**AGENCY NAME:**

# 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

[Accounting of Personal Funds 2](#_Toc157413975)

[Advocacy 3](#_Toc157413976)

[Back-up Staffing Plan 4](#_Toc157413977)

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[Succession Planning 33](#_Toc157413996)

[Title VI 34](#_Toc157413997)

[Transportation to People Supported 35](#_Toc157413998)

[Well-Trained Staff (paid and unpaid) 36](#_Toc157413999)

# Accounting of Personal Funds

## 

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

| **Required Critical Element(s)** | **Please 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 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*

| **Required Critical Element(s)** | **Please 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: 2. 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. 3. 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

| **Required Critical Element(s)** | **Please 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

| **Required Critical Element(s)** | **Please 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

| **Required Critical Element(s)** | **Please indicate POLICY NAME,**  **page #, and location** |
| --- | --- |
|
| 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. 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) (monthly) 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) |  |
| 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. 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 DIDD through the DIDD exemption process. DIDD 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 DIDD through the DIDD 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. 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 |  |

# 

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

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

| **Required Critical Element(s)** | **Please 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 DIDD 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 DIDD 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. Policy has been submitted to an HRC and approved. |  |
| 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

|  |  |
| --- | --- |
| **Required Critical Element(s)** | **Please 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 Cl, 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

|  |  |
| --- | --- |
| **Required Critical Element(s)** | **Please 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). |  |
| **FOR EMPLOYMENT SERVICE PROVIDERS ONLY:**  Verify providers of Supported Employment has a policy and procedure in place which addresses the following:   1. *documentation is maintained that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA.* 2. *the service will not duplicate other services provided through ECF CHOICES or Medicaid state plan services.* 3. *federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses disallowed in ECF CHOICES.* |  |

# **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*

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

| **Required Critical Element(s)** | **Please indicate POLICY NAME,**  **page #, and location** |
| --- | --- |
|
| 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 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. Providers must maintain 90% provider compliance. |  |
| 1. Providers must populate the EVV database with newly hired employees with social security number. |  |
| 1. \*ECF CHOICES providers are required to report as soon as possible to the MCO as it relates to any deviations from the members plan of care. Report may be made via email or phone. |  |
| 1. \*ECF CHOICES provider must have written in their policy that they only have 120 days from the actual date of services to get the claim submitted to the MCO. Any issues that are not exported from EVV are Included in the timely filing submission process |  |
| 1. \*ECF CHOICES provider must have written in their policy their process for verifying a member’s eligibility prior to services. |  |
| 1. \*ECF CHOICES 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. \*ECF CHOICES providers must train their staff as it relates to using GPS and telephony as the back-up in the event the staff cannot use the GPS device. |  |

*\*For the EVV policies, items marked with a “\*” only relate to ECF CHOICES.*

# **Emergency/Urgent Care**

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

| **Required Critical Element(s)** | **Please 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, PA, Respite, Other

#### This policy will be reviewed by DIDD Licensure. DIDD will confirm there is a policy present.

|  |  |
| --- | --- |
| **Required Critical Element(s)** | **Please 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)

|  |  |
| --- | --- |
| **Required Critical Element(s)** | **Please 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, PA, Respite, Other*

| **Required Critical Element(s)** | **Please 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, PA, Respite, Other

The applicant is advised to use the Medication Safety Policy that is located on the DIDD website <https://www.tn.gov/didd/divisions/health-services/--medication-administration.html>.

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

## Required for ALL service categories

| **Required Critical Element(s)** | **Please 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

| **Required Critical Element(s)** | **Please 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) | *ECF: the following are required for all ECF services, except CLSFM4, AT, and MHM* |
| 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. | *\*CHOICES n/a= IHR, CLS1-3; CLSFM 1-3* |
| 1. Provider will maintain a recent photograph and a description of the person supported in all person records. |  |

# **Personnel Procedures**

## Required for ALL service categories

| **Required Critical Element(s)** | **Please 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 Tuberculosis (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 DIDD 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 DIDD and TennCare policies, procedures, and rules for waiver service providers, and quality monitoring requirements. |  |

# **Protection & Promotion of Rights**

## Required for ALL service categories

| **Required Critical Element(s)** | **Please 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

| **Required Critical Element(s)** | **Please 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 DIDD current requirements; and      9. Application of the current DIDD 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

