STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
AND RELATED STATEWIDE PLANNING AND POLICY COUNCIL

Performance Audit Report

November 2017

Justin P. Wilson, Comptroller

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November 22, 2017

The Honorable Randy McNally
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The Honorable Mike Bell, Chair
Senate Committee on Government Operations
The Honorable Jeremy Faison, Chair
House Committee on Government Operations
and
Members of the General Assembly
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and
The Honorable Debra K. Payne, Commissioner
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and
Phillip Garner, Chair
Statewide Planning and Policy Council
410 Old Hog Creek Road
Waynesboro, Tennessee 38485

Ladies and Gentlemen:

We have conducted a performance audit of selected programs and activities of the Department of Intellectual and Developmental Disabilities and the related Statewide Planning and Policy Council for the period June 1, 2013, through June 30, 2017. This audit was conducted pursuant to the requirements of the Tennessee Governmental Entity Review Law, Section 4-29-111, *Tennessee Code Annotated.*

Our audit disclosed certain findings that are detailed in the Audit Conclusions section of this report. Management of the department has responded to the audit findings; we have included the responses following each finding. We will follow up the audit to examine the application of the procedures instituted because of the audit findings.

This report is intended to aid the Joint Government Operations Committee in its review to determine whether the department should be continued, restructured, or terminated.

Sincerely,

Deborah V. Loveless

Deborah V. Loveless, CPA
Director

DVL/li
16/191

Division of State Audit

Department of Intellectual and Developmental Disabilities
Performance Audit
November 2017

Our mission is to make government work better.

AUDIT HIGHLIGHTS

Department of Intellectual and Developmental Disabilities' Mission

To become the nation's most person-centered and cost-effective state support system for people with intellectual and developmental disabilities.

Scheduled Termination Date: June 30, 2018

We have audited the Department of Intellectual and Developmental Disabilities and the related Statewide Planning and Policy Council for the period June 1, 2013, through June 30, 2017. Our audit scope included a review of internal controls and compliance with laws, regulations, policies, procedures, and provisions of contracts in the following areas:

- services for individuals with developmental disabilities other than intellectual disabilities;
- Individual Support Plan development;
- the Family Support Program;
- waiting list and case management services;
- the direct support professional staffing shortage;
- Quality Assurance monitoring;
- departmental employee and volunteer background checks;
- Investigation Review Committee operations;
- death reviews;
- police and relative critical incident notification;
- employee misconduct;
- staffing ratios;
- Office of Risk Management and Licensure reviews;
- resident personal property and trust funds;
- regional office operations;
- transitions from developmental centers to community homes;
- information systems security and Community Services Tracking system replacement;
- pharmacy and supply inventories;
- Medicaid cost reports;
- miscellaneous fiscal and administrative functions; and
- Statewide Planning and Policy Council membership, meetings, and expenditures.

Key Conclusions

Findings

- The department did not provide case management to individuals on the Medicaid waiver waiting list according to policy, did not make adequate attempts to communicate new aging caregiver legislation, and again did not maintain the current needs status of supported individuals (page 29).

- Concerns emerged before, during, and after the launch of Employment and Community First CHOICES (page 47).

- Although the department has made improvements since the prior audit, it did not properly develop or review Individual Support Plans in some instances (page 70).

- The Office of Risk Management and Licensure did not perform annual reviews of problematic areas identified in our prior two audits, leading to nine repeated findings (page 81).

- For its employees directly caring for individuals with intellectual disabilities, the department did not perform background checks; sex offender, abuse, and other registry checks; and work history and credentials checks timely or at all (page 93).

- The department did not keep track of who volunteered at its facilities; performed criminal background, sex offender registry, abuse registry, and work history checks late or not at all; and accessed sensitive information about volunteers without permission (page 100).

- The department and its providers did not complete required death reviews timely (page 106).

- Continued weaknesses exist within the system the department designed to ensure that individuals with intellectual disabilities receive high-quality care (page 115).

- The department's policy for granting exemptions for people with criminal records to work with vulnerable individuals contains both design and implementation flaws (page 123).

- As noted in findings for the last 14 years, the department did not implement the internal controls necessary to keep track of the belongings of individuals under its care (page 143).

- Since 2003, the department has lacked adequate internal controls over the use of Resident Trust Fund accounts to make purchases (page 151).

- As noted in our October 2013 audit, the department did not ensure that the money belonging to individuals who died at, or were otherwise transferred from, its facilities ended up with the appropriate parties (page 157).

- Because of the department's inadequate monitoring, some individuals' account balances exceeded the maximum allowable amount, risking loss of Medicaid eligibility (page 162).

- The department did not provide adequate internal controls in five specific areas (page 170).

Observations

The following topics are included in this report because of the effect on the operations of the Department of Intellectual and Developmental Disabilities, the related Statewide Planning and Policy Council, and the citizens of Tennessee:

- The department and the Division of TennCare collaborated to launch a new program—Employment and Community First CHOICES—to fill critical gaps in the state's service delivery system (page 40).

- The department actively participates in federal and state integrated employment initiatives but has only recently begun collecting comprehensive data to evaluate its success (page 78).

- Department policy does not clearly differentiate between volunteers and visitors (page 105).

- The department lacks a conflict-of-interest policy for Investigation Review Committee members (page 110).

- Since its monitoring tool was populated incorrectly, the department runs the risk of incorrectly assessing a provider as either compliant or noncompliant (page 122).

- The Middle and West Tennessee regions did not have adequate internal controls in place when handling the personal funds of individuals residing in community homes (page 165).

- After 23 years and over $18 million spent, the department has progressed toward replacing its antiquated Community Services Tracking system, despite suffering additional setbacks and missed deadlines since our last audit (page 171).

- The department still did not require all employees to sign conflict-of-interest forms and did not update its conflict-of-interest policy (page 179).

- Infrequent meeting attendance by some Statewide Planning and Policy Council members might lead to the voices of the membership category they represent remaining unheard (page 185).

Emerging Issue

Tennessee faces a critical shortage of caregivers for individuals with intellectual and developmental disabilities (page 60).

Performance Audit
Department of Intellectual and Developmental Disabilities

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Performance Audit
Department of Intellectual and Developmental Disabilities

INTRODUCTION

AUDIT AUTHORITY

This performance audit of the Department of Intellectual and Developmental Disabilities and the related Statewide Planning and Policy Council was conducted pursuant to the Tennessee Governmental Entity Review Law, Title 4, Chapter 29, *Tennessee Code Annotated*. Under Section 4-29-239, the Department of Intellectual and Developmental Disabilities is scheduled to terminate June 30, 2018. Under Section 4-29-243, the Statewide Planning and Policy Council is scheduled to terminate June 30, 2022. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the agency and to report to the Joint Government Operations Committee of the General Assembly. This audit is intended to aid the committee in determining whether the department and the related council should be continued, restructured, or terminated.

BACKGROUND

The Department of Intellectual and Developmental Disabilities is responsible for administering services for Tennesseans with intellectual and developmental disabilities. The department's vision is to support all Tennesseans with intellectual and developmental disabilities to help them live fulfilling and rewarding lives. The department's mission is to become the nation's most person-centered and cost-effective state support system for people with intellectual and developmental disabilities.

General History

The department was previously known as the Division of Intellectual Disabilities Services and was part of the Department of Finance and Administration. Effective January 15, 2011, the Tennessee General Assembly, through Section 4-3-2701(a), *Tennessee Code Annotated*, established it as a stand-alone department. Additionally, the General Assembly moved responsibilities for the developmental disabilities service area from the Department of Mental Health and Developmental Disabilities (now the Department of Mental Health and Substance Abuse Services) to the newly formed Department of Intellectual and Developmental Disabilities.

The department's organizational chart is on page 10.

This transition to an independent department is described in Section 4-3-2705, *Tennessee Code Annotated*, which states,

> Notwithstanding any law to the contrary, January 15, 2011, all duties of the department of mental health and developmental disabilities and the department of finance and administration, whose duties fall within those duties required to be performed by the department of intellectual and developmental disabilities pursuant to Acts 2010, ch. 1100, shall be transferred to the Department of Intellectual and Developmental Disabilities. Also, all employees of the department of mental health and developmental disabilities and the department of finance and administration, whose duties fall within those duties transferred to the department of intellectual and developmental disabilities pursuant to Acts 2010, ch. 1100, shall be transferred to the department of intellectual and developmental disabilities.

The department was established on January 15, 2011, by Section 4-3-2705, *Tennessee Code Annotated*.

Definitions of Intellectual and Developmental Disabilities

State law defines **intellectual disability** as below-average cognitive ability that manifests before age 18 and is characterized by an intelligence quotient (IQ) of 70 or below, along with significant limitations in the ability to adapt and carry on everyday life activities.

Medical diagnoses classified as developmental disabilities include, but are not limited to, intellectual disabilities; autism; cerebral palsy; spina bifida; muscular dystrophy; various genetic, neurological, and chromosomal disorders; and head and spinal cord injuries.

Developmental disabilities are physical and/or mental impairments that begin before age 22 and alter or substantially inhibit an individual's capacity to perform activities of daily living, such as self-care, receptive and expressive language, learning, mobility, self-direction, or economic self-sufficiency.

SERVICES FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Developmental Centers and Community Homes

Developmental Centers

For decades, the department operated developmental centers to provide long-term residential services, habilitative care, and training programs for individuals with intellectual disabilities. After years of work to transition individuals from these institutions to community settings, the department closed its developmental centers as follows:

- Greene Valley Developmental Center in Greeneville closed in May 2017.

- Clover Bottom Developmental Center in Nashville closed in November 2015.
- Arlington Developmental Center in Arlington closed in 2010.
- Nat T. Winston Developmental Center in Bolivar closed in 1998.

The department continues to operate the Harold Jordan Center, a 28-bed facility for individuals with intellectual disabilities who have been charged with a crime or who have severe behavioral challenges. The Harold Jordan Center is located on the campus of the former Clover Bottom Developmental Center.

Community Homes

Pursuant in part to court orders arising from charges of unfavorable conditions at state-run facilities, the department constructed 33 four-person homes in integrated residential communities for former residents of developmental centers:

- The **East Tennessee Homes** are 16 homes located in Greene County.
- The **Middle Tennessee Homes** are 9 homes located in Davidson and Wilson Counties. Another home is state-owned but privately operated.
- The **West Tennessee Homes** are 8 homes located in Shelby and Fayette Counties. Another 4 homes are state-owned but privately operated.

One of the department's community homes in West Tennessee

Source: Auditor photograph.

The department's community homes are licensed intermediate care facilities for individuals with intellectual disabilities and provide 24-hour services and supports necessary to ensure the health, safety, and welfare of residents.

See page 167 for our work relating to transitions from developmental centers to community homes.

Funding for Developmental Centers and Community Homes

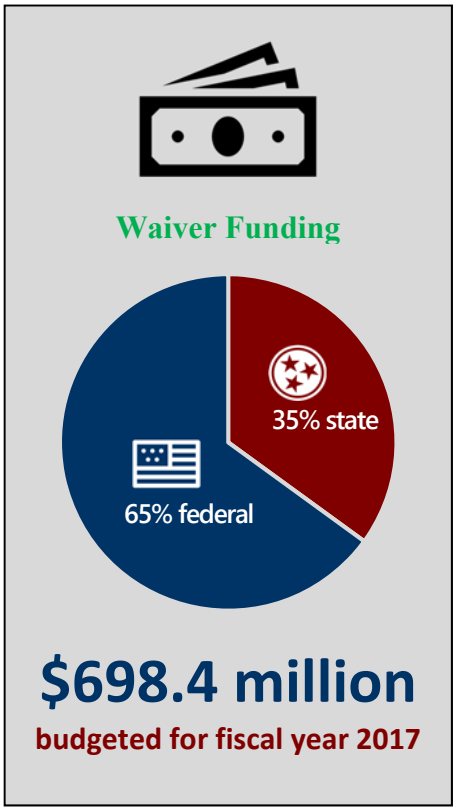
Through provider agreements with the Department of Finance and Administration's Division of TennCare, the department's intermediate care facilities receive funding under Title XIX of the Social Security Act (Medicaid) for those individuals who are Medicaid eligible. Each developmental center and community home must submit an annual cost report that is used in conjunction with budgeted information and other data to determine the facility's reimbursement

per diem rates. The cost reports contain a list of expenditures related to patient care and administration that are eligible for Medicaid reimbursement. The department submits eligible costs to TennCare, which then requests reimbursement from the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS). CMS is responsible for administering the Medicaid program.

