# The critical elements in each policy are provided to aid the provider in developing standards and expectations to ensure health, safety, and accessibility. The provider must clearly demonstrate in each policy all critical elements, concepts, expectations, and outcomes.

#### \*See Attachment 3

1. [**Accounting of Personal Funds**](#_Toc141175316)
2. [**Advocacy**](#_Toc141175317)
3. [**Back-up Staffing Plan**](#_Toc141175318)
4. [**Complaint Resolution**](#_Toc141175319)
5. [**Criminal Background Check**](#_Toc141175320)
6. [**Crisis Intervention including Use of Positive Approaches**](#_Toc141175321)
7. [**Deficit Reduction Act (DRA)**](#_Toc141175322)
8. [**Documentation of Service Delivery**](#_Toc141175323)
9. [**Electronic Visit Verification (EVV)**](#_Toc141175324)
10. [**Emergency/Urgent Care**](#_Toc141175325)
11. [**Fire, Sanitation, and Emergency Precautions**](#_Toc141175326)
12. [**Good Nutrition**](#_Toc141175327)
13. [**Health Care Needs**](#_Toc141175328)
14. [**Medication Safety**](#_Toc141175329)
15. [**Organization’s Person-Centered Approach**](#_Toc141175330)
16. [**Person Supported Records Management**](#_Toc141175331)
17. [**Personnel Procedures**](#_Toc141175332)
18. [**Protection & Promotion of Rights**](#_Toc141175333)
19. [**Quality Assessment, Assurance, and Improvement**](#_Toc141175334)
20. [**Reportable Event Management (REM)**](#_Toc141175335)
21. [**Respect to Persons Supported**](#_Toc141175336)
22. [**Succession Planning**](#_Toc141175337)
23. [**Title VI**](#_Toc141175338)
24. [**Transportation to People Supported**](#_Toc141175339)
25. [**Well-Trained Staff (paid and unpaid)**](#_Toc141175340)

# **Accounting of Personal Funds**

## 

## Required for the following service categories: Residential, Day, Employment and Other

| **Required Element(s)** | **Indicate policy name, page # and location** |
| --- | --- |
| 1. The person participates in their own finances to the extent of their capabilities. |  |
| 1. A statement of the agency's liability in the case of loss of personal funds due to staff negligence. |  |
| 1. Agency’s oversight of the accumulation of personal funds to prevent loss of benefits (SSI, Medicaid eligibility). |  |
| 1. Advancement of funds on behalf of persons supported if the agency chooses to advance funds including re-payment plan. |  |
| 1. The provider’s implementation, whenever feasible, of alternatives to Representative Payee arrangements, if the provider is the Representative Payee for an individual who is not under full conservatorship. |  |
| 1. The use of strategies that support individuals to:  * Utilize banks and maximize control, ownership, and management of their own bank accounts * Receive and manage their earned income through paycheck made out to the individual or direct deposit into the individual’s own bank account * Do necessary reporting and monitoring of income and assets in order to maintain eligibility for key benefits and programs * Develop and follow a personal budget, reflecting personal preferences for saving, spending and the need to meet specific obligations each month * Keep appropriate financial records in a secure place in the individual’s home (e.g., receipts, monthly bills, checkbook ledgers). |  |
| 1. Provider documentation includes evidence that assistance provided in the following areas is sufficient and appropriate for the person, while not being unnecessarily restrictive, given the person’s abilities    * Safeguarding personal funds at home    * Using or storing personal funds inside the home    * Carrying and using personal funds outside the home    * Conducting necessary bank transactions (e.g. deposits, withdrawals, and transfers) |  |
| 1. Limitations on staff access to personal funds |  |
| 1. A separation of duties concerning personal funds (Personal allowance and petty cash in the home). |  |
| 1. The staff positions authorized to approve disbursements. |  |
| 1. The staff positions authorized to sign checks drawn on personal accounts. |  |
| 1. Which fees and costs the individual is responsible for paying and the extent the agency will financially assist the individual in paying these costs, if necessary |  |
| 1. The procedure or basis used to determine a person's rent or room and board charges. |  |
| 1. Personal funds are kept separate from agency funds. |  |
| 1. Personal funds are not used to supplement agency funds. |  |
| 1. Staff does not borrow money nor accept personal benefits from people. |  |
| 1. How direct support and other designated staff are trained on agency policies and procedures. |  |

# **Advocacy**

## Required for the following service categories: All Services

| **Critical Element(s)** | **Indicate policy name, page # and location** |
| --- | --- |
|
| 1. Advocate for the person supported and arrange for external advocacy services as needed. |  |
| 1. Accessing Natural Supports and assisting the person’s supported to build a Natural Support Network. |  |
| 1. Providers are required to supply information and skills training as necessary to provide safe and effective natural supports. Consent must be obtained from the person served or their legal representative in writing before any personal information is shared. |  |
| 1. The provider has a policy and process that addresses the following:    * Supporting family members, friends, and/or other natural supports, if applicable, to encourage self-determination and informed decision-making and choice with the individuals they support.  * Supporting family members, friends and/or other natural supports, if applicable, through sharing, educating, and encouraging them to utilize supported decision-making strategies.  |  | | --- | |  | |  |
| 1. Delineates activities the agency may engage in to assist in advocacy efforts (e.g., participation on work groups, committees, task forces related to advocacy efforts; efforts at encouraging and supporting participation by individuals in advocacy groups). |  |
| 1. Opportunities available for staff to express their ideas, concerns or complaints which affect people they support (e.g., at regular staff meetings, meetings with supervisors of the agency, meeting with members of the board of directors) without fear of retribution and which ensure such issues will be seriously considered and addressed. |  |

# **Back-up Staffing Plan**

## Required for ALL service categories – EXCEPT for Ancillary

| **Critical Element(s)** | **Indicate policy name, page # and location** |
| --- | --- |
|
| 1. Provider has the capacity of staff to accept referrals based on contracted services and counties. |  |
| 1. Provider has the capacity to maintain supports per service type (i.e. residential, day, clinical, other, etc.). |  |
| 1. Provider has a back-up plan for staffing. (i.e. to cover last minute call-ins, etc.) |  |
| 1. Provider has 24-hour coverage including on call staff.   \*\*Residential and Day Services |  |
| 1. Clinical: Staff coverage for when provider is on vacation |  |

# **Complaint Resolution**

### Required for ALL service categories

| **Critical Element(s)** | **Indicate policy name, page # and location** |
| --- | --- |
| 1. Complaint resolution procedures for persons supported, family members, and legal representatives, including alleged Title VI violations |  |
| 1. Complaint data is tracked to resolution and utilized to monitor compliance with the federally mandated health and welfare assurance and related CMS-approved performance measures. |  |
| 1. Providers are also required to have a policy and a contact person identified to receive complaints and to maintain documentation of all complaints filed to resolution. |  |
| 1. Providing individuals and/or legal representatives, if applicable, with understandable information regarding their rights as citizens, and other rights including: the provider agency’s grievance and appeal rights; rights to confidentiality; rights to access records; and rights to decide with whom to share information. |  |

# **Criminal Background Check**

### Required for ALL service categories

**NOTE:** The applicant can elect to use the [Criminal Background Check Sample Policy](https://www.tn.gov/content/dam/tn/disability-and-aging/documents/provider-information/become-a-credentialed-provider/Criminal%20Background%20Check%20Sample%20Policy.docx) or develop its own policy. For the applicant to develop its own policy, each critical element below must be incorporated in the policy.

