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Thank you for your participation in the Tennessee service delivery system for individuals with intellectual and developmental disabilities. The development of an adequate provider network with focus on quality and cost effective services for people with disabilities is a priority for the Department of Intellectual and Developmental Disabilities.

The impetus for the latest revisions to the Provider Manual were the implementation of the Centers for Medicare and Medicaid Services (CMS) Home and Community Based Services (HCBS) Settings Final Rule, including the person-centered planning provisions; the Department's accreditation in Person-Centered Excellence by the Council on Quality and Leadership (CQL); renewal of the State's HCBS Waivers; and initiation of negotiations with parties to develop the Clover Bottom Exit Plan.

In light of these significant events the provider manual was revised with input from stakeholders, providers, DIDD staff, and the Bureau of TennCare. DIDD appreciates the feedback we received to make changes and improvements to the manual.

It is important to note that this manual does not encompass all provider requirements. This manual, as well as policies and provider agreements, are all necessary elements of operating a quality provider network. Providers are advised to familiarize themselves with all Departmental documents describing policies and guidelines, of which the Provider Manual is one such document.

DIDD, providers, and stakeholders are partners in a common goal to provide quality, person-centered and cost effective services to individuals with intellectual and developmental disabilities to live fulfilling and rewarding lives.

Sincerely,

Debra K. Payne, Commissioner, DIDD
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.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 details regarding DIDD policies and procedures are available on the DIDD web site under Provider Info.¹ Any TennCare policies that have been distributed by DIDD pertaining to Medicaid Waiver programs continue to be applicable to waiver service providers.

**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 web site in WORD and PDF formats.

**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 a public meeting and fiscal impact statement 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

¹ [http://www.tn.gov/didd/article/policies-procedures](http://www.tn.gov/didd/article/policies-procedures)
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.

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.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 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 web site.\(^2\)

**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 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. **Statewide Home and Community Based Services Waiver** (TN.0128), as amended.\(^3\)

2. **Comprehensive Aggregate Cap (CAC) Waiver** (TN.0357), as amended.\(^4\)

3. **Self-Determination Waiver** (TN.0427), as amended.\(^5\)

**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.

\(^2\) [http://www.tn.gov/assets/entities/didd/attachments/Family_Support_Program_-Guidelines.pdf](http://www.tn.gov/assets/entities/didd/attachments/Family_Support_Program_-Guidelines.pdf)
\(^3\) [http://www.tn.gov/assets/entities/didd/attachments/Statewide_Waiver.pdf](http://www.tn.gov/assets/entities/didd/attachments/Statewide_Waiver.pdf)
\(^4\) [http://www.tn.gov/assets/entities/didd/attachments/Comprehensive_Aggregate_Cap_Waiver.pdf](http://www.tn.gov/assets/entities/didd/attachments/Comprehensive_Aggregate_Cap_Waiver.pdf)
\(^5\) [http://www.tn.gov/assets/entities/didd/attachments/Self-Determination_Waiver.pdf](http://www.tn.gov/assets/entities/didd/attachments/Self-Determination_Waiver.pdf)
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.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 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 web site.⁶

**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 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

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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\(^7\) (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.\(^8\) 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\(^9\) (TennCare) is the medical assistance unit within the Division of Healthcare

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7 Additional information about CMS can be obtained by visiting the CMS web site at: [http://www.cms.gov/](http://www.cms.gov/).


9 Additional information about TennCare can be obtained by visiting the TennCare web site at: [http://www.tn.gov/tenncare](http://www.tn.gov/tenncare).
Finance and Administration of the Department of Finance and Administration, the designated Single State Medicaid Agency. TennCare contracted with CMS to administer and oversee Medicaid HCBS waiver programs. The Division of Long-Term Services and Supports within the TennCare Bureau is directly responsible for administration and oversight of Medicaid HCBS waivers which includes the Statewide, CAC, and Self-Determination waivers for persons with intellectual disabilities. The TennCare Bureau 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 adjudicated and clean file formatted 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 Interagency Executive and Senior Leadership Meeting.** Executive and Senior leadership of TennCare and DIDD meet on at least a monthly basis to discuss issues pertaining to operation and oversight of this (and other) HCBS waiver program(s) for individuals with intellectual disabilities.

- **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's Long-Term Services and Supports (LTSS) 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 purpose of this committee is to ensure TennCare’s involvement in the ongoing monitoring of overall waiver performance. This committee meets monthly and is focused on statewide systemic trends and issues. Isolated issues are presented as they relate to the minimum compliance threshold because TennCare and DIDD require a 100% remediation standard. The committee reviews, at a minimum:
  - Systemic remediations,
o Quality assurance summary (performance percentages of all providers by type),

o Status of providers receiving Mandatory Technical Assistance, and

o Focused performance measure review.

The goals of the SCQI committee are:

o Identifying systemic issues through the study of data,

o Intervene with appropriate, effective quality improvement strategies,

o Monitor implementation of quality improvement strategies to ensure prevention of recurrence of performance issues, and

o Brainstorm innovative ideas for continuously improving programs and services.

• The Abuse Registry Review 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. The SQMC contributes to the state level Quality Improvement Plan (QIP) that is submitted to CMS.


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.

TennCare Approval: pending
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. Implementation of a Quality Monitoring program and 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 mission is to become the nation’s most person-centered and cost effective state support system for people with intellectual and developmental disabilities.

**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.

**IN. 9. CQL Accreditation: Person Centered Excellence.** In January 2015, DIDD received official Person-Centered Excellence network accreditation from the Council on Quality and Leadership (CQL). The Person-Centered Excellence accreditation process is designed to assess the quality of services and supports delivered by the department and its contracted providers. As a result of the accreditation process, DIDD better understands how people using their services define quality of life. The department is using that information to guide changes to improve quality of life system-wide.

DIDD and CQL worked toward this milestone for more than two years through interviews with people using services, focus groups of families, staff, and managers, provider assessments, and a self-assessment of DIDD policies and
practices. DIDD has submitted a four-year plan to CQL to bring these factors into alignment, which includes increasing self-advocacy, assisting persons supported in learning about their rights, and refining the department’s Quality Assurance system to monitor compliance with CQL’s Basic Assurances®.

Not only was DIDD the first state department in the country to receive network accreditation, it also was the first state service delivery network to pursue accreditation with CQL.¹⁰

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 web site. 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. **Tennessee Family Support Program.** The eligibility criteria for this program are as follows:

1. The applying family must have a family member who has a severe disability.

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. The primary focus of the
Family Support Program\textsuperscript{11} is supporting: 1) families with children with a severe or developmental disability, school age and younger; 2) adults with a severe or developmental disability who choose to live with their families; and 3) adults with a severe or developmental disability who are residing in the community in an unsupported setting (not a state or federally funded program). For more information on eligibility criteria for enrollment see the Family Support Program guidelines which are available online on the DIDD website.\textsuperscript{12}

\textbf{1.4.b. Comprehensive Aggregate Cap Arlington Waiver (0357).} The Comprehensive Aggregate Cap (CAC) Waiver serves individuals who: 1) received services in a public Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID); 2) are part of a certified class because they were determined to be at risk of placement in a public ICF/IID; or 3) have significant services/support needs consistent with that of the population served in a public ICF/IID and who qualify for and, absent the provision of services provided under the CAC waiver, would require placement in an ICF/IID. The eligibility criteria for this HCBS waiver is as follows: Entry into this waiver is closed to enrollment other than those meeting all of the following criteria:

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;

\textsuperscript{11}Tennessee Code Annotated 33-5-203
\textsuperscript{12}http://www.tn.gov/assets/entities/didd/attachments/Family_Support_Program_-_Guidelines.pdf
2. Have been assessed and found to have mental retardation (i.e., have an intellectual disability manifested before eighteen (18) years of age, as specified in Tennessee State law (T.C. A. § 33-1-101). and

3. Have been identified by the state as a former member of the certified class in the United States vs. State of Tennessee, et al. (Arlington Developmental Center), a current member of the certified class in the United States vs. the State of Tennessee, et al. (Clover Bottom Developmental Center), a person discharged from a State Developmental Center (Clover Bottom or Greene Valley) or the Harold Jordan Center following a stay of at least 90 days, or an individual transitioned from the Statewide Waiver (#0128) upon its renewal on January 1, 2015, because he or she was identified by the state as receiving services in excess of the individual expenditure cap established for the Statewide Waiver.

1. 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 Self-Determination Waiver Program serves children and adults with intellectual disabilities and children under age six with developmental delay, who qualify for and, absent the provision of services provided under the Self-Determination waiver, would require placement in a private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The Self-Determination Waiver Program serves persons who have an established non-institutional place of residence where they live with their family, a non-related caregiver or in their own home and whose needs can be met effectively by the combination of waiver services through this program and natural and other supports available to them. The Self-Determination Waiver...
includes one residential service named Semi-Independent Living Services.

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., an 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., an 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 Statewide Home and Community Based Services Waiver serves adults with intellectual disabilities and children under age six with developmental delay who qualify for and, absent the provision of services provided under the Statewide Waiver, would require placement in a private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The eligibility criteria for this HCBS waiver are 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., an 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 an 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 these services 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) to accept applications and determines financial eligibility for Medicaid/TennCare services. DIDD has made arrangements with DHS for

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\[\text{Effective January 1, 2014, TennCare will make financial eligibility determinations.}\]
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 Social Security Disability Insurance (SSDI) disability determination is needed. When SSDI 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 TennCare 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 and allows for that the use of the persons supported 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 2300% of the SSI/FBR will be set aside for personal expenses for the Arlington Comprehensive Aggregate Cap, Statewide and Self-Determination waivers.

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. In general, people may not have more than $2000 in resources and maintain Medicaid eligibility. However, due to recent passage
of the Able Act a person who has more than $2000 in resources\textsuperscript{14},—may be financially eligible for Medicaid \textit{as long as they abide by the requirements of the Able Act}. The following may be excluded from consideration as resources:

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).

Things that are generally counted as resources include:

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

\textbf{1.5.d. Denial of Financial Eligibility}. When an applicant is denied eligibility for Medicaid, \textit{TennCare} 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

\textsuperscript{14}Pending passage of the ABLE Act in Tennessee Medicaid eligible individuals may be permitted to possess in excess of $2000.00 in resources. \textit{Tennessee Code Annotated (TCA) 71-4-801 – 71-4-812}.  

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followed. Discussion of involuntary disenrollment is provided later in this chapter.

1.5.e. Annual Redetermination and Reapplication and Ongoing Financial Eligibility. In order to continue to receive HCBS waiver services, the person's financial eligibility for Medicaid must be maintained. Unless the person is actively receiving SSI Benefits, eligibility information must be provided to TennCare for determination of continuing financial eligibility to be made. When the redetermination/reapplication is due, TennCare will contact the designated person or representative payee. Upon receipt, the person or representative payee must complete the required forms and process established by TennCare in which the person's current income and resources will be verified. If the forms are not completed in a timely manner, TennCare will determine the person to be ineligible for continuation of Medicaid which will cause the person to become ineligible for the HCBS waiver. 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 process for annual redetermination/reaplication within the specified time frames to avoid discontinuation of Medicaid-funded services, including HCBS waiver services.
1.6. Medical Eligibility for Medicaid Services.

1.6.a. Responsibility for Determination of Medical Eligibility. Prior to enrollment in an HCBS waiver, the person must meet both financial eligibility and medical eligibility criteria. 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.

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

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15 TennCare rules can be accessed online by visiting: http://share.tn.gov/sos/rules/1200/1200-13/1200-13.htm
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.

**1.8 Appeals.**

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

1.8.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.

A person who is enrolled in the HCBS waiver has the right to file an appeal in cases of denial of eligibility or denial of waiver-funded services. This includes fair hearing and due process rights. Provider responsibilities related to eligibility, service appeals and maintaining Grier compliance are described below.

**1.8.a. Provider Responsibilities Related to Eligibility Appeals.** Eligibility appeals are related to initial or continuation of eligibility to receive waiver services.
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.

1.8.b. Provider Responsibilities Related to 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.\textsuperscript{16}

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.

\textsuperscript{16} http://www.tn.gov/tenncare/topic/court-orders
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. Either if needed, the ISC/CM or the provider may support the person in filing an appeal.

1.8.c. 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.

1.9. Disenrollment from Medicaid Waiver Programs.

1.9.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.

1.9.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; provided however, that when the person is the dependent of a military service member who is a legal resident of the State, but has left the State temporarily due to the military service member's military assignment out of state, such dependent may re-enroll in the Waiver upon return to the State, so long as all conditions of eligibility are met.

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 one hundred twenty (120) days, if such period began prior to March 1, 2010, or a period exceeding ninety (90) days if such period begins on or after March 1, 2010.

10. Regarding and For individuals enrolled in the Self-Determination Waiver Program: 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. The condition or circumstances of a person enrolled in the waiver changes, which would require the provision of services in an amount that exceeds the cost limit in order to assure the person's health and welfare, and the person is not willing or able to enroll in a different waiver where his/her needs could be safely met.

11. For individuals enrolled in the Statewide Waiver: The condition or circumstances of a person enrolled in the waiver changes, which
would require the provision of services in an amount that exceeds the individual expenditure cap in order to assure the person's health and welfare.

DIDD is required to notify TennCare in writing prior to involuntary disenrollment of a person supported and shall give advance notice to the person of the intended involuntary disenrollment and of the person's right to appeal and have a fair hearing. If a person supported had been involuntarily disenrolled from the waiver, DIDD shall provide reasonable assistance to the person and offer assistance with making arrangements for locating 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 PROTECTION AND PROMOTION

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. 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.

2.2 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

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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.

8. Denying a person supported (or person who has been previously deprived of the opportunity) eligibility to participate as a member of a planning or advisory body which is an integral part of the program.

2.2.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. This documentation must be filed in the record for the person supported and available for inspection.

2. All providers must designate a Title VI Local Coordinator.

3. All providers must ensure that persons supported are informed of 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 supported. 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 housing decisions 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 maintain Title VI compliance.

2.2. 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.

2.3. The Rights of Individuals Receiving DIDD Services.

DIDD is committed to taking an active part in ensuring 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 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.

2.3.a. Individual Rights. Services and supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices. Individuals receiving DIDD services shall be entitled to the following rights including 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. If there are limits on the person's decision making, the alternate decision maker should explain the person's rights and responsibilities and involve the person in the decision making process to the maximum extent possible.

3. To due process.

4. To be involved in any Human Rights Committee formal reviews of restrictions of their rights, psychotropic medication reviews and restricted behavior support plans.

5. To receive information and provide informed consent regarding proposed services and other treatments, rights restrictions, psychotropic medication, and restricted behavior support plans.

6. To receive services regardless of gender, race, creed, marital status, national origin, disability, sexual orientation, ethnicity or age.

7. To be free from abuse, neglect and exploitation.

8. To receive appropriate, quality services and supports in accordance with their ISP and to drive their own person centered planning process.
9. To receive services and supports in the most integrated and least restrictive community setting that is appropriate based on the particular needs of the person supported.

10. To have access to and support in understanding DIDD rules, policies and procedures pertaining to services and supports.

11. To have access to and support in understanding personal records and to have services, supports and personal records explained so that they are easily understood.

12. To have personal records maintained confidentially.

13. To own and have control over personal property, including personal funds.

14. To have access to and support in understanding information and records pertaining to expenditures of funds for services provided.

15. To have choices and make decisions.

16. To have freedom of choice of providers and services and supports and the setting in which services and supports are delivered. The setting is selected from an array of options including those that are non-disability specific.

17. To have privacy and to be free from unauthorized intrusion and unwanted observation.

18. To receive mail that has not been opened by provider staff or others unless the person or legal representative has requested assistance in opening and understanding the contents of incoming mail.

19. To be able to associate, publicly or privately, with friends, family and others.

20. To have intimate relationships with other people of their own choosing.

21. To practice the religion or faith of one's choosing.
22. To be free from coercion and the inappropriate use of physical or chemical restraint.

23. To have access to transportation and community settings used by the general public.

24. To be fairly compensated for employment.

25. To seek resolution of rights violations or quality of care issues without retaliation.

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.¹⁰

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 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, including rights defined in the CMS HCBS Settings Final Rule, and provide services in a way that is driven by and 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 deliver 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 supporting the person's choices to the extent possible.

2.4.a. 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. People supported have the right within the bounds of the law to have intimate relationships with other people of their own choosing, unless such rights have been specifically restricted by a court order. This excludes relationships with persons supported own paid staff as this could potentially be viewed as sexual abuse. 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.

People supported define their own requirements for personal relationships and types of intimacy. They have the right to develop and express their sexuality. Each person supported is responsible for his or her relationships and sexuality. Just as persons supported are protected from abuse, neglect and exploitation, the person supported will not be supported in dominating or exploiting other people.

It is important that provider’s ensure that the choices people make are respected by all who deliver services and supports to them. People should be supported to explore feelings and desires, evaluate experiences and make choices about their intimate relationships. People should be supported in forming, pursuing and maintaining intimate relationships. For people supported who express interest in intimate relationships and sexuality, yet may lack experience with or knowledge about intimate relationships and sexuality, the provider should present options for education and support in expressing intimacy and sexuality.

2.4.b. Providers Implement Policies and Procedures that Promote People’s Rights. Organizations are expected to support and educate people
to understand their rights and support people to advocate for themselves and to exercise their rights and responsibilities. The provider is expected to be knowledgeable about which specific rights are most important to each person they support and for supporting each person in exercising those rights such as voting, managing money, moving freely, having privacy, using the telephone and other electronic communication devices, visiting and being visited by whomever they choose, accessing personal possessions, etc. Provider policy should contain the elements listed below at a minimum.

4. Define how the organization will protect and promote rights of people using services.

5. Contain a reference to rights afforded to all citizens as indicated by the United Nation's Universal Declaration of Human Rights²⁰ and by the constitution and laws of the United States of America.

6. Describe the organization’s procedures for individual rights assessments, assurances and documentation.

7. Describe, in a manner consistent with the HCBS Settings Final Rule, procedures for restricting a person’s rights.

8. Describe the organization’s procedures for requesting HRC formal review including prohibiting the use of a planned restrictive or intrusive medical or behavioral intervention without prior informed consent.

9. Prohibit standing policies and/or practices that restrict rights.

2.4.c. Rights Assessment. Support coordinators and case managers shall administer the Department’s approved rights assessment²¹ annually.

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during the planning process. The assessment will evaluate people's abilities to exercise their rights, especially those that are most important to them. The assessment will address people's civil and legal rights and personal freedoms. In addition to developing policies and practices to support people to exercise their rights, providers are expected to participate in the annual rights assessment process and support people to exercise those rights that are most important to them. Rights concerns identified in the annual rights assessment will be addressed in the ISP.

2.4.d. Staff Training. Providers must ensure that their staff has an understanding of individual rights of persons supported 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 is guided by provider policy. Staff should be trained to recognize and respect people's rights, to recognize and honor the person's preferences in regard to how people choose to exercise their rights, and trained in due process procedures for placing a limitation or restriction on a person's rights.

Providers must ensure they have a written procedure or policy that will ensure that all staff receive training to recognize and honor people's rights. The written procedure should describe how all staff will at least annually and on an ongoing basis receive training on the following topics:

1. Recognize and demonstrate respect for people's rights.

http://tn.gov/didd/topic/provider-manual
2. Recognize and honor preferences in regard to how people choose to exercise their rights.

3. The rights assessment process and to honor people's goals and support attainment of those goals in the best way possible.


5. Procedures for placing a limitation or restriction on a person's rights per the HCBS Settings Rule.

6. Demonstrate respect for and honor people's rights.

2.5—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 both the DIDD regional director and provider agency executive director or chief executive officer, as well as ensure that human and civil rights of persons receiving waiver services are not violated.

2.5.a. Local HRCs. Local HRCs may conduct HRC business for multiple providers or a single provider. Local HRCs must be authorized by the DIDD Regional Director. The provider executive director(s)/chief executive officer(s) is responsible for appointing 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 multiple providers jointly form a Local HRC, the executive directors/chief executive officers shall determine which agency is responsible for operational oversight and administrative support of the HRC. 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.

2.5.b. Regional HRCs. The primary role of Regional HRCs is to resolve human rights issues that cannot be resolved at the local level and provide technical assistance and training 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. DIDD regional office staff is responsible for oversight of Local HRCs and administrative support of the Regional HRC.

