Responses to Public Meeting
November 27, 2017
80.6.1 Human Rights Review Process

#	COMMENT	SOURCE	POLICY SECTION	DIDD RESPONSE
1	Definitions include a definition of "Highly Restrictive or Intrusive Behavior Safety Interventions." This is not a category that is reflected in Chapter 12. Will this be revised or adjusted for consistency?	Melissa Richards, Columbus Medical Svcs.	IV.K. K. Highly Restrictive or Intrusive Behavioral Safety Interventions shall mean techniques (i.e., supported recovery-separation, mechanical restraint, protective equipment, specialized behavioral safety interventions) that are only used in emergency circumstances and go beyond what is required to resolve the immediate crisis due to the persistent and ongoing risk of harm to the person supported or others.	Provider Manual 12.6 revised for consistency and definition added to the glossary.

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2	”Functions of Committee”_6.b. states that HRC does not have the authority to overrule or overturn consent for a restricted intervention. What prevents a conservator from insisting upon an unwarranted restriction if HRC is not required to approve it? I understand that any differences of opinion between the conservator and other parties can be reviewed by HRC, but there are many occasions when the conservator and agency may agree upon a restriction that is really not appropriate or may not be allowed by provider manual. How will HRC or DIDD become aware of these?	Melissa Richards, Columbus Medical Svcs.	VI.D.6.b. - Limitations in HRC authority The HRC does not have the authority to overrule or overturn the consent or refusal to consent provided by a person’s legal representative. The legal representative must be authorized to consent to the proposed treatment or rights restriction as stated in the order.	The HRC does not have the authority to prevent the person's legal representative from insisting upon a restriction that is unwarranted. Should a situation arise in which the legal representative insists upon a restriction that is inappropriate, the local HRCs can refer the matter to the Regional HRC for assistance and intervention. If there are significant concerns about a legal representative's ability to represent the best interest of the person supported, the Circle of Support can refer the matter to the DIDD Office of General Counsel and Regulatory Affairs for assistance.

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3	I am not sure that this policy clarifies one common HRC issue and that is what types of restrictions are allowed or prohibited and what is required to be in a BSP versus ISP. Recent example, person makes harassing phone calls and COS wants to restrict phone use to early evening and only in presence of a staff person. Behavior plan or ISP?	Melissa Richards, Columbus Medical Svcs.	General Comment	The policy provides guidance on protecting and promoting the rights of persons supported in the event a restriction is proposed or in certain circumstances, imposed without the person's consent. In the scenario described, if behavior services are implemented to address the behavior then the restriction would be documented in a BSP. However, if a restriction is implemented and it is not necessary for the person to receive behavior services then the restriction could be documented in the ISP.
4	My concern is that LBAs are the only licensed professionals contracted by DIDD that have such an encumbrance on their practice. The Human Rights Committee is not going to tell the licensed medical doctor what to do or explain herself for not doing as told.	Ryan Black, Behavior Solutions, LLC	General Comment	All providers contracted with the Department are held accountable for implementing services according the Department standards, not just licensed behavioral analysts. Any restriction is subject to the HRC requirements, including those proposed by other professions.

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5	ISC's need to be trained on this policy to be able to effectively include this requirement in the ISP.	Kristen Otto, Emory Valley Center	P.7, D.1.a - Ensure that any rights restriction that is implemented includes a fading plan for reducing or eliminating the need for restriction. (this is references as being documented in the ISP)	Concur. Training will be provided to support coordinators and providers.
6	Comment: In a crisis situation where dangerous items are temporarily removed to ensure safety but returned following crisis and cool down the following questions are asked: Would this need to be reviewed as the process outlines? Could this be handled through the IMC process as opposed to have a COS, consent, and HRC?	Kristen Otto, Emory Valley Center	P.7, D.2 - Emergency use of rights restrictions implemented based on an imminent risk of harm to the person supported or others by the person supported.	The provider has the option of involving the agency Incident Management Committee. However, the purpose of the retrospective review by the Regional Human Rights Committee is to ensure the person's rights were not violated and to ensure the person's rights are protected going forward.
7	There needs to be an option to obtain verbal consent and documenting this while waiting on signed consent to ensure there is no time a person would not go without their medications. There are times when people are not able to sign immediately	Kristen Otto, Emory Valley Center	P.8, Functions of IRC, #1 - Informed consent must be obtained from the person supported, or legal representative, prior to administration of said medication.	Concur. In Provider Manual chapter 10.5, guidance has been added regarding obtaining verbal consent for treatment.

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8	Which category would this fall under on the RIF?	Kristen Otto, Emory Valley Center	P.8, Functions of IRC, #2 - Submit a RIF to DIDD if discovered that psych med was administered without consent.	Chapter 7.c.26 Administration of Psychotropic Medication Without Consent
9	This does not stipulate BSP's with restricted interventions need to go through Regional HRC. Since restricted BSP's need to be approved by the BSC it makes the most sense that Regional HRC continue to review these BSP's.	Kristen Otto, Emory Valley Center	P.9, Functions of Local or Regional HRC, #2 - Consultative review of BSP	The authority of local vs. regional HRCs did not change in the current policy. We disagree that regional HRCs should be required to review all restricted procedures. Regional HRCs will continue to review Behavior Support Plans (BSP) containing restricted interventions; local HRCs may review BSPs containing restricted interventions. Regional Behavior Support Committees will continue to review BSPs containing restricted interventions.