Medicaid Home- and Community-Based Services Waivers

Waiver Definition and Background Information

In Tennessee, Medicaid provides funding for home- and community-based services waivers, along with the intermediate care facilities. The Medicaid waivers set aside certain requirements of the Social Security Act so that individuals can receive long-term care in their homes and the community as an alternative to institutionalized settings. The state must apply to CMS for permission to have Medicaid waivers.



As of September 2017, Tennessee offers three Medicaid waiver programs for citizens with intellectual disabilities: the statewide waiver, the comprehensive aggregate cap waiver, and the self-determination waiver. TennCare contracts with the department to operate these waiver programs. With regard to the funding breakdown for the programs, state dollars allotted to Medicaid are matched approximately 1.86:1 by federal Medicaid dollars (ratio of approximately 65% federal to 35% state). While the waivers closed to new enrollments on July 1, 2016, the department continues to serve individuals enrolled prior to that date.

Statewide Waiver

The statewide waiver offers a broad range of services to individuals who, absent the provision of waiver services, would be placed in an intermediate care facility. Statewide waiver enrollees have access to residential options, which are designed to provide individualized services and supports in community-based settings. Residential arrangements typically include staff to assist individuals with activities of daily living, personal funds management, medication administration, and other support as necessary. In addition, waiver recipients may participate in day services, which facilitate the acquisition, retention, and improvement of skills necessary to reside in a community-based setting. Based on assessed need, individuals may also use the statewide waiver to procure other preapproved health, therapeutic, and support services such as personal assistance, dentistry, behavioral analysis, transportation, and assistive devices.

In March 2015, the department instituted a cost neutrality cap, limiting each individual's services in the statewide waiver to the average annual cost of services in a private intermediate care facility. The Office of the Comptroller of the Treasury determines the amount of the annual cap (see **Table 1**).

Table 1
Statewide Waiver Annual Cost Neutrality Cap, 2015-2017

Calendar Year	Cost Neutrality Cap
2015	$153,416.80
2016	$154,289.15
2017	$155,700.00

Comprehensive Aggregate Cap Waiver

The comprehensive aggregate cap waiver (formerly known as the Arlington waiver) is a Medicaid home- and community-based program that is restricted to class members certified in the Arlington Remedial Order; former class members of the *People First of Tennessee v. Clover Bottom Developmental Center* lawsuit;[1] and individuals enrolled in the statewide waiver as of March 27, 2015, whose annual support costs exceeded the 2015 cost neutrality cap. These waiver participants have access to the same types of services available to statewide waiver recipients.

Self-Determination Waiver

The self-determination waiver serves individuals who have an established, non-institutional residence where they live with their family, a non-related caregiver, or in their own home and whose needs can be met effectively by the combination of waiver services and other supports available to them. This waiver lets participants lead the person-centered planning process and directly manage selected services, including recruiting and managing service providers. Self-determination waiver enrollees are typically limited to a personal annual budget of $30,000, of which a maximum of $23,000 may be used for community living services and $7,000 for professional and technical support services. The department may increase the overall budget to $36,000 as an extra measure of protection when the individual experiences a crisis or emergency situation that threatens his or her health and wellbeing. Individuals supported in the waiver may elect to manage their own annual budget or outsource this function to a support broker.

Benefits of the Employment and Community First CHOICES program include

- employment supports,
- transportation,
- personal assistance,
- skills training,
- community living,
- respite care,
- self-advocacy counseling, and
- basic dental care.

<u>Employment and Community First CHOICES Program</u>

On the day after the closure of the Medicaid waivers to new enrollments on June 30, 2016,

[1] We discuss the Arlington and Clover Bottom lawsuits further in the Achievements section of our report on page 16.

TennCare launched a new Medicaid program that offers long-term services and supports to individuals with intellectual and developmental disabilities. The Employment and Community First CHOICES program provides enhanced services that promote competitive, integrated employment and independent community living. TennCare contracts with the department to perform various administrative functions and services for the program, including processing applications from individuals who are not currently Medicaid eligible; managing critical incidents (such as abuse, neglect, and exploitation); and monitoring program quality. TennCare also contracts with three managed care organizations to administer the program's daily operations.

See page 40 for our work relating to Employment and Community First CHOICES.

Case Management, Family Support Program, and Seating and Positioning Clinics

The department also assists with several other types of programs for individuals with intellectual and developmental disabilities:

- Until the Medicaid waivers closed to new enrollments, the department provided case management services to individuals with intellectual disabilities on the department's waiting list for waiver services. See page 29 for our work relating to case management services.
- The Family Support Program is a community-based, state-funded program that provides assistance to families with a family member who has a severe or developmental disability. See page 26 for our work relating to the Family Support Program.
- The department operates seating and positioning clinics in Arlington, Nashville, and Greeneville. The clinics produce and repair customized wheelchair components and other positioning equipment to promote comfort and positive health outcomes for individuals supported in the department's service delivery system. See page 24 for our discussion of an achievement related to the introduction of a mobile seating and positioning clinic.

ORGANIZATIONAL STRUCTURE

Central Office

The department has a central office based in Nashville that is responsible for administering its service delivery system and housing support functions.

The **Office of Program Operations** provides Medicaid waiver management by developing community provider applications, policies, and procedures and offering technical assistance to provider staff ranging from program design and fiscal consultation to programmatic compliance with CMS and waiver requirements. This office is responsible for provider

recruitment, enrollment, and orientation and also oversees regional operations and the department's intermediate care facilities located throughout Tennessee.

The **Office of Policy and Innovation** reviews, develops, and maintains the department's *Provider Manual*, consumer informational materials, and waiver applications and amendments.

The **Office of Accreditation and Person Centered Practice** is responsible for implementing the department's Person Centered Excellence agreement with the Council on Quality and Leadership.[2] The office also offers training and mentoring to assist the department's providers with creating better quality lives for individuals served through the means of active social roles, community connections, enhanced planning, and significant influence with independent decision-making.

The **Office of General Counsel** provides legal support and advice to the department; represents the department in judicial and administrative litigation; reviews contracts and other legal documents; and ensures departmental compliance with the Health Insurance Portability and Accountability Act. The office additionally oversees the Family Support Program. Also, the office houses the Protection from Harm Division, which manages incidents that cause or could cause harm to a supported individual and investigates allegations of abuse, neglect, or exploitation.

The **Office of Quality Management's** Quality Assurance program provides direction and oversight for qualitative surveys of contracted service providers to determine performance levels. The office's Fiscal Accountability Review Unit monitors providers that bill for services in excess of $500,000 per year to ensure their billings are supported by appropriate documentation. Furthermore, the office is responsible for surveying the quality of services and supports at privately operated intermediate care facilities for individuals with intellectual disabilities.

The **Office of Risk Management and Licensure** responds to and evaluates allegations of criminal wrongdoing and fiscal mismanagement involving department staff and the community provider network. This unit oversees facility compliance with life safety standards.

The **Office of Health Services** consists of clinicians from various disciplines who educate staff, community providers, families, and other stakeholders on health issues pertinent to individuals with intellectual and developmental disabilities. Health Services staff review incident and investigation reports and death reports submitted by the regional offices and determine clinical issues to be addressed statewide from a prevention perspective.

The **Office of Civil Rights and Customer Focused Services** consists of two primary areas. The Office of Civil Rights ensures the department's compliance with federal non-discrimination laws by investigating and mediating civil rights complaints, conducting reviews,

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[2] The Council on Quality and Leadership serves as the department's accrediting body. For more information about the council, see the Achievements section on page 18.

and providing technical assistance. The Office of Customer Focused Services is a resource for supported individuals and their families to improve their quality of care and quality of life and to improve the department's delivery system. Office responsibilities include receiving, investigating, and resolving complaints affecting individuals receiving departmental services and supports. The complaint resolution system addresses issues and concerns expressed by supported individuals, their families, legal representatives, paid advocates, and concerned citizens.

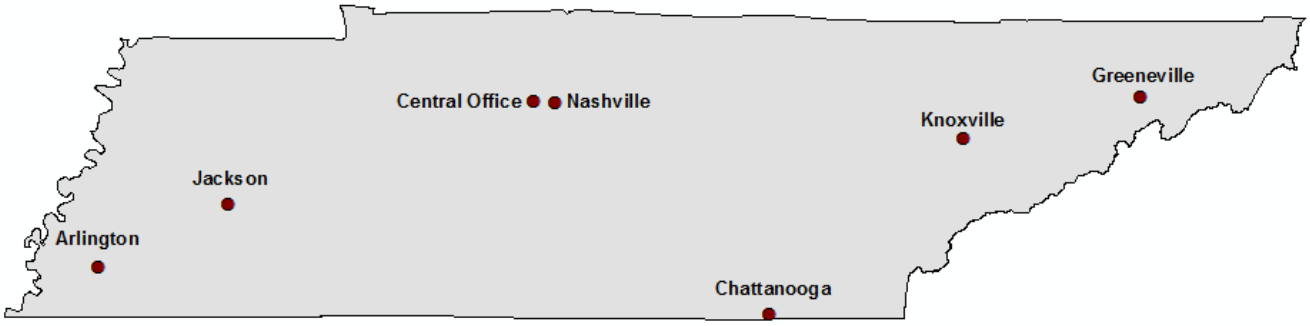
The **Office of Communications and External Affairs** handles public relations, media inquiries, outreach and communication with stakeholders, event planning, and the department's website and social media sites. The office works in conjunction with the department's Legislative Liaison to track legislation affecting the department and responds to lawmakers' questions and concerns. In addition, the office prepares and distributes departmental publications, including its weekly *Open Line* newsletter.

The **Office of Fiscal and Administrative Services** facilitates the department's operations by providing a range of business services, including budget development, fiscal support, procurement, and facilities management.

The **Office of Human Resources** oversees the department's personnel function, including new hires, orientation, job analysis, disciplinary actions, service awards, and other employee relations activities.

Regional Offices

Figure 1
Map of Departmental Regional and Satellite Office Locations



Along with the central office, the department has primary regional offices in Nashville, Knoxville, and Arlington and satellite regional offices in Jackson, Greeneville, and Chattanooga (see **Figure 1**). The regional offices perform activities necessary for the day-to-day operation of the three Medicaid waiver programs. The functions of the regional offices include administrative services, case management, transition, clinical services, and compliance. Additionally, regional office staff perform certain intake functions for TennCare's Employment and Community First CHOICES program.

Related Councils

The Tennessee General Assembly established the Statewide Planning and Policy Council in 2011. The council assists the department in planning a comprehensive array of high-quality prevention, early intervention, treatment, and habilitation services; advising the department on policy and budget requests; and developing and evaluating services and supports.

The General Assembly also established four subcouncils within the Statewide Planning and Policy Council: the Developmental Disabilities Planning and Policy Council; the West Regional Planning and Policy Council; the Middle Regional Planning and Policy Council; and the East Regional Planning and Policy Council. These four subcouncils advise the Statewide Planning and Policy Council.[3,4]

ASSISTANCE FROM OTHER STATE AGENCIES

In accordance with Executive Order No. 39 and in an effort to consolidate workstation support for 21 executive-branch agencies, the department's Office of Information Technology Services transferred to the Department of Finance and Administration's Strategic Technology Solutions, effective July 2016. The staff are now under Strategic Technology Solutions leadership, but they are still housed in the department's office space.