| **Critical Element(s)** | **Indicate policy name, page # and location** |
| --- | --- |
|
| 1. Does agency policy address criminal background check and registry check requirements for all employees, subcontractors, and volunteers? |  |
| 1. For employees, subcontractors, and volunteers of providers who will be providing direct contact with, or direct responsibility for, members, the criminal background check and registry check must have been performed within thirty (30) days of the first day the employee, subcontractor, or volunteer begins providing direct contact with, or direct responsibility for, members.   As it relates to volunteers providing direct contact, providers may accept a criminal background check conducted by an agency which has provided the volunteer instead of conducting an additional background check on the volunteer, as long as the criminal background check meets the provider’s criteria (e.g., goes back the same number of years the provider requires for checks of its staff), and was conducted no later than three hundred and sixty-five (365) calendar days earlier from the date the volunteer will begin assisting any member. However, even if the provider is relying on the results of a criminal background check conducted by the volunteer agency, the provider shall still conduct the required registry checks of the six registries listed above itself prior to the volunteer providing direct contact with, or direct responsibility for, a member. |  |
| 1. All applicants for employment must be informed of the fingerprint sample and/or the criminal background check requirement. |  |
| 1. Employment applications must require that applicants list any and all prior convictions, or if they have been required to register as a sexual offender. |  |
| 1. A signed release authorizing information from the background check to be disclosed to the provider |  |
| 1. 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 |  |
| 1. Policy addressing staff substantiation of abuse, neglect, and/or exploitation of people receiving services including but not limited to staff termination, suspension, or placement on the Department of Health’s Tennessee Abuse Registry. |  |
| 1. Personnel file will contain the following information: 2. Employee Name and Position 3. Valid State Issued Driver’s License 4. Hire/Start Date 5. Employment Application w/Convictions List 6. Confidentiality Statement (Signed) including HIPAA and HITECH 7. Current Job Description (Signed) 8. License/Certification Verification 9. First Aid and CPR training certificate for required staff |  |
| 1. Registry checks, to be signed and dated by reviewer with the person’s name and last four of social security number noted on the report: 2. TN Abuse Registry 3. TN Sexual Offender Registry 4. National Sexual Offender Registry 5. TN Department of Correction Felony Offender Information (FOIL) 6. EPLS (Excluded Parties List System) 7. OIG Fraud Prevention & Detection Search on LEIE (List of Excluded Individuals/Entities) Exclusions (monthly) 8. Criminal Background Check 9. SAM (System for Award Management) (monthly) 10. TennCare Terminated Provider List (TTPL) (monthly) |  |
| 1. Regarding SAM: If an employee with no previous findings has a finding on the next report, they will be terminated. |  |
| 1. The Provider is required to maintain the background and any additional relevant records including any approved exemptions for five (5) years after the employment relationship between the provider and employee has terminated. |  |
| 1. The agency will retain on file any reports of a criminal background check for all employees stating whether the employee met criteria for employment. |  |
| 1. Prohibited Staff – Providers shall not have a blanket policy of not hiring applicants with prior felony or misdemeanor convictions. Providers shall develop a process by which an applicant with a prior felony or misdemeanor (as outlined below) conviction may ask for an exemption to the felony hiring restriction. If approved by the provider through their internal process the request must be submitted to DDA through the DDA exemption process. DDA shall have final approval of all exemptions. Furthermore, the Provider shall not employ, retain, hire or contract with any individuals, as staff or volunteers, who would have direct contact with or direct responsibility for persons served; and who have been convicted of (unless approved by DDA through the DDA exemption process): (i) any felony or; (ii) a misdemeanor involving physical harm to a person including but not limited to neglect or abuse or a misdemeanor involving financial harm/exploitation to a person including but not limited to theft, misappropriation of funds, fraud or breach of fiduciary duty; or *This is NOT a valid provider agreement and should not be considered authorization to provide services.* (iii) a misdemeanor involving illicit drugs, drug/alcohol misuse or sexual misbehavior (e.g. indecent exposure, voyeurism). Misdemeanor convictions covered in this subparagraph, (f) (iii), shall not have occurred during a period of less than seven (7) years prior to employment with the Provider, unless the misdemeanor conviction is a first and only occurrence of a DUI (DUI 1), public intoxication, or simple possession of marijuana, then it shall not have occurred during a period of less than one (1) year prior to employment with the Provider. |  |
| 1. The criminal background check returns results of a prior felony or misdemeanor conviction and/or the employee, subcontractor, or volunteer appears on the Tennessee Felony Offender Information Lookup (the 6th registry), the provider must use its discretion as to whether that individual is appropriate to have direct contact with members and/or direct responsibility for that member. This means conducting an individualized assessment of the potential employee, subcontractor, or volunteer’s background check.   The individualized assessment must consider the following three (3) factors:  a. Whether or not the evidence gathered during the individualized assessment shows that the criminal conduct is related to the job in such a way that could place the member at risk;  b. The nature and gravity of the offense or conduct, such as whether the offense is related to physical or sexual or emotional abuse of another person, if the offense involves violence against another person or financial harm to a person; and  c. The time that has passed since the offense or conduct and/or completion of the sentence. |  |
| 1. Appearance on the FOIL or SIRI are not mandatory exclusions for direct support staff, and such appearances shall require providers to perform an individualized assessment consistent with Equal Employment Opportunity Commission guidelines |  |
| 1. If the employee, subcontractor, or volunteer will be in a position that involves *either* providing direct contact with a member and/or involves direct responsibility for a member, the provider must conduct a criminal background check on that employee, subcontractor, or volunteer which complies with all requirements established in Title 52 for obtaining a criminal background check and/or fingerprint check from the Tennessee Bureau of Investigation or, as an alternative, a criminal background check from a state licensed private investigation company. For an employee, subcontractor, or volunteer 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 employee, subcontractor, or volunteer has lived during the past seven (7) years or since the age of eighteen (18) years, whichever is fewer.   The criminal background check, including registry checks, must be performed prior to that employee, subcontractor, or volunteer having direct contact with persons receiving services and/or direct responsibility. If a potential employee, subcontractor, or volunteer's name appears on any of the registries listed in (1)- (5) above, that individual is disqualified from providing services. |  |
| 1. INCIDENTAL CONTACT: An employee, subcontractor, or volunteer who does not have direct contact with a member or direct responsibility for a member, but who has incidental contact only, is an individual who will *not* provide hands on support with any activities of daily living, who does *not* have supervisory authority or responsibility for either the member or for staff having direct contact with a member, and who has limited face-to-face interaction with that member. For purposes of this protocol, face-to-face interaction can be conducted both in-person and through virtual interaction with the member.   If the employee, subcontractor, or volunteer will not have direct contact with, or direct responsibility for, a member receiving service, but will instead have incidental contact only, that employee, subcontractor, or volunteer must have registry checks conducted for all six registries listed above prior to having incidental contact with persons receiving services but does not require a criminal background check. If the potential employee, subcontractor, or volunteer's name appears on any of the registries that individual is disqualified from having incidental contact with members. |  |
| 1. If the Incidental Contact employee, subcontractor, or volunteer appears on the Tennessee Felony Offender Information Lookup (FOIL), the provider must use its discretion as to whether that individual is appropriate to have incidental contact with members. This means conducting an individualized assessment. The provider should, therefore, not have a blanket policy of not hiring applicants with prior felony convictions.   For all employees, subcontractors, and volunteers who qualify to provide services constituting only incidental contact with members, the provider shall maintain proof that requisite registry checks were completed and provide these records to the MCO, TennCare and/or DDA for review upon request. |  |
| 1. If the employee, subcontractor, or volunteer will not have direct or incidental contact then the background check and registries are not required to be checked for that employee, subcontractor, or volunteer. |  |