2.5.c. HRC Training Requirements.

1. All HRC chairpersons shall complete DIDD sponsored training, before attending a meeting that requires a vote. Completion of required training may be documented in the meeting minutes or other format developed by the HRC. Evidence that training has been completed must be readily available for inspection.

Chairpersons and members may participate in the same training.
2. All new local and regional HRC members shall complete DIDD sponsored training and orientation before attending a meeting that requires a vote. Completion of required training may be documented in the meeting minutes or other format developed by the HRC. Evidence that training has been completed must be readily available for inspection.

3. The provider executive director(s)/chief executive officer(s), or their designee, is responsible for providing local HRC training and shall be responsible for scheduling ongoing training. A sample training manual is available upon request from DIDD.

4. Training records shall be maintained in the Department’s ELM (electronic learning management system). The provider executive director(s)/chief executive officer(s), or their designee shall maintain a log of local and regional HRC training which must contain the following information: date, time and training location, participant first and last name, provider agency. The log must be available for inspection upon request.

5. Ongoing training shall be provided to all HRC members to assist them in carrying out their responsibilities. This training shall occur at least every three years or sooner if there is a change in the majority (membership required for a quorum) of committee members since the last training.
6. Training topics shall include at a minimum topics numbered a thru e. The topics numbered f thru j are optional and may be provided based on the needs of particular HRCs.

   a. Rights of people with disabilities and persons supported.
   b. Due process rights of persons supported.
   c. Role and responsibilities of the Human Rights Committee, including HRC procedures.
   d. Confidentiality and privacy rights of persons supported.
   e. Informed consent and release of information.
   f. Disabilities (e.g., intellectual and developmental disabilities, autism, head and spinal cord injuries, and related disabilities).
   g. Behavior support.
   h. Medications (including dosages, interactions, contraindications, and side-effects).
   i. Principles of least restrictive alternatives, normalization, inclusion, protection from harm, active treatment, individualized supports, quality of life issues, etc.
   j. HCBS Settings Final Rule
   k. Other areas that may be specified by the Human Rights Committee, DIDD or the provider agency.

2.5.d. Provider Responsibilities for Maintaining Authorization as a Local HRC. To continue authorization to perform HRC functions, the provider executive director/chief executive officer responsible for operational oversight of the HRC must:
1. Provide an annual roster of HRC membership to the DIDD regional director within thirty (30) days of the beginning of each calendar year.

2. Obtain a signed approval letter from the DIDD Regional Director prior to holding the first meeting of the new calendar year.

3. Notify the regional director of any changes in membership, change of chairperson or change of entity responsible for operational oversight within thirty (30) calendar days of the change occurring.

4. Ensure that the HRC is duly constituted at all times.

2.5.e. Composition of an HRC. All HRCs will be composed of, at a minimum, five (5) members. In order to take action, at least one third (1/3) of the human rights committee members present must not be affiliated with DIDD.

HRC membership shall include:

1. A minimum of one (1) person receiving waiver services from a provider in the region or from a provider involved in forming the committee.

2. A community representative who serves as the chairperson.

3. A minimum of one (1) community representatives, not to exceed three (3), 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.

4. A minimum of one (1) family member of a person receiving waiver services from a provider in the region or from a provider involved in forming the committee.

2.5.f. Conflict of Interest. Any HRC member who is involved in a matter under review or consideration by the HRC shall not participate in the
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 receiving services by their employer or concerning other employees of the same agency. Behavior analysts who developed a behavior support plan (BSP) or who will be responsible for ensuring implementation of a BSP shall not be involved in decision making regarding approval of that BSP.

2.5.g. Functions of the Local and Regional HRC. In addition to its advisory role concerning the rights of the people supported, in those limited situations where HRCs have the authority to approve restrictions, the HRC’s function is to ensure that rights limitations are temporary in nature and that they occur in very specifically defined situations. It must be emphasized that rights restrictions can only be authorized with the consent of the person supported and/or their legal representative and must comport with the HCBS Settings Rule.

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 an HRC are:

1. Ensure the HRC is duly constituted at all times.

2. Review BSPs that include restricted interventions or other rights restrictions for potential human rights violations. This includes any planned action(s) that conflicts with an individual’s right specified in this chapter.
a. At a minimum, the committee shall review the benefit-risk analysis completed in development of the BSP or plans for rights restrictions.

b. Ensure the proposed restriction is the least restrictive viable alternative, is not excessive and assures that interventions and supports will not cause harm.

c. Ensure adequate documentation demonstrating all other least restrictive measures have been attempted and failed, which has led to the current restriction(s).

d. Determine that the restricted interventions or other rights restrictions are not used in the absence of other treatments and are designed to increase the likelihood of positive skills.

e. Ensure that the BSP includes a fading plan for reducing or eliminating the need for the restricted intervention.

f. Ensure the proposed restricted intervention or other rights restriction is not for staff convenience.

g. Ensure that the person or legal representative has provided informed consent for the BSP and/or rights restriction.

3. Approve or disapprove BSPs or other rights restrictions or recommend changes to BSPs.

4. Review of psychotropic medications and informed consent to ensure informed consent was obtained prior to the use of psychotropic medication.

5. Review of emergency use of rights restrictions based on an imminent risk of harm to the person supported or others shall occur at the next scheduled Regional HRC meeting or within 30 days whichever is sooner. In these reviews, HRCs shall:

   a. Verify that the provider sought informed consent within one (1) calendar day and that, if not obtained within five (5) calendar days, the restriction was withdrawn.
b. Verify that the Circle of Support assessed the need for the rights restriction and possible less restrictive alternatives to the rights restriction. This meeting shall take place as soon as possible to protect the rights of the person. Documentation of the meeting shall be submitted in time for the HRC Committee meeting.

c. Ensure that all appropriate notifications were made related to the rights restriction and the event that prompted it.

d. Make recommendations regarding the person’s supports and services and alternatives to the use of rights restrictions.

e. Approve or disapprove the plan for future use of the rights restriction or approve the plan with changes under the same standards used for all rights restrictions.

6. Additionally, the Human Rights Committee will:

   a. Review substantiated allegations of abuse, neglect or exploitation.

   b. Review and approve the crisis intervention policy for each residential, day, and personal assistance agency. (See Chapter 12 Section 12.7)

   c. Review provider agency policies, procedures and practices that have the potential for rights restrictions.

   d. Review and make recommendations regarding complaints received pertaining to potential human rights violations.

   e. 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.
f. 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. (Regional only)

2.5. h. Documentation Requirements for Local and Regional Human Rights Committees. For each meeting of the HRC, ensure the minutes summarizes the discussion concerning each individual and justifies decisions made about individual's rights restrictions, restricted BSPs and recommendations for follow-up. The minutes shall be sent to the DIDD regional director or designee within 10 calendar days of the meeting date.

a. Name of Committee
b. Date of Meeting
c. Members present
d. Non-voting attendees
e. Chair Approval Signature
f. Identifying Information
   i. Name of person
   ii. Name of agency
   iii. Name/title of presenter
g. Purpose of the Review
   i. Initial, follow-up, and annual review of restricted BSPs
   ii. Initial or follow-up review of restitution
iii. Initial, follow-up, and annual review of psychotropic medications

iv. Initial, follow-up, and annual review of other restrictions

h. Resolution
   i. Issues adequately addressed
   ii. Issues inadequately addressed
   iii. Issues addressed with the following conditions

i. Actions necessary for resolution

j. Date of follow-up

k. Note whether informed consent was obtained

l. In addition, restricted BSPs and other restrictions should include what the restrictions are and their justification.

m. Psychotropic reviews should include:
   i. Whether the medication is new, increased, or annual
   ii. Name of the medication
   iii. Dosage and frequency, date prescribed
   iv. Diagnosis purpose including treatment targets
   v. Physician or other prescriber

n. Ensure that all HRC performance standards and requirements are met.

2.5.i. 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.

2.5j. 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.

2.5. Options for Individuals Determined Unable to Make Decisions. A person under Tennessee law is presumed 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, utilizing the least restrictive, most time-limited alternative available. Anyone exercising alternate decision-making for a person supported must do so in accordance with his or her instructions and wishes, if known. The alternate decision-maker must determine the best interest of the person supported in the context of the person's values and beliefs.

Decision-making should never be removed from a person supported for the convenience of the provider or DIDD. Neither a person's refusal to accept particular services or treatments nor his or her exercise of poor
decision-making justifies alternate decision-making. Alternate decision-making is only appropriate in circumstances in which it has been determined that the person is unable to make informed decisions with or without support. If it appears that alternate decision-making, including conservatorship, is not necessary or that a less restrictive means of decision-making support is appropriate, the DIDD Regional Director should be contacted, with regional follow up with the Office of General Counsel for advice if needed.

2.5.a. Court-Ratified Alternate Decision-making.

2.5.a.1. Conservatorship. A conservator is appointed by a court as its agent to act as a decision maker on behalf of a person whom the court has formally determined to be a ‘person with a disability’ as found in T.C.A. § 34-1-101(13).

Any party having knowledge of circumstances necessitating appointment of a conservator can file a conservatorship petition. When a conservator is appointed, the court order will specify the particular rights removed from the individual and vested in the conservator, and conservators may render decisions regarding only those rights. The conservator should be invested in the person and know them well enough to desire to ensure their desirers and preferences are considered rather than holistically making decision without discussing with the person their desires. All other rights remain with the person with a disability.
As part of each person supported’s annual ISP meeting, the Circle of Support must assess and appropriately document the person’s ability to make decisions and whether there is a continuing need for a conservatorship. If the Circle believes that the person may no longer be in need of a conservator or that the scope of the conservatorship is broader than needed, contact should be made to the DIDD Regional Director. The Regional Director will consult DIDD’s Office of General Counsel.

2.5.a.2. Expedited Limited Healthcare Fiduciary. Where a hospitalized person is not under a conservatorship and where the options summarized in 2.5.b. below are not available, a court may appoint an expedited limited healthcare fiduciary only for purposes of hospital discharge, transfer or admission to another healthcare facility (and decisions directly necessary to effectuate these purposes) and only for sixty (60) days maximum.

2.5.b. Power of Attorney (POA) and Other Forms of Alternate Decision-making Which Are Not Court-ratified. A Power of Attorney (POA) is a signed agreement in which one person appoints another to carry out specific duties on his or her behalf. A person must be competent at the time of establishing or modifying a POA. POAs do not have to be court-approved and may be revoked much more easily than conservatorships. With a POA the person supported retains decision making authority along with the POA. The POA’s role is to help the person supported under circumstances the
person is unable to act for him or herself. There are various types of POAs, including those which focus specifically on health care decision-making.

Other forms of alternative decision-making are allowed in very limited circumstances, particularly those related to end of life decisions. Durable Powers of Attorney for Healthcare (aka Medical Powers of Attorney), Living Wills and DNR (Do Not Resuscitate Orders) executed by a person supported at the time of capacity can guide end of life choices upon subsequent incapacity. Under the Tennessee Health Care Decisions Act, in the context of hospitalization and end of life care, if a person is deemed to lack capacity, does not have a conservator or did not previously (while having capacity to do so) designate an alternative decision-maker as a surrogate - or if those persons are reasonably unavailable - the supervising health care provider may designate a surrogate. Relatives of the person supported, such as a spouse, adult child, parent or sibling have preference under the statute. Important considerations in the selection of the alternate decision-maker include availability, regular contact, and demonstrated care and concern for the person supported.

Additionally, T.C.A. § 33-3-217-220 set forth criteria for decision-making by a surrogate for developmental center admission or discharge and for routine dental, medical or mental health treatment of a person with a developmental or intellectual disability who does not have a conservator and who is determined by the involved health care professional to lack capacity. That determination must be based on a prescribed assessment process. If an eligible adult is determined to be capable of making decisions for the person
supported, he or she may do so provided that the person supported does not reject the proposed surrogate, assuming the alternate decision-maker has adequate information on which to make an informed decision.

2.5.c. Providers and Family Members Serving as Alternate Decision-makers. It is improper for an individual or entity acting as a conservator or other alternate decision-maker to be in a position to profit (receive gain) from decisions made on behalf of the person with a disability.

Therefore, the following must be adhered to:

1. Management or a person in a decision-making capacity for a provider agency are not permitted to serve as an alternate decision-maker for a person supported by that agency (except in the case of agencies established to serve only one person); and

2. Neither a provider agency nor a family member will be paid for providing direct services to a person supported for whom the entity or family member has alternate authority for decisions, unless a court order is obtained expressly allowing same. In the event of such circumstances, the Department must not be required to pay more than DIDD's appropriate and applicable rate or amount for the services supplied.

2.5.d. Provider Responsibilities Related to Persons in an Alternate Decision-making Role as Addressed in 2.5. Providers, conservators, individuals serving in the Power of Attorney role, and other decision making surrogates are expected to work cooperatively with conservators, individuals serving in the Power of Attorney role, and other decision-making surrogates. Providers must have a copy readily available of the conservatorship order, POA or other document under which the decision-maker is exercising his or
her authority to make decisions on behalf of the person supported. 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 people with alternate decision-making authority.

4. Assist in determining the scope of the authority of the alternate decision-maker.

5. Provide appropriate information and individual records to the alternate decision-maker in a timely manner when requested and in accordance with the authority granted to the alternate decision-maker.

6. Collaborate and consult with the alternate decision-maker as needed to ensure service provision in accordance with the ISP.

7. Resolve issues of concern regarding the provision of services presented by the alternate decision-maker in a timely manner. If unable to provide services as requested by the alternate decision-maker, work with that person to identify a suitable alternative.
CHAPTER 3

INDIVIDUAL SUPPORT
PLANNING AND IMPLEMENTATION


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.

On January 16, 2014 CMS published the Final Rule which defines, describes, and aligns home and community-based setting requirements and defines person-centered planning requirements for persons receiving Medicaid-reimbursed services in HCBS settings under 1915(c) and other specified waivers.

The Person-centered plan identifies the needs and preferences of the person supported as described by that person, in collaboration with family, friends, and other team members selected by the person supported, so that the person may receive needed services supports in the manner they prefer. CMS states the person-centered planning process will be led by the person supported where possible. The person's representative should have a participatory role, as needed and as defined by the person supported. In addition to being led by the person supported the person-centered planning process:

- Includes people chosen by the person supported.
- Provides necessary information and support to ensure that the person supported directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
- Is timely and occurs at times and locations of convenience to the person supported.
- Reflects cultural considerations of the person supported and is conducted by providing information in plain language and in a manner that is accessible to the person supported and persons who are limited English proficient.
- Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.
- Offers informed choice to the individual regarding the services and supports they receive and from whom.
- Identifies clinical and support needs through an assessment of functional need.
• Is conducted to reflect what is important to the person to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare.

• Identifies the strengths, preferences, and the desired outcomes of the person supported.

• Includes a method for the individual to request updates to the plan as needed.

• Prevents the provision of unnecessary or inappropriate services and supports.

• Records the alternative home and community-based settings that were considered by the person supported.

• Is signed by person supported, all other individuals and providers responsible for its implementation and a copy of the plan is provided to the person supported and his/her legal representative.

Providers of HCBS for the person supported or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan.

States are currently required to complete “participant-centered service plans” for persons supported and the final rule includes specific requirements for the person-centered planning process and the resulting person-centered plan. CMS expects that states are already in compliance with the person-centered service plan requirements.

The person-centered service plan must reflect the services and supports that are important for the person supported to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports.
Commensurate with the level of need of the individual, and the scope of services and supports available under the State's 1915(c) HCBS waiver, the written plan must:

- Assume the person has the rights, freedom and ability to make their own decision and participate in activities of their choice.
- Reflect that the setting in which the person supported resides is chosen by the person supported. The setting chosen by the person supported must be integrated, and support full access of persons supported receiving Medicaid HCBS to the greater community.
- Include individually identified goals and desired outcomes the person needs support in achieving, including: preferences related to relationships, desired engagement in community participation, interest in seeking employment, goals related to personal finances including income and savings, health, education and other personal goals.
- Reflect the services and supports (paid and unpaid) that will assist the person supported to achieve identified goals, and the providers of those services and supports, including natural supports.
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.
- Identify the individual and/or entity responsible for monitoring the plan.
- Include those services, the purpose or control of which the person supported elects to self-direct.
Additionally, CMS specifies modifications to the HCBS Settings Rule (restrictions that are necessary to be placed on someone) must be justified in the person-centered services plan. The following requirements must be documented in the person-centered service plan when a modification to the Rule is being requested:

- Identify a specific and individualized assessed need.
- Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
- Document less intrusive methods of meeting the need that have been tried but did not work.
- Include a clear description of the condition that is directly proportionate to the specific assessed need.
- Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- Include informed consent of the person supported.
- Include an assurance that interventions and supports will not cause harm to the person supported.

Any restrictions on individual choice “must be focused on the health and welfare of the individual and the consideration of risk mitigation strategies.” The restriction, “if it is determined necessary and appropriate in accordance with the specifications in the rule, must be documented in the person-centered plan, and the individual must provide informed consent for the restriction.”

The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

3.2. Individual Support Planning.

The ISP is Tennessee’s format for the federally required person-centered service 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 reflects the assumption that with supports, the person has the ability to function as anyone else including people not receiving Medicaid reimbursed services. The ISP should only list restrictions and modifications from the HCBS Settings Final Rule when determined through needs assessment process (as described above) to be absolutely necessary. The ISP is not designed to restrict a person and provide freedom under certain circumstances. Instead the ISP assumes the person lives his/her life and only has restrictions under very specific circumstances.

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.

All individual goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable, based on the needs and preferences of the person supported. CMS refers to person-centered planning as “underpinning all aspects of successful HCBS.” In addition to the essential elements described in section 3.1.a., 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, and what supports are needed to accomplish their vision of a preferred life.
3. Developing the skills needed to achieve their goals.
4. How to accomplish the person’s desired outcomes.
5. What is important to the person including things that help a person feel happy, satisfied, and content and fulfilled.
6. 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. The Department requires COS meetings to be scheduled at the convenience of the person supported. It is essential that providers and other members of the COS realize that
services and supports are selected by the person supported. These services and supports are required to support the person’s independence and full integration in the community, as well as ensure the person’s choices and rights. Finally, services and supports are required to comport fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, except as supported by the individual’s specific assessed need and set forth in the person-centered ISP.

3.4. The Circle of Support.

The person supported and his/her legal representative, if applicable, coordinates the COS. The person supported and/or the person’s legal representative identifies and 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. For example, 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 (including direct support professionals) the person receives. Friends, advocates, and all other non-paid supports are included at the invitation of the person supported. The person should be the one directing the date, time, and place for the ISP meeting.

During an 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. When creating the ISP it is important to discuss the person’s vision of a preferred life. What is the goal of the ISP? What does the person want to enhance or maintain? How can the ISP help the person accomplish these things? The person’s
vision of a preferred life should be the foundation of the ISP, and the ISP should support the person's vision.

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. COS members can also include unpaid natural supports.

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

Person centered planning is the foundation for supporting the person to create their vision for his/her preferred life. It is essential that all providers of services and supports possess the requisite person centered thinking skills to support the person in developing the ISP. 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 network 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 skills support and guide the actions that have the outcomes described above.

Person-Centered Thinking skills must be used in the development of an ISP. Each skill can stand alone as a way to discover important information or they can be used together. There are a number of Person-Centered Thinking skills available. Use of one or more of the skills can assist in the development of an ISP. These skills 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
9. Morning Ritual
10. Communication Chart

More information regarding these skills and how they can be effectively implemented is available on the DIDD web site.

24 [http://tn.gov/assets/entities/didd/attachments/Skills_Reflection.pdf](http://tn.gov/assets/entities/didd/attachments/Skills_Reflection.pdf)
Information learned when applying these skills 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 as described in the manual **CQL Personal Outcome Measures®**. In support of the Department’s accreditation in Person Centered Excellence, ISCs/CMs are required to utilize CQL’s personal outcome measures (POM) during development of the ISP. The purpose of the POM assessment is multi-fold:

1. Learning about the person supported and how much specific outcomes mean to him or her.

2. Facilitating and planning the services and supports necessary for achievement of outcomes, based on the preferences of the person supported.