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10	Can the Local HRC review these, or is there a reason they cannot? It stipulates the review should be completed within 30 calendar days of use which would be extremely difficult for the Regional HRC to complete given the number they review. The Local HRC would be able to complete this review much quicker.	Kristen Otto, Emory Valley Center	P.10, Regional HRC Only, #4 - Review of emergency use of rights restrictions based on an imminent risk of harm to the person supported or others by the person supported.	Due to provider agency IMC conducting psychotropic medication reviews (not PRN or emergency) instead of the Regional HRC, there should be more time for the Regional HRC to devote to review of emergency use of rights restrictions.
11	Can the Local HRC review these, or is there a reason they cannot? This is especially important considering the HRC would not have the right to overturn consent to move forward with the research.	Kristen Otto, Emory Valley Center	P.10, Regional HRC Only, #5 - Review and make recommendations regarding research proposals or academic projects involving persons supported receiving services through DIDD.	Due to the in-depth review required to approve research proposals or academic projects, and the likely involvement of the Department in the project, it is necessary for this review to remain at the regional level.

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12	Policy should clearly state how we are to proceed when a person's rights violate or endanger the rights of others, particularly other people supported.	Kristen Otto, Emory Valley Center	P.10, Limitations in HRC Authority, a&b - The HRC does not have the authority to overrule or overturn the consent or refusal to consent provided by person supported who does not have a legal representative.....or by a person's legal representative.	There are already processes in place to address the concern if felt that a conservator or legal representative is not acting in the best interests of the person supported. For example, assistance can be obtained from Customer Focused Services, the Person Centered Planning Unit or Office of General Counsel and Regulatory Affairs, as a last resort.

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13	The HRC Committee is made up of volunteers. Membership can be difficult to maintain. The addition of these training requirements, and the mandate that these must be completed through DIDD, adds a fairly significant burden in maintaining members for this committee. The volunteers are already expected to either be a person supported or family member, or be in a related field which already gives them some knowledge. Proposal is made that the Chair be responsible for completing the training and those Providers have the ability to provide trainings such as review of policies covering related topics.	Kristen Otto, Emory Valley Center	P.11, HRC Training Requirements, #2 - Initial and ongoing training. (including list of trainings)	Do not concur. It is important that all members of the HRC completed prescribed training. Efforts will be made to ensure training is concise, readily available and able to be scheduled at the member's convenience.
14	So are they no longer reviewing their daily psychotropic medication?	Tiffany Whittenbarger, Michael Dunn Center	P.10, #3, "Review emergency and PRN use of psychotropic medication."	Correct. Daily psychotropic medication will be reviewed by the IMC.
15	Then there was a fading plan. I was just wondering if we could get an example of what the fading plan needs to look like.	Tiffany Whittenbarger, Michael Dunn Center	P.10, G, Fading Plan	The Department will develop and implement training on fading plans, for people who are not clinicians. An example will be provided.

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16	This appears to be the only area where the review of psychotropic medication is listed, so I'm interpreting that to indicate that we are no longer going to be required to prescribe psychotropic medications to an HRC prior to them being administered, only that we get informed consent from the person that's not been adjudicated incompetent and/or their legal representative. And if that is the case, that's a very positive change in this policy for all providers, I think, because that has been an ongoing challenge to get through that process for many years now. So thank you so much if that interpretation is the correct one for us providers.	Dotty Bell, RHA Health Services	P.8, Functions of the agency Incident Review Committee.	It has never been Department policy that HRC approval be obtained prior to administration of psychotropic medication. Per policy 80.6.1, someone can request HRC review if they do not agree to the medication that has been consented to.

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17	The last sentence in that paragraph is, "The licensed practitioner of behavior analysis who developed a BSP, or who will be responsible for ensuring implementation of a BSP, shall not be involved in the process of review and recommendation regarding that BSP." So the clarification on that section as to whether or not the behavior analyst can be present for presenting their recommended BSP and those restrictions.	Dotty Bell, RHA Health Services	P.13, 13-1, Conflict of Interest	The policy has been revised to read as follows: The licensed practitioner of behavior analysis who developed a BSP or who will be responsible for ensuring implementation of a BSP may present the BSP however, he/she shall not be involved in the process of making decisions and/or recommendations regarding that BSP.
18	C says that if there's a disagreement over the restriction, then the matter shall go before the local HRC for further review. So who makes that final decision, to say if the person has a conservator and the conservator consents, but the person supported still doesn't want to do that, who makes that decision? Because that's where I get confused.	Tiffany Whittenbarger, Michael Dunn Center	P.7, B and C, "If the person or, if applicable, legal representative refuse to consent to the restriction, then the restriction must be discontinued and the ISP has to be amended."	There are limitations to HRC authority. There are already processes in place to address the concern if felt that a conservator or legal representative is not acting in the best interests of the person supported. For example, assistance can be obtained from Customer Focused Services, the Person Centered Planning Unit or Office of General Counsel and Regulatory Affairs, as a last resort.

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19	First of all, I'd like to commend the Department for including in the training for the HRC the supported decision-making. The only thing I would like to add to that is, you might want to define that because a lot of people may not know what that is, and I think that if dignity of risk in that section is defined, and I think supported decision-making is defined, that will be helpful.	Sherry Wilds, Disability Rights Tennessee	General Comment	A definition for supported decision-making will be developed and implemented after the proposed legislation is passed.