# 

# **Crisis Intervention including Use of Positive Approaches**

## Required for the following service categories: Residential, Day, Employment, Personal Assistance, Respite, Other

| **Critical Element(s)** | **Indicate policy name, page # and location** |
| --- | --- |
| 1. Instructions for use of PRN psychotropic medications and behavioral safety interventions as applicable. |  |
| 1. References to de-escalation and redirection techniques which are used prior to behavioral safety interventions. |  |
| 1. The policy must classify behavior interventions as unrestricted or restricted in accordance with the DDA provider manual. |  |
| 1. The policy must outline interventions which are allowed and which are prohibited by the agency. |  |
| 1. The policy must provide for the development of support teams which meet to regularly evaluate behavioral data and solve problems of quality of life for persons. |  |
| 1. Assurance that procedures are only used in response to behaviors which present risk of harm. |  |
| 1. Assurance that procedures are in alignment with DDA procedural definitions. |  |
| 1. Assurance that behavioral safety interventions are only used when they are in the safest most appropriate response. |  |
| 1. Safeguards to prevent misuse of behavioral safety interventions. |  |
| 1. Mechanisms for ensuring a behavior assessment is requested when a person has 3 uses of behavioral safety intervention of PRN medication within a 6-month period. |  |
| 1. General procedures for managing crisis situations involving outside entities including staff monitoring of a person’s status until it is clear the person has been admitted to a facility. |  |
| 1. The policy must state that restrictive interventions may only be used after less restricted interventions have been tried except when the person’s behavior poses a risk of injury to self or others. |  |

# **Deficit Reduction Act (DRA) Policy on fraud, waste, and abuse**

### Required for ALL service categories

|  |  |
| --- | --- |
| **Critical Element(s)** | **Indicate policy name, page # and location** |
| *fraud, waste, and abuse reporting protocols, and a plan for fraud, waste and abuse employee training as required by Deficit Reduction Act of 2005 Section 6032:* **requires all entities that receive $5 million or more in annual Medicaid payments** to establish written policies that provide detailed information about the Federal False Claims Act, the administrative remedies for false claims and statements, applicable state laws that provide civil or criminal penalties for making false claims and statements, the “whistleblower” protections afforded under such laws and the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs. |  |

# **Documentation of Service Delivery**

### Required for ALL service categories

|  |  |
| --- | --- |
| **Critical Element(s)** | **Indicate policy name, page # and location** |
| Provider has a policy and procedure in place to provide and document initial and ongoing education to employees on Documentation of Service Delivery. (i.e., documentation of the tasks and functions performed during the provision of services). |  |

# **Electronic Visit Verification (EVV)**

## Required for the following service categories across ALL PROGRAMS: Personal Assistance; Respite; Supportive Home Care; Nursing services; Behavior services; Physical Therapy; Occupational Therapy; Speech Language and Pathology; and Nutrition

**NOTE:** The applicant can elect to use the [Electronic Visit Verification (EVV) Sample Policy](https://www.tn.gov/content/dam/tn/disability-and-aging/documents/provider-information/become-a-credentialed-provider/EVV%20Sample%20Policy.docx) or develop its own policy. For the applicant to develop its own policy each critical element below must be incorporated in the policy.

|  |  |
| --- | --- |
|  |  |

| **Critical Element(s)** | **Indicate policy name, page # and location** |
| --- | --- |
|
| 1. Provider will have at least one (1) dedicated staff assigned to work EVV during and after business hours. |  |
| 1. There must be at least one (1) backup staff to manage the EVV system as it relates to billing, exception handling, scheduling, and late and missed visit reporting. |  |
| 1. Providers must have an on-call process outlined for after-hours monitoring of EVV. |  |
| 1. Provider must ensure they have sufficient staff to provide services in accordance with the member's plan of care. The provider is responsible for having adequate backup staff in the event the originally scheduled worker cannot provide services in accordance with the pIan of care. |  |
| 1. Provider must comply with timely submission of any and all information needed regarding the members visit status, i.e. late and missed visits |  |
| 1. Provider must schedule all visits in EVV in advance. |  |
| 1. Providers must work all EVV exceptions within 24 hours of occurrence. |  |
| 1. Provider only has 120 days from the actual date of services to get the claim submitted. Any issues not exported from EVV are Included in the timely filing submission process. |  |
| 1. Provider must have written in their policy their process for verifying a member’s eligibility prior to services. |  |
| 1. Providers must have in their policy their process for notifying the MCO of any member status changes, i.e. hospitalizations, vacations, or nursing facility stays. |  |
| 1. Billing for all services is performed within the current billing contractor’s (Therap) EVV system. |  |
| 1. The EVV service visit will be captured in the Therap EVV system. All visits in the Therap system will be verified against acknowledged authorizations in the Therap system. After the billing process has been completed by the provider in Therap, the claim will be sent onto the person’s MCO for verification and payment by the approved MCO.   This will occur if the EVV Service visit is in the system with all elements required by EVV (whether auto-verified by the staff or manually edited by the provider agency). All visit/s that are not in a verified state (either by auto-confirmed or provider manual confirmation) will be unable to be captured and billed through the Therap system. Failure to check in and out by a staff person or lack of visit maintenance by the provider (if applicable) will result in payment delay until the corrections have been made. Therap Claims are captured and rolled over to the Therap system for final submission to the MCOs on a daily basis.  Daily notes and timesheets must be available for any DDA, State, or Federal review and/or audit |  |
| 1. Provider must train all staff, that provide services in the members home, how to clock in and out of the system as well as enter the task performed while in the member’s home. Training must include Education for workers on what to expect if the system is not utilized correctly |  |
| 1. Provider must have a mechanism in place for updating staff contact information in the EVV system and with Therap. The training must include pertinent phone, fax, and e-mail information to ensure provider agency is aware of any Therap updates. |  |
| 1. Provider has a policy and procedure in place to provide and document initial and ongoing education to employees on EVV System. |  |
| 1. Provider has training materials and sign-in sheets on EVV System. |  |
| 1. Provider must populate the EVV database with newly hired employees with social security number. |  |
| 1. The Provider is expected to maintain 100% compliance with EVV usage. Although less than 100% will result in outreach from DDA, 90% of auto-verified visits are the benchmark for compliance. Failure to comply will result in other administrative actions, as described in the section below. |  |
| 1. All providers and their agency staff must use the Therap system regardless of other EVV systems in place. |  |
| 1. The Direct Support Professional (DSP) must successfully record the EVV Service visit by checking in and checking out during the visit. DSPs will be required to check-in and check-out with their unique ID assigned by the agency. This includes family members paid to act as the DSP.   There are two preferred means for staff to check-in and check-out using EVV: Phone-Based Telephony (TVV) and Mobile Visit Verification (MVV) via bringing your own device (BYOD). The preferred method, when checking in from the person's home, is BYOD.  Allowable phone numbers are any numbers associated with the person supported. *The Independent Support Coordinator (ISC) for the person supported is responsible for keeping phone numbers up-to-date with DDA, once the Provider has made them aware of a change so that the Department's case management system (TITAN) can be updated to reflect the correct information.* Please be aware that phone numbers cannot be associated with the agency.  If the person supported does not have a phone available, bring your own device (BYOD) must be utilized unless the Provider elects to provide a fixed device in the home.  If there is an unexpected issue with cell service at the time of the visit, Therap’s MVV application will work in offline mode and transmit the captured data the next time the MVV application is opened.  In areas where cell service and internet connection are always an issue, the Therap Offline Scheduling application will allow users the ability to check in and out of pre-scheduled visits when they do not have access to an internet connection or when the Therap web application is unavailable due to maintenance.  The offline scheduling application must be configured in advance via the user’s mobile application dashboard ‘Settings’ page. Please note this only works if schedules are created ahead of time and the visits are added to the offline application in advance of being without internet or cell service.  If there are no phone capabilities in the person’s residence, there is the final option of placement of a fixed device (additional cost) in the person receiving services home. This is known as Fixed Visit Verification (FVV). |  |
| 1. DDA recommends Providers perform visit Maintenance daily. Maintenance is vital to the Therap EVV system for monitoring. Failure to perform this maintenance could result in delayed payment in billing claims until the corrections have been made.   Each agency will identify agency users who will perform this function and assign permission roles accordingly. A note must be entered whenever a call is not captured automatically in the Therap system. These types of events are referred to as exceptions, and DDA will look for a comment on each exception. Exceptions require manual confirmations of the visit by the agencies' dedicated staff.  Providers are expected to verify that visits have occurred if there is an exception by verifying there is a timesheet and daily note for the visit before the visit is confirmed in the EVV system. If more detailed reasons are needed for this manually confirmed visit, DDA may request this information be made available upon request.  Any discrepancies noted by the provider agency, such as but not limited to GPS location with non-associated locations of the person, services not being provided at the time requested or manner based on the person's preference, or overall visit concerns are to be addressed by the provider agency and can be found by their continuous visit oversight maintenance.  Please note: The manual confirmation by the EVV service provider of service visit process is not compliant with the Cures Act. Each manually confirmed visit and reason needs to be tracked and addressed by the Provider.  Provider agencies must continue to use timesheets and service notes to document service delivery.  Documentation of these processes must be available for any DDA, State, or Federal review and/or audit. |  |
| 1. EVV Compliance will be measured in the DDA Program Operations unit. It will focus primarily on data collected relative to successful check-ins and check-outs and by successful scheduling of visits by the Provider. The review period will be for the previous month of services.    1. The following cumulative data points will be collected by DDA and reported to TennCare: o Total EVV confirmations:    2. o Total number of telephony (IVR) Confirmations    3. o Total number of MVV Confirmations (BYOD/Personal Device)    4. o Total number of Manual Confirmations    5. o Percent of manual confirmations due to Provider/Worker error    6. o Percent of manual confirmations due to DDA/System error    7. o Primary reasons for manual confirmations (can be determined through reports, using notes made by the Provider and/or outreach to the Provider by DDA)   Compliance Score is calculated as follows: IVR visits + MVV visits + Manually Confirmed visits=total number of visits and Total IVR and MVV Confirmations divided by the total number of visits confirmed equals the percentage of compliance (assumes manual confirmations are non-compliant)  EXAMPLE:   * 21 IVR visits + 1 MVV visit (total EVV visits) + 4 manually confirmed visits (non-compliant confirmations) =26 total visits * 22 EVV visits /26 total confirmed visits =85% compliance |  |