DEMOGRAPHIC INFORMATION

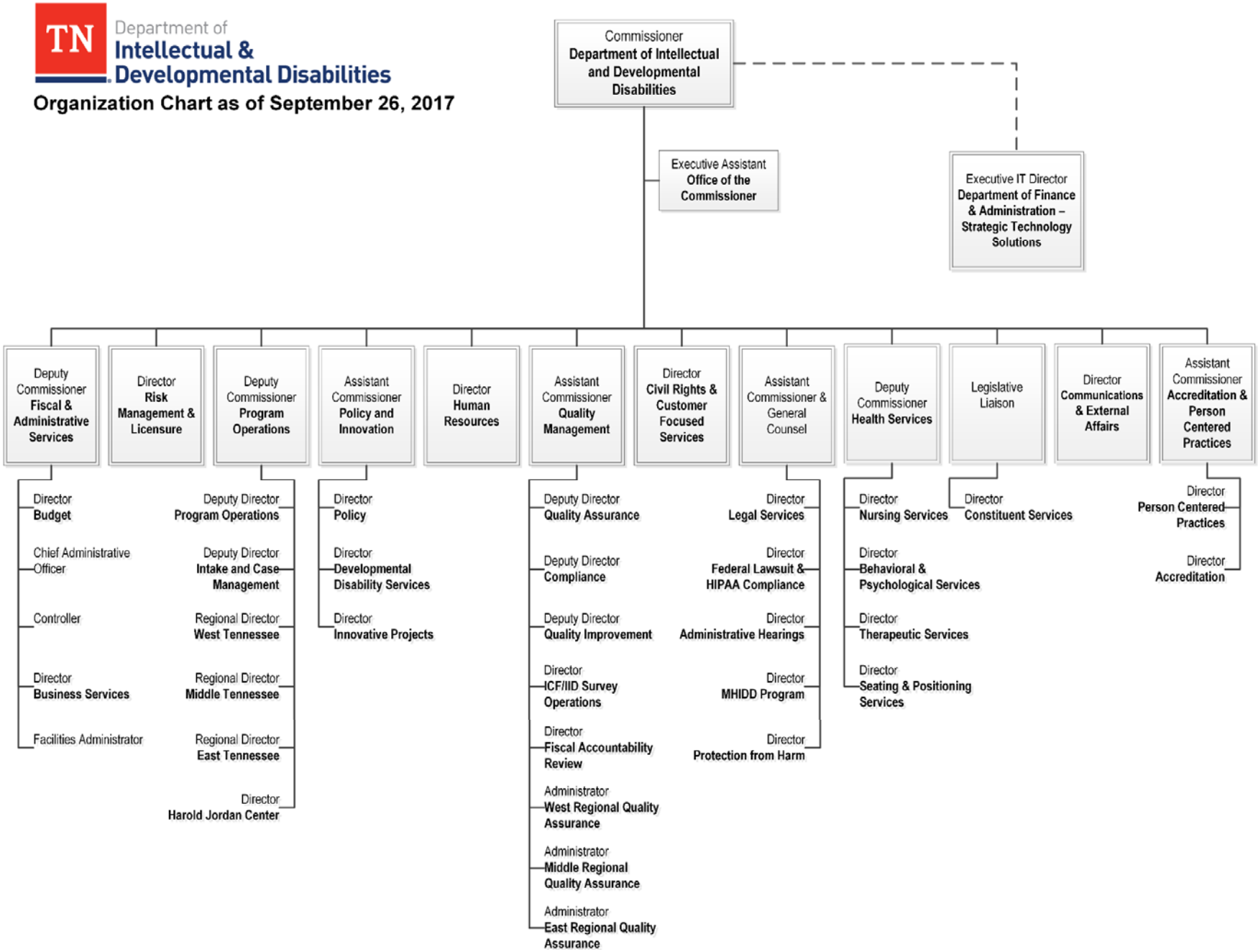
As of August 2017, the department was serving 7,979 individuals—7,814 in the Medicaid waiver programs, 147 in the community homes, 12 in full state-funded services, and 6 in Medicaid-funded Harold Jordan Center services. Of the 7,814 in the Medicaid waiver programs, the department served 4,951 through the statewide waiver, 1,674 through the comprehensive aggregate cap waiver, and 1,189 through the self-determination waiver. See **Figure 2** and **Figure 3** for the number of individuals served by state senate and house district, respectively.

The department's Family Support Program served 4,506 individuals in 2016.

An organization chart of the department is on the following page.

[3] With Executive Order No. 50, Governor Haslam transferred the Tennessee Council on Developmental Disabilities from administrative attachment to the Department of Intellectual and Developmental Disabilities to a free-standing entity, effective July 1, 2016.

[4] The General Assembly established the Tennessee Council on Autism Spectrum Disorder effective July 1, 2017 (following the conclusion of our audit fieldwork). The council is administratively attached to the Department of Intellectual and Developmental Disabilities and is responsible for developing a long-term plan for the care of individuals with autism spectrum disorder and their families.



Source: Adapted from the department's divisional organization charts.

Figure 2
Medicaid Waiver Enrollees by Senate District as of July 25, 2017

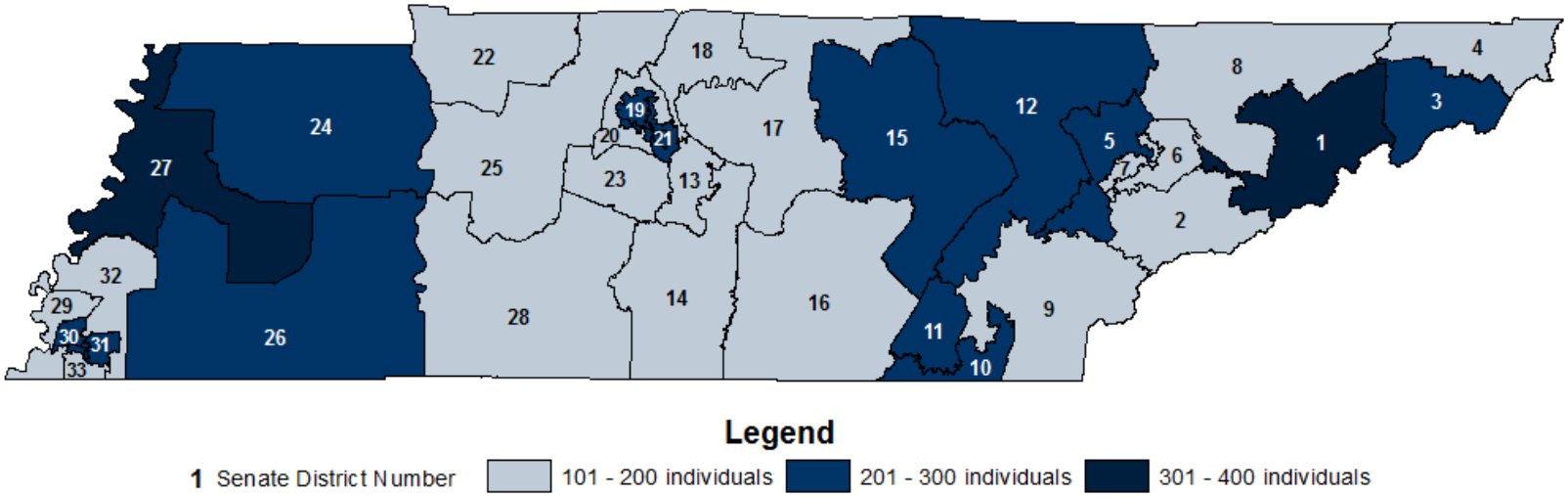
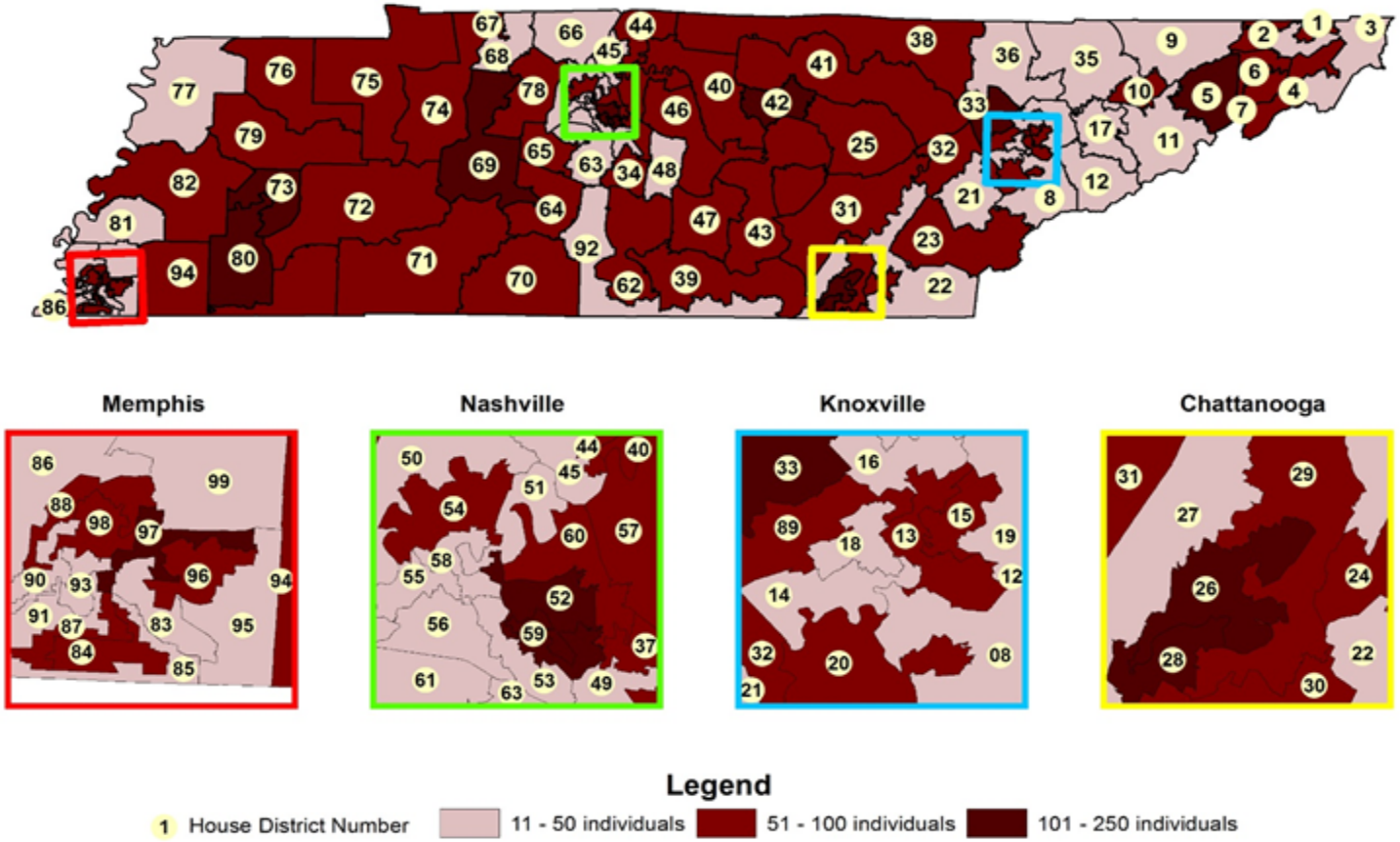


Figure 3
Medicaid Waiver Enrollees by House of Representatives District as of July 25, 2017



AUDIT SCOPE

We have audited the Department of Intellectual and Developmental Disabilities and the related Statewide Planning and Policy Council for the period June 1, 2013, through June 30, 2017. Our audit scope included a review of internal control and compliance with laws, regulations, and provisions of contracts or grant agreements in the following areas:

- services for individuals with developmental disabilities other than intellectual disabilities;
- Individual Support Plan development;
- the Family Support Program;
- waiting list and case management services;
- the direct support professional staffing shortage;
- Quality Assurance monitoring;
- departmental employee and volunteer background checks;
- Investigation Review Committee operations;
- death reviews;
- police and relative critical incident notification;
- employee misconduct;
- staffing ratios;
- Office of Risk Management and Licensure reviews;
- resident personal property and trust funds;
- regional office operations;
- transitions from developmental centers to community homes;
- information systems security and Community Services Tracking system replacement;
- pharmacy and supply inventories;
- Medicaid cost reports;
- miscellaneous fiscal and administrative functions; and
- Statewide Planning and Policy Council membership, meetings, and expenditures.