3. Evaluating whether or not the person’s desired outcomes were attained, according to feedback obtained from the person supported.
In summary, the person centered planning process is the vehicle that links the person’s desired personal outcomes to services and supports. The ISP is the document that describes the person’s vision for his/her life and the outcomes he/she wants to achieve and the services and supports required for the person to fulfill and achieve his/her vision. All providers are expected to understand the PCP process as they help implement the services and supports on the ISP.

Employment is the preferred option for all persons supported, based on each person’s needs and preferences. In support of DIDD’s Employment First initiative\textsuperscript{25}, the COS is responsible for ensuring that each ISP must addresses 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.\textsuperscript{26} 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.e.g., 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.

\textsuperscript{25} U.S. Department of Labor’s Employment First web site: http://www.dol.gov/odep/topics/EmploymentFirst.htm

\textsuperscript{26} DIDD considers an array to mean more than two (2) options based on a person’s interest, education, and background.
## ASSESSMENT PROCESSES

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Information Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Third Party Payer Services and Community Supports</td>
<td>Information about the services a person is receiving through resources outside DI DD programs such as the Managed Care Organization, Medicare or other organization.</td>
</tr>
<tr>
<td>Informal Conversation with the person, family, friends and/or legal representative.</td>
<td>Ideas and suggestions about what things the person does well or needs help with <strong>can and cannot do</strong>, what things are important to the person and what things are liked and disliked by the person.</td>
</tr>
<tr>
<td>Uniform Assessments (e.g., ICAP or SIS)</td>
<td>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.</td>
</tr>
<tr>
<td>Risk Assessments (Risk Issues Identification Tool)²⁷</td>
<td>Identify potential risks in a variety of areas, as well as, risks associated with the personal choices of the person supported.</td>
</tr>
<tr>
<td>Clinical Assessments</td>
<td>Identify needs for clinical services and treatment.</td>
</tr>
<tr>
<td>Medical Assessments</td>
<td>Dental, health, and mental health records as applicable, as well as physician orders and physical examinations.</td>
</tr>
<tr>
<td>Vocational Assessments</td>
<td>Assist the person in determining strengths and interests and preferences in paid work.</td>
</tr>
<tr>
<td>Individual Experience Assessment (IEA)</td>
<td>Information about the setting in which the person is receiving services and supports to determine compliance with CMS final rule.</td>
</tr>
<tr>
<td>CQL Personal Outcome Measures (POM)®</td>
<td>Information about the person's quality of life and the degree to which the agency's services and supports facilitates achievement of personal outcomes.</td>
</tr>
<tr>
<td>Rights Assessments</td>
<td>Assess the person's understanding of their rights and identify which rights are most important to the person.</td>
</tr>
</tbody>
</table>

3.7. **Timelines for Completion and Review of the ISP.**

The ISC/CM is responsible for ensuring that the ISP, including amendments when applicable, is developed and finalized within sixty (60) calendar days of the person’s enrollment into an HCBS waiver. 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 determined by TennCare. When services are state-funded, the initial ISP is due within thirty (30) sixty (60) calendar days from the date of the person’s enrollment in services. The date of enrollment for people enrolled in a Medicaid waiver or state-funded services is the date that services initially began as determined by TennCare.

The ISP must be reviewed at least monthly by the ISC/CM, as specified in TennCare Rule 1200-13-01-.25,-.28 and -.29(7)(b)(1) and the 1915 (c) HCBS waiver, as approved by the Centers for Medicare and Medicaid Services. The initial ISP can be used for a period of 365 days from the effective date of the ISP. During that time period, changes in the ISP may be accomplished through ISP amendments.

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 as determined by TennCare. The effective date is used to determine when annual updates are due. The effective date of an ISP new plan can be no more than one (1)

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29 Go to Providers, Waiver Information: [http://www.tn.gov/didd/section/providers](http://www.tn.gov/didd/section/providers)
calendar year from the effective date of the previous ISP plan. The ISP is considered expired after 365 days from the effective date and must be updated and services authorized before it expires.

3.9. ISP Amendments.

Amendments to the ISP must be requested and processed in accordance with policies 80.3.4 Authorization of Services and 80.3.6 Amending the Initial Plan of Care Before Development of the ISP. The ISP must be amended when any of the following occur:

1. The person supported or legal representative requests an amendment.
2. The action steps and outcomes change.
3. Services or service providers change.
4. There is a significant change in overall service and support needs.
5. The person has made major changes to his/her preferred lifestyle.
6. If the person moves to a new residence (address change).

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.

Providers should work closely with the COS when supporting the person to determine which outcomes and action steps the person supported wants to work on for the ISP year. Outcomes and action steps should not be completed without the person being present.

3.10.a. Residential, Day and Personal Assistance Provider Responsibilities for Periodic Reviews. Residential, day and personal assistance providers who employ direct support staff are required to complete periodic reviews of the ISP. Cooperate with therapists and other clinical service providers in developing and implementing staff instructions related to therapy services, when such staff instructions are necessary.

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 (20th) 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 all actions and outcomes. Each provider is responsible for submitting periodic reviews to the ISC/CM, using the current template\textsuperscript{30}, describing progress related to the services they are responsible for providing. Ongoing evaluation of risk, via the risk assessment process, is to be incorporated in 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, including a summary of the progress towards achievement of actions and outcomes.
4. Any new or updated staff instructions.
5. Any recommendations for changes to the ISP based on direct request or input from the person supported or observations of the person’s response to services provided. All recommendations for changes to the ISP must be submitted with the understanding and consent of the person supported.
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.

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\textsuperscript{30} [http://www.tn.gov/assets/entities/didd/attachments/Provider_Review_Form.pdf](http://www.tn.gov/assets/entities/didd/attachments/Provider_Review_Form.pdf)
CHAPTER 4

SUPPORT COORDINATION AND CASE MANAGEMENT

4.1 Responsibility for Support Coordination and Case Management.

Support Coordination is the assessment, planning, implementation, coordination, and monitoring of services and supports that assist individuals with intellectual and developmental disabilities to develop personal relationships, participate in their community, increase control over their own lives, and develop the skills and abilities needed to achieve these goals, as specified in the person centered Individual Support Plan (ISP). Support Coordination is required to be provided in a manner that comports fully with standards applicable to person-centered planning for services delivered under Section 1915(c) of the Social Security Act.

For people enrolled in the “Arlington Comprehensive Aggregate Cap Waiver HCBS Waiver for Persons with Mental Retardation (control # TN.0357) or the Statewide Waiver HCBS Waiver for the Mentally Retarded and Developmentally Disabled (control # TN.0128), an ISC will perform the functions and tasks specified in the service definition. 31 For persons enrolled in the Tennessee Self Determination

31 http://www.tn.gov/assets/entities/didd/attachments/Waiver_Service_Definitions.pdf
Waiver Program (control TN. 0427) a DIDD case manager (CM) will perform the case management functions.

4.2. **Independent Functioning of Support Coordination Agencies and DIDD Case Management.**

The intent of providing an independent support coordination option in the Arlington Comprehensive Aggregate Cap and Statewide Waivers is to ensure that planning and coordination of services is led by the person supported and not unduly influenced by other entities providing or funding services. The DIDD Case Management provides the same planning and coordination function for the Self-Determination Waiver.

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 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, ISC agency management staff and board members 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 relevant 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 experience in working directly with persons with intellectual disabilities or other developmental disabilities or mental illness. Support Coordinators who do not have a Bachelor’s degree in a human services field must be supervised by someone who does meet that qualification.

Support Coordinators must successfully complete required pre-service training courses as well as periodic in-service training and any other re-training required to maintain approval to be a Support Coordinator. 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-five (35) 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 appropriately licensed and 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. Initial and Ongoing Assessment of Individual Strengths and 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. During the assessment process, it is vitally important that support coordinators obtain information about what is important to and for the person, including preferences for delivery of services and supports, and also talk about the person’s vision of a preferred life. Assessment also refers to the ongoing process of reevaluating the person’s strength and 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. Providers of waiver services and supports.
3. Individual rights and responsibilities of people using services including information regarding the right to file an appeal which must be provided annually.
4. Self-advocacy groups and self-determination opportunities.
5. Necessary information and support for the person’s facilitation of the person centered planning process to the maximum extent desired and possible. Person centered planning meetings must be conducted at a time and place convenient to the person supported.
6. Resolution processes, including reporting abuse/neglect/exploitation, provider conflict resolution, DIDD Customer Focused Services (CFS) 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. The ISC/CM is required to support the person’s informed choice of providers, services and supports, and settings in which services and supports are delivered. Services settings must conform to expectations described in the CMS Final Rule on home and community based services. Therefore, ISC/CM are expected to support the person’s choice of residence, roommate, and privacy expectations in accordance with the CMS Final Rule.

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, based on assessed needs, provided in an ICF/IID or in a Medicaid HCBS waiver. Federal Medicaid law requires that this choice between institutional and community-based services 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. ISC/CM support the person’s informed choice and quality of life by ensuring that services and supports are integrated in and support full access to the community in the same degree of access as individuals not receiving Medicaid HCBS, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources.

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, and service settings, 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 DIID.
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. ISC/CM are required to coordinate services with the person’s MCO in accordance with TennCare’s Coordination of Benefits (COB) protocol. ISC/CM is primarily responsible for establishing contact with the MCO CM to coordinate benefits for the person supported, as needed. All ISC/CMs will conduct assessments to determine if there is a need to coordinate benefits, pursuant to DIDD protocols which guide the determination of service requests. 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 and in scope of the individual expenditure cap for individuals enrolled in the Statewide Waiver.

2. Facilitate the development of the ISP, which is driven by the person supported, with the COS.

3. Provide assistance with securing needed transportation supports.

4. Monitor to ensure that services are being delivered in accordance with the ISP and within the scope of the individual expenditure cap for persons enrolled in the Statewide Waiver.

5. Review the delivery of services and supports to determine the extent to which the needs of the person are being met.

6. Coordinate with the person’s health care providers and MCOs (as applicable), to ensure timely access to and receipt of needed physical and behavioral health services.

The ISC/CM must arrange for services or supports, in accordance with TennCare’s COB protocol, 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 services or from the community system to a hospital).

6. The person moves from one area of the state to another.
4.6.e. **Actual Development, Ongoing 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 or upon the request of the person supported and or legal representative. ISC agencies may be sanctioned by DIDD for failing to submit documents required for timely authorization of the ISP or ISP amendments.

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.
3. Identify the need for ISP amendments and/or other actions to address a change in the person’s condition or situation.
4. Address concerns which may include reporting to management level staff within the provider agency, or reporting to DIDD when resolution is not achieved and the ISP is not being implemented.
5. Document specific modifications to HCBS settings requirements based on the needs of the individual and in accordance with processes

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prescribed in federal and state regulation and protocol (see pages 3-6 through 3-7).

**4.6.g. Contact Requirements.** Minimal requirements pertaining to support coordination and case management contacts with persons are listed in the table below. If the person supported needs more frequent contacts from the ISC/CM on an ongoing basis, the frequency should be specified in the ISP and support coordination and case management is required to be provided in accordance with the person’s needs as specified in the ISP. include:

<table>
<thead>
<tr>
<th>Waiver</th>
<th>Level of Need</th>
<th>Contact Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Determination Waiver</td>
<td>In-Person or Telephone Contact with persons supported in the Self-Determination Waivers receiving Level 1, 2, or 3, residential and/or day services.</td>
<td>Monthly in-person or telephone contact (with an interval of at least fourteen (14) calendar days between contacts)  These persons shall be visited across all environments face-to-face by their CM at least quarterly (i.e., once per quarter) with an interval of at least thirty (30) calendar days between contacts.  Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the person’s needs and/or request which shall be documented in the ISP, or based on a significant change in needs or circumstances.  More frequent face-to-face and/or telephone contacts shall be conducted when appropriate based on the member’s needs and/or request which shall be documented in the ISP, or based on a significant change in needs or circumstances.</td>
</tr>
<tr>
<td>Statewide and Comprehensive Aggregate Cap</td>
<td>In-Person or Telephone Contact with persons supported in the Statewide</td>
<td>Monthly in-person or telephone contact (with an interval of at least 14 calendar days between contacts)</td>
</tr>
</tbody>
</table>
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), 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 in accordance with TennCare’s COB protocol.

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.

34 [http://www.tn.gov/assets/entities/didd/attachments/80.3.4_-_ISC_CM_Monthly_Doc_Form.pdf](http://www.tn.gov/assets/entities/didd/attachments/80.3.4_-_ISC_CM_Monthly_Doc_Form.pdf)
2. If the person supported is unable to inform the ISC/CM of their assigned MCO, the ISC/CM may contact the DIDD Director of Person Centered Practices 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 and adequate preparation for reductions in services, if applicable. The 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. Care coordination is addressed in the TennCare COB protocol.

**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. ISCs may also take advantage of the complaint resolution process described in chapter 2, section 2.6.a.
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 and are available on the DIDD website:

34 http://www.tn.gov/assets/entities/didd/attachments/80.3.4_-_ISC_CM_Monthly_DOC_Form.pdf
1. The **Support Coordination 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 monitoring and narrative documentation of the progress made with respect to each action step and outcome. 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 by contacting the DIDD Regional Office.
To initiate selection of a new ISC within the current agency the ISC agency should be contacted. A change in ISC agency shall be in accordance with policy 80.4.7 Community Transition. 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 essential information to the receiving support coordination provider in accordance with transfer of records policies indicated in policy 80.4.7 Community Transition.

### 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.

35 [http://www.tn.gov/assets/entities/didd/attachments/80.4.7-Community%20Transition%20Policy.pdf](http://www.tn.gov/assets/entities/didd/attachments/80.4.7-Community%20Transition%20Policy.pdf)
4.9. **Annual Re-Evaluation and Re-Determination**

**4.9 Assessment/Determination of LOC and HCBS Settings Compliance.**

The ISC/CM is responsible for ensuring completion of processes required for a person to remain medically eligible for Medicaid benefits. Additionally, the ISC/CM is required to initiate and oversee at least annual re-assessment of the person’s level of care (LOC) eligibility for ICF/IID services. ISC agencies may be sanctioned by DIDD for failing to timely submit the documents that are required for re-assessment documentation of the person’s need for ICF/IID services.

The ISC/CM is required for the initial and at least annual reassessment of the person’s individual’s experience to confirm that the need for ICF/IID services the setting in which the person is receiving services and supports fully comports with the standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including requirements applicable to provider-owned or controlled homes/settings, except as supported by the person’s specific assessed need and set forth in the person centered ISP. ISC agencies may be sanctioned by DIDD for failing to timely submit the documents that are required for re-evaluation and re-determination of the person’s eligibility.
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 utilization reviews. Proof of licensure may be required during other reviews or surveys, such as those conducted by CMS, the TennCare Bureau, the Tennessee Office of the Comptroller, or the Tennessee DOH. Licensure information is available on the DIDD web site.\(^\text{36}\)

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. Additionally, for including persons supported in the hiring process of staff to the extent they desire, where applicable (e.g., direct support professionals staffing supported living homes).

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.\(^{37}\)

7. Procedures for maintaining a drug-free workplace pursuant to Tennessee Code Annotated Title 50 Chapter 9 and 42 CFR 2, including the release of an employee’s drug and alcohol test results to DIDD for the purpose of internally investigating allegations of abuse, neglect and or exploitation of people using services. As a condition of the person’s voluntary employment a signed consent release shall be obtained at the time of hiring. The release shall be in effect the duration of his/her employment.

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\(^{37}\) For additional information visit the DOH web site: [http://tn.gov/health/article/tuberculosis-testing-program](http://tn.gov/health/article/tuberculosis-testing-program)
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 Information List (FOIL), 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.
5.2.c. Requirements for Background Checks. In accordance with requirements established in Title 33 of the T.C.A., the approved waiver and by DIDD, each provider must have a process for ensuring that statewide criminal background checks are performed for each employee, volunteer or subcontractor (or subcontractor employee), and students and interns 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. The evaluation process should include feedback from persons supported by 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. It is strongly recommended that providers check the Tennessee Abuse Registry regularly (e.g., monthly) to rule out the possibility that a person has been placed on the registry without the provider’s knowledge.

3. The provider must screen its employees and subcontractors initially and on an ongoing monthly basis to determine whether any of them has been terminated, debarred or excluded from participation in the Medicare, Medicaid, SCHIP, or any federal health care program (as defined in Section 1128B (f) of the Social Security Act). Providers shall and not employ or contract with an individual or entity that has been excluded. See Provider Agreement Section A.5(d)(ii).

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. Complaint resolution. See section 5.11.b. 2.6.
4. Using positive behavior approaches with people using services, including prohibited interventions.

5. Facilitating and supporting natural support systems. The policy should include a description about the value of natural supports, how the provider will support people to sustain existing relationships and build new ones, maintain communication (including in-person visits) with natural supports and documenting people’s involvement and contact with their natural support network. See section 6.3.h and Factor 3 in the CQL Basic Assurances manual.

6. Volunteers. See section 6.3.f

7. Medication safety. See section 8.5.

8. First aid. See section 8.7

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

10. Addressing the health care needs of people using services, as specified in the individual support transition plan (ISTP) or ISP. The policy should include how the provider will support people to be involved in making health care decisions and managing their own health care.

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

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

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

14. Safely transporting persons supported, including supporting people to learn to use public transportation. See section 15.5.b.

15. Managing and accounting for personal funds of people using services, including supporting people to manage their own personal funds to the extent possible.
16. Maintaining a well-trained workforce, including how training will be tracked to assure that only fully trained staff will be assigned to work with people supported. The policy should describe how the provider will ensure that staff complete training in accordance with DIDD requirements (subjects, timelines). Additionally, the policy should address hiring, retention, evaluation and incentives for staff.

17. Managing and reporting incidents.

18. Maintaining Title VI compliance.

19. Human Rights Committee. See policy 80.6.1. section 2.9

20. Providing services to individuals with LEP.

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

22. Quality assessment, assurance and improvement of provider services, including input from people supported and other stakeholders (e.g., family, legal representative, advocates).

23. Protection from and prevention of harm.

24. 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.


26. Description of how the provider will comply with the CMS Final Rule for HCBS Settings and Person Centered Planning, as applicable.

27. Description of how the provider will implement Employment First!, if applicable.
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 service (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 and compliance with the CMS HCB Settings Final Rule. 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 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.

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38 [http://www.tn.gov/assets/entities/didd/attachments/CQLs_Basic_Assurances_Self-Assessment_Tool.pdf](http://www.tn.gov/assets/entities/didd/attachments/CQLs_Basic_Assurances_Self-Assessment_Tool.pdf)
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, absenteeism 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 persons supported, as well as provider staff, should have access to the QI plan and the opportunity to provide input. 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.

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, and as a result of input received from persons supported, provider staff and other stakeholders.

5.6. **Supervision Plans.**

A written supervision plan is required when a provider employs or contracts with staff that 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 the preferences and choices of people supported by the agency will be considered when identifying regularly assigned staff.
2. Ensuring the development of staffing plans and on-duty work schedules.
3. Ensuring back-up and emergency staffing procedures.
4. Ensuring that staff understands their job duties and performance expectations. *Specifically, ensure that staff is trained on the ISP for each person they support. See 6.4.b., Information and Training Specific to the Person.*
5. Ensuring that staff acquires the knowledge and skills needed to complete job duties and meet performance expectations.
6. 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.
7. 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 at the home, including sleep hours, on weekends and on holidays.

b. Family Model (unless otherwise specified due to quality monitoring results) - a minimum of one (1) visit each calendar month for LON 1-3 and a minimum of two (2) visits each calendar month for LON 4-6, at the home including weekends and on holidays.

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

d. Personal Assistance – a minimum of one (1) visit each calendar month at the home, including weekends and holidays (if applicable).

8. 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.

9. Developing and implementing policies that prevent 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 service (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 person-centered 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).

7. A description of the provider’s annual hiring plan based on data and procedures for working with outside job placement services agencies.

8. A description of the provider’s procedures for conducting employee satisfaction surveys and exit interviews.

9. A description of the provider’s procedures for including people supported in developing recruitment and retention programs.

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

3. Minutes of all Board meetings will be taken and maintained.

4. Board meetings will be held at least quarterly and more frequently if necessary to effectively discharge Board duties.

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

6. 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.

7. New board members must be oriented 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.39

39 Go to http://www.tn.gov/didd/section/providers, Provider Training & Development
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.

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. 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.