# **Emergency/Urgent Care**

## Required for the following service categories: *Residential, Day, Employment,* *Personal Assistance, Respite, Other*

| **Critical Element(s)** | **Indicate policy name, page # and location** |
| --- | --- |
|
| 1. Notification requirements per Reportable Events Management standards. |  |
| 1. Provider documentation includes evidence that the provider has a process in place for resolving emergencies and notifying the legal representative/family member, if applicable, immediately, and notifying the MCO Support Coordinator within 24 hours. |  |
| 1. Documentation includes:  * Evidence of emergency and/or urgent health care obtained * Evidence that appropriate action was taken within the specified timeframes to ensure the safety of the individual supported. |  |
| 1. Instructions on what an emergency looks like. Including what to do and who to contact in an emergency for people identified as having high medical and/or behavioral or mental health needs. |  |
| 1. Addresses first aid kits to include the following: accessibility, locations, contents, security, and periodic review and restocking. |  |
| 1. Instructs staff 911 calls must not be delayed. |  |
| 1. Indicates information regarding initiation of emergency first aid procedures. |  |
| 1. Indicates requirements for provision of information to emergency medical staff. |  |
| 1. Indicates requirements for notification of designated provider supervisory staff. |  |

# **Fire, Sanitation, and Emergency Precautions**

#### Required for the following service categories: Residential, Day, Employment, Personal Assistance, Respite, Other

|  |  |
| --- | --- |
| **Critical Element(s)** | **Indicate policy name, page # and location** |
| 1. Agencies will maintain and display approved compliance record from fire, health, and environmental safety authorities*.* |  |
| 1. Agencies have emergency plan in effect in the event of fire, severe weather, or health crisis (includes an evacuation plan and documented regular drills.) |  |
| 1. Persons served are not put at risk for safety hazards (i.e.; people serving more than one person in a wheelchair have adequate staff for evacuation procedures.) |  |
| 1. Homes/facilities must be maintained in a safe manner and continuing effort made to eliminate potential hazards. |  |
| 1. Homes/facilities must be maintained in a sanitary and clean condition, free from all accumulation of dirt and rubbish, well ventilated, and free from foul, stale, or musty odors. |  |
| 1. Homes/facilities must be kept free of mice, rats, and other rodents |  |
| 1. Housekeeping practices and standards must be maintained which will ensure the eradication of flies, roaches, and other vermin. |  |

# **Good Nutrition**

###### Required for the following service categories: *Residential*

###### *For writing the* *Good Nutrition policy, please see the “Basic Nutrition & Dr Prescribed Diets Resource Guide” found:* [*HERE*](https://www.tn.gov/content/dam/tn/didd/documents/providers/resources-manuals/Basic_Nutrition_and_Doctor_Prescribed_Diets-Resource_Guide.pdf)

|  |  |
| --- | --- |
| **Critical Elements** | **Indicate policy name, page # and location** |
| 1. Are all reasonable resources (EBT, SNAP, WIC, food stamps, etc.) reviewed on a regular basis to determine eligibility and need? |  |
| 1. Does the policy address people having the opportunity to participate in their meal planning, preparation, and shopping as they desire? |  |
| 1. Is the provider providing adequate food supply based upon their needs and prescribed diet? |  |
| 1. Is food accessible to the person? If not, was the restriction approved by HRC and noted in the PCP? |  |
| 1. Does the provider offer opportunities for education and trainings following prescribed diets? |  |

# **Health Care Needs**

### Required for the following services: *Residential, Day, Employment, Personal Assistance, Respite, Other*

| **Critical Element(s)** | **Indicate policy name, page # and location** |
| --- | --- |
|
| 1. Name of current MCO/BHO and ID# are in the person’s file. (Including additional insurances). |  |
| 1. Description of individual’s overall health and specific issues or conditions is listed in the person’s file as specified in the Person-Centered Service Plan (PCSP). |  |
| 1. Name and contact information or specific requirements:   a). For contact people, PCP, medical specialists, dentist, therapies, home health services, medical supplies, transportation, outpatient services, diagnostic/labs, hospitalizations, and emergencies.  b). Information regarding medications  c). Individual medical history  d). Information regarding equipment (assistive, durable medical, durable supplies, and communication devices)  e). Information regarding any special medical condition and the treatment required. |  |