Management of the department is responsible for establishing and maintaining effective internal control and for complying with applicable laws, regulations, and provisions of contracts and grant agreements.

For our sample design, we used nonstatistical audit sampling, which was the most appropriate and cost-effective method for concluding on our audit objectives. Based on our professional judgment, review of authoritative sampling guidance, and careful consideration of underlying statistical concepts, we believe that nonstatistical sampling provides sufficient appropriate audit evidence to support the conclusions in our report. Although our sample results provide reasonable bases for drawing conclusions, the errors identified in these samples cannot be used to make statistically valid projections to the original populations. We present more detailed information about our methodologies in Appendix 1 of this report.

We conducted our audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

PRIOR AUDIT FINDINGS AND OBSERVATIONS

Section 8-4-109, *Tennessee Code Annotated*, requires that each state department, agency, or institution report to the Comptroller of the Treasury the action taken to implement the recommendations in the prior audit reports dated April 2013 and October 2013. The April 2013 risk-based performance report contained 7 findings and focused primarily on the department's fiscal operations, while the October 2013 sunset performance report contained 10 findings and focused primarily on the department's programmatic operations. The Department of Intellectual and Developmental Disabilities filed its reports with the Comptroller of the Treasury on September 27, 2013, and April 1, 2014. In order to present the General Assembly with a complete picture of the department, we conducted a follow-up of all **17 prior audit findings** as part of the current audit.

In addition to the findings, the April 2013 report included 1 observation and the October 2013 report included 10 observations, for a total of 11 prior observations. We followed up on select observations during our current audit.

RESOLVED AUDIT FINDINGS AND OBSERVATIONS

April 2013 Audit Report

The current audit disclosed that the department has corrected the April 2013 audit findings and observation concerning the following:

Findings

- Fiscal Accountability Review provider monitoring;
- Greene Valley Developmental Center's pharmacy and supply inventories; and
- Medicaid cost reports.

Observation

- follow-up actions on provider monitoring reviews.

October 2013 Audit Report

The current audit disclosed that the department has corrected the October 2013 audit findings and observations concerning the following:

Findings

- developmental disabilities;
- the Family Support Program; and
- overturned Protection from Harm cases.

Observations

- inability to meet a deadline for closing the Clover Bottom Developmental Center and opening the Middle Tennessee Homes; and
- dismissal of two federal lawsuits.

REPEATED AUDIT FINDINGS

The prior audit reports also contained findings concerning the following:

April 2013 Audit Report

1. information system controls;[5]
2. Clover Bottom Developmental Center and Harold Jordan Center operations; and
3. Greene Valley Developmental Center and East Tennessee Homes operations.

October 2013 Audit Report

4. departmental employee background checks;
5. departmental volunteer background checks;
6. Quality Assurance monitoring;
7. Individual Support Plan development;
8. regional office operations; and
9. waiting list and case management services.

These findings have not been resolved and are repeated in the applicable sections of this report.

[5] We combined the two information system findings from the April 2013 report into a single finding in the current report.

AUDIT CONCLUSIONS

ACHIEVEMENTS

Since June 1, 2013, the Department of Intellectual and Developmental Disabilities has celebrated multiple achievements.

Resolved Arlington Lawsuit

In January 1992, the U.S. Department of Justice sued the State of Tennessee for violations of the Civil Rights of Institutionalized Persons Act at the Arlington Developmental Center. This case is known as *United States v. State of Tennessee (Arlington)*. As a result of the lawsuit, in November 1993, the U.S. District Court ordered the facility to correct subpar conditions. The court appointed a monitor to ensure the facility complied with the terms of the court's remedial order.

The department's legal counsel reported that in 2007, the state embarked on a three-year process to close the Arlington Developmental Center. In preparation for the impending closure, the state sought appropriate placements that would meet the needs of each existing facility resident. As required by the remedial order, the department worked with the court monitor to secure her approval for each resident's transition. One element of this endeavor involved the state building 12 four-person homes in the Arlington area to meet the needs of the more medically fragile residents. The state owns and operates these homes, called the West Tennessee Homes, as intermediate care facilities for individuals with intellectual disabilities. The state officially closed the Arlington Developmental Center in October 2010 after moving the final residents to their new community homes.

In January 2012, following the facility's closure, the state filed a motion with the federal court to vacate all outstanding orders and to dismiss the case. In September 2012, the court denied the state's motion and issued an order for mandatory mediation. The state subsequently appealed this ruling to the U.S. Court of Appeals for the Sixth Circuit. The order for mandatory mediation resulted in the state's and the other lawsuit parties' agreement upon an exit plan in December 2012. In January 2013, the U.S. District Court approved the exit plan and signed the agreed order. The exit plan established an implementation time frame of on or before December 31, 2013.

Our discussions with the department's legal staff disclosed that as of February 2013, the department had begun implementing the exit plan, which stipulated that the department must fulfill the following six objectives in order for the courts to dismiss the Arlington Developmental Center lawsuit:

1. perform an intake review of 182 potential new at-risk lawsuit class members;

2. complete a review of Arlington class members who currently reside in nursing facilities to determine if they are appropriate for community placement and to provide them with transition services if they wish to move from the nursing facility to the community;
3. subcontract with the Department of Health to undertake certain survey, certification, and enforcement functions for privately operated intermediate care facilities;
4. submit to the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) and (if approved) implement, on or before October 1, 2013, both an amendment to the statewide home- and community-based services waiver that permits the state to cover intensive behavioral residential services and also a renewal of the self-determination waiver that permits the state to cover semi-independent living services for enrollees in that waiver;
5. continue developing meaningful opportunities for class members to obtain competitive employment, supported work, and/or volunteer jobs in the communities by taking certain steps and advancing actions already in place; and
6. oversee the demolition of all residential cottages on the Arlington Developmental Center grounds, except those attached to the Baker Building (which must not be used for residential purposes) and develop a plan for the proposed sale of the facility's property.

On October 31, 2013, the department completed the Arlington exit plan. The court issued an order dismissing the case on December 4, 2013.

Gained ICF/IID Status for the Harold Jordan Center

The department's Harold Jordan Center, located in Nashville, provides services to individuals with intellectual disabilities who have been charged with a crime. The facility includes three separate divisions:

- the Forensic Assessment Unit;
- the Behavioral Stabilization Unit; and
- the Day One Program, a program for individuals needing a high level of structure.

The Harold Jordan Center has 28 total beds available: 8 for the Forensic Assessment Unit, 4 for the Behavioral Stabilization Unit, 12 for the Day One Program, and 4 for use only on a reserve/overflow basis. In fiscal year 2014, the department gained CMS' intermediate care facility for individuals with intellectual disabilities status for the Harold Jordan Center's Day One Program. This achievement allows the department to receive federal reimbursement for allowable expenditures, thereby decreasing the outflow of state dollars by the same amount. Thus far, the Harold Jordan Center has qualified for the following federal reimbursement: $2,132,072 in fiscal year 2014; $2,178,220 in fiscal year 2015; and $2,431,130 in fiscal year 2016.

Earned Council on Quality and Leadership Accreditation

The Council on Quality and Leadership has worked with human service organizations and systems for over 40 years to continuously define, measure, and improve quality of life and quality of services. The council offers training, accreditation, consultation, and certification services to organizations and systems that share their vision of dignity, opportunity, and community. The accreditation process consists of three important tools:

1. *basic assurances* – ensure accountability for health, safety, and security;
2. *personal outcome measures* – identify people's quality of life outcomes, plan supports, and gather information and data about individual outcomes; and
3. *8 key factors and 34 success indicators for organizational excellence* – define quality in terms of person-centered supports and services.

The council began a three-year partnership with the department in August 2012 to assess its operations. Assessment methods included interviews with individuals served; focus groups of families and provider staff; reviews of provider agencies; and the department's evaluation of its own policies and practices. On January 22, 2015, the department received formal recognition from the council for Person-Centered Excellence Network Accreditation, becoming the first state system in the United States to gain this status. The accreditation lasts for four years and can be extended if certain criteria are met. The department considered the accreditation a natural next step after participating in a national program in 2007 to become a person-centered organization through the National Association of State Directors of Developmental Disability Services.

As an outgrowth of its work with the council, the department earned another honor. On April 13, 2016, CMS granted the department approval—the first in the nation—for its Statewide Transition Plan to bring settings into compliance with the federal home- and community-based services regulations found in Title 42, *Code of Federal Regulations*, Part 441, Sections 301(c)(4)(5) and 710(a)(1)(2).

Developed Intellectual and Developmental Disabilities Toolkit

Due in part to communication difficulties, individuals with intellectual or other developmental disabilities face a cascade of health disparities in the United States. The department therefore tries to help doctors focus on the cause of the medical issue prompting the office visit, rather than on the outward signs of the disability. Using its Deputy Commissioner of Health Services' previous work in Canada as a foundation, the department partnered with the Vanderbilt Kennedy Center and the University of Tennessee Boling Center to create an intellectual and developmental disabilities (IDD) toolkit. The Special Hope Foundation provided a grant for the toolkit's development, and it was released online in January 2014.

The department's Deputy Commissioner of Health Services stated that the "tools" in the IDD toolkit have been downloaded more than a quarter of a million times worldwide. Tools encompass

- *general issues* – such as effective communication, informed consent, and office organization;
- *physical health issues* – such as preventative care checklists for males and females;
- *health watch tables* – for disabilities such as Down syndrome; and
- *behavioral and mental health issues* – such as initial management of behavioral crises in primary care and a risk assessment tool for adults with disabilities in behavioral crisis.

See **Figure 4** for the agenda of a training course offered through the IDD toolkit.

Figure 4
Training for Medical Professionals in IDD Toolkit

Course Agenda

Module 1 – Introduction
Module 2 – Communication
Module 3 – Common Physical Health Issues
Module 4 – Approach to Challenging Behavior
Module 5 – Autism Spectrum Disorder
Module 6 – Non-pharmacologic Treatments for Challenging Behavior
Module 7 – Psychotropic Medications, Part 1
Module 8 – Psychotropic Medications, Part 2

Source: https://cme.mc.vanderbilt.edu/content/appropriate-use-psychotropic-medications-people-idd-helping-individuals-get-best-behavioral.

Going forward, the department's Deputy Commissioner of Health Services is seeking funding to translate the tools into apps for physicians to use in their offices.

Conducted Law Enforcement Training

As part of the exit plan in the *People First of Tennessee v. Clover Bottom Developmental Center* lawsuit, the department developed informational materials for law enforcement officers. The law enforcement training has two main purposes: (1) to help officers be more successful in their encounters with individuals with intellectual and developmental disabilities and (2) to prevent circumstances that may lead to allegations of mistreatment. Specific topics covered include

- the definition and prevalence of developmental and intellectual disabilities;
- how to recognize a disability;

- a description of the department's services;
- the risk of positional and aspirational asphyxiation;[6]
- the role of the department's investigators in allegations of abuse, neglect, and exploitation; and
- specific strategies for law enforcement officers to use when encountering individuals with intellectual and developmental disabilities, who might not respond like a typical person would.