2. Minutes of all advisory group meetings will be taken and maintained.
3. Advisory group meetings will be held at least quarterly and more frequently if deemed necessary to fulfill its responsibilities.

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.  

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

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40 Go to [http://www.tn.gov/didd/section/providers](http://www.tn.gov/didd/section/providers), Provider Training & Development
staffing plan. Providers of clinical 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. See section 11.1.i.1 Staffing Plan Requirements.

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.

5.11. 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. General Requirements for Waiver Services.

5.11.a The following list of requirements are applicable to providers of Medicaid funded HCBS waiver services 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 and for people in the Statewide Waiver, the individual expenditure cap.
3. The provision of services shall be documented in sufficient detail to support the provider’s billing.
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. 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.

41 http://www.tn.gov/assets/entities/didd/attachments/Waiver_Service_Definitions.pdf
42 https://www.dropbox.com/sh/weg5yxlk997buujxAADt0ko_ziSYN-VXS-8j3Fa/2011/Memo%202015%20Yes%2C%20but%20Revised%20205.27.11.pdf?dl=0
8. Providers are required to abide by regulations of the Occupational Safety and Health Administration (OSHA) regarding blood borne pathogens and hazard communications.\(^{43}\)

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.\(^{44}\)

10. Providers shall work cooperatively with all other service providers (including clinicians) and shall coordinate their services and supports and or treatments with other providers who support the person. The purpose of this collaboration is to ensure that the person receives services and supports and treatments without interruption, as well as prevent inadvertent duplication of services.

11. Per the HRC policy, providers shall participate in Human Rights Committees. This purpose is to promote and protect the individual rights of persons supported and to ensure that limitations to those rights do not occur without formal review by the HRC.

5.11.b. Complaint Resolution Process.

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

\(^{43}\) For a free Power Point on the blood borne pathogen standard: [http://www.powershow.com/view/499ac-MmJkZ/OSHA_Bloodborne_Pathogens_Training_powerpoint_ppt_presentation](http://www.powershow.com/view/499ac-MmJkZ/OSHA_Bloodborne_Pathogens_Training_powerpoint_ppt_presentation)


\(^{44}\) [http://www.tn.gov/assets/entities/didd/attachments/80.4.3-Personal%20Funds%20Management.pdf](http://www.tn.gov/assets/entities/didd/attachments/80.4.3-Personal%20Funds%20Management.pdf)
assist with complaint resolution. Complaints are monitored via the DIDD database to ensure timely and satisfactory resolution.

5.11.b.1. 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:

a. Designation of a staff member as the complaint contact person.
b. Maintenance of a complaint contact log.
c. Documentation and trending of complaint activity.

Complaint contact logs shall include the following:

a. Date complaint received.
b. Contact information.
c. Name of complainant.
d. Name of person supported.
e. Agency and ISC involved.
f. Description of Complaint.
g. Description of Resolution (complainant confirmed).
Upon admission providers must notify each person, family members and/or legal representative of the provider’s and DIDD’s complaint resolution system, its purpose and the steps involved to access it. This information shall identify both the provider and DIDD contact persons and their contact information. 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.

Providers must attempt to resolve all complaints within 30 days of the date that the complaint was filed. If a resolution cannot be achieved between the provider and the complainant, a formal complaint may be filed with the DIDD (CFS) Unit or other DIDD representatives. The provider shall present the complainant with DIDD CFS Unit contact information. Upon being contacted, the DIDD CFS Unit will engage the Complaint Resolution System for addressing unresolved issues regarding the quality of service and supports.

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

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45 Reference DIDD policy 10.2.8 Complaint Resolution System
https://www.dropbox.com/s/xjdw05olkd4ebx/10.2.8%20-%20Complaint%20Resolution.pdf?dl=0
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.

5.11.b.2 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.

5.11.c. Privacy and Confidentiality of Records.

5.11.c.1. 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.

5.11.c.2. 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.**

5.11.c.3. **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.**
5.12. Notification to DIDD of Changes in Provider Information.

Providers are required to notify DIDD Central Office and the respective regional licensure office prior to the following changes in provider information using the Disclosure Form for Provider Entities or Disclosure Form for A Provider Person, unless otherwise noted. Such changes may necessitate a new provider application, provider agreement, or license.

1. Change in provider name.
2. Change in provider ownership.
3. Change in provider legal structure such as change from sole proprietor to corporation.
4. Change in provider information required for billing purposes such as federal tax identification number (e.g., Employer ID Number). In addition, terminating former provider employee access to Provider Claims Processing.
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. (Submit via email)
8. Addition or discontinuation of services offered. (Submit via email)
9. Change of address of the person supported (regional office only). (Submit via email)
10. Change in agency emergency contact information. (regional office only) (Submit via email)

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46 For DIDD Central Office, email Provider.changes@tn.gov; For Licensure Office: http://www.tn.gov/didd/topic/office-of-licensure
In addition, aforementioned changes must also be made, as applicable, to the provider’s Medicaid registration application in the TennCare Provider Registration Portal.\footnote{https://pdms.tenncare.tn.gov/ProviderPersonRegistration/Process/Register.aspx}


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.

5.13.b. Electronic Signatures. Providers are required to abide by policy 80.4.4 Electronic Records and Signatures.\footnote{https://www.dropbox.com/s/69aqbprn9g3o9ekf/80.4.4%20Electronic%20Records%20and%20Signature%20Policy.pdf?dl=0}
CHAPTER 6

STAFF DEVELOPMENT

6.1. Introduction.

All providers who contract with DIDD must ensure that all staff have adequate and suitable training completed timely 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. Departmental training requirements align with CMS quality performance measures and regulations. 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. The DIDD Staff Development Plan/Training Resource Guide is available on the DIDD website.⁵⁰

Dental services providers and audiology services providers are not considered clinical services staff for purposes of training and are excluded from meeting DIDD training requirements. Additionally, also

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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.51

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 according to the training requirements for provider staff categories located on the DIDD training web site. on Individual Rights, Title VI, The Americans with Disabilities Act (ADA), and Protection from

51 http://www.tn.gov/assets/entities/didd/attachments/Training - Requirements for Provider Staff Categories.pdf
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 and shift supervisor. In any instance where direct support services are provided, 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 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.52 *Information and Training Specific to the Individual* shall only be provided by the entity holding the provider agreement with 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.53

6.3.b.8. **Agency Designated 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

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52 See Section 6.4.b.
53 [http://www.tn.gov/didd/topic/training-requirements](http://www.tn.gov/didd/topic/training-requirements); [http://www.tn.gov/assets/entities/didd/attachments/Training_-Requirements_for_Provider_Staff_Categories.pdf](http://www.tn.gov/assets/entities/didd/attachments/Training_-Requirements_for_Provider_Staff_Categories.pdf)
competency-based, meaning the staff must be capable of competent return demonstration of all steps. Designated trainer training must also be competency-based, meaning the staff person must be capable of return demonstration for training another person.

If, at any time, staff suspects 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 be made to a clinician. Staff instructions may not be changed by anyone except a clinician in the an appropriate discipline. The COS shall review staff instructions that remain in place after a clinician discharges the person at least annually to assure they appear to 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 on the web site 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.

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 (constant, stable, steady, long-lasting, and established) friends of the person using services. A natural support can be someone who is relatively new in the life of the person using services. The intent here is to express that a meaningful friendship exists between the person supported and the individual serving as a natural support regardless of the length of time they have known one another.

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. *These relationships are likely to sustain over time regardless of changes in the person’s services or location.* Natural supports shall not supplant paid staff nor be assigned responsibility to perform the
duties of trained and paid direct support staff. The provider responsible for the person supported served shall supply information and training as necessary to ensure the person supported and the natural support remain safe. Information and training specific to the needs of the person supported may be based on the time the natural support and the person supported are spending together with the person. Consent must be obtained from the person supported served or their legal representative (if applicable) 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 of all categories of staff (as described in this manual). 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 having direct responsibility for working alone with a person supported, individual specific training is required for direct support professionals. 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 or ISP is amended 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 competency-based training on written staff instructions for how to provide safe supports and promote independence during mealtime, transfers, ambulation, positioning, bathing, toileting, communicating person-specific services relevant to dining, positioning,
toileting and other ADLs as well as how to implement other components of 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. For information on required training related to behavior services, see Chapter 12 Behavior Services, particularly Section 12.7 Residential, Day and Personal Assistance Agency Responsibilities in Behavioral Health Interventions.

A DIDD sample format, Personal Training Profile, can be found on the DIDD web site54, 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 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.

48 Go to Training, Forms and Templates: http://www.tn.gov/didd/topic/forms-templates
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 specify 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 per the Medication Administration for Unlicensed Personnel guidelines. Agencies shall contact the Regional Office Nurse Educator for training documentation verification of all new staff and rehires.

**6.4.d. Certification Requirements.** Certification and re-certification is also 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 four (4) training courses mandated as part of participation in the federally funded waiver program. Either federal regulations or DIDD requires annual training on these topics. In order to help agencies meet these 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 Insurance Portability and Accountability Act (HIPAA).** This training is to assure that a person’s private information is protected.

6.4.g. **Centers for Medicare and Medicaid Services HCBS Settings Final Rule Requirements.** In addition to the required training mandated by DIDD, CMS has published in the Federal Register
the Final Rule for home and community-based setting requirements. For staff training purposes, there are courses available that have been identified that can be used to meet or exceed these CMS HCBS requirements. These courses are located on a course crosswalk to the CMS HCBS requirements, which is located on the DIDD training web site.55

6.4.h. Human Rights Training. This training is to reinforce the principle that individuals with disabilities, regardless of the nature, type, or severity of the disability, have the same opportunity as their nondisabled peers to experience and enjoy working, leisure time activities, and other life experiences. (Rehabilitation Act Amendments of 1992) Many courses available through the web training platform address human rights and the office of Civil Rights has created an ADA training that is strongly recommended for staff. The Office of Civil Rights continues to create and offer both training specific to Human Rights Committee members and chair persons, as well as this general ADA training on human rights and posts it on their web site and on the web training platform.56

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.

55 http://www.tn.gov/didd/topic/rlms-course-crosswalks
6.5.a. Phase I or Pre-Service Training for All Staff. 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 for All Staff. 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 only. This training is to be completed within 60-90 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 only. 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. The Department’s preference is that all agencies conduct all testing in the web-based training portal site so that all training is recorded in the electronic learning management (ELM) system. If web-based testing is prohibitive and an agency elects to conduct testing
in a classroom setting, it is essential that test results are manually entered in the ELM for each learner so that the test is captured on the learner's electronic transcript. 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 web site.

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 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.

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 per State, CMS and other federal guidelines.

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. 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, Human Rights

57 Go to Training, Forms and Templates: http://www.tn.gov/didd/topic/forms-templates
Committee training and skill-based trainings such as Challenges in 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. 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 can 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 and individual scored tests (if applicable) are accepted proof of agency classroom 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.
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 Incident 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 on a systemic level, as well as on an individual level, 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>
<thead>
<tr>
<th>TYPE OF INCIDENT / EVENT</th>
<th>NOTIFY AS SOON AS POSSIBLE AND NO LATER THAN FOUR HOURS</th>
<th>NOTIFY AS SOON AS POSSIBLE AND NO LATER THAN TWENTY-FOUR HOURS</th>
<th>NEXT BUSINESS DAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death</td>
<td>Regional Office AOD for all deaths</td>
<td>Legal Representative or Primary Contact&lt;sup&gt;60&lt;/sup&gt; (document all attempts)</td>
<td>Reportable Incident Form (RIF) to DIDD Central Office</td>
</tr>
<tr>
<td></td>
<td>DIDD Investigations Hotline if death is suspicious, abuse or neglect may be involved, or if unexpected or unexplained</td>
<td></td>
<td>Notice of Death Form and RIF to Regional Director</td>
</tr>
<tr>
<td></td>
<td>If criminal activity: Law Enforcement</td>
<td></td>
<td>RIF to ISC Agency</td>
</tr>
<tr>
<td>Alleged or suspected abuse, neglect, or exploitation</td>
<td>DIDD Investigations Hotline</td>
<td>Legal Representative or Primary Contact (document all attempts)</td>
<td>RIF to DIDD Central Office</td>
</tr>
<tr>
<td></td>
<td>Department of Human Services (DHS) Adult Protective Services or Department of Children’s Services (DCS) Child Protective Services</td>
<td></td>
<td>RIF to ISC Agency</td>
</tr>
<tr>
<td></td>
<td>If criminal activity: Law Enforcement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serious injury of known or unknown</td>
<td>If unknown, DIDD Investigations Hotline,</td>
<td>Legal Representative or Primary Contact (document all attempts)</td>
<td>RIF to DIDD Central Office</td>
</tr>
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<td></td>
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</tbody>
</table>

<sup>60</sup> The person supported must have signed a Title 33 and HIPAA compliant release of information authorizing the primary contact to receive confidential information.
<table>
<thead>
<tr>
<th>TYPE OF INCIDENT / EVENT</th>
<th>NOTIFY AS SOON AS POSSIBLE AND NO LATER THAN FOUR HOURS</th>
<th>NOTIFY AS SOON AS POSSIBLE AND NO LATER THAN TWENTY-FOUR HOURS</th>
<th>NEXT BUSINESS DAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>unknown cause</td>
<td>DHS Adult Protective Services or DCS Child Protective Services If criminal activity: Law Enforcement</td>
<td>Primary Contact (document all attempts)</td>
<td>RIF to ISC Agency</td>
</tr>
<tr>
<td>Suspicious injury (i.e., suspicious for being caused by abuse or neglect)</td>
<td>DIDD Investigations Hotline DHS Adult Protective Services or DCS Child Protective Services If criminal activity: Law Enforcement</td>
<td>Legal Representative or Primary Contact (document all attempts)</td>
<td>RIF to DIDD Central Office RIF to ISC Agency</td>
</tr>
<tr>
<td>Reportable medical incident</td>
<td>Regional AOD if for any unplanned Hospitalization</td>
<td>As specified by Legal Representative or Primary Contact</td>
<td>RIF to DIDD Central Office RIF to ISC Agency</td>
</tr>
<tr>
<td>Medication variances, omissions or administration by someone untrained and uncertified or unlicensed</td>
<td>DIDD Investigations Hotline, except for medication variances in categories AE through DI</td>
<td>As specified by Legal Representative or Primary Contact</td>
<td>RIF to DIDD Central Office RIF to ISC Agency</td>
</tr>
<tr>
<td>TYPE OF INCIDENT / EVENT</td>
<td>NOTIFY AS SOON AS POSSIBLE AND NO LATER THAN FOUR HOURS</td>
<td>NOTIFY AS SOON AS POSSIBLE AND NO LATER THAN TWENTY-FOUR HOURS</td>
<td>NEXT BUSINESS DAY</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
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</tr>
<tr>
<td>Reportable Behavioral incident</td>
<td>Regional AOD for: Any hospitalization (unplanned) resulting from a behavior or psychiatric incident, or any behavioral incident with Law Enforcement or Mental Health Mobile Crisis Team involvement at the scene</td>
<td>As specified by Legal Representative or Primary Contact</td>
<td>RIF to DIDD Central Office</td>
</tr>
<tr>
<td>Missing person</td>
<td></td>
<td></td>
<td>RIF to ISC Agency</td>
</tr>
<tr>
<td>Sexual aggression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criminal conduct</td>
<td>Any incarceration</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If criminal activity: Law Enforcement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reportable staff misconduct incident</td>
<td>Regional AOD</td>
<td>As specified by Legal Representative or Primary Contact</td>
<td>RIF to DIDD Central Office</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>RIF to ISC Agency</td>
</tr>
<tr>
<td>Request for emergency service authorization approval outside of regular DIDD business hours</td>
<td>Regional AOD</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
All reportable incidents must be submitted to the Department, within required timelines, on the DIDD RIF, which can be found on the DIDD website, along with instructions.\footnote{Click on the link for the RIF for the appropriate region: \url{http://www.tn.gov/didd/article/incident-management}} under the heading Forms & Tools, Reportable Incident Forms. Instructions for completing the RIF can be found on the DIDD website under the same heading.

\section*{Categories of Incidents or Allegations Reportable to the Hotline.} The following categories of incidents shall be reported to the DIDD Investigations Hotline\footnote{East Tennessee Hotline poster: \url{http://www.tn.gov/assets/entities/didd/attachments/PFH_Investigators_Flyer_-_East.pdf} Middle Tennessee Hotline poster: \url{http://www.tn.gov/assets/entities/didd/attachments/PFH_Investigators_Flyer_-_Middle.pdf} West Tennessee Hotline poster: \url{http://www.tn.gov/assets/entities/didd/attachments/PFH_Investigators_Flyer_-_West.pdf}} as well as to the Incident Management Unit using a RIF:

1. **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. Corporal punishment, 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 supported...
and anyone affiliated with DIDD as a staff person, employee or a contracted provider or volunteer. between
a person supported and anyone affiliated with DIDD as a staff person, employee or a contracted provider 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), or other acts resulting in mental anguish, directed to or within eyesight or audible range of the person supported.

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.\(^{65}\)

c. **Exploitation:** [T.C.A. § 33-2-402 (8)] actions including but not limited to the deliberate misplacement, misappropriation or wrongful temporary or permanent use of belongings or money\(^{66}\) 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.

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\(^{65}\) Neglect towards a person supported 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.

\(^{66}\) The loss of $50.00 or more within a sixty (60) calendar day period.
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 where abuse or neglect is suspected or that is unexpected or unexplained.

### 7.1.c. Other Reportable Incidents and Interventions

The following categories of incidents and interventions must also be reported to the Incident Management Unit using the RIF:

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. **Reportable Medical:** any medical incident which requires assessment and treatment beyond first aid. Specific types of reportable medical incidents for tracking and trending include: constipation, dehydration, pneumonia, seizure, insect/animal bite, skin issue and urinary tract infection (UTI). Any other reportable medical incidents not noted above should be reported as reportable medical – other.

4. **Fall:** to unintentionally drop suddenly to a lower position; whether or not assessment and/or treatment is needed.

5. **Vehicle Accident:** any vehicle accident in which a person supported is in the vehicle regardless of injury or who is at fault.

6. **Reportable Behavior:** an event in which a person supported presents a challenging action(s) which requires an intervention.

7. **Physical Aggression:** hostile, injurious or destructive challenging behavior that is not directly related to property destruction.
8. **Property Destruction by a Person Supported Exceeding $100 in Value.**

9. **Person Missing Longer Than 15 Minutes:** any person receiving services who after being unexpectedly absent for longer than 15 minutes and after a reasonable search was conducted unless the absence is specified in a plan whose whereabouts are unknown for longer than 15 minutes.\(^6^8\)

10. **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.

11. **Sexual Aggression:** acts of a sexual nature, associated with potentially violent behavior of a person supported, regardless of the desire for participation on the part of the other person, whether or not the person supported is the aggressor or victim.

12. **Hospitalization:** a medical or psychiatric admission whether planned or unplanned.

13. **Psychiatric Hospitalization:** a psychiatric admission whether planned or unplanned.

14. **Admission to a Skilled Nursing Facility.**

15. **Admission to or discharge from ICF/IID:** an admission to or discharge from an intermediate care facility for individuals with intellectual disabilities.

16. **Use of Cardiopulmonary resuscitation (CPR) or an automated external defibrillator (AED).**

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

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\(^6^8\) Reference HB1512/SB1485
18. **Use of Abdominal Thrust, Back Blows or Heimlich Maneuver:** techniques used for dislodging food or foreign objects from the windpipe.

19. **Choking:** mealtime distress that does not require intervention such as but not limited to, coughing, gagging, watery eyes, etc.

20. **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.

21. **Serious Injury to Another by a Person Supported:** any injury to another person that requires assessment and treatment beyond basic first aid and was the result of a challenging behavior by a person supported.

22. **Manual Restraint:** as defined in the glossary.

23. **Protective Equipment:** as defined in the glossary. Unless, when appropriate, a reporting variance has been requested and approved.

24. **Mechanical Restraint:** as defined in the glossary.