# **Medication Safety**

## Required for the following service categories: Residential, Day, Employment, *Personal Assistance*, Respite, Other

The applicant is advised to use the Medication Safety Policy that is located on the DDA website <https://www.tn.gov/content/dam/tn/disability-and-aging/documents/about-us/divisions/clinical/nursing/med-admin/DDA%20Medication%20Safety%20Policy%20Sample.docx>

# **Organization’s Person-Centered Approach**

## Required for ALL service categories

| **Critical Element(s)** | **Indicate policy name, page # and location** |
| --- | --- |
|
| 1. The provider will strive to use person-centered practices throughout their operation. |  |
| 1. The provider will ensure the person’s circle of support (CoS) obtains their maximum input regarding their choices, desires, and decisions. This includes but is not limited to the person identifying the place/times for planning meetings, meeting attendees, interviewing of potential housemates, and participating in the interviewing of potential staff/staff matching. |  |
| 1. If the person is an imminent danger to self or others, then it is feasible and necessary to expect the circle of support or conservator to intervene in order to ensure the safety of the person. |  |
| 1. The person’s cultural background must be recognized and valued in the decision-making process. |  |
| 1. To help people achieve a meaningful life, services and supports should include choices which connect the person’s goal and vison of a preferred life while also promoting independence and beneficial skills to help the person achieve independence and advancement. |  |

# **Person Supported Records Management**

Required for ALL service categories

| **Critical Element(s)** | **Indicate policy name, page # and location** |
| --- | --- |
|
| 1. Providers shall create an individual record for each person supported that contains documentation of services provided. |  |
| 1. 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 secure and confidential in accordance with applicable state and federal laws, rules, regulations, policy and ethical standards. |  |
| 1. Providers shall honor individual rights as specified in HIPAA & HITECH 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. |  |
| 1. Providers must implement written policies pertaining to records maintenance, including the location of required components and staff responsible for records maintenance. |  |
| 1. Records must be maintained for a period of ten (10) years from date of death or discharge. |  |
| 1. Records must be maintained in a manner that ensures the records are accessible and retrievable. |  |
| 1. Professional support services licensure (PSSL) rules require maintenance of records for people with developmental disabilities for ten (10) plus one (1) years from date of death or discharge. |  |
| 1. 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. |  |
| 1. Providers must maintain original (e.g., paper or electronic) documents for the services provided by their employed staff. |  |
| 1. Providers must maintain copies of required documentation obtained from contracted staff and other providers. (*For example: Clinical services*) |  |
| 1. Provider will collect enrollee specific data (as evidenced by the following, including but not limited to: progress notes, daily logs, incident reports, or monthly service call checks) |  |
| 1. Provider will document services performed at each visit and will include a services rendered checklist that will be signed by the enrollee and the employee, and then initialed by the employee's supervisor. |  |

# **Personnel Procedures**

## Required for ALL service categories

| **Critical Element(s)** | **Indicate policy name, page # and location** |
| --- | --- |
|
| 1. Policy addressing **employee complaints**. |  |
| 1. Policy addressing **employee progressive disciplinary actions**. |  |
| 1. Policy addressing **Employee Records Management** | \*Includes retention of at least 5 years after date of separation |
| 1. Job Descriptions and/or policy addressing **Hiring Procedures, Process & Minimum Qualifications** |  |
| 1. Policy addressing **drug-free workforce** |  |
| 1. Policy addressing **TB testing** |  |

|  |  |
| --- | --- |
| 1. Training requirements to be maintained in the file: 2. Evidence Orientation/Training was conducted (CHOICES/ECF CHOICES EVV System, individual Assigned GPS Device, CHOICES/ECF CHOICES Web Portal, Caring for Elderly and Disabled Population, Critical Incident Reporting, Community Living Support and HCBS Settings Rule). Within 90 days of hire the DRA training must be completed. 3. (ECF Only): If this staff is the incident coordinator, have they been trained on it? 4. (ECF Only): Evidence of ECF DSP (Direct Support Professional) Staff Training / Qualifications 5. (ECF Only): Evidence of ECF Employment Services Staff Qualifications 6. (ECF Only-Group 7 &8): Evidence of ECF Employment Services Positive Behavior Supports (PBS) Staff Training 7. (ECF Only-Group 7 &8): Evidence of ECF Employment Services Co-occurring Mental Health Conditions with I/DD Staff Training 8. (ECF Only-Group 7 &8): Evidence of ECF Employment Services Integrated Behavior Health Services & Supports Staff Training 9. (ECF Only-Group 7 &8): Evidence of ECF Employment Services Agency-Approved Crisis Management Procedures Staff Training 10. (ECF Only- Group 7 &8): Evidence of ECF Employment Services Member-Specific Training on Plans Staff Training 11. Proof of completion of required trainings for DDA and MCO |  |
| 1. What is the agency's system to ensure all employees are evaluated per the agency's policies & procedures? 2. What are the agency's timelines for the evaluation of employees? 3. Who conducts evaluations? 4. Is documentation maintained in personnel files? |  |
| 1. Procedures for hiring staff including minimum qualifications for each staff position. 2. Staff must be at least eighteen (18) years of age. 3. 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. 4. 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. 5. 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. 6. 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. 7. Family members who are paid to provide services must meet the same standards as providers who are unrelated to the person. 8. All providers must comply with DDA and TennCare policies, procedures, and rules for waiver service providers, and quality monitoring requirements. |  |

# **Protection & Promotion of Rights**

## Required for ALL service categories

| **Critical Element(s)** | **Indicate policy name, page # and location** |
| --- | --- |
| * + - 1. Are provider policies outlining rights of people supported made available to the people the agency supports? |  |
| 1. Are the policies regularly reassessed for compliance and effectiveness and amended as necessary? |  |
| 1. People served will be entitled to their rights and must be assisted in understanding the responsibilities associated with certain rights. Any restrictions must be reviewed by the Human Rights Committee. |  |
| 1. The agency will have the Behavior Analyst take BSPs inclusive of restrictive interventions through an approved Human Rights Committee for review. |  |
| 1. A local Human Rights Committee will be constituted according to requirements. |  |
| 1. If there is any rights restriction, restricted intervention or psychotropic medication being used by the person, the person and his/her family and/or legal representative have received information about risks, benefits, side effects and alternatives, and have given voluntary, informed, documented consent for the use of the intervention or medication. |  |
| 1. The person has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy. |  |
| 1. The person has the right to a prompt and reasonable response to questions and requests. |  |
| 1. The person has the right to know who is providing medical services and who is responsible for his or her care. |  |
| 1. The person has the right to know what rules and regulations apply to his or her conduct. |  |
| 1. The person has the right to be given by the healthcare provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis. |  |
| 1. The person has the right to refuse any treatment, except as otherwise provided by law. |  |