Resource: <https://www.dropbox.com/s/t1st0dmapd8plhr/One%20System%20REM%20Protocol.pdf?dl=0>

| **Required Critical Element(s)** | **Please indicate POLICY NAME,**  **page #, and location** |
| --- | --- |
| 1. Utilizes the Reportable Event Forms (REF) DIDD-750. |  |
| **Reportable TIER 1 EVENTS are defined per the REM one aligned protocol:** | |
| 1. Tier 1 Events: 2. All allegations of sexual abuse. 3. Allegations of physical, emotional, or psychological abuse that required medical intervention or treatment. 4. Allegations of neglect that required medical intervention or treatment, and all neglect that is potentially felonious in nature when there is not an injury. 5. All unexplained or unexpected deaths including suicide. 6. A suspicious injury where abuse or neglect is suspected and required medical treatment or intervention, and the nature of the injury does not coincide with explanation of how the injury was sustained. 7. Serious injury of an unknown cause. For purposes of this section, serious injury shall mean an injury that requires assessment and treatment beyond first aid that can be administered by a lay person. Assessment and treatment for a serious injury is in a hospital emergency room, in an urgent care center, or from a physician, nurse practitioner, or physician's assistant and/or nurse. Includes, but not limited to: decubitus ulcers, fractures, dislocations, concussions, cuts or lacerations requiring sutures, staples, or Dermabond torn ligaments (e.g. severe sprain) or torn muscles or tendons (e.g. severe strain) requiring surgical repair, 2nd and 3rd degree burns, and loss of consciousness. Serious injuries can be both known and unknown. 8. Exploitation by provider personnel (employees or volunteers) of more than $1,000 (Class E felony). |  |
| 1. Verbal notice is given to the DIDD Investigations Hotline as soon as possible but within 4 hours. |  |
| 1. The provider Event Management Coordinator (EMC), or designee, shall submit a Reportable Event Form (REF) via DIDD’s REM Focus system to DIDD and the MCO by close of the next business day after the telephonic report to DIDD 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. (APS/CPS reporting) |  |
| 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 DIDD, providers are required to immediately remove an employee or volunteer alleged to have acted in a manner consistent with sexual abuse or physical abuse resulting in medical treatment, named in a Tier 1 Reportable Event that DIDD opens for investigation, from providing direct support to any person(s) supported until DIDD 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). Providers may, pursuant to agency policies, choose to remove staff concerning other events at their discretion, pending completion of the investigation. |  |
| 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 DIDD 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 DIDD 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, DIDD, 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. 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. DIDD or the MCO can request follow-up action to unsubstantiated informational findings, to include *Late Reporting*. |  |
| 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. 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 DIDD 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. Allegations of physical abuse, emotional/psychological abuse, or neglect that do not require medical intervention or treatment, including allegations that provider personnel (e.g. employees, volunteers) engaged in disrespectful or inappropriate communication about a person [e.g. humiliation, harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures)], or any other similar acts that do not meet the definition of emotional or psychological abuse and which are directed to or within eyesight or audible range of the person supported (the CONTRACTOR shall include such complaints in the CONTRACTOR’s non-discrimination reporting pursuant to A.2.30.22.3.2.1). 3. Suspicious Injury in which abuse/neglect is suspected but did not require medical treatment or intervention. 4. The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of belongings or money valued between $250 and $1,000, i.e. less than the threshold for misappropriation |  |
| 1. The provider EMC or designee will submit a REF to both DIDD and MCO by close of the next business day after the occurrence or discovery of occurrence of a Tier 2 Reportable Event via the DIDD REM Focus system. |  |
| 1. All providers are responsible for conducting investigations of Tier 2 Reportable Events and submitting an investigation report via the DIDD REM Focus system for each Tier 2 allegation. A completed investigation report and attachments shall be entered in the DIDD 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. |  |
| 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 DIDD Abuse Hotline. The provider must forward the investigation immediately back to DIDD 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. |  |
| 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. DIDD or the MCO can request follow-up action to unsubstantiated Informational Findings, to include Late Reporting. |  |
| **Additional Medical Reportable Events and Interventions:** | |