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

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

27. **Reportable Staff Misconduct:** actions or inactions by staff of contracted providers, contracted employees, volunteers or others associated with a contracted provider which is providing care for persons supported by DIDD, that are contrary to sound judgment and/or training and 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, and do not result in injury or adverse effect, and the risk for harm is minimal.
28. **Medication Variances and Omissions**: in addition to notification to the DIDD Investigations Hotline, the submission of categories E to I on the Medication Variance Form shall require a RIF, with a copy of the DIDD Medication Variance Report. In all cases, medication administration by a person who was not trained and certified, or was not licensed by the State of Tennessee to administer medications requires notification to the DIDD Investigations Hotline.

7.2. **Notification.**

When any of the above listed types of incidents occur, the reporter provider’s Incident Management Coordinator (IMC) must complete and/or review to ensure completeness and accuracy, complete and electronically submit the front page of the RIF to DIDD and to the ISC within one (1) business day. If the primary provider is not the submitting party, the initial reporter shall also send a copy to the primary provider within one (1) business day. If additional information is needed then DIDD will inform the agency that submitted the report. The agency is required to submit the any information within one (1) business day of receiving the request from any member of the Protection from Harm Unit.

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 for the person supported at the time of the incident. Unless instructed otherwise by a DIDD investigator, a copy of the RIF should be sent to the other provider(s) with the name of the reporter redacted.

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If an incident involves suspected abuse, neglect or exploitation, serious injury of unknown cause, suspicious injury, medication variances in categories E to I, 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 as soon as possible and no later than four (4) hours after the incident or discovery of the incident. The legal representative or primary contact for the person supported must also be notified of incidents in these categories, as well as death (regardless of cause) as soon as possible and not later than twenty-four (24) 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.

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). Sexual abuse and/or any incidents of a criminal nature towards a person supported must be reported to law enforcement authorities regardless of the alleged perpetrator’s affiliation with DIDD or lack thereof.

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 and fulfilling all of the incident management responsibilities discussed herein. Specific responsibilities of the IMC include:

1. Acts as the primary contact for the DIDD Protection from Harm Unit (Incidents and Investigations) to ensure the investigative process is followed.
2. Review of all incidents for timely and appropriate action.
3. Ensure that all reportable incidents have been reported as required, including reports to the DIDD Investigations Hotline.
4. Ensure that the RIFs are typed, complete and electronically submitted by the reporter to DIDD, the ISC and primary provider of the person supported; with the exception of anonymous reports. Reports by private citizens and other individuals not affiliated with DIDD or a provider agency will have the RIF completed by the DIDD on-call investigator or provider agency IMC.
5. Ensure that DIDD recommendations and findings 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 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 should 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 and findings relating to incidents in 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 persons served supported.

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 upon request within two business days.

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 supported 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 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 reflect 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 or suspicious death has occurred, a DIDD investigation shall will be conducted in most cases. DIDD reserves the right to conduct an investigation into any incident.

2. If a provider challenges the decision not to open a particular investigation, a request for reconsideration should be forwarded by email to the Director of Investigations, who will make the final decision.

3. When notified that an investigation will be initiated, providers are expected to cooperate fully with the investigator and respect the investigative process. The provider will produce documents requested by the investigator which are within its possession within one (1) business day of the request, including but not limited to verification of social security numbers, proof of background checks, daily notes, drug and alcohol test results, personnel files,
and training records. Any video of the incident must be preserved and its existence made known to the investigator. Staff witnesses will be made available for interviews as requested by the investigator in consultation with provider management. If a witness is no longer employed, the provider shall furnish the most recent contact information to the investigator upon request.

4. Interviews by the DIDD investigator of witnesses during an investigation are to be conducted privately. If it is anticipated that any person other than the investigator and witness is to be present, the provider will notify the investigator no later than one (1) business day prior to the scheduled interview so that it may be rescheduled, if necessary, and arrangements made for another DIDD representative to also attend.

5. A witness, after completion of a DIDD investigation, may request a copy of his or her written or recorded statement by directing such request, in writing, to the investigator. The name(s) and identifying information of any person(s) supported will be redacted.

6. DIDD may conduct investigations of allegations involving DIDD employees, management or staff of contracted providers, agency sub-contracted providers, volunteers or other persons subject to DIDD oversight.

7. 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 advisory board chairperson owner or chief corporate executive of a for-profit provider. If the owner or chief corporate executive is a subject of the investigation, the report will be sent to the DIDD Regional Director, who will contact the other board members. The recipient of the Final Investigation Report will be required to respond if allegations are substantiated.

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72 The provider will be asked to produce a copy of any RIF that it submitted to DIDD, the ISP of any person supported who was involved and personnel records of the alleged perpetrator(s), including background checks and training information. Other documents deemed relevant by the investigator will also be requested.
8. 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.

9. When an employee of a provider or its agent or volunteer is implicated in allegations of physical or sexual abuse, or threats thereof, 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 supported or supervision of other staff who provide direct care, pending the completion of the investigation. This action should be taken by the provider without waiting for notice that an investigation has been opened or for instructions from DIDD.

   a. If the provider contends that the staff involved in physical or sexual abuse investigations should not be placed on administrative leave or reassigned, the provider may file a written request for an exception to this requirement with the DIDD Director of Investigations or designee.

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

10. Providers shall develop and implement a policy concerning appropriate actions in connection with 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 shall instruct all staff that the facts and circumstances being investigated are not to be discussed with anyone except the DIDD investigator, APS or law enforcement officers.

    c. The provider’s policy and administrative staffing actions will be reviewed during the investigation.

11. 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) ten (10) calendar days of receipt of the Final Investigation Report, the provider shall notify the person investigated, in writing, of the outcome of the investigation.

b. The provider is responsible for notifying parties of the outcome of the investigation. Within fifteen (15) calendar 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 and/or primary contact, if any, to participate in this discussion. This meeting shall be documented by the provider. The provider may send a copy of the summary of the investigation to the legal representative and/or primary contact, if that person is authorized to receive such information.

c. Address late reporting (if applicable).

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

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

a. What procedures that have been implemented for protecting person(s) supported from risk of further abuse, neglect or exploitation, including steps to prevent similar occurrences in the future.

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 occurred as a result of the findings of the investigation.

e. A response to any incidental findings contained in the investigation report.

13. DIDD will notify the provider when the POC is accepted.
14. If allegations were not substantiated, a POC is not required.

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


Providers, ISCs/CMs, and persons supported and/or their legal representatives may request review by the DIDD Investigations Review Committee (IRC) of a DIDD Final Investigation Report, if the request meets the Department’s criteria. The request must be submitted within fifteen (15) calendar days of receipt by submitting via mail or email, a written request, using the DIDD Request for Investigation Review Form, to the Office of the Director of Protection from Harm. A request for review does not alter the requirements of section 7.4.12.

Requests for review 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. For an investigation which is eligible for review, the request must present genuine and material factual issues affecting the challenged conclusion(s). Incidental findings, including reportable staff misconduct, will not be reviewed. Classification of a Level II substantiation will not be reviewed. DIDD will notify the requesting party within thirty (30) calendar

73 Click here http://www.tn.gov/didd/topic/protection-from-harm and select Request for Investigation Review
days of receipt of the request as to whether or not the request for review has been approved. If further investigation is warranted, or additional information needed, an interim notification will be issued. The requesting party will be notified of the committee’s decision within five (5) business days of the meeting at which the IRC renders a final decision.

DIDD reserves the right to submit any Final Investigation Report at any time to the IRC for review. This provision does not apply to investigations of incidents involving persons supported at DIDD-operated facilities. Such requests for review will be subject to the same standards and procedures applicable to requests for review submitted by providers.

7.6. **Review of Class I Substantiations and Referrals to the Abuse Registry.**

Individuals who are substantiated in DIDD investigations for Class I offenses are considered by the Abuse Registry Review Committee (ARRC) for placement on the State’s Registry of Persons Who Have Abused, Neglected or Misappropriated the Property of Vulnerable Individuals (“Abuse Registry”), established and maintained by the Department of Health. If the ARRC concludes that a substantiated perpetrator’s name should be placed on the Abuse Registry, that person has the right to request a file review and/or hearing before a hearing officer challenging that decision, as well the underlying substantiation. If the ARRC declines to refer the substantiated perpetrator’s name for placement on the Abuse Registry, he or she may nonetheless request a file review and/or hearing challenging the substantiation. To utilize either or both forms of review, the individual must submit to DIDD, within sixty (60) days from the date of notice sent to the perpetrator by DIDD of the disposition by the ARRC, a signed election form.
setting forth the requested type and scope of review. The procedures to be followed to request review, and those for conduct of the review process, are specified by Rules promulgated by the Department.

### 7.7 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 to be taken against personnel substantiated for abuse, neglect, or exploitation, and for reportable staff misconduct.
2. A description of procedures for addressing such incidents promptly and appropriately to minimize the future risk of similar incidents.
3. A procedure to develop and utilize trend studies of reportable incidents and substantiations for abuse, neglect or exploitation, for the purpose of identifying and reducing risks to persons supported using services.
4. A procedure for conducting risk assessments of persons supported who are 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 supported 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.

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74 Reference Tennessee Code Annotated 68-11-1003
e. For residential, day, nursing and personal assistance providers, maintaining and monitoring an after-hours emergency number to facilitate contact between the DIDD on-call investigator and agency management.

6. Measures to ensure the reporting of incidents timely and accurately; cooperation with DIDD investigators; and furnishing requested information and documentation promptly upon request, as required in 7.4.3.

7. Consequences 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. The provider is expected to adopt a zero tolerance policy for such infractions, conduct, which is specifically prohibited by DIDD.

8. Measures to prevent intimidation of or retaliation against any person, which is specifically prohibited by DIDD, 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. Measures to ensure that the provider’s management and staff do not interfere with or compromise the investigative process and that matters under investigation shall not be discussed except with the DIDD investigator, APS and law enforcement. These restrictions are applicable to agency internal investigations and include conversations with any staff, persons supported or other persons pertaining to the incident which is the subject of the DIDD investigation. Violations are specifically prohibited by DIDD.
10. 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 supported.
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 readily 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 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 symptoms 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. This includes insuring that informed consent was granted prior to provision of psychotropic medications. A new informed consent is required if specifications are not included and changes occur after the consent was signed.

2. 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. Providers are expected to coordinate with the SelectCommunity nurse care manager or other representative from the person’s Managed Care Organization to ensure the person receives necessary health care services, if applicable. Because of their extensive responsibility for the person, they shall document the following policies.

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75 Providers may request review of a person’s psychotropic medications by contacting the Regional Director of Behavior Services and requesting a referral to the Psychopharmacology Review Team.
and/or practices were implemented 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 or appointment on time.
   b. All necessary preparation for any health care encounter 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 relevant health information including documentation of allergies, medications and physical or behavioral health concerns.

4. Health care encounters and appointments and all recommendations are appropriately documented.

5. Outcomes from health care encounters and 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 Provider 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, prevention, 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. Table 8.3-1 describes TennCare, CMS, and DIIDD minimum requirements for medical examination by the physician.

<table>
<thead>
<tr>
<th>Age</th>
<th>Minimum Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to age 21</td>
<td>In accordance with TennCare Early Periodic Screening, Diagnosis and Treatment (ESPDT) standards.</td>
</tr>
<tr>
<td>Ages 21-64</td>
<td>Every one (1) to three (3) years as determined and documented by the PCP.</td>
</tr>
<tr>
<td>Ages 65 and older</td>
<td>Annually</td>
</tr>
</tbody>
</table>

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. If the waiver service limits are encountered, the representative payee is responsible for ensuring the person's needs are met in the order of their priority.

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).

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. This requirement does not apply to behavioral services.
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 and standards. Providers shall ensure that all unlicensed staff who administer medication have 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.

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.

5. PRN psychotropic medications may only be administered by a licensed nurse after an RN or prescribing practitioner has determined less

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77 Notice of Rulemaking Hearing, Department of Intellectual and Developmental Disabilities http://www.tn.gov/assets/entities/didd/attachments/Medication_Administration_Rules.pdf
78 Ibid.
79 Ibid.
restrictive measures have been taken and failed to stabilize the situation. Informed consent is required before the doctor’s order is implemented. The provider shall notify the prescribing physician of each administration of the PRN psychotropic medication within one (1) business day. HRC formal review is required within 30 days if the person supported does not assent to the psychotropic medication. A summary of all PRN psychotropic medications administered since the previous appointment shall be provided to the prescribing physician at the time of the person’s next quarterly appointment.

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 and obtain informed consent. 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

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80 Psychopharmacology Review Teams have been established in each grand region to provide consultation and recommendations for prescribing clinicians.
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. *See Chapter 12, Cross Systems Crisis Plans*

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.
5. Periodic review and restocking.
8.8. **Primary Provider Responsibilities for Hospitalizations.**

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/CM, including after-hours contact information, in addition to other contact information such as the legal representative and family.

3. Provide communication links between the person and or legal representative, residential service provider and hospital staff.

4. Collaborate 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. Collaborates with the ISC/CM to ensure the ISP is updated when indicated after 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. Collaborates with the ISC/CM regarding arrangements to resume or change previous professional services as appropriate and/or arrangements for providers of any new services and supports needed post discharge.

9. Collaborates with the ISC/CM regarding arrangements for any environmental modifications, new equipment or supplies needed post discharge.

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81 Refer to **Section 10.5.a**, subsections 1, 2, and 3 and **Section 10.15**.
10. Informs the Day Service provider of the hospitalization and the results. This communication can occur via email or in-person or telephone.

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. This information must be documented in the ISP.

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 in a state-operated ICF/IID or developmental center) 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.\(^82\) This requirement does not pertain to the Family Support Program.

8.11. **Autopsies.**

The Department encourages family members and or legal representatives of persons supported to request an autopsy for deaths that are unexpected and unexplained. These autopsies will be performed without cost to the family or legal

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\(^82\) [http://www.tn.gov/assets/entities/didd/attachments/90.1.2-Death_Review_Policy.pdf](http://www.tn.gov/assets/entities/didd/attachments/90.1.2-Death_Review_Policy.pdf)
representative. In the event the family or legal representative objects to the autopsy, the Department will respect their wishes.
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. As the funding entities of HCBS waiver services, state and federal governments are responsible for oversight of such programs to ensure that the services are meeting the needs of persons by focusing on the things that are important to and for them.

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 person-centered 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 person-centered 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 a person’s 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/implemention, and re-measurement to determine the effectiveness of strategies employed for improvement of the system.
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 publicly available.
7. The QMS must identify deficiencies and opportunities for validation.
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:

2. Provider Performance Surveys.
3. Individual Waiver-Specific Record Reviews.
5. Person Satisfaction Surveys.
6. Incident and Investigation (I&I) Data Analysis.
7. Complaint Resolution Tracking.
8. Death Reviews.
10. Individual Experience Assessments.
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. **Per CMS requirements, this process may**


include the development of Quality Improvement Plans by DIDD and TennCare to address specific areas of concern.


It is the provider’s responsibility to develop and implement policies, procedures and systems congruent with DIDD, TennCare and CMS regulations, including the HCBS Settings Final Rule. 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.
4. Rights, Respect, and Dignity.
5. Health.
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\(^3\) 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 via review of compliance with requirements of the CMS Qualified Provider assurance, to

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develop an effective management structure including a self-assessment process and a QI strategy, and to 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.

When appropriate, a focused review is conducted. A focused review is one that gives attention to a particular area that may have created challenges for a provider. During a QA or other review, if it becomes evident that the provider is experiencing difficulty in a given area, e.g., incident management, then the survey may be expanded to include additional review of that area. Systemic findings at the provider level are those that were problematic across several people in the sample or the entire sample. Statewide systemic findings are those that reveal themselves across reviews of a group of providers. When this occurs, it is DIDD's responsibility to analyze the cause of the systemic finding and work to find strategies that will help the system as a whole to improve.

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. When a provider achieves Three or Four Star status, DIDD reduces the frequency of monitoring for the next review cycle. 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. Providers achieving Two Star status continue to have annual surveys.

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 after the agency begins providing services.

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. A written final survey report will be provided to the provider as soon as possible following
the survey. The final report will also be sent to the provider agency’s board chair or chief officer.

9.5.h. Provider Response to Provider Performance Surveys. The provider agency 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 web-site.

**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 web-site.84

**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

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remediation timeframes. Remediation actions will be validated by designated DIDD Regional Office staff and by TennCare Quality and Compliance 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 or verify the risk of harm to the person has been removed.

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\textsuperscript{85} 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 may be affected by immediate jeopardy findings during a survey, even when timely corrections are implemented.

\textsuperscript{85} Go to Forms & Tools, Reportable Incident Forms. Click on the link for the RIF for the appropriate region. \url{http://www.tn.gov/didd/section/providers}
9.8. **Other Components of the QMS.**

9.8.a. **Satisfaction Surveys.** Personal satisfaction surveys provide information about the quality of services and supports directly from the people who receive them. The person’s perspective is a valued and essential component of the QMS. The 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 personal surveys and use the information obtained to improve the quality of services and supports. For support coordination agencies, evaluation of personal satisfaction with independent support coordination services occurs with completion of the Support Coordination Monthly Documentation Form\(^8\). Other provider agencies are required to conduct an annual survey, the results of which are reviewed during DIDD Provider Performance Surveys. Development of the satisfaction survey is the agency’s responsibility.

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 web site. The PTP survey involves face-to-face interviews with persons and/or family members conducted by an independent evaluator employed by the contractor.

\(^8\) http://www.tn.gov/assets/entities/didd/attachments/Support_Coordination_Monthly_Documentation_Form.pdf
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.\(^{87}\)

9.11. Provider HCBS Final Rule Self-Assessments

CMS requires that states review and evaluate HCBS waiver settings, including residential and non-residential settings, and demonstrate compliance with the new HCBS Setting Final Rules (effective March 17, 2014). This rule was developed to ensure that people receiving long-term services and supports through Medicaid – reimbursed HCBS waiver programs have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate. New providers of DIDD Residential Habilitation, Family Model Residential Services,

\(^{87}\) http://www.tn.gov/assets/entities/didd/attachments/90.1.2-Death_Review_Policy.pdf
Day and/or Employment Services must assess each licensed site that they own, co-
own and/or operate. New providers of DIDD Supported Living Services must 
complete one self-assessment per region. All providers must demonstrate 
compliance with the final rule by providing evidence that policies, procedures, 
training and operating practices are in place and regularly assessed for this 
compliance. DIDD will work with providers to assure compliance.

**9.12. Individual Experience Assessments (IEAs)**

The Individual Experience Assessment has been designed to crosswalk with 
the HCBS Settings Provider Self-assessment in order to identify areas where the 
provider indicates compliance and the individual’s responses supports compliance. 
Conversely, the assessment will also identify areas where there is a gap between 
what the provider believes is compliant and what the individual reports. 
Independent Support Coordinators (ISCs)/Case Managers are responsible for 
conducting face-to-face assessments and submitting these assessments for each 
person in their caseload who receives residential and/or non-residential (day or 
employment) services. This assessment will be conducted annually, and may be 
conducted during the person’s annual review, or quarterly or monthly visit or as a 
separate face-to-face assessment. DIDD will analyze the responses and be 
responsible for identifying follow up actions.

**9.13. 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. In addition, information regarding licensure may be obtained by visiting the DIDD web site.88

9.14. **Regional and State Quality Management Committees.**

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

9.14.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 meets monthly and 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.

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9.15. **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. The RPST also supports existing providers performing below acceptable standards in QA Domain 2 (Individual Planning and Implementation), Domain 3 (Safety and Security), Domain 5 (Health) and/or Domain 9 (Provider Capabilities and Qualifications). New providers will be assisted in all domains. Activities of the RPST are reported regularly to the RQMC.

9.15.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.
**9.15.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.

**9.15.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 Individual Planning and Implementation (Domain 2), areas related to safety and security (Domain 3), health (Domain 5) or Provider Capabilities/Qualifications (Domain 9).

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.

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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.

9.15.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.

9.15.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.

9.15.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 that will receive TA 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.
9.15.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. The validation tool is individually designed for the provider requiring technical assistance. It consists only of outcomes and indicators and interpretive guidance taken from the QA Survey Tool. It is not a new QA tool or checklist.

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.

8. If there are extenuating circumstances after the first 60-day extension, e.g., change in director or senior management, natural disasters (fire, tornado), etc., and compliance is still not achieved, SQMC may authorize an additional 60-day extension, prior to the imposition of benchmarks.

9.15.h. Conclusion of Technical Assistance. Technical assistance will be concluded when the provider has achieved compliance with the outcomes described in the QI Plan 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.