# **Quality Assessment, Assurance, and Improvement**

## Required for ALL service categories

| **Critical Element(s)** | **Indicate policy name, page # and location** |
| --- | --- |
|
| 1. Providers must have a process for conducting on-going self-assessments. |  |
| 1. 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. The self-assessment process allows the provider to:    1. Identify systemic issues,    2. Initiate corrective actions for the identified systemic issues, and    3. Incorporate external monitoring report(s) findings (i.e. QA Survey, FAR, HCBS Final Settings Rule, etc.). |  |
| 1. All providers must address the systemic issues identified during their self-assessment activities via a Quality Improvement Plan (QIP) until resolution. |  |
| 1. Providers must react to self-assessment findings by determining the causative factors and taking action to improve quality or compliance. Each provider is required and responsible for completion of self-assessment activities and to evaluate and revise their self-assessment process on an on-going basis, as needed. A provider may use the Council for Quality Leadership (CQL) Basic Assurances Self-Assessment OR include, at minimum, the following components within their self-assessment activities in order to meet this requirement:    * 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 or other health and safety factors;      4. Review of external monitoring reports for the previous twelve (12) month period;      5. Review of any sanctions imposed during the previous twelve (12) month period;      6. Review of personnel practices, including staff recruitment and hiring, staff training, and staff retention and turnover;      7. Review of processes intended to ensure timely access to health-related interventions, such as health care appointments and follow-up activities;      8. Review of policies to ensure continuing alignment with DDA current requirements; and      9. Application of the current DDA QA Survey Tool to a sample of persons supported. |  |
| 1. The QIP should outline any necessary systemic improvements which should be made through a process which includes:    1. Analysis of the cause of any serious issues and problems identified;    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; and    5. Modification of policies, procedures, and/or the management plan (potentially the QIP) to prevent recurrence of issues and problems which were resolved. |  |

# **Reportable Event Management (REM)**

## Required for ALL service categories

**NOTE:** The applicant can elect to use the [Reportable Event Management (REM) Sample Policy](https://www.tn.gov/content/dam/tn/disability-and-aging/documents/provider-information/become-a-credentialed-provider/REM%20Sample%20Policy.docx) or develop its own policy. For the applicant to develop its own policy, each critical element below must be incorporated in the policy.