The department's Director of Behavioral and Psychological Services created the training based on his own experience working with individuals with intellectual and developmental disabilities. He also coordinated with the Orange Grove Center in Chattanooga and consulted material from Maryland's law enforcement training. Beginning in May 2015, the Director of Behavioral and Psychological Services has conducted approximately 20 training sessions with over 500 participants.

The Principal Deputy Assistant Attorney General of the U.S. Department of Justice's Civil Rights Division, stated,

> We applaud the state's efforts to ensure that law enforcement officers engage safely and effectively with people who have intellectual or developmental disabilities and their families. This initiative is good for those people, for officers who serve in communities across the state, and for effective law enforcement. Tennessee joins a new national trend in recognizing and preparing for the intersection between law enforcement and people with disabilities.

Closed Clover Bottom Developmental Center

Following years of work, the department successfully closed Clover Bottom Developmental Center in November 2015. See **Table 2** for details.

[6] Positional asphyxiation is death caused by restraining a person in a position where his or her breathing is compromised. Aspirational asphyxiation includes choking on vomit. Source: the Director of Behavioral and Psychological Services' *DIDD Services and Investigation Processes Training for Tennessee Law Enforcement Officers* PowerPoint presentation dated April 2015.

Table 2
Clover Bottom Developmental Center Timeline

Date	Event
1923	Clover Bottom Developmental Center, located in Nashville, opened and admitted 248 individuals during its first 9 months of operation.
1963	At its peak, Clover Bottom housed more than 1,500 individuals.
1980s	The standard model of care for individuals with intellectual and developmental disabilities shifted from institutionalization to community-based living, where individuals reside in more traditional home settings, have opportunities to interact with the general population, and hold jobs in integrated settings. The number of individuals residing at Clover Bottom declined in subsequent years as the community model became increasingly popular.
December 1995	*People First of Tennessee v. Clover Bottom Developmental Center* challenged the center's conditions.
December 2009	In response to the litigation, the state announced its intent to close Clover Bottom.
January 26, 2010	The department submitted its Clover Bottom Developmental Center Closure and Community Transition Plan to the U.S. District Court.
June 2010	The state established this month as the deadline for moving the more medically fragile and physically challenged Clover Bottom residents to community-based intermediate care facilities, known as the Middle Tennessee Homes.
November 19, 2012	The department broke ground in Davidson County for the construction of the first 4 of the 9 Middle Tennessee Homes, which would house 4 people each.
December 2012	42 individuals remained at Clover Bottom.
2013	Problems related to land acquisition, facility design, and construction delays caused the department to extend the homes' completion date to June 30, 2014.
October 2013	In our sunset performance audit report, we published an observation that the department would not meet its June 30, 2014, deadline.
November 19, 2015	After 92 years of service, Clover Bottom officially closed as the final residents moved into their new homes in the community.

Source: October 2013 performance audit report of the department and http://tn.gov/news/19320.

Clover Bottom Developmental Center

Source: http://wjhl.com/2016/01/21/tennessee-one-step-away-from-dismissal-of-clover-bottom-greene-valley-lawsuit/.

Closed Greene Valley Developmental Center

The department closed the Greene Valley Developmental Center after 56 years in operation in order to resolve the federal *People First of Tennessee v. Clover Bottom Developmental Center* lawsuit (discussed in detail below). The final two individuals moved from Greene Valley to homes on May 26, 2017. At its height, the center housed 1,100 individuals.

Greene Valley Developmental Center

Source:http://wjhl.com/2017/05/26/greene-valley-developmental-center-officially-closes-last-residents-transition-to-new-homes/.

With Greene Valley's closure, Tennessee joined 13 other states and the District of Columbia in having no large, state-run institutions for individuals with intellectual disabilities.

Resolved *People First* Lawsuit

In December 1995, *People First of Tennessee v. Clover Bottom Developmental Center* challenged the conditions at the Clover Bottom Developmental Center in Nashville, the Nat T. Winston Developmental Center in Bolivar, the Greene Valley Developmental Center in Greeneville, and the Harold Jordan Center in Nashville. The parties in the lawsuit reached a settlement agreement in 1996.

Since that time, the State of Tennessee closed the Nat T. Winston Developmental Center in 1998, and the courts released Greene Valley from the litigation in 2006 and the Harold Jordan Center in 2008 based on substantial compliance with the agreed order. In an attempt to also propel Clover Bottom toward compliance, the state announced its intent to close the center in 2009 and successfully closed it in November 2015 (as described above).

In January 2015, the U.S. District Judge entered an order calling for a two-phase dismissal of the lawsuit based on the state completing the exit plan's obligations:

- The first phase consisted of eight responsibilities the department and the Division of TennCare must have completed by December 31, 2015, in order for the lawsuit to be partially dismissed. These responsibilities included
    1. developing behavior respite services in East and Middle Tennessee;
    2. revising Individual Support Plan templates and requiring support coordinator training;
    3. developing training for licensed physicians on the use of psychotropic medications for individuals with intellectual and developmental disabilities;
    4. enhancing training for local law enforcement entities who may come into contact with individuals with intellectual or developmental disabilities;
    5. revising the form describing freedom of choice rights;
    6. allowing current and former lawsuit class members to choose to receive services through the comprehensive aggregate cap waiver;
    7. classifying three individuals who resided at the Harold Jordan Center as class members; and
    8. crafting additional program educational materials.
- The second phase required Greene Valley to be closed by June 30, 2016, but allowed for two 6-month extensions. The state used both of these extensions.

With the closure of Greene Valley in May 2017 (as discussed earlier), the state fulfilled the last term of the exit plan. On September 8, 2017, the U.S. District Court dismissed the lawsuit, ending 25 years of federal litigation.

In the press release for Greene Valley's closure, Governor Haslam stated, "We have fundamentally changed the way we serve some of our most vulnerable citizens in Tennessee. I'm grateful for the tireless work of so many people to get to this point and ultimately improve the lives of thousands of Tennesseans with intellectual and developmental disabilities."

Opened Mobile Seating and Positioning Clinic

The department operates seating and positioning clinics in Greene, Davidson, and Shelby Counties to provide custom wheelchairs and positioning equipment to individuals with intellectual and developmental disabilities. The department's website describes the importance of customized equipment:

> When the wheelchair and wheelchair seating system meet a person's needs, he/she can participate in each day without wasting energy on being uncomfortable or attempting to maintain an upright and functional position in his/her wheelchair against gravity. . . . Therapeutic positioning beyond the wheelchair is used to prevent reflux and aspiration and promote improvement in mobility, skin integrity, respiratory capacity, eating, digestion, and elimination. In addition, when used consistently throughout the day and during the night, custom positioning can prevent as well as reverse the progression of asymmetrical posture . . . which can reduce secondary health complications and lead to improved wheelchair seating and function.

Tennessee's budget for fiscal year 2017 included $398,500 in state funds for the department to establish a mobile seating and positioning clinic unit to bring services to individuals unable to travel to the existing clinics. The department received the mobile clinic on June 1, 2017. The mobile clinic has two main areas:

- a production area with tool and material storage, a work bench, band saw, ladder, and lift to raise equipment so staff can work on it; and
- a clinician area with a padded table, a lift to help individuals in and out of their equipment, and a chair lift to get in and out of the unit.

As of June 1, 2017, the department plans to station the mobile clinic in East Tennessee to serve the individuals who are the longest distance from the stationary clinics.

SERVICE DELIVERY SYSTEM OPERATIONS

The Department of Intellectual and Developmental Disabilities' service delivery system comprises a range of programs designed to enhance the quality of life of Tennesseans with disabilities. The department's programs include three home- and community-based services Medicaid waivers; the Family Support Program; and the Employment First initiative. The department also provides administrative functions and services for the Employment and Community First CHOICES program under an interagency agreement with the Division of TennCare. We focused our audit work on a selection of components of the department's service delivery system.

Developmental Disabilities

State law defines developmental disabilities as physical or mental impairments that manifest before age 22, are likely to continue indefinitely, and substantially limit three or more major life activities. Section 33-1-201, *Tennessee Code Annotated*, designates the department as the state's developmental disabilities authority; as such, it is responsible for planning and promoting a comprehensive array of services for this population. Our October 2013 audit report disclosed that since becoming a standalone department, it had neither implemented services specifically for individuals with developmental disabilities other than intellectual disabilities nor sufficiently engaged in planning efforts to do so.[7]

Medicaid Waivers and the Employment and Community First CHOICES Program

TennCare contracts with the department to administer three Medicaid waivers for individuals with intellectual disabilities: statewide, comprehensive aggregate cap (formerly Arlington), and self-determination. The department maintains a network of private providers that deliver services to waiver enrollees in accordance with each person's Individual Support Plan. Our October 2013 audit report included several findings related to the department's Medicaid waivers. Specifically, we reported that

- over 7,000 individuals were on the department's waiting list for waiver services, but the department only had sufficient funding to offer enrollment to individuals in crisis;
- department personnel did not always maintain accurate category of need information for individuals on the waiting list; and

[7] Source of "March is Developmental Disabilities Awareness Month" logo: http://nacdd.org/.

- the department's Individual Support Plan development process contained deficiencies.

As the result of efforts to reform the state's service delivery system for individuals with intellectual and developmental disabilities, the department closed its waiting list for the waivers on June 30, 2016. On July 1, 2016, TennCare launched Employment and Community First CHOICES, a new long-term services program for individuals with intellectual and developmental disabilities. The department collaborated with TennCare to design this program, and TennCare in turn contracts with the department to provide various administrative services and functions.[8]

Family Support Program

The department's Family Support Program is designed to help individuals with severe disabilities and their families remain together in their homes and communities. The program provides funding for families to purchase goods or services they may need, including respite care, personal assistance services, child care, homemaker services, minor home and vehicular modifications, transportation services, health care costs not otherwise covered, and other approved items. Program guidelines limit individuals to a maximum annual benefit of $4,000.

The department contracts with agencies throughout the state to operate the program at the local level. Contract agencies are responsible for assisting each individual/family with the provided services by assessing their needs and preparing a written plan. Our October 2013 audit report included a finding related to the department's lack of verification of Family Support Program data submitted by contract agencies.

Figure 5
Excerpt From the Department's *Tennessee Family Support Guidelines*

Family
To be eligible for Family Support, a family must have a family member with a severe or developmental disability. Pursuant to T.C.A. § 33-5-201(2), family is defined as a unit that consists of either a person with a severe or developmental disability and the parent, relative, or other caregiver who resides in the same household or a person with a severe or developmental disability who lives alone without such support.

Employment First

The department is part of an Employment First initiative to facilitate the full inclusion of individuals with varying degrees of abilities in the workplace and in the community. Under the Employment First approach, community-based integrated employment is the first and preferred employment service option for youth and adults with significant disabilities. Integrated employment refers to individuals with disabilities working in typical workplace settings where

[8] We display the fiscal year 2017 budget for Employment and Community First CHOICES in **Appendix 2** on page 207.

the majority of employees have no disabilities, earn at least minimum wage, and receive payment directly from the employer.

Office of Risk Management and Licensure

The department's Office of Risk Management and Licensure functions to protect supported individuals and other state citizens against unlicensed service providers; unsafe environments; inadequate education and training of personnel; physical and mental abuse; and any unscrupulous acts deemed detrimental to the treatment and general welfare of individuals with intellectual and developmental disabilities.

We concentrated our testwork on the office's Risk Management Unit, which is responsible for monitoring the department's internal operations.