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.  

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90 Recoupment Policy: [http://www.tn.gov/assets/entities/didd/attachments/80.4.5-Recoupment.pdf](http://www.tn.gov/assets/entities/didd/attachments/80.4.5-Recoupment.pdf)

Sanctions Policy: [http://www.tn.gov/assets/entities/didd/attachments/80.4.6-Sanction%20Policy.pdf](http://www.tn.gov/assets/entities/didd/attachments/80.4.6-Sanction%20Policy.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 in Appendix A or in the Medication Administration training either must not be used, or if used, must be spelled out in complete form followed with the abbreviation, acronym or symbol in parenthesis. It is acceptable to abbreviate a person’s name in order to maintain confidentiality.

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. See Section A of the Provider Agreement for additional details.
7. Providers must maintain copies of required documentation obtained from contracted staff and other providers.
8. Records must be secured and 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.91

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91 [http://www.tn.gov/didd/section/providers](http://www.tn.gov/didd/section/providers)
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.
7. Law enforcement or Court upon receipt of a valid court order under Title 33 of the Tennessee Code Annotated.

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.

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 (if applicable) that are filed in records for people using services:

1. MARs.
2. Medication Profile Sheets.
3. Elimination, weight, menstrual, seizure and/or sleep records.
5. The Uniform Assessment (ICAP or SIS).
6. The Physician Ordered Treatment Log.
7. The current ISP.
8. The current BSP, if applicable.
9. HRC formal review and Behavior Support Committee approvals.
10. Staff communication notes.
11. Staff instructions.
13. The Emergency Disaster Plan.
14. Plan(s) of Care Training documentation.
15. ISP and BSP implementation data.
16. Clinical services quarterly reviews and progress notes.
17. Date of admission/enrollment.
18. DHS Form 2350 and 2362 (or such forms as required for eligibility) for a three-year period.
19. The PAE packet.
21. Documentation of information about Title VI.
22. The annual Medical and Assessment plan.
23. A current photograph of the person.
24. Emergency contact information.
25. Health care surrogates, POAs, guardianship (for minors if applicable) and Order of Conservatorship.
27. Insurance cards, including TennCare information.
30. All current physicians’ orders.
31. The Individual Transition Plan, if applicable.
32. The Individual Education Plan, if applicable.
33. The Individual Plan for Employment, if applicable
34. The annual physical unless otherwise indicated by the physician. See Table 8.3.1 for additional details.
35. The dental examination.
36. Correspondence.
37. Discharge summaries.

10.5.a. Responsibility for Maintaining Persons’ Comprehensive Records. The primary provider is responsible for maintaining the Comprehensive Record and for using those records to understand the person’s needs holistically, inform the Person Centered Planning process and facilitate the effectiveness of the Circle of Support. 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 nor 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. All staff providing services must sign and date the Staff Communication Note. 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 the name, address, and telephone number of:

- The name, address, and telephone number of the contact(s).

1. The name, address, and telephone number of the person’s primary care physician.

2. 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.

3. The name and telephone number of the person’s legal representative(s), if applicable;

4. The name and telephone numbers of any family members who are not legal representatives that are to be notified in event of an emergency.

5. The name of the person’s residential provider, if applicable, and the name of a contact person and that person’s telephone number;

6. 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, guardianship (for minors if applicable) and Order of Conservatorship.
7. Emergency contact information.
8. A current photograph of the person supported.
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 (ICAP or SIS).
2. Reports from medical and other consultants (e.g., therapy consultation reports, specialty physician consult report, psychiatric consult report, etc.).
3. Individual Experience Assessment / Personal Outcome Measures ® tool
5. DHS Form 2350 and DHS Form 2362 (or such forms as required for eligibility) for a three (3) year period.
6. Medicaid medical eligibility documentation (the PAE packet).
7. The dental examination.
8. The Annual Medical and Assessment Plan, (for developmental center transitions, as applicable).
9. The annual physical unless otherwise indicated by the physician. See Table 8.3.1 for additional details.


12. Emergency contact information.

13. A current photograph of the person.

14. The current ISP.

15. The current BSP, if applicable.

16. The ISTP (for developmental center transitions).

17. The Individual Education Plan, if applicable.

18. The Individual Plan for Employment, if applicable

19. Support coordination monthly reviews.

20. Correspondence, as applicable.

21. Discharge summaries, if applicable.

22. Plans of care or treatment for nursing, therapeutic, therapy-related, or dental services.

23. Required ISC documentation forms.

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

25. Health Care Surrogates, POA, guardianships (for minors if applicable) and Order of Conservatorship.


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, audiologists, 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.
9. Correspondence as applicable.
10. A discharge summary, if applicable.

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

2. The current ISP and BSP.
3. The ISTP, 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. HRC an Rights—formal review and Behavior Support Committee approvals.

8. Correspondence, as applicable.

9. A discharge summary, if applicable.

10. Training documentation as 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.


7. Current ISP.

8. Therapy Contact notes.


10. Staff instructions (if applicable).

11. Training documentation as applicable.

12. Correspondence as applicable.

13. Discharge summary as applicable.
Record retention is ten (10) years plus one (1) after date of death or discharge for services requiring a Professional Services Support License (PSSL) and ten (10) years after date of death or discharge 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, guardianship (for minors if applicable) 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, guardianship (for minors if applicable) 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. Periodic 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, guardianship (for minors if applicable) 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.

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 providers 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.


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 Tennessee Felony Offender Information List (FOIL), 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.
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.


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:
a. ISP due dates.
b. Due dates for level of care reevaluations or financial eligibility determinations.
c. Dates of any medical or other appointments already scheduled.
d. Due dates for annual medical, dental or other appointments that have not been scheduled.

2. Pending or outstanding issues, such as:
   a. Pending ISP updates or amendments that need to be submitted or have been submitted to the DIDD Regional Office.
   b. Pending referrals.
   c. Outstanding health or mental health-related recommendations.
   d. Outstanding medical equipment or equipment repairs.
   e. 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.
11.1. Residential Services Requirements.

All residential services are required to comport fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, except as supported by the individual’s specific assessed need and set forth in the person-centered individual support plan (ISP).

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, and family model residential support, medical residential services, supported living and semi-independent living services.

Individuals receiving services may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing,
qualified provider who can safely meet the needs of each resident in the home.

The list below describes several shared living arrangement scenarios.

1. A person receiving Medical Supported Living services may reside with a person receiving Supported Living.

2. A person receiving Medical Residential Services may reside with a person receiving Residential Habilitation.

3. A person receiving Supported Living, Semi-Independent Living, Family Model or Residential Habilitation may reside with a person receiving Choices CLS.

4. A person receiving Residential Habilitation may not reside with someone receiving Family Model or Supported Living.

5. A person receiving Semi-Independent Living may not reside with someone receiving Supported Living.

All providers of residential services are required to abide by the following list of general requirements, in addition to specific requirements for the particular waiver service being delivered and the waiver service definition. 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. Licensure is not required for agencies that serve only one (1) person.
2. With the exception of Semi-Independent Living Services, 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.

3. Residential services may be provided out-of-state, with the exception of semi-independent living.

4. The residential property can be rented, owned, or occupied by the person supported under tenant law or there is a lease agreement with the provider for each person supported.

5. The home and the person’s bedroom can be locked by the person supported and only necessary provider staff has keys, as addressed in the person’s ISP.

6. Persons supported who have a shared living arrangement have a choice of roommates who will reside in the home.

7. Persons supported have freedom to furnish and decorate their sleeping and living units, within the confines of the lease or tenancy agreement if applicable.

8. Persons supported have freedom and are encouraged to control their own schedules and activities and have access to food at any time.

9. Persons supported have the freedom to have visitors of their own choosing at any time.

10. All residential settings must meet the individual accessibility and safety needs of persons supported.

11. The provider is responsible for oversight of the person’s health care needs.

11.1.a. Requirements Applicable to Residential Habilitation Providers. Each home shall meet standards specified by the Tennessee State Fire Marshal and shall be licensed by DIDD. The provider may charge the person supported room and board as described in policy 80.4.3 Personal
Funds Management\(^92\). With the exception of agencies that serve only one (1) person, a residential habilitation home cannot be owned by\(^93\):

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

In family model residential support services, the people supported live in the home of the caregiver family. The provider may charge the person supported room and board as described in policy 80.4.3 Personal Funds Management. 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 1-8 listed below pertain to the provider agency, not the sub-contracted provider (if applicable).

\(^{92}\) [http://www.tn.gov/assets/entities/didd/attachments/80.4.3-Personal%20Funds%20Management.pdf](http://www.tn.gov/assets/entities/didd/attachments/80.4.3-Personal%20Funds%20Management.pdf)  
\(^{93}\) Providers may request an exemption to this requirement accordance with policy 30.1.6 Exemption Process, which is available on the DIDD web site Policies and Procedures home page. [http://www.tn.gov/assets/entities/didd/attachments/30.1.6-Exemption%20Policy.pdf](http://www.tn.gov/assets/entities/didd/attachments/30.1.6-Exemption%20Policy.pdf)
1. Following placement of a person, the provider is required to perform an unannounced supervisory visit to the home as follows: a minimum of one (1) visit each calendar month for LON 1-3 and a minimum of two (2) visits per calendar month for LON 4-5, 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 service 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 any time.

7. The provider agency may serve as the representative payee for the person supported. Individuals residing in the home may not serve as the representative payee. Individuals residing in the home may not serve as the conservator unless a court order was obtained prior to this provider manual becoming effective March 25, 2014 that expressly allowed them to do so. See Chapter 2, Section 2.5.c

8. The person may be assigned reasonable responsibilities, commensurate with expressed interests and abilities, in the home environment.
9. In keeping with the Department of Labor, Fair Labor Standards Act, final rule of January 1, 2015\(^4\) provider agencies are restricted from the following activities:
   a. Determining whether a caregiver chooses to participate in the program.
   b. Determining whether a caregiver will bring a particular person supported into his or her home.
   c. Directing Day-to-day routines and schedules within the home.
   d. Directing or managing the delivery of services and supports.
   e. Leasing a residence in which the service and supports will be provided.
   f. Making frequent visits or phone calls to the home (unless related to the monitoring of service delivery and quality assurance purposes).
   g. Instructing the caregiver about particular tasks to perform or ways to fulfill or not fulfill duties.

11.1.c. Requirements Applicable to Medical Residential Support Services. The distinguishing feature of medical residential support services is the person supported has a medical diagnosis that requires the ongoing provision of direct skilled nursing services in the residential setting. These supports can occur in a Supported Living setting or the home can be licensed for residential habilitation. 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 personal 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.

9. Nurses may perform non-skilled services including assistance with eating, toileting, grooming and other activities of daily living.

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 provide a residential option which allows the person supported greater involvement and control in the operation of the home. The supported living provider is responsible for oversight of the health care needs for the person supported. 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 be fully informed of 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.
   a. When approved by special exception, a person supported may live with other family members when the family member is a minor child living with a parent receiving services or the spouse of a person receiving services.
   b. For companion model supported living homes: the companion staff’s spouse, significant other or family can live in the home as long as the person supported agrees and is addressed in the person’s ISP.

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.e. Requirements Applicable to Semi-Independent Living Services. Semi-Independent Living Services is available through all three (3) of Tennessee’s HCBS Waivers and is a service for people who need intermittent or limited support to remain in their own home and do not require staff that lives on-site. It 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. Home Inspection Requirement for Supported Living and Semi-independent Living. Because these sites do not require individual licensing and are not provided in the home of a family member or caregiver, all supported living residences and semi-independent residences are 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 trained life safety codes inspector employed or contracted by DIDD. Inspections will be
conducted utilizing the DIDD Home Inspection Form for Supported Living and Semi-Independent Living provided on the DIDD web site.

**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.

11.1.g. **Lease Requirements Applicable to All Residential Services.** The following requirements are applicable regarding lease arrangements for persons receiving residential services:

1. **The preferred lease option is for the home lease to be signed by the person supported or legal representative.** However, for Residential Habilitation and Family Model Residential Supports that utilize a room and board model, a tenancy agreement is appropriate in lieu of a lease. Such agreement must ensure the same protections a person would otherwise be entitled to under applicable Landlord and Tenant laws.

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

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95 [http://www.tn.gov/assets/entities/didd/attachments/Waiver_Service_Definitions.pdf](http://www.tn.gov/assets/entities/didd/attachments/Waiver_Service_Definitions.pdf)
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 residential 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. This process requires that the wishes and desires of the person supported be considered by the COS and incorporated into the planning process. 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.

96 http://www.tn.gov/assets/entities/didd/attachments/80.4.7-Community%20Transition%20Policy.pdf
7. The owner of a supported living home may not be an employee or board member employed or appointed by the supported living provider unless a single person agency. The purpose of this requirement is to avoid that conflict of interest that would occur if this practice were allowed.

8. The lease or tenancy agreement must provide for a thirty (30) day notice to the person supported prior to termination of the lease agreement (unless the county of residence requires a longer period by statute) and a thirty (30) day notice to the person supported prior to an 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 tenancy or lease agreement must be provided to the person supported, and/or legal representative or other person designated by the person.

14. The residential setting shall be physically accessible to the individual.

11.1.d.2. Availability of Mortgage and Lease Documentation

Individual leases or tenancy agreements 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/tenancy/mortgage payment information must also be available for review if the provider is involved with assisting the person in managing financial resources.

11.1.h. 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. The staffing plan must be individualized according to the specific needs of each person supported. If the person's staffing plan specifies that two (2) staff are necessary to perform certain activities (based on the person's individual assessed needs) then the presence of two (2) staff during a shift change briefing or shift change overlap will not be considered sufficient. Daily documentation in the person's record must indicate that needed services and supports were provided as required.

Providers are cautioned that if staffing was not provided in accordance with the staffing plan and was billed as if the service was appropriately staffed then an investigation will be conducted to identify potential fraud, waste and abuse. If payment was made in error (e.g., DIDD reimbursed the provider for LON 4 services but LON 3 services were provided) it is subject to full recoupment based on federal program integrity regulations.

11.1.i.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 person’s 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, Supported Living, Medical Residential and Special Needs Adjustment, Level Descriptions for Respite Services, Staffing Standards for Residential and Day Services. 97

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.i.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.

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 provided on the DIDD web site. Providers may submit a copy of the Section 8 housing inspection to DIDD in lieu of the DIDD housing inspection.

97 http://www.tn.gov/didd/section/providers, Level Descriptions and Staffing Standards
11.1.j. Requirements for Services Provided Out-of-State. Waiver services may only be provided out-of-state for a maximum of 14 days per person per waiver (calendar) year for supported living, residential habilitation and Family Model Residential Services as outlined in TennCare Rule 1200-13-01-.25-2(w) and the waiver service definition.\textsuperscript{98} Waiver services outside of the country will not be reimbursed by Medicaid funds.

11.2. Employment and Day Services Requirements.

Employment and day services are individualized services and supports selected by the person supported, that help the person to seek employment and work in competitive integrated settings and engage in community life, based on his or her individualized needs and preferences and as reflected in the person-centered ISP, and to acquire, retain, or improve skills in the area of self-care, sensory/motor development, socialization, daily living skills, and communication, in order to pursue and achieve his or her personal employment and/or community living goals. Providers of employment and/or day services are required to abide by the requirements specified in the waiver service definition,\textsuperscript{99} this manual and other applicable departmental policies and procedures.

All individual employment and day services goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP and shall include

\textsuperscript{98} http://www.tn.gov/assets/entities/didd/attachments/Waiver_Service_Definitions.pdf
\textsuperscript{99} Ibid.
opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the individual. The Department permits flexibility in scheduling the hours that employment and day services are provided in order to support the goals specified in the ISP.

Day services are required to 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 employment services, community based day services, and facility based day services and in-home day services. Except for students who have graduated prior to May of 2014, Day Services for school aged persons (i.e., under the age of 22) are limited to regular school break periods.

Transportation of the person to and from the person's place of residence to the location where Employment or Day Services will be provided is the responsibility of the employment or day services provider. With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol, transportation that is needed during the time that the person is receiving day services is the responsibility of the day services provider.

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 through engagement, experience,
and exploration. 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.
8. Informational interviews.
9. Participating in Discovery to learn more about the individual’s strengths, goals, and conditions for employment.

**11.2.a. Day Services Settings.** Providers are responsible for ensuring that day services are provided in settings that comport with the Centers for Medicare & Medicaid Services (CMS) HCBS Settings Final Rule. CMS published a fact sheet that provides guidance regarding the settings in which day services are provided. The fact sheet can be obtained online. Providers are advised to familiarize themselves with the requirements of the final rule. The qualifications include the following criteria:

1. The setting is integrated in and supports full access to the greater community.
2. Is selected by the person supported.

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3. Ensures individual rights of privacy, dignity, and respect and freedom from coercion and restraint.

4. Optimizes autonomy and independence in making life choices.

5. Facilitates choice regarding services and who provides them.

11.2.b. Employment Services. Tennessee is an Employment First state which is based on the premise that all citizens with disabilities, including individuals with significant disabilities are capable of full participation in integrated employment and community life. 101 It is a concept to facilitate the full inclusion of individuals with varying degrees of abilities in the workplace and in the community. Persons supported by DIDD who are over 22 years of age should be provided with the experience, exposure and education needed to make an informed choice regarding participation in day activities and employment. DIDD expects that integrated employment (including individual supported employment) be considered and encouraged in planning with every individual.

Employment is the preferred option for all persons supported based on each person's needs and preferences. The Department supports the preferences of people who are retirement age 102. Additionally, if the person supported is of retirement age and prefers to work then the expectation is that the provider support the person to obtain and maintain integrated employment. Persons supported who desire to obtain integrated employment at competitive wages

102 United States Department of Labor, Fair Labor Standards Act (FLSA) establishes the minimum age for employment is age 14. The Social Security Administration establishes the retirement age as 62 to 67 depending on the year the person was born.
should be supported to have a job along with the necessary and appropriate supports to successfully maintain the job.

Vocational exploration and discovery focused vocational assessments may be performed whenever needed and are required at least every three years; unless the person supported or legal representative (as applicable) has explored what integrated employment is and has decided that s/he does not wish to seek employment and declines to sign a consent for the assessment. ¹⁰³ For those individuals who choose other day service options, the minimum DIDD requirement is that the option of integrated employment be reconsidered during the Circle of Support meeting and documented during each annual ISP update.

11.2.b.1 Vocational Rehabilitation (VR). Persons supported that wish to become employed must be referred to apply for VR services prior to approval for DIDD employment services. VR will determine eligibility based on their guidelines¹⁰⁴ and provide eligibility documentation. Documentation provided by VR needs to be submitted to DIDD in order to receive approval to provide HCBS waiver employment services. DIDD expects that the employment provider will build on the services provided as per the Memorandum of Understanding with VR to ensure seamless transition from VR to waiver services. Providers of day services other than employment are expected to complement employment planning and supports.

11.2.b.2 Supported Employment. These services must be provided in accordance with the following requirements:

¹⁰³ DIDD considers an array to mean more than two (2) options based on a person's interest, education, and background.
1. The provider shall oversee the person’s supported employment services including on-site supervisors, and shall have a minimum of one contact per week with the person including at least one contact per month at the work site;

2. A job coach employed by the Day Services provider shall be on-site at the work location and shall support the person; or

3. A job coach employed by the Day Services provider must be available on call if needed to come to the work site immediately upon request from the person supported or the employer of the person supported.

4. A job coach employed by the Day Services provider shall not jeopardize the person's employment and shall conduct him/herself in a professional manner while on the job site and abide by the policies and procedures of the organization employing the person supported.

The Workforce Investment Act (WIA) was changed to the Workforce Innovation and Opportunity Act (WIOA) under the Rehabilitation Act section 511, which now addresses the payment of sub-minimum wages to youth with disabilities. WIOA is designed to provide job seekers with access to employment, education and training needed to succeed in the labor market. Effective July 1, 2016, Section 511 requires a series of steps before an individual under the age of 24 can be placed in a job paying less than minimum wage. Section 511 also prohibits schools from contracting with providers that have 14(c) certificates and pay subminimum wages.