| 1. Additional Medical Reportable Events and Interventions : *Additional Reportable Events* and *Interventions*, which are not related to abuse, neglect, or exploitation, are events and interventions that the provider, MCO, or FEA staff shall be responsible for reporting to the MCO and/or DIDD as specified in TENNCARE protocol. Reporting and review of such *Reportable Events* and *Interventions* is secondary to any medical attention required by the person supported. |  | |
| 1. Reportable Medical Events require assessment and treatment at an emergency room or urgent care facility (with the exception of 2.12.20.1.3 below, which may or may not be performed by a medical professional at an emergency room or urgent care facility). Shall mean an event that occurs during the delivery of services or discovered during the delivery of services, outside of a diagnosed chronic condition, which requires assessment and treatment in an emergency room or urgent care facility. It is not a reportable event when assessment and treatment result from the discovery of a medical event occurring outside the provision of services, nor when referred to the emergency room for assessment or treatment by the primary care provider. |  | |
| 1. Reportable Medical Events include: a) Deaths (other than those that are unexpected/unexplained); b) Cellulitis; c) Choking episode requiring physical intervention (e.g.., use of abdominal thrust or Heimlich maneuver; d) Fall with injury (including minor or serious); e) Insect or animal bite requiring treatment by a medical professional; f) Pressure ulcer/Decubitis Ulcer; g) MRSA; h) Fecal impaction; i) Severe dehydration requiring medical attention; j) Seizure progressing to status epilepticus; k) Pneumonia; l) Severe allergic reaction requiring medical attention;  m) Influenza;. n) Sepsis; o) Skin Infection (other than Cellulitis and MRSA) ; p) Urinary Tract Infection; q) Serious Injury of Known Cause. Serious injury shall mean an injury that requires assessment and treatment beyond first aid that can be administered by a lay person. Assessment and treatment for a serious injury is in a hospital emergency room, in an urgent care center, or from a physician, nurse practitioner, or physician’s assistant and/or nurse. Includes, but not limited to: decubitus ulcers, fractures, dislocations, concussions, cuts, or lacerations requiring sutures, staples, or Dermabond, torn ligaments (e.g. severe sprain) or torn muscles or tendons (e.g. strain) requiring surgical repair, 2nd and 3rd degree burns, and loss of consciousness; and  r) Other (CONTRACTOR to explain on REF). |  | |
| 1. Additional Behavioral Reportable Events and Interventions: Reportable Behavioral Events include Reportable Psychiatric Events. A Reportable Behavioral Event is an event in which a person presents a challenging action(s) which requires the use of a behavior safety intervention or a restrictive behavioral procedure (with the exception of 2.12.20.2.2, 2.12.20.2.3, 2.12.20.2.6, 2.12.20.2.8, and 2.12.20.2.12 below, which may or may not involve the use of such interventions/procedures) that is not captured as an appropriate response in a plan(s) of care (ex. PCSP, BSP, Behavioral Health Plan of Care, etc.) that pertain(s) to that person. A Reportable Psychiatric Event is an event in which a person present evidence of psychiatric destabilization which requires the use of a psychiatric intervention or crisis services (with the exception of 2.12.20.2.2, 2.12.20.2.3, 2.12.20.2.6, 2.12.20.2.8, and 2.12.20.2.12 below, which may or may not involve the use of such intervention/services) that is not captured as an appropriate response in a plan(s) of care (ex. PCSP, BSP, Behavioral Health Plan of Care, etc.) that pertain(s) to that person. |  | |
| 1. Reportable Behavior and Reportable Psychiatric Events include: a) Criminal conduct/probable criminal conduct. Criminal Conduct/Probable Criminal Conduct shall mean acts which violate existing criminal codes which lead to or can reasonably be expected to lead to police involvement, arrest, or incarceration of a person using services or an employee, during the provision of services; b) Engagement of law enforcement; c) Sexual aggression; d) Physical aggression;  e) Reportable Behavior involving physical aggression and/or self-injurious behavior resulting in injury to another person (housemate, staff, private citizen, etc.);  f) Suicide attempt; g) Self-injurious behavior (SIB) (For SIB to be reportable via REF, there must be an injury that requires assessment and treatment beyond basic first aid that can be administered by a lay person); h) Property destruction greater than $100; i) Behavioral crisis requiring protective equipment, manual or mechanical restraints, regardless of type or time used or approved by PCSP (all take-downs and prone restraints are prohibited); j) Behavioral crisis requiring emergency psychotropic medication; k) Behavioral crisis requiring crisis intervention (i.e., call);  l) Psychiatric admission (or observation), including in acute care hospital; |  | |
| 1. Other Additional Reportable Events include:  a) Administration of Routine Psychotropic Medication without consent;  b) Emergency Situations, including fire, flooding, and serious property damage, that result in harm or risk of harm to persons supported;  c) Fall with Injury – Minor (an injury that is treatable by a lay person) and Serious (resulting in medical intervention and treatment);  d) Medication Variance and Omission; e) Victim of fire;  f) Enabling Technology Remote Supports: failure to implement Emergency Back-up Plans;  g) Unsafe Environment (lack of cleanliness/hazardous conditions not otherwise expected to normally exist in the environment;  h) Vehicle Accident – Minor (not resulting in an injury; treatable by a lay person) and Serious (resulting in medical intervention and treatment); § Vehicle Accident – Minor (not resulting in an injury; treatable by a lay person) and Serious (resulting in medical intervention and treatment);  i) Missing Person>(greater than) 1 hour; |  | |