Audit Results

1. **Audit Objective:** Did the department correct the October 2013 finding by establishing sufficient services for individuals with developmental disabilities and adequately engaging in planning efforts to do so?

   Conclusion: We found that the department collaborated with TennCare to design and implement the Employment and Community First CHOICES program, which extends eligibility for long-term services to individuals with developmental disabilities (see **Observation 1**).

2. **Audit Objective:** Did the department correct the October 2013 finding by working to reduce the number of individuals on the waiting list for Medicaid services?

   Conclusion: Based on our testwork, management worked to reduce the number of individuals on the waiting list for Medicaid services by instituting an annual cost neutrality cap on the statewide waiver; protecting waiver services from funding cuts despite required base budget reductions; expanding waiver capacity for individuals with aging caregivers; and implementing the Titan information system, which improved waiting list management.

3. **Audit Objective:** Did the department correct the October 2013 finding by maintaining the current needs status of all individuals served?

   Conclusion: Our testwork disclosed that the department did not maintain the current needs status of all individuals served (see **Finding 1**).

4. **Audit Objective:** Did department personnel adequately communicate with individuals on the waiting list?

Conclusion: According to our testwork results, department personnel did not communicate with individuals on the waiting list in accordance with the internal case management policy (see **Finding 1**).

5. **Audit Objective:** Were the workloads reasonable for case managers overseeing individuals on the waiting list?

   Conclusion: Case managers' workloads did not allow them to fulfill their responsibilities in accordance with department policy (see **Finding 1**).

6. **Audit Objective:** Did the department fill empty Medicaid waiver slots as soon as practicable?

   Conclusion: The department did not fill vacated waiver slots as soon as they reopened each January 1 but instead rationed the empty slots for use throughout the calendar year. The waivers closed to new enrollments on July 1, 2016.

7. **Audit Objective:** Did the state fill empty Employment and Community First CHOICES program slots as soon as practicable?

   Conclusion: Employment and Community First CHOICES did not reach its first-year target enrollment; we also identified other concerns (see **Finding 2**).

8. **Audit Objective:** Are Tennessee's waiting list numbers comparable to other states' numbers?

   Conclusion: Although other states' waiting list numbers are not directly comparable due to differences in population and service delivery systems, Tennessee's Medicaid waiver waiting list numbers were similar to those of other states with like geographic and demographic characteristics.

9. **Audit Objective:** Did the department address the state's shortage of caregivers (known as direct support professionals)?

   Conclusion: The department took action to address the shortage, yet the crisis continues (see **Emerging Issue**).

10. **Audit Objective:** Did the department correct the October 2013 finding by properly developing Individual Support Plans for individuals receiving services through the Medicaid waiver?

    Conclusion: Despite making improvements, the department sometimes did not properly develop Individual Support Plans (see **Finding 3**).

11. **Audit Objective:** Did the department comply with the monthly and annual review and monthly visit requirements established in its Individual Support Planning policies?

    Conclusion: We identified noncompliance with the review and visit requirements (see **Finding 3**).

12. **Audit Objective:** Did the department correct the October 2013 finding by verifying data submitted by Family Support Program contract agencies?

    Conclusion: Our testwork results revealed that the department corrected the prior finding.

13. **Audit Objective:** Did the department ensure that contract agencies used Family Support Program funds for approved purposes?

    Conclusion: Based on our testwork results, the department ensured that contract agencies appropriately used program funds.

14. **Audit Objective:** Has integrated employment for individuals with disabilities increased?

    Conclusion: While the department is actively participating in the Employment First initiative, it is still in the process of collecting comprehensive data to show whether integrated employment has increased (see **Observation 2**).

15. **Audit Objective:** Did the Office of Risk Management and Licensure perform regular reviews of the risk areas identified as findings in the April 2013 and October 2013 audit reports?

    Conclusion: We determined that the office did not perform regular reviews of these risk areas (see **Finding 4**).

Finding 1 – The department did not provide case management to individuals on the Medicaid waiver waiting list according to policy, did not make adequate attempts to communicate new aging caregiver legislation, and again did not maintain the current needs status of supported individuals

Department of Intellectual and Developmental Disabilities personnel did not follow policy regarding providing case management services to those on the Medicaid waiver waiting list. Consequently, individuals on the waiting list did not receive adequate assistance and information about additional services, including the Aging Caregiver Program. We also found that although the department properly filled open waiver slots with individuals from the waiting list based on its established procedures, staff did not always update the records of those individuals who were transferred to a waiver—a deficiency we initially identified in our October

2013 audit. This deficiency compromised the data integrity of the waiting list, which management used to make decisions regarding funding and services for programs such as Employment and Community First CHOICES.

Background

Waiting List Origin and Process for Joining the Waiting List

The department began maintaining an official waiting list for Medicaid waiver services in 2004 in response to the Brown Waiting List Settlement Agreement. The department routed all inquiries received from individuals seeking access to services through its regional offices' Intake and Case Management units. If the department did not have an open waiver slot for the referred individual, then the Intake and Case Management staff added him or her to the waiting list. The department maintained waiting list member information in paper files until May 2014, when it implemented the Titan information system's waiting list and case management module.

Waiting List Classifications

The department classified individuals on the waiting list into one of four categories based on need (see **Figure 6**).

Figure 6
Description of Waiting List Classifications

Crisis

The person needs services immediately due to the most intense needs WITH one or more of the following being met:

Homeless
Death or Incapacitation of ALL available caregivers
IMMEDIATE danger to self or others

Urgent

The person needs services soon and meets one or more of the following criteria:

Aging or failing health of caregiver and no alternate caregiver is available to provide supports
Living situation presents a significant probability of abuse or neglect
Increasing risk of aggressive or assaultive behavior toward self or others
Stability of current living situation is severely threatened due to extensive support needs or family catastrophe
Discharge from other service system (including but not limited to school, DCS, RMHI, Forensics) is imminent

Active

The person and/or conservator/guardian is requesting services as of now but does not have the intensive needs which meet the criteria for "crisis" or "urgent"

Requests services now, but does not have intensive needs which meet the urgent or crisis criteria

Deferred

The person's need for services is more than one year away.

Source: https://www.tn.gov/didd/article/the-waiting-list (accessed during fieldwork but now removed).

Department's Provision of Case Management Services

The 2004 Brown Waiting List Settlement Agreement required the department to offer case management services to each individual on the waiting list. Management implemented Policy 80.3.11, "Case Management Services While on the DIDD [department] Waiver Waiting List," which included provisions for

- assignment of an intake case manager to each individual on the waiting list;
- case managers to maintain contact with individuals on the waiting list at least annually and based on the documented contact preferences of the person and/or his or her legal representative;
- case managers to help individuals on the waiting list seek services in the community and from other state and federally funded programs; and
- an individual's removal from the waiting list when he or she enrolled in a waiver or was no longer eligible for, or interested in, services.

Process for Removing Individuals From the Waiting List to Medicaid Waivers

The department approved individuals on the waiting list to begin Medicaid waiver enrollment based on level of need. The department's three Regional Intake Committees (one each in the East, Middle, and West regions) and a Central Office Intake Committee oversaw waiting list removals to a waiver. The three regional committees met monthly to evaluate cases and determine which individuals in each region had the most serious need. The regional committees then forwarded the names of those individuals to the central committee, which also met monthly to review the case files submitted by the regional committees and provide final approval for selected individuals to initiate the waiver enrollment process.

Automatic Waiver Enrollment to Individuals With Aging Caregivers

At the urging of advocacy groups, the General Assembly unanimously passed legislation in 2015 to relieve the burden of elderly Tennesseans caring for a loved one with intellectual disabilities. Effective July 1, 2015, state statute expanded enrollment in the self-determination waiver or a similarly capped waiver to any individual on the waiting list within 6 months of his or her custodial parent or caregiver reaching 80 years of age. The General Assembly subsequently revised the caregiver age threshold from 80 to 75 years, effective April 6, 2016, to align with average life expectancy in Tennessee. The department secured approximately $3.5 million in additional state funding for fiscal year 2016 to serve 151 waiting

"Many aging caregivers do not deal with their own health issues because they are focused on the needs of their disabled son or daughter. . . . Older caregivers also may be hindered by physical limitations of age—such as the inability to lift a loved one or fading sight or hearing that leads to unintentional neglect."

Source: Bliss, Jessica. "Aging caregivers of Tennesseans with intellectual disabilities fear for the future." *The Tennessean*, January 19, 2014. http://www.jacksonsun.com/story/news/health/2014/01/20/aging-caregivers-of-tennesseans-with-intellectual-disabilities-fear-for-the-future/4655103/.

list occupants who were newly eligible for waiver enrollment due to the passage of the aging caregiver legislation.

The department's Commissioner stated the following in an April 11, 2016, press release about the aging caregiver legislation: "This law was designed to give relief to people who have taken care of their loved ones for decades, and may even now require care themselves. The assistance provided through [the department] will help people remain in their homes, while lessening the burden on caregivers who have worked tirelessly for the ones they love."[9]

Closure of Medicaid Waivers to New Enrollments

On July 1, 2016, TennCare launched Employment and Community First CHOICES, a new Medicaid program serving individuals with intellectual and developmental disabilities. The department closed the Medicaid waiver to new enrollments, ceased waiting list case management services, and transferred the waiting list to TennCare on June 30, 2016. We detail concerns about Employment and Community First CHOICES separately in **Finding 2**.

Case Management Testwork Results

To determine whether the department's case managers adequately communicated with individuals on the waiting list, we obtained the waiting list as of June 30, 2016, its final day of operation. We identified the following problems.

Invalid Case Manager Assignments

Based on our analysis, 109 of 5,783 individuals on the waiting list (2%) did not have a valid case manager assigned as of June 30, 2016. Of those 109,

- 78 individuals had a former department employee assigned as their case manager; and
- 31 individuals did not have an assigned case manager at all.

Management asserted that all individuals had been assigned a valid case manager at the time of the their initial contact with the department, but updates and modifications to Titan sometimes prevented the system from recording formal case manager assignments. Management did not present us with evidence of valid case manager assignments outside of Titan, however.

Contact Preferences Not Documented or Followed

We selected a haphazard, nonstatistical sample of 96 individuals from the population of 5,783 waiting list members. Our sample comprised 1 waiting list member per category of need per case manager. We also haphazardly selected 1 waiting list member without an assigned case manager per region per category of need. For each individual selected, we tested the provision of case management services according to policy for the period June 1, 2013, through June 30, 2016.

[9] Source: https://www.tn.gov/didd/news/39555.

For 92 of 96 individuals tested (96%), case managers either did not document the person's preferences (or those of the legal representative) for contact type and frequency in the case file or (based on case file notes) did not communicate according to the documented preferences. We found the following:

- For 74 individuals, the case manager did not document the person's contact type and frequency preferences in the case file. Without this documentation, we could not determine whether the type and frequency of contact aligned with the individual's preferences, as required by department policy.
- For 18 individuals, the case manager documented contact preferences but then did not communicate accordingly (for example, mailing an annual letter rather than fulfilling the individual's request to receive a call twice a year). In addition, we identified several instances where the case manager documented unrealistic contact type and frequency preferences without explaining to the individuals the problems associated with their requests. For example, one individual in "deferred" status wanted his case manager to make semi-annual home visits and quarterly telephone calls, even though he did not need access to services for at least 12 months in the future.

We also found that for 2 individuals in our sample, case managers documented contact type and frequency preferences on a form that conflicted with the department's Policy 80.3.11. Specifically, the form included an option for case manager contact only once the individual is selected for waiver enrollment. The 2 individuals selected this option, although policy required case managers to maintain at least annual contact.

Management concurred and commented that, in retrospect, the use of contact preferences was not valuable for the majority of individuals on the waiting list given the department's caseload numbers and focus on individuals in critical situations. Management stated that the contact preference option should have been removed from the policy. We maintain, though, that the department should have collected and abided by the preferences to ensure all individuals on the waiting list (or their legal representatives) had periodic opportunities to talk to a case manager and update their contact or category of need information, if necessary.