| **Critical Element(s)** | **Indicate policy name, page # and location** |
| --- | --- |
| 1. Utilizes the Reportable Event Forms (REF) DDA-750. |  |
| **Reportable TIER 1 EVENTS are defined per the REM one aligned protocol:** | |
| 1. Tier 1 Reportable Event: The alleged wrongful conduct affecting the person by acts or omissions of abuse, neglect, exploitation, or misappropriation of money or property, that resulted in one or more of the following consequences to the person: 2. death, 3. serious injury, or physical harm; 4. physical or sexual abuse; 5. significant pain, 6. intimidation or mental anguish that required medical intervention, 7. loss of funds or property greater than $1,000 in value, or 8. missing prescription-controlled medication with a replacement value greater than $1,000.   Note: *Deaths that occurred while the person supported was receiving hospice or palliative care or that occurred outside the provision of services with no allegations of abuse/neglect against a paid caregiver do not need to be reported to the hotline and are appropriately reported via REF. Allegations against non-paid caregivers (i.e., family member, spouse, significant other) are not reportable to DDA as DDA has no jurisdiction. These allegations are to be reported to Adult Protective Services and/or Law Enforcement.* |  |
| 1. Verbal notice is given to the DDA Investigations Hotline as soon as possible but within 4 hours.   *Tier 1 Reportable Events must be reported initially by calling the DDA’s Abuse Hotline (1-888- 633-1313) as soon as possible, but no later than four (4) hours after the occurrence of the event or the discovery thereof. The event shall also be reported to Adult Protective Services (APS), Child Protective Services (CPS), and/or law enforcement, as required by law.* |  |
| 1. A corresponding Reportable Event Form (REF) must be submitted by the Event Management Coordinator (EMC) or designee to DDA within one (1) business day of the Hotline report by utilizing the reporting link (https://stateoftennessee-cvlyz.formstack.com/forms/ref). Providers are required to send a copy of the REF to the Independent Support Coordinator (ISC) or DDA Case Manager, as applicable to the person supported, for their records of any Reportable Events associated with that person, once the telephonic report to DDA is made. The provider and the MCO shall not move forward with their own “reviews” once a Tier 1 Reportable Event has been reported. |  |
| 1. Suspected abuse, neglect, and exploitation of members who are adults is immediately reported in accordance with TCA 71-6-103 and suspected brutality, abuse, or neglect of members who are children is immediately reported in accordance with TCA 37-1-403 or TCA 37-1-605 as applicable.   *“The event shall also be reported to Adult Protective Services (APS), Child Protective Services (CPS), and/or law enforcement, as required by law.”* |  |
| 1. Providers immediately (which shall not exceed twenty-four hours) take steps to prevent further harm to any and all members and respond to any emergency needs of members. |  |
| 1. Excluding when an exception is granted by DDA, providers are required to immediately remove an employee or volunteer named in a Tier 1 Reportable Event and alleged to have acted in a manner consistent with sexual abuse or physical abuse resulting in medical treatment from providing direct support to any person(s) supported until DDA has completed their investigation, either by placing the named employee or volunteer on administrative leave or in another position in which he or she does not have direct contact with or supervisory responsibility for a person(s). |  |
| 1. If a Tier 1 Reportable Event, or any other event that poses an immediate threat to the health and safety of a person occurs, provider staff must be on site with the person, and in addition to reporting this event, such staff shall be required to remain with the person until the threat is removed or the person receives needed medical treatment, if appropriate. |  |
| 1. Providers cooperate with any investigation conducted by the CONTRACTOR or outside agencies (e.g., TENNCARE, APS, CPS, and law enforcement). |  |
| 1. For any Reportable Event, the provider has supervisory staff (including clinical staff, as applicable) review the *Reportable Event* and determine appropriate follow up. |  |
| 1. Providers are expected to send all information related to the investigation to DDA as soon as possible upon request. |  |
| 1. The provider shall instruct all staff that the facts and circumstances being investigated are not to be discussed with anyone except the DDA Investigator, law enforcement officers, or other state investigative entities (APS, Department of Children’s Services, Disability Rights TN, etc.). |  |
| 1. All waiver program providers, persons supported, legal representatives, case managers/support coordinators, MCO, DDA, or TennCare representatives may request a review of an investigative report within fifteen (15) days of an investigation closing. Requests must be based on new or additional information, evidence not considered during the investigative process, raise matters that bring into question the integrity of an investigation, or provide basis for disputing the investigative conclusion. All Investigation Review requests must be submitted in writing, express the reason for the disagreement, and include additional evidence if applicable. The Committee will not review any file requests that are incomplete or not submitted within the allotted timeframe. (Process for requesting an *Investigation Review*) |  |
| 1. Following the closure of the Final Investigative Report, the provider will have ten (10) business days to draft an Action Plan and submit it to the DDA Investigations Follow-Up Unit and the respective MCO.   The Action Plan shall include the following information:   * The procedures that have been implemented to mitigate future risks to the person, including steps to prevent similar occurrences in the future; * Verification that the substantiated perpetrator(s) was notified of the outcome of the investigation in writing; * A statement of what, if any, disciplinary action, training, reassignment, or any other remediation occurred as a result of the findings of the investigation; and * A response to any informational findings contained in the investigative report. |  |
| 1. All Reportable events P&P are updated to include the *One Alignment* process and provider demonstrates knowledge for accessing REM website/resources. |  |
| 1. Demonstrates knowledge of *Reportable Event Management* process as it related to the *Quality Monitoring Tool* through identified processes and implementation of those processes. (completed guidance of OUTCOME 7 of QMT) |  |
| 1. Class 1 Substantiations (i.e. the wrongful conduct affecting the person constituted abuse, neglect, exploitation, or misappropriation of money or property, and resulted in one or more of the following consequences to the person: death, serious injury, or physical harm; physical or sexual abuse; significant pain, intimidation or mental anguish; probable risk of serious harm; loss of funds or property greater than $1,000 in value or prescription controlled medications with a replacement value of greater than $1000; or, through supervision neglect harming a citizen in the community or engaging in criminal acts resulting in arrest and confinement. Wrongful conduct in this category is of a nature serious enough to call into question whether the offender should be entrusted with the care of a vulnerable person). A Final Investigative Report reflects that the evidence supports that the identified staff acted in accordance with this definition. |  |
| 1. ECF TRAINING: All ECF CHOICES provider agreements shall require that all direct support staff (i.e., provider staff working directly with people in ECF CHOICES) complete required training as prescribed by TENNCARE within thirty (30) days of hire and prior to providing direct support to members. |  |
| 1. NON-COMPLIANCE: The MCO will be notified and responsible for ensuring provider cooperation with the investigation if provider staff does not send the requested information to DDA by the following business day. ECF CHOICES and CHOICES will maintain their current processes for imposing progressive disciplinary action (e.g., monetary sanctions). |  |
| **Reportable TIER 2 EVENTs are defined per the REM one aligned protocol:** | |
| 1. Tier 2 Events 2. The alleged wrongful conduct affecting the person by acts or omissions of abuse, neglect, exploitation, or misappropriation of money or property, that resulted in one or more of the following consequences to the person: intimidation or mental anguish; 3. Probable risk of serious harm; 4. Loss of funds or property between $250 and $1,000 in value or prescription-controlled medications with a replacement value of less than $1,000; or, 5. Through supervision neglect harming a citizen in the community or engaging in criminal acts resulting in arrest and confinement. The person did not require medical treatment or intervention and is not at continued risk of serious harm. |  |
| 1. Allegations that are reported to DDA and consistent with the Tier 2 Reportable Events categories/definition (with the exception of Physical Abuse allegations), will be referred as appropriate to the provider to perform the investigation (unless the specific provider is excluded from performing their own investigations for another reason further explained below). All Physical Abuse allegations opened for investigations will be conducted by a DDA State Investigator. Tier 2 Reportable Events and all allegations of abuse, neglect or exploitation shall also be reported to Adult Protective Services (APS), Child Protective Services (CPS), or law enforcement, as required by law.   The EMC or designee will submit a REF to DDA by utilizing the reporting link within (1) business day after the occurrence or discovery of occurrence of a Tier 2 Reportable Event. Providers are required to send a copy of the REF to the Independent Support Coordinator (ISC), or DDA Case Manager, for persons supported by a 1915(c) State funded waiver. |  |
| 1. All providers are responsible for conducting investigations of Tier 2 Reportable Events and submitting an investigation report via the DDA REM Focus system for each Tier 2 allegation. A completed investigation report and attachments shall be entered in the DDA REM Focus system within twenty-five (25) calendar days of the anchor date. |  |
| 1. Providers, after seeking the victim/person’s preference and/or that of the legal representative (if applicable), shall determine at their discretion and in accordance with their policy, whether to remove an employee or volunteer named in a *Tier 2 Reportable Event* from any or all direct support until the provider has completed their investigation.   If the allegation is substantiated as a Class 2 level, the employee or volunteer may be terminated, or removed until the completion of any action plan (e.g., training) deemed appropriate by the provider. In lieu of removing an employee or volunteer named in a Tier 2 Reportable Event from any or all direct support, the provider may opt to utilize a modified assignment or increased supervision. The provider is expected to ensure that adequate steps are taken for the protection and safety of all persons during the investigation process. |  |
| 1. Should the Provider Investigator discover evidence that would result in the allegation rising from a Tier 2 to a Tier 1, the *Provider Investigator* shall stop the investigative process immediately and notify the *Investigations Specialist* (if during normal business hours), or the DDA Abuse Hotline. The provider must forward the investigation immediately back to DDA to investigate. |  |
| 1. For any *Reportable Event*, the provider has supervisory staff (including clinical staff, as applicable) review the *Reportable Event* and determine appropriate follow up. |  |
| 1. If the allegation is substantiated as a Class 2, the employee or volunteer may be terminated, or removed until the completion of any action plan (e.g., training) deemed appropriate by the provider. In lieu of removing an employee or volunteer named in a *Tier 2 Reportable Event* from any or all direct support, the provider may opt to utilize a modified assignment or increased supervision. The provider is expected to ensure that adequate steps are taken for the protection and safety of all persons during the investigation process.   Class 2 Substantiations (i.e. the wrongful conduct affecting the person constituted abuse, neglect, exploitation, or misappropriation of money or property, but resulted in minimal or no physical harm or injury, pain, or mental anguish; minimal risk of serious harm; loss of funds or property of up to $1,000 in value; loss of prescription controlled medication with a replacement value less than $1,000; or violation of plans of care with minimal or no adverse consequences. Wrongful conduct in this category is of a nature that disciplinary action and/or additional training may reasonably be deemed sufficient to address). A Final Investigative Report reflects that the evidence supports that the identified staff acted in accordance with this definition. |  |
| 1. If allegations were not substantiated, an *Action Plan* is not required. For both substantiated and unsubstantiated investigations, providers must ensure that informational findings are acted upon in a timely manner. DDA or the MCO can request follow-up action to unsubstantiated Informational Findings, to include Late Reporting.   DDA and MCOs are responsible for reviewing investigation reports submitted by DDA Investigators and Provider Investigators. The DDA Investigations Follow-Up Unit and the MCO shall determine the necessity for any follow-up review needed. The provider will complete the Action Plan for all substantiated allegations, both Class I and Class II.  Following the closure of the Final Investigative Report, the provider will have ten (10) business days to draft an Action Plan and submit it to the DDA Investigations Follow-Up Unit and the respective MCO. The Action Plan shall address each Informational Finding and late reporting discovered as a means of provider self- improvement. During this time, the provider will continue to 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.  The Action Plan shall include the following information:   * The procedures that have been implemented to mitigate future risks to the person, including steps to prevent similar occurrences in the future; * Verification that the substantiated perpetrator(s) was notified of the outcome of the investigation in writing; * A statement of what, if any, disciplinary action, training, reassignment, or any other remediation occurred as a result of the findings of the investigation; and * A response to any informational findings contained in the investigative report. |  |
| **Non-Reportable Events are defined per the REM one aligned protocol.** | |
| 1. Although non-reportable events are not reportable to DDA or the MCO, providers are expected to document, perform data collection, trend analysis, and address these events internally as part of strategic quality improvement processes that lead to improved outcomes. Provider oversight for non-reportable events will continue to be monitored by DDA during annual quality assurance surveys and/or recredentialing, as applicable. |  |
| **Provider Reportable Event Review Team (PRERT):** Provider agencies that provide day, residential, and personal assistance services will develop a Provider Reportable Event Review Teams (PRERT). | |
| 1. Provider Reportable Event Review Team (PRERT) is established. The purpose of the PRERT is to review and evaluate the provider’s reportable events, investigations, and trends to inform internal prevention strategies. |  |
| 1. The PRERT shall meet regularly, but no less than monthly, and membership and representation is specific to each provider’s Event Management policy. |  |
| 1. PRERT meetings will be documented and will reflect discussion and follow up actions concerning reported events and investigations, their causes, actions taken, and recommendations made by the review team. |  |
| **Event Management Coordinator(EMC)** | |
| 1. Each contracted provider is responsible for the designation of an Event Management Coordinator (EMC). |  |
| 1. Provider should have an identified back up to the EMC and P&P for back process/implementation. |  |
| **Certified Provider Investigator (CPI)** | |
| 1. Providers shall ensure that all Tier 2 investigations are conducted by a certified Provider Investigator. As part of the certification, provider Investigators must complete the required training as determined by TennCare in collaboration with DDA. |  |
| 1. A trained Provider Investigator (PI) is designated, or a sub-contract is identified. The provider may have multiple DDA certified Provider Investigators or may contract with a DDA certified Provider Investigator. The provider shall notify the Investigations Specialist, via the DDA REM Focus system, the identity of the Provider Investigator. |  |
| 1. If the provider requests not to investigate an allegation and shall result in a DDA Investigator conducting the investigation. The provider shall be responsible for submitting an Exception to Investigation form to the Director of Investigations or designee within two (2) business days of the anchor date with an explanation related to one or more of the following:  • Conflict of interest associated with the investigation. • The complexity of the investigation impedes the provider’s ability to investigate. • When the alleged perpetrator has 3 prior substantiations with that agency within a 24 rolling month period, the provider can request the state to investigate any subsequent investigation. |  |

