, benefits of the proposed treatment, alternatives, and consequences of no treatment, so that the person can make an intelligent, or informed choice.

Investigation shall mean a formal procedure for the review and examination of allegations of abuse, neglect, or exploitation of an individual receiving services and supports through DIDD.

Legal Representative shall mean a person who has been appointed by a court of competent jurisdiction under applicable law to represent a disabled person in making decisions regarding legal, financial, health care and other personal matters, as specified in the court order.

Mandated Technical Assistance (MTA) shall mean a requirement that a provider receive training and assistance from DIDD or secure training and assistance from a source identified by the provider and approved by DIDD.

Outcomes shall mean personal outcomes that are centered on the person supported, not on programs or program categories. The focus is on the items and issues that matter most to the person. Organizations that are working on personal outcomes recognize the connections between services/supports and interventions and the person.

Patient Liability shall mean the person's financial obligation toward the Medicare, Medicaid, private insurance costs of care not covered.

Personal Funds shall mean financial resources, including earned and unearned income, which is used to pay personal expenses of the person served. This includes any monthly income received from employment, donations, gifts, training stipends, and benefits that can be used solely for the person's needs and leisure activities (e.g., meals, movies, concerts, etc.) or to purchase personal items (e.g., clothing, personal grooming, hobbies, etc.) or to pay insurance premiums.

Personal Outcomes and Actions shall mean statements within the ISP concerning what the person is working to accomplish within the ISP year. Personal Outcomes and Actions are developed by the person and his/her COS, starting with what is important to the person and balancing that with what is important for the person's health, safety, and well-being, when necessary. They must be observable and measurable actions are specific steps needed to attain an Outcome.

Pre-Admission Evaluation (PAE) shall mean the Medicaid data collection form used to document that the person supported meets the initial level of care criteria for reimbursement of services through an HCBS waiver, an ICF/IID, or a nursing facility.

Primary Care Provider (PCP) shall mean the terminology used inter-changeably in reference to a person's Physician or Advanced Practice Nurse or Physician's Assistant.

Primary Provider shall mean a person's primary provider is typically their residential provider; however depending on the supports and services a person receives, the primary provider could be the day services provider, personal assistant provider or support coordination/case management provider.

Provider Agreement shall mean a signed agreement between DIDD, TennCare and an approved provider that specifies the terms and conditions a provider must meet to receive reimbursement for services provided.

Psychotropic Medication shall mean a potent drug that affects psychic function, behavior, or experience and can result in serious and irreversible side effects. Psychotropic drugs include anti-depressants, anti-anxiety drugs, sedative-hypnotics and anti-psychotics.

Qualified Intellectual and Developmental Disabilities Professional (QIDDP)/Case Manager shall mean the staff member who coordinates, facilitates, and documents all COS meetings and the entire ISP process.

Remediation shall mean a process where a provider resolves issues or findings related to performance measures within 30 days of notification.

Representative Payee (Rep Payee) shall mean an individual or organization that receives Social Security and/or Supplemental Security Income payments for a person who requires assistance to manage personal funds.

Safety Delay shall mean restricting the person's freedom of movement and community access for period of less than two (2) hours to ensure that the person is calm and that the risk of engaging in unsafe behavior has decreased to an acceptable level.

TennCare shall mean the single State Medicaid Agency responsible for the administration of the State's Medicaid Program.

Validation shall mean the process where Regional Provider Support Team (RPST) confirms resolution of an agency's remediation of issues or findings relative to performance indicators within 60 days of the finding.

Department of Intellectual and Developmental Disabilities
Office of Policy & Innovation
Division of Policy

Summary of Revisions to the DIDD Provider Manual
August 29, 2013

Summary: The Department of Intellectual and Developmental Disabilities (DIDD) conducted an extensive review and revision of the DIDD Provider Manual, which has been condensed from 544 to 225 pages. The Department's approach to this process was to eliminate redundant information, clarify existing provider requirements, describe requirements associated with new waiver services, and describe new processes developed by the Department in order to support providers (e.g. New Provider Support Process). The primary purpose of this document is to present a high level overview of new requirements for providers. The document is organized by chapter, with annotations to the applicable section of the provider manual. This summary attempts to highlight as many of the changes as possible but cannot be all inclusive based on the size and complexity of the document and review.