No Annual Contact

Case managers did not document making at least annual contact with 39 of 96 individuals tested or their legal representatives (41%). Those 39 individuals included

- 3 in the "crisis" category of need,
- 8 in the "urgent" category of need,
- 14 in the "active" category of need, and
- 14 in the "deferred" category of need.

Management asserted that administrative assistants often completed annual bulk mailings to waiting list members and did not document these mailings in individual case files. Without

documentation to support the bulk mailings, however, we could not verify that case managers maintained annual contact as required by policy.

Management also pointed to the department's internal Waiting List Audit Review that began in 2014, crossed two calendar years, and involved attempts to contact individuals on the waiting list. This review's existence did not negate the errors we identified because staff's review notes had already been documented in Titan or the review did not satisfy annual contact requirements for each year under our audit.

When attempting to identify the cause of this deficiency, we noted a correlation between the frequency of contact and the average regional caseload. Based on our analysis of the waiting list as of June 30, 2016, average caseloads varied significantly amongst the department's West, Middle, and East regional offices (see **Table 3**).

Table 3
Waiting List Caseload Distribution by Region as of June 30, 2016

Region	Case Managers	Number of Cases	Average Caseload per Manager
East	8	2,156	270
Middle	6	1,903	317
West	10	1,724	172

The West office, which represented 5% of individuals with no documented annual contact, had the most case managers but the lowest overall caseload. The Middle office, with an average caseload of 317 per manager, and the East office, with an average caseload of 270 per manager, represented 64% and 31% of individuals with no documented annual contact, respectively. We concluded that unreasonably heavy caseloads contributed to case managers not fulfilling their duties as described in department policy.

Management disagreed with our conclusion and explained that the West region had the most case managers to comply with settlement terms pursuant to the *United States v. State of Tennessee (Arlington)* lawsuit, which required provision of services to class members and was subject to external monitoring. Due to required budget cuts throughout our audit period, management said the department lacked funding to match the number of case managers in the East and Middle regions with the West region.

Information Collected for Referral to Aging Caregiver Program

To identify individuals with an aging caregiver, the department sent a mass mailing to the waiting list in July 2015 with the instructions exhibited in **Figure 7.**

Figure 7
Excerpt From the Department's Aging Caregiver Mass Mailing

> Please complete the form sent with this letter and to return the form with the required proof of age in the stamped self-addressed envelope provided. Please complete and return the form and proof of age ***even if*** your caregiver is younger than 80 years old. Returning the completed form with proof of age is the ***only way*** for the DIDD to begin tracking information that will help us know when you may qualify for enrollment into the Self-Determination Waiver or other programs that might be available.

We determined that 72 of 77[10] individuals tested (94%) did not return their aging caregiver form to the department, and case managers did not follow up to collect the form. The 72 individuals who did not return the form were various ages and may or may not have met the aging caregiver criteria.

Management explained, and we agreed, that the mass mailing was not the only strategy to inform individuals on the waiting list about aging caregiver eligibility. The department's communication efforts also included press releases, public information events, and advocacy group outreach. Management stated that case managers started collecting caregiver age information during intake of new waiting list members; during a review of the waiting list data; and during regular case management.

Moreover, management detailed the challenges of collecting information from waiting list members, including the following:

- Individuals who did not meet the aging caregiver criteria had little incentive to return the form.
- Some individuals may have had difficulty managing their mail or reading and understanding the correspondence.
- Some individuals may have lacked access to photocopying or scanning equipment to provide the requested documentation of their caregiver's age. We observed that the aging caregiver mailing directed individuals to contact their regional office or The Arc (an advocacy group) if they had any questions.

Management claimed it would have been unrealistic to call everyone on the waiting list due to staffing shortages and because eligible individuals would have needed to provide evidence of their caregiver's age. We believe that the potential offer of thousands of dollars' worth of services would have been enough

[10] From our sample of 96, we excluded from this procedure 13 individuals who joined the waiting list after July 1, 2015 (the effective date of aging caregiver legislation), and 6 individuals whose circumstances indicated that they should have been removed from the waiting list prior to July 1, 2015.

incentive for those requiring assistance, or their families/legal representatives, to obtain and transmit the caregiver age documentation.

We subsequently obtained all primary caregiver information collected by the department and determined that the department had data for only 896 of the 5,783 individuals on the waiting list (15%) as of June 30, 2016. The department compiled this data into an Excel spreadsheet. Based on our additional analysis, the department did not always make adequate attempts to contact individuals known to have an aging caregiver in order to facilitate their enrollment in a Medicaid waiver (see **Table 4**).

Table 4
Limited Contact Attempts for Aging Caregiver Program

Individual's Name	Individual's Age as of 6/30/2016	Primary Caregiver's Age as of 6/30/2016	Interested in Services?	Contact Attempts
Individual 1	59	78	Yes	1. 4/12/2016 – Call at 11:05 a.m. – No answer. 2. 4/12/2016 – Call at 1:35 p.m. – Left voicemail. 3. 4/20/2016 – Call at 1:25 p.m. – No answer.
Individual 2	57	80	Yes	Last attempted contact 11/14/2014, before the aging caregiver legislation passed.
Individual 3	37	76	Yes	1. 4/10/2015 – Call – Disconnected number. Case manager will have to mail letter to locate. 2. 4/12/2016 – Call – Case manager spoke to caregiver to inform her of change to aging caregiver legislation. Family is interested in services. Case manager to call family and schedule a visit. 3. 4/28/2016 – Case manager called caregiver to check on additional proof of eligibility. She was not available to talk to case manager today. Case manager will call back another day.

These three individuals were still not enrolled in services as of the end of our audit period.

We inquired why the department did not maintain a complete list of primary caregiver ages. Management explained that the law changed to lower the aging caregiver threshold from

age 80 to age 75 in April 2016—less than three months before the department's waivers closed to new enrollment. Anticipating the department would lose responsibility for aging caregiver enrollment when the waivers closed, management determined that the department no longer needed comprehensive aging caregiver information for budget and program planning purposes.

Furthermore, while following up with management on specific individuals with data available, we found that the department's aging caregiver spreadsheet contained numerous errors. For example, some individuals were listed on the spreadsheet as being interested in services, but the department's case file documentation indicated otherwise. Some individuals were listed as not receiving services, but they had already been enrolled.

We also asked management whether the department had transferred the aging caregiver data it did have on file to TennCare following the closure of its waivers. Management asserted that because the department had either enrolled those with aging caregivers in waivers or recently contacted them to inquire about enrollment, the department did not transmit the list of ages to TennCare at the time of Employment and Community First CHOICES implementation, nor did TennCare request the list. Management added that letters sent out by TennCare in July 2016 and February 2017 indicated that those individuals with an aging caregiver would be given priority enrollment into Employment and Community First CHOICES.[11]

Individuals Not Removed From the Waiting List

We identified 12 of 96 individuals tested (13%) who remained on the waiting list after a change in circumstances warranted their removal, including

- 5 individuals who were already enrolled in a waiver;
- 2 individuals who could not be located;
- 2 individuals who did not provide evidence of an intellectual disability;
- 1 individual who moved out of state; and
- 2 individuals who requested to be removed from the waiting list.

Failure to remove these individuals appeared to be a series of oversights.

Category of Need Testwork Results

Our October 2013 audit report contained a finding identifying deficiencies in the department's case management practices, including outdated waiting list removal records. Specifically, department personnel failed to update the category of need records for 15% of individuals removed from the waiting list to a waiver to reflect that they met "crisis" category criteria. In its response, management did not agree that it was necessary to maintain the correct

[11] We discuss TennCare's Employment and Community First CHOICES program correspondence further in **Finding 2**.

category of need information for an individual undergoing waiver enrollment, as long as he or she met "crisis" criteria.

For the current audit, we performed testwork to determine whether the department corrected the prior finding. We obtained the population of 1,019 individuals removed from the waiting list to a waiver during the period June 1, 2013, through June 30, 2016. We analyzed the list to identify 62 individuals who were not classified in the highest category of need ("crisis") when they transferred to a waiver, and we selected a random, nonstatistical sample of 60 individuals for testwork.

Based on testwork performed, regional Intake and Case Management staff failed to update the category of need records for 31 of 60 (52%) individuals removed to a waiver. Management attributed this deficiency to the new Titan system's failure to correctly record updates in some circumstances and to data entry error in other cases.

When we discovered that some individuals removed from the waiver were not classified as having the most serious need (i.e., included in the crisis category), we requested and reviewed the waiver enrollment forms for those individuals. We found that the individuals had actually experienced worsening conditions and therefore met the crisis category requirements prior to waiver enrollment.

Risks Resulting From Problems Noted

When case managers did not communicate with individuals on the waiting list in the frequency and manner prescribed by policy, these individuals might have missed opportunities for services in the community. Because the department did not make adequate attempts to communicate and compile aging caregiver information, for example, some individuals might not be receiving services to which they are entitled. Additionally, by failing to remove individuals from the waiting list when indicated and by not updating category of need records, the department compromised the integrity of the waiting list data. The waiting list served as a key tool that both department management and the state as a whole used to make decisions regarding funding and services (such as Employment and Community First CHOICES) for individuals with intellectual disabilities.

Recommendation

As noted in the finding, the department's responsibility for providing case management services for the waiting list ended on July 1, 2016, when TennCare launched the Employment and Community First CHOICES program. Our recommendations pertain to the department's continuing obligation to provide case management for self-determination waiver enrollees and intake for Employment and Community First CHOICES.

1. The Deputy Director of Intake and Case Management should generate a periodic analysis to verify that all individuals in case management services are assigned a valid case manager in the department's information system.

2. The Deputy Commissioner of Program Operations, in conjunction with the Deputy Director of Intake and Case Management, should review all policies and, where possible, revise or remove provisions that are not feasible in practice.
3. The Deputy Commissioner of Program Operations and the Deputy Director of Intake and Case Management should remind case management personnel of the importance of maintaining complete and current casefile documentation.
4. The department should coordinate with TennCare to a) follow up on the three individuals we noted who appear to be eligible for service enrollment under the Aging Caregiver Program and b) compile a comprehensive set of aging caregiver data. The department should also transfer data already on file to TennCare.

Management's Comment

We concur with the recommendations. As noted by the auditors, continual budgetary reductions over several years impacted caseloads and contributed to all of the issues identified.

We respectfully disagree with the auditor's assessment that contact was not adequate about the aging caregiver legislation, as contact was initiated in every instance where a person returned the aging caregiver form and identified an aging caregiver, including the instances identified by the auditors. It is also worth noting that some people who responded to the mailing and had a caregiver who met the age requirements in the law indicated they did not want services at the time.

As to the above recommendations focused on case management in the self-determination waiver, we offer the following responses.

1. We concur; however, no one in the self-determination waiver was identified as not having an assigned case manager. Nevertheless, the Deputy Director of Intake and Case Management will perform a periodic analysis to ensure that all individuals receiving case management services are assigned a valid case manager in the department's information system.
2. We concur and the Deputy Director of Intake and Case Management will coordinate with the department's policy committee to review case management policies with an eye toward modifying or removing those provisions that are not feasible in practice.
3. We concur; however, no one in the self-determination waiver was identified as having deficient case file documentation. Nevertheless, the Deputy Director of Intake and Case Management will ensure case management personnel are reminded of the importance of maintaining complete and current case file documentation.
4. We concur. DIDD [the department] will continue its longstanding collaboration with the Division of TennCare. As suggested, the Deputy Director of Intake and Case Management transmitted information about the individuals identified by the auditors to TennCare for their consideration and follow up on November 20, 2017. Should TennCare decide to compile a comprehensive set of aging caregiver data, DIDD will certainly participate in that effort as per TennCare's request/guidance.