# **Respect to Persons Supported**

## Required for ALL service categories

| **Critical Element(s)** | **Indicate policy name, page # and location** |
| --- | --- |
| 1. Agency staff is informed and practice the First Amendment Rights. |  |
| 2. Level of satisfaction is obtained from persons served concerning services received and personal life situations. |  |
| 3. Persons served participate in meaningful employment and activities, privacy and advocacy. |  |
| 4. Agency policy and procedures reflect people first language. |  |
| 5. Reflects dignity and respect through positive interaction, refraining from activities that draw undue attention to a person's disability or differences, enhancement of self-esteem, and non-intrusive non-demeaning services and supports. |  |
| 6. Reflects how agency will facilitate and support natural support systems. |  |

# **Succession Planning**

Required for ALL service categories – *except* for Ancillary services

*Succession planning is a strategy for passing on leadership roles—often the ownership of a company—to an employee or group of employees. It ensures that businesses continue to run smoothly after a company's most important people move on to new opportunities, retire, or pass away.*

| **Critical Element(s)** | **Indicate policy name, page # and location** |
| --- | --- |
| 1. Who will manage the continuity of business and performance of duties in the absence of the owner/Executive Director (Person in Charge of Day-to-Day) leaves? |  |
| 1. Was a policy or business model (including succession planning) submitted for review? |  |

# **Title VI**

## Required for ALL service categories

| **Critical Element(s)** | **Indicate policy name, page # and location** |
| --- | --- |
| 1. Ensures the person receives equal treatment, equal access, equal rights and equal opportunities without regard to race, color, national origin or Limited English Proficiency (LEP). |  |
| 1. Agency has a designated Title VI Local Coordinator. |  |
| 1. Addresses a system to ensure people know who the Local Coordinator is and how to contact him/her. |  |
| 1. Addresses employee training to ensure Title VI compliance during service provision, recognition of and Employee progressive disciplinary actions Title VI violations, complaint procedures and appeal rights pertaining to violations and governing response to employees who do not maintain Title VI compliance in interacting with people. |  |
| 1. Provides meaningful access and arranges language assistance to persons of limited English proficiency (interpreters and/or language appropriate written materials). |  |
| 1. Discusses how people supported are informed of Title VI. |  |
| 1. Describes a mechanism for advising people of their options for filing a Title VI complaint. |  |
| 1. Title VI materials are displayed in conspicuous places accessible to all. |  |
| 1. Residential providers must ensure room assignments and transfers are made without regard to race, color, or national origin. |  |
| 1. Employees are oriented to their Title VI responsibilities and the penalties for noncompliance within the first sixty (60) days of employment with documentation placed in personnel files. |  |
| 1. Annual Title VI in-service training is completed and documented in personnel file. |  |
| 1. All providers must ensure that vendors, subcontractors and other contracted entities are clearly informed of Title VI responsibilities and are required to maintain Title VI compliance. |  |
| 1. All providers must complete and submit an annual Title VI self-survey. |  |

# **Transportation to People Supported**

## Required for the following service categories: Residential, Day, Employment, Personal Assistance, Respite, Other

| **Critical Element(s)** | **Indicate policy name, page # and location** |
| --- | --- |
|
| 1. Vehicles in which people are transported in have operable seat belts and used in the proper manner based on the person’s needs. |  |
| 1. Any mobility support needs applicable to the person’s transportation must be met in accordance with the ISP or staff instructions. |  |
| 1. Policy addresses how the agency will document the vehicle being used to transport people are safe and it meets all the transportation service requirements whether the vehicle is owned by the provider or by provider staff. |  |
| 1. 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. |  |
| 1. First aid supplies are maintained in the vehicle. |  |
| 1. Providers may not charge people supported or their families for the cost of routine maintenance or the cost of cleaning the vehicle owned by the provider or provider’s staff. |  |
| 1. 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. |  |

# **Well-Trained Staff (paid and unpaid)**

## Required for ALL service categories

#### Resources: Please visit the tn.gov/DDA website for information <https://www.tn.gov/disability-and-aging/about-us/divisions/training.html#collapse04cd3470c3054abea535cd3df361ba04-5>

| **Critical Element(s)** | **Indicate policy name, page # and location** |
| --- | --- |
|
| 1. A training system is in place for ensuring all trainings are successfully completed within the contracted requirements. |  |
| 1. An identified employee coordinates, monitors, assigns, and trains, as applicable, to ensure all employee training is completed and current. |  |
| 1. Provide appropriate information and skills training to volunteers as necessary to protect the health and safety of the person served and the volunteer. Information and Training Specific to the Person. Under no circumstance will a volunteer be left alone with a person served or assigned responsibility to perform the duties of trained and paid staff. Consents must be obtained from the person served or their legal representative before any personal information is shared. |  |
| 1. Has a policy and procedure in place to provide and document initial and ongoing education to employees on the Community Living Support Daily Services process to include standardization of individuals' binder. Binder should include DNR, Emergency Plan, CC and family contact information, MCO Community Living Support Daily Note, Travel log/activity, individual specific (Plan of Care, Risk Agreement, Medication Agreement) Medication Administration Record/Outpatient Therapy Services provided within the home. (This section should include the provider follow-up form). |  |
| 1. Conduct and document initial and ongoing education with staff who will provide direct care to CHOICES and ECF CHOICES individuals that includes training in First Aid and Cardiopulmonary Resuscitation (CPR) |  |
| 1. Training Materials and sign-in sheets will be utilized and maintained for each MCO required training conducted by agency staff. This includes, but is not limited to the following: 2. Introduction to the population they support (Caring for Elderly and Disabled Population/Disability Awareness and Cultural Competency, first person language, etiquette when meeting and supporting individuals who use alternative forms, sign language or non-verbal, or relies on alternative forms of communication, Common Mental and Behavioral Health issues, The paid caregiver’s responsibility in promoting healthy lifestyle choices and in supporting self-management of chronic health conditions) 3. Documentation of Service Delivery. |  |