Revisions throughout the Provider Manual

- Updated the Department name to reflect change from Division to Department
- Removed outdated terminology such as service recipient and mental retardation and replaced with current terminology such as person supported and intellectual disability
- Waiver service definitions are now separate from the Provider Manual and available on the Department's web site. It must be emphasized that providers are still required to comply with the requirements contained within the waiver services definitions.

Introduction

- Updated the Department's statements of Mission, Vision, and Values

Chapter 1: Eligibility, Enrollment, and Disenrollment

- No new requirements for providers

Chapter 2: Rights Applicable to All People with Intellectual Disabilities

- 2.7.b – Providers required to comply with Health Information Technology for Economic and Clinical Health Act (HITECH)
- 2.10.c – Provider Responsibilities Related to Court-Appointed Legal Representatives

Chapter 3: Individual Support Planning and Implementation

- Table 3.6.1 – Independent Support Coordinators (ISCs) and Case Managers (CMs) required to collect information on Third Party Payer Services and Community Supports
- 3.10.b – Residential, Day, and Personal Assistance Providers required to complete periodic reviews

Chapter 4: Support Coordination and Case Management

- 4.6.h - Independent Support Coordinators (ISCs) and Case Managers (CMs) are responsible for coordinating services with the person's Managed Care Organization
- 4.6.i - Independent Support Coordinators (ISCs) and Case Managers (CMs) are responsible for coordinating services prior to the person's 21st birthday

Chapter 5: General Provider Requirements

- 5.2.b – Providers required to confirm potential employees are not listed on the Office of Inspector General's List of Excluded Individuals/Entities
- 5.4 – Providers required to have an ongoing self-assessment process
- 5.6.4.b – Requirements for unannounced supervisory visits for Family Model Residential
- 5.5 – Providers required to have an Internal Quality Improvement (QI) Plan
- 5.12 – Providers required to notify DIDD of changes in provider information

Chapter 6: Staff Development

- 6.5.c – Requirements applicable to provider staff delivering employment supports. Phase III Training for Job Coaches

Chapter 7: Protection from Harm

- 7.1.c – Added categories of reportable incidents: Manual Restraint, Mechanical Restraint, Protective Equipment

Chapter 8: Health Care Management

- 8.3.a – Providers required to obtain consents and releases of information
- 8.4 – Providers required to integrate behavioral and therapeutic health supports
- 8.8 – Primary Provider has requirements related to hospitalizations
- 8.9 – ISCs required to address end of life issues with persons supported

Chapter 9: Quality Management

- 9.4 – New provider support process. This requirement impacts new providers, not existing providers

- 9.13 – Regional Provider Support Teams. This requirement impacts providers who are not performing according to Quality Management standards

Chapter 10: Creation and Maintenance of Provider Records

- 10.3 – Providers required to give person's supported and their legal representative, access to the person's records
- 10.8.b.6 – Behavior Service provider's requirements applicable to behavior service records. Contact Notes are validated by a co-signature line for staff at the service location that includes time in and out, or by the behaviorist's signature in the service location's visitor log that includes time in and out

Chapter 11: Residential and Day Services

- 11.1.e – Requirements applicable to Semi-Independent Living Services
- 11.1.f – Requirements applicable to Intensive Behavior Residential Services
- 11.1.g.1 – Requirements described in the following documents: Level Descriptions for Day Services, Level Descriptions for Family Model Residential Services, Level Descriptions for Residential Habilitation and Supported Living, Level Descriptions for Respite Services, Staffing Standards for Residential and Day Services

Chapter 12: Behavior Services

- 12.2 and 12.3 – Provider work product must meet standards described in Behavior Services Work Product Review
- 12.5 – Requirements applicable to Cross Systems Crisis Plans
- 12.5.a.4 – Requirements applicable to Behavior Safety Procedures
- 12.5.e – Requirements applicable to manual restraint, mechanical restraint, and protective equipment
- 12.8 – Requirements applicable to Self-Assessment and Internal QI
- 12.9 – Required provider policies

Chapter 13: Therapeutic and Therapy-Related Services

- 13.3 - Providers are responsible for assuring staff coverage for authorized services and must have a back-up plan for extended clinician illnesses, leave, or vacations
- 13.7 – Provider requirements for Self-Assessment and Internal QI

Chapter 14: Nursing, Vision and Dental Services

- No new requirements

Chapter 15: Other Waiver Services

- No new requirements