105 http://www.doleta.gov/WIOA/
11.2.c. **Community-Based Day Services.** Community-based Day Services are required to support each person’s full engagement in community life, based on his or her individualized needs and preferences and as reflected in the person-centered ISP, and the acquisition, retention, or improvement of skills in the area of self-care, sensory/motor development, socialization, daily living skills, communication, and social skills in order to pursue and achieve his or her personal employment and/or community living goals. This includes assisting the person to build relationships and natural supports.

Community-based Day Services are designed such that the person spends the majority of his/her time, while participating in this service, actively engaged in activities in the community. Supervision, monitoring, training, education, demonstration, or support is provided to assist with the acquisition of skills in the following areas, including but not limited to: leisure activities and community/public events, utilizing community resources (e.g. public transportation), acquiring and maintaining employment, educational activities, hobbies, unpaid work experiences (e.g. volunteer opportunities), and maintaining contact with family and friends.

11.2.d. **In-Home Day Services.** In-home Day Services are provided in the person’s residence only if selected by the person supported because there is a health, behavioral, or other medical reason or if the person has chosen retirement or is unable to participate in services outside the home. Therefore, although this service is available to meet specific and well documented needs, it is to be used only in exceptional circumstances. These circumstances may include limited provision of these supports due to behavioral or psychiatric destabilization, medical concerns or 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. If the reason for the request for In-home Day Services is retirement then the information in the ISP should indicate that the person was employed and has chosen retirement. It is not necessary that the person be of official retirement age according to Social Security guidelines, nor does the person have to retire because they are of retirement age.

11.2.e. Facility Day Services. Day Services may be provided in a facility setting only when selected by a person supported who needs time limited pre-vocational training, when such training is not available on the job site, and to persons who, through their person-centered planning process choose to participate in a facility based program in order to focus on the development of individualized and specific skills that will support them in pursuing and achieving employment and/or community living goals. Facility-based day services must allow for opportunities for all persons supported to be engaged in the broader community when appropriate and be specified in the person-centered ISP. Opportunities to transition into more integrated settings, including competitive integrated employment will be evaluated at least every six (6) months. Providers should refer to the joint TennCare and DIDD memos issued on July 16, 2015 and June 20, 2016 regarding appropriate billing of facility based day services and supported
employment services.\textsuperscript{106} It should be noted that the joint memos referenced above are consistent with CMS guidance issued in 2011.\textsuperscript{107}

11.2.f. 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.g. 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. 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.

\textsuperscript{106} \url{http://tn.gov/assets/entities/didd/attachments/FB_vs_SE_Memo_to_Providers.pdf}
\textsuperscript{107} \url{http://tn.gov/assets/entities/didd/attachments/Authorization_Changes_for_Facility_Based_Day_Services.pdf}
5. 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.
CHAPTER 12

BEHAVIOR SERVICES

12.1. Introduction.

Behavior is the final common pathway for a host of psychological, medical, physical, and environmental influences. These influences merge to create the observable behavior that we see in a particular individual. Knowing that a person displays challenging behavior is not helpful in designing treatment to overcome that behavior. It is far more important to understand factors that bring about that behavior.

DIDD supports the practice of Applied Behavior Analysis in conjunction with positive behavior supports 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 providers, nurses, psychiatrists, and psychologists to ensure that the person receives comprehensive and integrated services.
Several providers must work in concert to ensure persons receiving behavior services are served in a safe, appropriate, and effective manner. Chapter 12 outlines roles and requirements for behavior service providers and other providers in the provision of behavior services.

12.2. Behavior Service Provider Responsibilities.

Behavior services must be provided in accord with HCBS waiver definitions provided on the DIDD web site, and the person-centered planning provisions and rights protection provisions of the CMS HCBS Setting Final Rule. Services include Behavior Services: Assessment, Behavior Services: Planning and Development, Behavior Services: Other, and Behavior Services: Presentation at Meetings. The process for the provision of behavior services has four stages. They are: 1) Assessment: Completion of a Behavior Services Assessment Report, 2) Planning: Completion of a Behavior Support Plan or Staff Instructions, 3) Follow-up: Completion of Clinical Service Reviews, and 4) Discharge. Behavior analysts must also document their contacts with persons served for billing purposes. These steps in the process are outlined in greater detail below.

1. **Behavior Services Assessment Report (BSAR).** Behavior analysts shall conduct an initial clinical assessment of behavior in accord with DIDD professional standards. The Behavior Services Assessment Report shall include all information relevant to the reason for referral and recommended behavior interventions, as applicable. When the Behavior Services Assessment Report has been completed and reviewed and approved by the person supported and his/her COS, the behavior analyst may request that
the ISC submit a request for additional behavior services that may be needed.

2. **Behavior Support Plans.** Behavior Support Plans (BSPs) are developed through the person centered planning process and monitored by behavior analysts to address health and safety risks to the person supported or other behaviors that significantly interfere with home or community activities.

The BSP shall only be written by a behavior analyst or a behavior analyst in conjunction with a behavior specialist. The behavior specialist may implement the BSP, perform data collection, and train others to implement the plan. However, the behavior analyst retains overall responsibility and clinical oversight for the BSP and its effectiveness implementation. The agency or entity employing persons implementing the plan retains the responsibility to ensure the BSP is followed and to promptly notify the behavior analyst if conditions occur that impede implementation.

a. Behavior analysts shall work in collaboration with the person receiving the services, family members, the conservator if applicable and others selected by the person who will be supporting the person receiving the services, and responsible for implementing the BSP, with the person supported, his/her conservator and COS members in the development of a BSP. All members of the COS shall have the opportunity to review and provide feedback on the BSP prior to its implementation.

b. Any BSP to be implemented by a DIDD contracted agency shall receive appropriate consent and approval from the person supported and or legal representative, regardless of the funding source for behavior services.
c. BSPs shall be implemented in a timely manner. Plans including unrestricted procedures should be implemented within thirty (30) days of start date of the authorized BSP development. Unrestricted procedures in plans involving restricted procedures should also be implemented within thirty (30) days of the start date. An additional thirty (30) days may be allowed to obtain approval and to implementation of restricted procedures that require approval. All restricted procedures must be understood and approved by the person supported and the COS. In addition, the person supported must consent to the restrictions which must be detailed in the person-centered BSP and include all components of Rule modifications per the CMS HCBS Settings Final Rule, including the plan for evaluating the effectiveness of the restriction on a regular basis and methodology for removing the restriction. For a plan to be considered “implemented,” DSPs shall be trained in carrying out the procedures required in the BSP. Providers shall document any barriers to meeting stated timelines in clinical service reviews or other documentation. In cases where obtaining conservator consent is a barrier, behavior analysts should contact the DIDD Director of Behavioral and Psychological Services for further guidance.

d. Requirements for BSP review by Regional Behavior Support Committee and HRC review are provided in section 12.6. Classification of Procedures and Associated Requirements. Requirements for BSP review by the Human Rights Committee are described in policy 80.6.1 Human Rights Committee. BSPs shall be reviewed annually by all appropriate committees.

e. 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 simple staff instructions which may remain in effect after discharge. Staff instructions shall include only unrestricted procedures that help the person served remain successful. The COS is responsible for managing and revising
staff instructions that remain after the person is discharged from behavioral services.

3. **Staff Instructions in a Consultative Behavior Services Model.** In circumstances where the behavior analyst has completed a Behavior Services Assessment Report and determined that a BSP is not required, he or she may provide a list of staff instructions that may be included in the person’s ISP documented in the person-centered ISP. If appropriate, the behavior analyst may utilize Behavior Services: Presentation at Meetings to follow-up on these instructions at periodic COS meetings and document any recommended changes to staff instructions in their contact note. A limited number of Behavior Services: Other (not to exceed 8 units per month) may also be used for this consultative service. This service may also be useful when a BA is seeking to fade their involvement or provide a maintenance level of support to the person and the COS. The following shall apply to this service:

a. The Behavior Services Assessment Report BSAR or most recent Clinical Service Quarterly Review must clearly state the purpose for the consultative service in the recommendations section. Behavioral objectives shall be required for target and replacement behaviors.

b. Each contact note shall include information regarding whether the staff instructions are adequate as presently written and outline an action to be taken if changes are necessary.

c. The service shall include ongoing data collection for targeted and replacement behavior and Clinical Service Quarterly Reviews shall be completed in accord with parameters outlined in section 12.2.4. Clinical Service Monthly Reviews are not required for this service.
4. **Clinical Service Reviews for Behavior Services.** 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.

   a. Clinical Service Monthly Reviews provide a brief assessment of progress toward implementing the clinical service plan of care.

   b. A copy of the Clinical Service Monthly Review shall be submitted to the ISC/CM and primary provider, by the twentieth (20th) calendar day of the month for the preceding month of service.

   c. Clinical Service Quarterly Reviews are a comprehensive assessment of progress toward implementing the clinical service plan of care every third month in lieu of a monthly review and include an analysis of relevant data and observations to verify behavioral function. A copy is to be submitted to the ISC/CM and the primary provider agency by the twentieth (20th) calendar day of every fourth (4th) 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.

   d. 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 clinical service review and any work product to the Regional or Central Office within two (2) business days for clinical review and QA.

5. **Discharge.** 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; and

   b. Description of progress across the course of treatment; and
c. Reason for discharge; and

d. Discharge plan including reference to simple instructions in an ISP that will remain in effect when the BSP is discontinued.

6. **Contact Notes.** Contact notes shall be completed for all behavior services. Name of service, in/start time, out/stop time, and number of units provided shall be provided for all contact notes. The following requirements apply to contact notes for specific behavior services:

a. **Notes for Behavior Analysis Other:** Notes shall also include a brief narrative of what activities were completed during the appointment and how they apply to ISP outcomes. They may also include other relevant data collected during the course of the visit. Behavior service providers shall also have a staff member or other witness sign their contact note as verification of the service.

b. **Behavior Services Assessment and Behavior Services: Planning and Development:** must be supported by contact notes shall describe the provider's activities, but do not require a staff signature since these services are not required to be completed face-to-face with the person supported.

7. **Billing for Behavior Services.** Providers of behavior services are required to abide by the following in accordance with the waiver service definition:\(^{108}\):

a. Behavior analysts are required to document their contacts with persons supported for billing purposes.

\(^{108}\) [http://www.tn.gov/assets/entities/didd/attachments/Waiver_Service_Definitions.pdf](http://www.tn.gov/assets/entities/didd/attachments/Waiver_Service_Definitions.pdf)
b. Behavior Services shall be provided by a Behavior Analyst face to face with the person supported except for:

i. Completion of the behavior assessment (Behavior Services Assessment Report and Behavior Support Plan)

ii. Person supported-specific training of staff, except in instances when the Behavior Analyst can demonstrate appropriate interventions in real time.

iii. Presentation of behavior information of the person supported at human rights committee meetings, behavior support committee meetings, and planning meetings related to the person supported.

12.3. Behavior Analyst Collaboration with Other Service Providers.

Behavior analysts shall work cooperatively with all other service providers and shall coordinate their treatments with other clinicians who support the person. To the extent possible, behavior analysts should make an effort to attend psychiatric appointments to provide reports of the person’s response to psychiatric interventions and provide treatment alternatives to adding more medication. Developing relationships with particular psychiatrists, making arrangements so that a behavior analyst’s caseload is seen during a block of time, or evening scheduling are examples of approaches that may facilitate this type of collaboration.

All Behavior Services Assessment Reports, Behavior Support Plans, and Clinical Service Reviews shall meet quality criteria outlined in the Behavior Services Work Product Review which is published on the DIDD web site.

12.5. Behavior Support Committees.

1. Regional Behavior Support Committees (BSCs) shall be available in each region for the purpose of reviewing BSPs with Restricted and Special Individualized Interventions, plans for providers who are new to the DIDD system, and plans that have involved higher than typical uses of restraint or other behavior safety interventions.

2. The Regional Office Behavior Analyst Director or DIDD Director of Behavioral and Psychological Services may request a BSC review of any BSP implemented in the DIDD system as needed. All relevant materials for such reviews shall be submitted within two (2) business days of the request.

3. Special Individualized Interventions, variances to DIDD behavioral service requirements, and procedures not currently classified by DIDD shall be reviewed by a Statewide BSC chaired by the DIDD Director of Behavioral and Psychological Services composed of the three RBSC chairpersons and other qualified staff as appropriate. The chair shall have the discretion to delay or not consider BSARs or BSPs that do not meet quality standards laid out in the Behavior Services Work Product Review.

4. Plans reviewed by BSCs shall be approved, disapproved or approved with changes.

109 http://www.tn.gov/assets/entities/didd/attachments/Health_Services-Behavior_Services_Work_Product_Review.xlsm
12.6. **Classification of Interventions and Associated Requirements.**

DIDD adheres to person-centered principles and a model of positive behavior supports, with an understanding that individual needs may require interventions designed to set appropriate limits for persons supported to sustain their regard as a valued member of the community. BSPs shall be developed using procedures that most effectively produce a desired behavior change.

DIDD has designated three (3) classifications of behavioral treatment interventions: unrestricted interventions, restricted interventions, special individualized interventions. Behavioral safety interventions and specialized behavioral safety interventions are classified separately because they are used to address safety concerns, and are not used for treatment.

The Department DIDD also has a list of prohibited procedures. Procedures classified within the following broad categories may be found on the DIDD Health Services web site under Behavior Services110.

1. **Unrestricted Interventions:** Unrestricted interventions are used to teach, train, increase desired behavior, or maintain desired behaviors and design environments to support the person. In some cases, the procedures involve mild forms of negative feedback, such as social disapproval.
   a. The DIDD encourages COSs to engage in informal problem solving and the use of supportive intervention strategies when appropriate. Referrals for behavior services shall only be made when such informal processes have been tried and were not are inadequate to address the behavior and the services of a behavior analyst are needed to help resolve the inappropriate behaviors.

110 [http://www.tn.gov/didd/article/behavior-services](http://www.tn.gov/didd/article/behavior-services)
b. A BSP that incorporates only unrestricted behavior interventions requires informed consent from the person or his legal representative, but does not require approval by a Behavior Support Committee (BSC) or HRC. Behavior analysts may request review by BSCs or HRCs for technical assistance regarding the interventions or potential human rights concerns.

2. **Restricted Interventions**: Restricted interventions involve the use of a consequence that has the objective of decreasing the frequency, intensity, or duration of challenging behavior.
   a. Restricted procedures require a BSP developed by a behavior analyst in conjunction with the person and his/her COS.
   b. Consent from the person or his legal representative and the approval of the Regional BSC and an HRC are required prior to implementation of restricted procedures. Any BSP to be implemented in a DIDD contracted agency shall receive appropriate consent and approval from Human Rights Committee (HRC) even if the plan is developed by a provider with an external funding source (e.g., a MCO).

   b. The Regional BSC shall review the use of restricted procedures after three months of implementation to evaluate effectiveness of the plan and shall approve, approve with changes, or disapprove the plan for continued use. The Regional BSC may approve a plan for up to one year.

3. **Special Individualized Interventions**. Special individualized interventions, as classified by DIDD, are interventions that involve the delivery of an aversive stimulus, vary from provider manual requirements, or are not defined in the classification system. Special Individualized Procedures may only be implemented through a BSP that has been approved by the person...
supported and or legal representative, their Circle of Support, the Regional BSC, the Regional HRC, and the Statewide BSC. Review by an HRC may be required. See policy 80.6.1 Human Rights Committee.

4. **Behavioral Safety Interventions.** Behavioral safety interventions (e.g., supported recovery, safety delay, or manual restraint) are procedures that prevent harm to the person or others and shall only be used when alternative strategies are ineffective and a person's behavior poses an imminent risk of harm to self or others.

   a. The focus of behavioral treatment must be the prevention of the need for behavioral safety interventions. The use of behavioral safety interventions represents a failure in the treatment provided to the person served.

   b. The use of behavioral safety interventions shall be outlined in the crisis section of the person's BSP, or in an agency policy for their use. Parameters for a policy regarding behavioral safety interventions may be found in section 12.7.1.c of this manual.

   c. BSPs involving the use of behavioral safety interventions shall include clear descriptive criteria for the initiation and termination of the procedure. When appropriate, the BSP may refer to the agency's policy for the initiation and termination of behavioral safety interventions.

   d. BSPs that contain behavioral safety interventions and no other restricted, special individualized, or specialized behavioral safety interventions do not require approval by a BSC or HRC.

   e. Any use of behavioral safety interventions that does not conform to the rules stated above or the procedural definitions listed on the DIDD web site shall require approval by the Statewide BSC as a variance to this manual.
f. Following the occurrence of a behavior safety intervention, an agency
designee shall conduct a debriefing regarding what worked and did
not work with the procedure. The debriefing shall be documented in a
daily note.

g. When a person served has had three (3) uses of a particular behavior
safety intervention or PRN medications within the previous six (6)
months, its use shall be outlined in the crisis section of a BSP. If the
person supported does not currently receive behavior services, a
behavior services assessment shall be requested.

5. **Specialized Behavioral Safety Interventions.** Specialized behavioral safety
interventions (e.g., supported recovery-separation, mechanical restraint, or
protective equipment) are only used in emergency circumstances, but go
beyond what is required to resolve the immediate crisis. Specialized behavior
safety interventions are only used when there is a persistent and ongoing
risk of harm to self or others. Implementation of these procedures requires
the consent of the person support and or legal representative. The consent
should be obtained during a time that the person supported is not in crisis
and is supported to understand that when they are in crisis these procedures
may be necessary.

a. Specialized behavioral safety interventions may only be used in the
crisis section of a BSP.

b. Devices used as mechanical restraint or protective equipment shall be
commercially produced and in good repair.

c. BSPs involving the use of specialized behavioral safety interventions
shall include clear descriptive criteria for the initiation and termination
of the procedure in accord with the procedural definitions.

d. Specialized behavioral safety interventions shall require the initial and
annual approval of the person supported, his/her COS, the Regional
BSC, an HRC, and the Statewide BSC. Review by an HRC may be required. See policy 80.6.1 Human Rights Committee.

e. Behavior service providers may request a reporting variance from the DIDD Director of Behavioral and Psychological Services when uses of specialized behavioral safety interventions are anticipated to exceed ten (10) uses per month. A form for these requests may be found at the DIDD web site. 111 (http://tn.gov/didd/health_services/index.shtml).

6. **General Precautions in the Use of Behavioral Safety Interventions.**

Restraints and protective equipment may be used only when necessary to protect the person supported or others from harm and when less intrusive methods have been utilized and found to be ineffective in maintaining the safety of the person and others. The application of restraint or protective equipment must be implemented carefully to ensure protection from harm and to protect the person’s rights. Use of restraints and protective equipment carry the risk of psychological trauma, positional asphyxiation, restriction of circulation, and pressure on the muscular and skeletal system. Because of these risks the following person-centered practices and precautions shall be followed.

a. **Person-centered planning and use of restraints.**

i. The potential for use of restraints must be identified in the ISP and BSP and implemented only if the person supported consents.

ii. Restraints are only used to ensure the safety of the person and others.

iii. Restraints are only used as specified in the plan for emergency circumstances and not as an ongoing intervention or treatment.

iv. All staff supporting the person must be trained in the use of restraints.

v. The ISP must indicate what positive interventions have been used prior to the use of restraint.

vi. The ISP must indicate what has been tried before but did not work.

vii. The ISP must indicate timelines for periodic reviews to determine if restraints are still necessary and plans must be reviewed on an individual basis.

b. 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.

c. The physical condition of the person being restrained or protected shall be evaluated continuously throughout the restraint. Persons showing abnormalities of breathing, skin color, or other abnormalities shall be immediately released from restraint.

d. Restraint or Protective Equipment shall not be used when its use is contraindicated. 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.

e. 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 individualized risk-benefits analysis shall be reported in the document that outlines the use of the restraint or protective equipment.

7. **Prohibited Procedures.** The Department prohibits procedures that cause harm to the person or violate the person’s human rights. The following procedures are prohibited.

   a. **Chemical restraint.** Chemical restraint is defined as the inappropriate use of a medication prescribed to control behavior or to restrict the movement of the person supported for convenience or as a punishment.

   b. **Prone and supine restraints.** Horizontal restraint of an individual in a face up or face down position. Side immobilizations are not prohibited if they are part of a DIDD approved procedure.

   c. **Take downs.** Forcibly moving a person from a vertical (standing or seated) position to a horizontal position. Side immobilizations may be used only when the individual is already in a horizontal position.

   d. **Seclusion.** Seclusion shall mean placing a person in a room alone while holding or locking the door or otherwise preventing egress.

   e. **Noxious or painful stimuli.** Events that persons may describe as unpleasant to the senses or that result in tissue damage or lasting impairment.