| 1. Reportable Interventions include:  a)Abdominal Thrust/Back Blows/Heimlich Maneuver;  b) Administration of PRN Psychotropic Medication;  c) Admission to: Assisted Care Living Facility, Skilled Nursing Facility, ICF/IID, Incarceration, Planned and Unplanned Medical Hospitalization, and Psychiatric Hospitalization;  d) CPR or Automated External Defibrillator (AED);  e) Crisis Services: 911 Call, EMT, ER Visit, Fire, Mobile Crisis Services, Police, and Urgent Care Facility;  f) Discharge from: Assisted Care Living Facility, Skilled Nursing Facility, ICF/IID, Incarceration, Planned and Unplanned Medical Hospitalization, and Psychiatric Hospitalization;  g) Manual Restraint;  h) Mechanical Restraint;  i)Protective Equipment; and  j) X-Ray (to rule out fracture. |  | |
| 1. For any Reportable Event, the provider has supervisory staff (including clinical staff, as applicable) review the Reportable Event and determine appropriate follow up. For Additional Reportable Events and Interventions, this may include follow up with the member’s PCP or behavioral health provider, as applicable, to provide information and determine any needed treatment adjustments, follow up with the person’s Support Coordinator regarding any needed adjustments in the PCSP, and targeted training or assistance for agency staff who support the person. All Reportable Additional Reportable Events and Interventions, any medical attention provided, and follow up shall be documented in the member’s record. |  | |
| 1. The provider shall be responsible for tracking and trending all Additional Reportable Events and Interventions as outlined above and evaluating such events to determine how to prevent or reduce similar occurrences in the future whenever possible. Such efforts may be targeted to an individual person supported, a particular service setting or location, a particular type of Reportable Event, a particular provider, or may be system-wide. |  | |
| **Non-Reportable Events are defined per the REM one aligned protocol.** | | |
| 1. Any instance of disrespectful or inappropriate communication, e.g., humiliation, harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures) or any other acts pertaining to a person supported that is not directed to or within eyesight or audible range of the person supported and that does not meet the definition of emotional or psychological abuse (the CONTRACTOR shall require providers under this Section to report such complaints to the CONTRACTOR and the CONTRACTOR shall include such complaints in the CONTRACTOR’s non-discrimination reporting pursuant to A.2.30.22.3.2.1); |  |
| 1. Minor injury not requiring medical treatment beyond first aid by a lay person and is not associated with abuse or neglect; |  |
| 1. Staff misconduct that falls outside the definition of Reportable Events (see Section A.2.15.7.6) or actions or inactions by staff of contracted providers, contracted employees, volunteers or others associated with or providing care for the persons supported, that are contrary to sound judgement 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 events 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. |  |
| 1. All contracted providers shall be responsible for documenting, performing data collection and trend analysis, and addressing Non-Reportable Events, which do not rise to the level of Reportable Events as defined by TENNCARE. The provider shall immediately contact DIDD by appropriate hotline number or the MCO and DIDD within twenty-four (24) hours if during a provider’s review of a Non-Reportable Event the provider discovers the Non-Reportable Event should be classified as a Tier 1 or Tier 2 Reportable Event |  |
| **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 DIDD. |  | |
| 1. A trained Provider Investigator (PI) is designated, or a sub-contract is identified. The provider may have multiple DIDD certified Provider Investigators or may contract with a DIDD certified Provider Investigator. The provider shall notify the Investigations Specialist, via the DIDD REM Focus system, the identity of the Provider Investigator. |  | |
| 1. If the provider requests not to investigate an allegation and shall result in a DIDD 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

| **REQUIRED CRITICAL ELEMENT(S)** | **PLEASE 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.*

| **REQUIRED CRITICAL ELEMENT(S)** | **PLEASE 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

| **REQUIRED CRITICAL ELEMENT(S)** | **PLEASE 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, PA, Respite, Other

| **REQUIRED CRITICAL ELEMENT(S)** | **PLEASE 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/didd website for information [Training (tn.gov)](https://www.tn.gov/didd/divisions/training.html)

| **REQUIRED CRITICAL ELEMENT(S)** | **PLEASE 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). | ***\*CHOICES n/a: HDM, IHR, IPR, AC, PC, ET*** |
| 1. Conduct and document initial and ongoing education with staff who will provide direct care 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. | * + - 1. ***\*CHOICES n/a: AT, IPR, MHM, PERS, PEST, ET***       2. ***CHOICES n/a for ADC & IPR*** |