1. **Crisis Intervention Policy.** All residential, day, and personal assistance agencies shall have a policy for crisis intervention that is approved by an HRC. As applicable, policies shall also include instructions for the use of PRN psychotropic medications and behavioral safety interventions. These instructions shall include the following:
a. Assurance that the procedures are only used in response to behaviors that pose a risk of harm to self or others; and

b. Assurance that use of the procedures is in alignment with DIDD procedural definitions and HCBS Settings Final Rule; and

c. Reference to de-escalation and redirection techniques that prevent the need for behavioral safety interventions; and

d. Assurance that behavior safety interventions are used only when they are the safest, most appropriate response for a given crisis situation, and that other less intrusive alternatives are considered, and have been tried, in making a decision to use them; and

e. Safeguards to prevent misuse of behavioral safety interventions; and

f. Mechanisms for recording and reviewing the provider agency’s use of behavior safety interventions that are not otherwise reportable incidents as applicable (e.g., supported recovery, safety delay and supported recovery-separation); and

g. Mechanisms for ensuring that a behavior assessment is requested when a person has had three (3) uses of a particular type of behavioral safety intervention or PRN medication within the previous six (6) months; and

h. General procedures for managing crisis situations involving external entities (e.g., police, mobile crisis, etc.). In the event of psychiatric hospitalization, the Cross-Systems Crisis Plan shall state that agency provider staff must monitor the person’s status and remain close by until it is clear that the person has been admitted to the hospital. Tele-health options may be used to minimize the necessity for extensive travel by staff.

2. Cross-Systems Crisis Plans. Cross-systems crisis plans are used to provide guidance for seeking and obtaining assistance from others in an emergency
situation. Persons at-risk for crisis shall have an individualized cross-systems crisis plan developed with the person supported by the residential provider personnel and other COS members or professionals as appropriate. If the person supported is not receiving residential services then the primary provider is responsible for development of the cross-systems crisis plan.

a. Persons served who have had a behavioral health crisis involving an outside entity (e.g., police, mobile crisis, behavioral respite, crisis stabilization unit, psychiatric hospital) within the past two (2) years are identified as at-risk for crisis.

b. When a person at-risk for crisis is receiving behavioral services, provider agencies shall consult with behavior analysts in the development of the crisis plan to ensure that it is as consistent as possible with the person's behavioral treatment. The behavior analyst is responsible for the interactional components of crisis intervention and the provider agency is responsible for the systemic components of crisis intervention.

c. Cross-Systems Crisis Plans shall contain the following elements:

i. How to identify an emerging crisis for the person supported; and

ii. A list of strategies for problem solving within the person's network of support (e.g., PCP, psychiatrist, behavior analyst, psychologist, COS members); and

iii. Guidance for obtaining assistance from external service providers and outside crisis entities (e.g., mobile crisis, telehealth, police, respite facilities, psychiatric hospitals, etc.). The plan shall define the specific circumstances under which people or entities should 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; and

iv. Interventions shall be hierarchically arranged addressing systemic methods for preventing the crisis (e.g., urgent COS meetings, changes to BSP, psychiatric appointments, etc.) as well as systemic responses when the person reaches a point where external placement (e.g., behavioral respite, crisis stabilization unit, psychiatric hospital) may be needed; and

v. Background information that will help external service providers understand the person. Medical and psychiatric diagnoses, behavior assessment information, and trauma and family history are examples of information that should be included; and

vi. Contact information for any person or entity that may need to be reached during a crisis. At a minimum, the plan shall include contact information for the following (as applicable): The person’s legal representative, agency director(s), behavior analyst, ISC, mobile crisis services, respite services, and psychiatric hospitals; and

vii. 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, mobile crisis agencies shall have the opportunity to contribute content to the crisis plan. They may also have a copy of the crisis plan to keep on file if the person supported or the legal representative consents to release the information. Consent is not required to share information during a crisis.


1. Behavioral Respite Services shall mean short-term behavior-oriented services for a person supported who is experiencing a need for behavioral

PM Chapter 12 Behavior Services
Department of Intellectual and Developmental Disabilities
Effective: pending
TennCare Approval: pending
stabilization crisis that will be facilitated by requires removal placement in an alternative from the current residential setting, in order to resolve the behavioral crisis.

2. Immediately upon admission, the behavior respite provider shall coordinate with the person’s residential provider to assist with planning and coordinating the person’s return to the residential setting.

3. Upon admission to a behavioral respite site, the respite provider shall be provided with or obtain all current physician’s orders, medications, and, as applicable, the person’s dining plan or mealtime instructions and mealtime and other adaptive equipment.

4. In addition, if not provided at the time of admission to the respite site, the following items will be provided to the respite facility, as applicable:
   a. Individual Support Plan; and
   b. Behavior Support Plan; and
   c. Cross-Systems Crisis Plan; and
   d. List of appointments that are scheduled for the person.

5. Each respite facility shall have a standard data collection system that allows for the recording of behavioral incidents and the person’s response to intervention.

6. For each person entering Behavioral Respite Services, the agency shall ensure that a clinician (e.g., psychiatrist, psychologist, behavior analyst, behavior specialist, nurse, social worker) is assigned to oversee the supports provided at the respite facility. The clinician shall do the following:
   a. Conduct weekly visits to review the clinical record and observe each person supported; and
   b. Complete a weekly progress note that includes but is not limited to the following:
i. A description of the person's response to supports provided during the respite stay; and

ii. Description and analysis of behavioral data pertaining to the person supported; and

iii. An analysis of factors that may have had an impact on the person's response; and

iv. Identification of any action steps that may need to be taken to address clinical concerns; and

v. Individualized treatment instructions for the staff to follow.

7. A clinician shall also complete a discharge summary for the respite stay. The report shall include a summary of data, summary of interventions used during the stay, and recommendations for improving the quality of life and clinical treatment for the person supported. The report shall also include recommendations for preventing recurrence of behavior that led to the respite stay and shall be provided to the receiving provider at the time of discharge.

8. If needed, the person's BA shall provide training regarding changes to the BSP and/or the agency designee shall provide training regarding changes to the ISP, following discharge from the respite stay.

9. The person's COS shall review the recommendations from the respite facility and as appropriate, the COS members shall work with the person and his/her ISC to make any necessary adjustments to the person's ISP as well as work with the person and his/her BA to make any necessary adjustments to the person's BSP.
12.9. Self-Assessment and Internal Quality Improvement (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.
4. Review of any personnel practices, including staff recruitment and hiring, staff training, and staff retention and turnover.
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.
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.


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).

12.11. Behavior Service Providers Disciplinary Procedures. Behavior service provider qualifications and disciplinary procedures are published on the DIDD website.  

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112 http://www.tn.gov/assets/entities/didd/attachments/Health_Services-Behavior_Provider_Qualifications.pdf
CHAPTER 13

THERAPEUTIC AND THERAPY-RELATED SERVICES

13.1. Introduction.

Therapeutic services for adults with intellectual disabilities are geared towards habilitative services to promote new skills necessary to overcome barriers, 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 specialized medical equipment supplies and assistive technology (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.113

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, family member, or DIDD staff may identify a need and make request a referral be made for a therapeutic service assessment through the ISC/CM. In order for an assessment to be authorized, there must be an identified reason for referral that meets criteria set forth in the medical necessity protocols. In addition, various DIDD staff may assist in identifying needs.

113 http://www.tn.gov/assets/entities/didd/attachments/Waiver_Service_Definitions.pdf
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 (e.g., 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 separately and are subject to medical necessity review prior to authorization.

2. An assessment must be completed prior to the authorization of services, in order to establish/justify a need for a particular service.

3. Assessments and services must be provided within authorized time frames in order to be billed.

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.

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.

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 current 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:
      i. A criminal background check including either fingerprint samples for a criminal history background check conducted by the Tennessee Bureau of Investigations (TBI) or the Federal Bureau of Investigation (FBI) or information necessary for a criminal background check to be conducted by a Tennessee-licensed private investigation company.
      ii. For an individual who has lived in Tennessee for one year or less, a nationwide background check is required. Such nationwide background checks may be limited to those states in which the person has lived for the past seven years or since the age of eighteen, whichever is less.
      iii. Tennessee Abuse Registry.
      iv. Tennessee Sexual Offender Registry.
      v. Search of the Office of Inspector General (OIG) List of Excluded Individuals/Entities. See Chapter 5, Section 5.2.g.3 for requirement regarding ongoing screening.
      vi. 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:

      A criminal background check including either fingerprint samples for a criminal history background check conducted by the Tennessee bureau of Investigations (TBI) or the Federal Bureau of Investigations (FBI) or information necessary for a criminal background check to be conducted by a Tennessee-licensed private investigation company.

      For an individual who has lived in Tennessee for one year or less, a nationwide background check is required. Such nationwide background checks may be limited to those states in which the person has lived for the past seven years or since the age of eighteen, whichever is less.

      Tennessee Abuse Registry.

      Tennessee Sexual Offender Registry.
Search of the Office of Inspector General (OIG) List of Excluded Individuals/Entities. See Chapter 5, Section 5.2.g.3 for requirement regarding ongoing screening.

Tennessee Felony Offender Information Lookup (FOIL).

a. Job descriptions, work history, credentials, and verification of references.

b. Ensuring a well-trained workforce.

c. Procedures for tuberculosis testing.

d. Periodic performance evaluations for employed or contracted staff.

2. Maintenance and confidentiality of medical records.

3. Self-assessment and QI.

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 (if applicable).

**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.


4. Review of any personnel practices, including staff recruitment and hiring, staff training, and staff retention and turnover.

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 any documentation issues and service effectiveness.


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.¹¹⁴

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.¹¹⁵

13.9. Supervision Requirements.

¹¹⁴ TennCare Quick Guide to TennCare services: http://www.tn.gov/tenncare/topic/quick-guide-to-tenncare-services

¹¹⁵ Memo 0155 Acceptable reasons for service recipients not receiving services in the amount, frequency, or duration specified in the ISP: https://www.dropbox.com/sh/weg5yxqk997bujx/AADtI0ko_zi5YN-VXS-8z3Fa/2011/Memo%200155%20Yes%2C%20but%20Revised%205.27.11.pdf?dl=0
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.

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:


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 any present modifications in the person’s current home (e.g. person has a ramp and a roll-in shower), transfer ability, 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.). In addition, particularly if a person is transitioning to a new agency, the clinician should consider the impact any potential changes in staffing might have for the person as well as address any potential changes in vehicle accessibility if they will be using a different vehicle when moving.

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. Subjective information as indicated from the person, family, staff etc. regarding perceived progress, decline, or any other concerns.
6. Objective measurement of individual response to intervention and status in relation to goals addressed.
7. Updated status of any equipment procurement.
8. Service provider’s signature, credentials, and date.
9. Signature of the staff, family, and/or person supported and dates 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 identified 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. This includes competency based training of necessary staff and or training of a designated trainer as appropriate to carry out remaining training of staff.

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 (20th) of the month following the month of service provision.

Monthly progress notes must be completed by the therapist, not 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 required 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 (e.g., staff instructions that need to remain in place)
5. Relevant indicators for re-referral (as applicable)
6. Service provider's signature, credentials, and date

Discharge summary must be completed, signed and dated 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.

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.


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.


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 and/or through the waiver as applicable. Clinicians are responsible for following up on the status of equipment being authorized, assisting with funding appeals when necessary, and assuring authorized equipment gets ordered. When the authorized equipment is
delivered, the clinician is responsible for assuring the equipment is in good working order and is adjusted etc. to fit/support the person. The clinician is also responsible for developing/revising staff instructions and training the person supported and staff.

13.15. Required Training.

See Chapter 6 of this manual.


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 web site 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, or an O&M specialist, or a behavior analyst. Documentation of recommendations must be submitted with the service request for modifications to the person's
ISP/CM. Eligibility for waiver funding for EAM is specified in the waiver service definition.

For individuals who may be eligible for EAM services and who require an assessment of their accessibility needs, an occupational therapist, physical therapist, or in certain cases an 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 himself/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 shall be appropriately licensed according to state law (e.g. Limited Licensed Plumbers, Limited Licensed Electricians).

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.116

13.17.d. Obtaining Bids for EAM. The ISC/CM shall obtain three (3) competitive bids from qualified EAM providers when the amount exceeds limits set forth by the State Purchasing Division. Each DIDD contracted

116 Go to Providers, Forms & Tools, Environmental Accessibility Modifications
http://www.tn.gov/didd/section/providers
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.
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 meet 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 **Specialized Medical Equipment Supplies and Assistive Technology (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/authorized 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 necessary 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 services 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.
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.
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 skilled nursing services such as changing wound dressings, administering injectable medications and other
medications that cannot be administered by direct support staff in accordance with state law.

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. The nursing services described in this section of the manual are skilled nursing services. Such nursing services are reimbursed based on the number of units billed. A unit is defined as a quarter (1/4) hour. 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.

14.3. Dental Services.

14.3.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 apply to all dental services provided in a Medicaid waiver. The waiver definition shall also be used to define dental services provided in other DIDD-funded programs. persons enrolled in the “Arlington” Waiver.

14.3.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 outpatient 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 three (3) 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 at the quarter hour rate and the service will be documented by the quarter hour. For hourly use of respite, the use of any part of a day constitutes the use of one (1) of the 30 days per calendar year per person.

9. For respite provided over eight (8) hours a day the appropriate daily respite rate will be billed and the service documented by the hour.

10. Levels 1, 2, 3 and 4 respite and combinations thereof are limited to 30 calendar days per calendar year per person.

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 web site.

117 [http://www.tn.gov/assets/entities/didd/attachments/Personal_Assistance_Environmental_Checklist_Form.pdf](http://www.tn.gov/assets/entities/didd/attachments/Personal_Assistance_Environmental_Checklist_Form.pdf)
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. Individuals receiving services may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home.

3. Personal Assistance providers are required to implement services as specified in the individualized ISP and to develop a staffing plan that identifies a back-up plan in the event of a staffing vacancy. Changes in the amount, frequency and or duration of PA services must be documented and addressed in the ISP.

4. A single personal assistant may provide PA services to more than one individual residing in the same home at the same time, provided each person’s needs can be safely and appropriately met.

5. Only one unit of service will be billed for each unit of service provided, regardless of the number of persons supported. Documentation must be maintained for each person supported.

6. Home Care Organizations licensed by DOH may, that have an approved Provider Agreement with DIDD to provide personal assistance services, but must ensure that staff meets DIDD training requirements for personal assistance staff.
7. 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.

8. An individual may receive both personal assistance services and day services, but not concurrently during the same time period.

9. 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.

10. The personal assistance provider must meet general records requirements as described in Chapter 10 and must document quarter-hourly services provided.

11. The personal assistance provider must complete periodic 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

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ABA</td>
<td>Applied Behavior Analysis</td>
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<tr>
<td>ADA</td>
<td>Americans With Disabilities Act</td>
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<td>ADL</td>
<td>Activities of Daily Living</td>
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<tr>
<td>AED</td>
<td>Automated External Defibrillator</td>
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<tr>
<td>AOD</td>
<td>Administrator On Duty</td>
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### B

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>BA</td>
<td>Behavior Analyst</td>
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<tr>
<td>BSP</td>
<td>Behavior Support Plan</td>
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### C

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>CAC</td>
<td>Comprehensive Aggregate Cap Waiver</td>
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<tr>
<td>CFR</td>
<td>Code of Federal Regulations</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<tr>
<td>CNA</td>
<td>Certified Nursing Assistant</td>
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<tr>
<td>CNT</td>
<td>Certified Nursing Technician</td>
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<tr>
<td>COS</td>
<td>Circle of Support</td>
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<tr>
<td>CPR</td>
<td>Cardiopulmonary Resuscitation</td>
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<tr>
<td>CQL</td>
<td>Council for Quality and Leadership</td>
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D

DCS  Department of Children’s Services
DHS  Department of Human Services
DIDDD 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 Database

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

ISTP Individual Support Transition Plan

J

K

L

LEP Limited English Proficiency
LPN  Licensed Practical Nurse

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

PFH  Protection from Harm

POA  Power of Attorney

POC  Plan of Correction

PT  Physical Therapy

PRN  As needed or necessary
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>PSSL</td>
<td>Professional Services Support License</td>
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<tr>
<td>PTP</td>
<td>People Talking to People</td>
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<tr>
<td>QA</td>
<td>Quality Assurance</td>
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<tr>
<td>QIDDP</td>
<td>Qualified Intellectual &amp; Development Disabilities Professional</td>
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<tr>
<td>QI</td>
<td>Quality Improvement</td>
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<tr>
<td>QMS</td>
<td>Quality Management System</td>
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<tr>
<td>RIF</td>
<td>Reportable Incident Form</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>RPST</td>
<td>Regional Provider Support Team</td>
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<tr>
<td>RQMC</td>
<td>Regional Quality Management Committee</td>
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<tr>
<td>SCQI</td>
<td>Statewide Continuous Quality Improvement</td>
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<tr>
<td>SIS</td>
<td>Supports Intensity Scale</td>
</tr>
<tr>
<td>SLP</td>
<td>Speech Language Pathology</td>
</tr>
<tr>
<td>SMESAT</td>
<td>Specialized Medical Equipment Supplies and Assistive Technology</td>
</tr>
<tr>
<td>SQMC</td>
<td>State Quality Management Committee</td>
</tr>
<tr>
<td>SSI</td>
<td>Supplemental Security Income</td>
</tr>
<tr>
<td>SSI/FBR</td>
<td>Supplemental Security Income Federal Benefit Rate</td>
</tr>
<tr>
<td>TAR</td>
<td>Tennessee Administrative Register</td>
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TBI  Tennessee Bureau of Investigation
TCA  Tennessee Code Annotated

USCA  United States Code Annotated
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 caregivers will take to change the behavior of a person supported.

Centers 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 Responsibility For shall mean supervisory authority or responsibility for either the person served or staff providing direct care for, or having direct contact with, a person served.
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 a 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.).

Emergency Psychotropic Medication shall mean psychotropic medication prescribed pursuant to a specific behavioral incident (i.e. not part of a routine medical order and not prescribed for a specific medical procedure). An incident is responsible for any use of medication contingent upon behavior. A PRN order does not preclude this requirement.

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) Unit shall mean the Fiscal Accountability Review Unit in the Office of Internal Audit in the Department of Intellectual and Developmental Disabilities.

Health Insurance 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 (ICF/IID). The HCBS waivers for Individuals with Intellectual Disabilities in Tennessee are operated by the Department of Intellectual and Developmental Disabilities (DIDD) 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 the 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 formal Human Rights review, 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 he/she resides.

**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 made 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 collection, review and examination of evidence regarding allegations of abuse, neglect, or exploitation, serious injury of unknown cause, or unexpected or unexplained death 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.

**Manual Restraint** shall mean 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 activities of daily living and 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.

**Mechanical Restraint** shall mean 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.

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 activities of daily living and 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.

5. Use of mechanical restraints by law enforcement officers.

**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 for costs of care not covered by the Medicare, Medicaid, or private insurance.

**Personal Funds** shall mean financial resources, including earned and unearned income, which are 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 that 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 interchangeably in reference to a person’s physician or advanced practice nurse or physician's assistant.

**Primary Provider** shall mean typically 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.
Protective Equipment use of protective equipment shall mean 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.

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. a Qualified Intellectual Disabilities Professional as defined in 42 CFR 483.430.

Remediation shall mean a process by which 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.

Restricted Intervention shall mean a restrictive behavior analytic procedure that may only be prescribed by a behavior analyst, and must be approved by a
behavior support committee and a human rights committee, and appears on the DIDD list of restricted procedures.

**Rights Restriction** shall mean any action imposed on a person supported in response to a risk to his/her health, safety, or finances that limits or prevents the person supported from freely exercising his or her human and civil rights and privileges.

**Safety Delay** shall mean restricting the person's freedom of movement and/or 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.

**Skilled Nursing facility** shall mean a skilled nursing facility registered with the Bureau of TennCare.

**TennCare** shall mean the single State Medicaid Agency responsible for the administration of the State's Medicaid Program.

**Validation** shall mean the process by which 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.