Observation 1 – The department and the Division of TennCare collaborated to launch a new program—Employment and Community First CHOICES—to fill critical gaps in the state's service delivery system

Until July 2016, the Department of Intellectual and Developmental Disabilities and the Division of TennCare offered no long-term services for individuals with developmental disabilities other than intellectual disabilities. These state agencies also lacked the capacity to serve individuals with intellectual disabilities who were not in crisis. After planning and input from stakeholders, the department and TennCare created a new program, Employment and Community First CHOICES, to expand service offerings to individuals who were previously ineligible because they had a developmental disability other than an intellectual disability and to individuals who remained on the waiting list for services—an average of 8 years and some as long as 28 years— because they were not in crisis.

Background

The department and TennCare share responsibility for serving individuals with intellectual and developmental disabilities. TennCare administers the state's Medicaid program, which funds services for people with disabilities. TennCare's Medicaid program includes three home- and community-based services waivers[12] to provide long-term care to individuals who prefer to live at home or in the community, rather than in an institution. Through an interagency agreement, TennCare has delegated certain day-to-day operational responsibilities of the Medicaid waivers to the department. The Medicaid waivers are the primary mechanism the department uses to serve its target population. The waivers closed to new enrollments on June 30, 2016, but the department continues to serve individuals enrolled in the waivers prior to that date. The department additionally operates intermediate care facilities for individuals with intellectual disabilities (known as community homes) and the entirely state-funded Family Support Program.

Our October 2013 audit report disclosed two critical gaps in the department's service delivery system:

1. The department lacked sufficient services for individuals with developmental disabilities. The target population of the department's Medicaid waivers includes individuals with an intellectual disability who qualify for the level of care provided in an intermediate care facility. With limited exception for children under age six, individuals with developmental disabilities (other than intellectual disabilities) are ineligible.
2. The department had a high number of individuals with intellectual disabilities on its waiting list for Medicaid waiver services. Due to limited funding, the department could only remove individuals with the most intense needs from the waiting list to provide them with waiver services.

[12] These waivers operate under Section 1915(c) of the Social Security Act.

The department collaborated with TennCare to redesign the state's service delivery system to address these problems. Beginning in December 2013, the state agencies hosted meetings with individuals who needed services and their families, advocacy groups, and service providers. In May 2014, the agencies published a "Concept Paper" identifying stakeholders' recommendations for program reform, including the following:

> *Continue to offer high quality services that support choice, self-determination and independence in the most integrated settings appropriate, with a strong focus on integrated, competitive employment and independent community living;*
>
> *Deliver services more cost-effectively and in accordance with the individual's assessed needs; [and]*
>
> *Realign incentives and reallocate new and existing [intellectual disability] service funds to serve more people (including people with intellectual and other developmental disabilities).* [emphasis added]

Following a year of intense planning and ongoing consultation with subject matter experts and interested parties, in June 2015 the department and TennCare submitted a detailed proposal to amend the state's service delivery system to the federal Centers for Medicare and Medicaid Services (CMS). The proposal recommended a number of key changes, such as

- establishing Employment and Community First CHOICES, a new program for both individuals with intellectual disabilities and individuals with developmental disabilities; and
- upon launch of the program, closing the department's waiting list for Medicaid waivers to new enrollments.

On February 2, 2016, CMS approved Tennessee to implement the new Employment and Community First CHOICES program on July 1, 2016. On June 30, 2016, the department closed the waiting list for Medicaid waivers in preparation for the launch of the new program.

Key Features of Employment and Community First CHOICES

The state designed the Employment and Community First CHOICES program differently from the Medicaid waivers. While the Governor's Office chose TennCare to administer the program, TennCare has delegated key functions to the department and three private managed care organizations. Based on our review of program documentation and discussion with department and TennCare management, we highlight key differences between the two service models below and in **Table 7**.

Differences in Employment and Community First CHOICES and Medicaid Waivers

Eligibility

The Medicaid waivers serve individuals with intellectual disabilities and children under age six with developmental delays who, without waiver services, would require placement at an intermediate care facility for individuals with intellectual disabilities. Employment and Community First CHOICES extends eligibility to individuals of all ages with intellectual or developmental disabilities who, without program enrollment, would require or be at risk[13] of placement at a nursing facility.[14]

Enrollment Priority

As noted in our October 2013 audit report, the department classified individuals on its waiting list for Medicaid waiver services into one of four categories of need: crisis, urgent, active, and deferred.[15] When a waiver slot opened due to a supported individual's death or disenrollment, the department selected an individual from the "crisis" category of need to fill the vacancy. Because the waivers served those with the most intense needs, individuals who needed minimal to moderate supports (such as young adults transitioning from high school to the workforce) would remain on the waiting list unless their circumstances worsened and their status changed to "crisis."

In contrast, Employment and Community First CHOICES promotes integrated employment and community living for individuals with intellectual and developmental disabilities. The program's goals align with Governor Haslam's Executive Order 28 issued in 2013 to support integrated, competitive employment opportunities for Tennesseans with disabilities.[16] Accordingly, Employment and Community First CHOICES prioritizes enrollment for individuals who already have a job; who are preparing to enter the workforce from education or training; or who do not have a job but are interested in working (see **Table 5**).

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[13] TennCare considers any individual with proof of an intellectual or developmental disability to be at risk of nursing facility placement.

[14] Individuals must meet financial eligibility criteria to be enrolled in both the Medicaid waivers and the Employment and Community First CHOICES program.

[15] We describe these categories of need in detail in **Finding 1** on page 29.

[16] We discuss integrated employment further in **Observation 2** on page 78.

Table 5
Employment and Community First CHOICES Enrollment Priority Categories

Priority Category	Target Population
A	Individuals who have a job but need help keeping their job.
B	Young adults preparing to transition from education or training to the workforce, who have a job offer but need supports to accept the offer.
C	Individuals who have lost their job and need help finding and keeping a new one.
D	Young adults preparing to transition from education or training to the workforce, who need help finding and keeping a job.
E	Individuals who do not have a job but who want to work and need help finding and keeping a job.
F	Young adults in school and living at home who need help preparing to transition to the workforce.
G	Individuals who do not have a job but are open to the possibility of working and agree to participate in career exploration services.
H	Senior adults who need help to live in and be part of the community.

Employment and Community First CHOICES also includes reserved slots to serve individuals with aging caregivers, individuals with emergent circumstances,[17] families who need support to help their loved one continue living at home, individuals who need help transitioning to a more stable living environment, and adults with multiple complex health conditions.

Cost Limits

Tennessee's Medicaid waivers provide a comprehensive array of services, but at significant cost per individual supported. The state's Annual Report on Home and Community Based Services Waivers to the Centers for Medicare and Medicaid Services for the 2013 reporting period[18] disclosed average waiver expenditures per participant as shown in **Table 6.**

[17] TennCare defines emergent circumstances as (1) the individual's caregiver has died or is incapacitated; (2) the individual is being abused, neglected, or exploited and has nowhere else to go; (3) the individual needs assistance to move out of a nursing home; or (4) the individual is at risk of serious harm to self or others.

[18] This is the most recent reporting period for which data was available from the Centers for Medicare and Medicaid Services as of July 30, 2017.

Table 6
Average Annual Medicaid Waiver Expenditures per Participant, 2013 (Unaudited)

Waiver Name	Average Annual Expenditures per Participant (2013)
Statewide Waiver	$85,107
Comprehensive Aggregate Cap Waiver	$141,000
Self-Determination Waiver	$17,747

Source: Centers for Medicare and Medicaid Services.

Since its inception, the self-determination waiver has included an annual benefit limit of $30,000. Beginning in 2015, the department implemented an annual cost neutrality cap on the statewide waiver. The cap varies annually and is equal to the average annual cost of private intermediate care facility placement for an individual with intellectual disabilities. This amount, which the Office of the Comptroller of the Treasury determines annually, was $155,700 in 2017.

Employment and Community First CHOICES includes modest individual annual benefit expenditure limits to ensure the program's cost effectiveness and financial sustainability.[19] Based on their needs and circumstances, program enrollees join one of three benefit groups:

- Essential Family Supports assists children under the age of 21 living at home with family to prepare for transition to employment and independent living in adulthood.
- Essential Supports for Employment and Independent Living provides critical services to help adults plan and achieve their employment, independent living, and community integration goals.
- Comprehensive Supports for Employment and Community Living offers more intensive services to promote employment and independence in individuals with more significant needs.

We present the annual expenditure limits in each of the program's three benefit groups in **Figure 8**.

[19] Individuals who have exceptional medical or behavior support needs can receive services up to the same limit as would be available if eligible for and enrolled in the statewide waiver (up to the comparable cost of institutional care).

Figure 8
Employment and Community First CHOICES Annual Benefit Limits

* Individuals in Comprehensive Supports for Employment and Community Living with exceptional needs have higher cost caps.

Managed Care Service Model

Although it is the state's Medicaid authority, TennCare has contracted with the department to administer the waivers. The department's responsibilities include intake and enrollment (until the waivers closed to new enrollment on June 30, 2016), service provider management, claims processing, and quality assurance (evaluating service provider performance).

Instead of contracting with the department to administer the new program's daily operations, TennCare integrated Employment and Community First CHOICES into its existing managed care service model. Three managed care organizations or MCOs (BlueCare, Amerigroup, and UnitedHealthcare) operate TennCare's medical and behavioral health plans. Each MCO creates its own network of contracted providers and processes the claims for services delivered to plan members. TennCare amended its contracts with the MCOs to include administration of long-term services for Employment and Community First CHOICES enrollees. The MCOs assist their existing health plan members with enrolling in Employment and Community First CHOICES and deliver integrated medical, behavioral, and long-term care services to program enrollees.

The department's role differs significantly under the managed care service model. The department is responsible for helping individuals who are not already TennCare members to complete the Employment and Community First CHOICES intake and enrollment process.[20]

[20] During the program's first year of operations, the department also assisted UnitedHealthCare members with applying to the program and selecting a new MCO, since UnitedHealthCare did not implement the program until July 1, 2017.

Once TennCare accepts a non-member into the program, the individual selects one of the three MCOs to administer his or her Employment and Community First CHOICES services. The individual also receives TennCare health benefits through his or her selected MCO.

TennCare has contracted with the department to administer other aspects of Employment and Community First CHOICES as well, particularly critical incident management, quality monitoring, and provider training.

Table 7
Comparison of Medicaid Waivers and Employment and Community First CHOICES

	Medicaid Waivers	Employment and Community First CHOICES
Status	Closed to new enrollments on June 30, 2016.	Opened to new enrollments on July 1, 2016.
Eligibility	Individuals with intellectual disabilities and children under age six with developmental delays.	Individuals with intellectual disabilities and individuals with developmental disabilities.
Enrollment Priority	Individuals in crisis, who are defined as homeless, whose caregivers have died or are incapacitated, or who pose imminent danger to self or others.	Individuals who need support to maintain or gain employment; youth transitioning from education or training to the workforce; and senior adults seeking help to live in the community. Reserved enrollment slots ensure program availability for individuals with aging caregivers or other emergent needs.
Responsibility for Program Operations	The department.	TennCare's managed care organization contractors and the department.
Types of Services Available	Behavior; employment and day; dental; environmental accessibility; residential; transportation; nursing; nutrition; occupational therapy; personal assistance; physical therapy; residential habilitation; respite; specialized medical equipment; support coordination; and speech, language, and hearing.	Employment, independent community living, family caregiving, self-advocacy, family empowerment, dental, community transportation, minor home modifications, and assistive technology.
Annual Expenditure Cap	$30,000 for the self-determination waiver and the average annual cost of private intermediate care facility placement for the statewide waiver.	$15,000 to $60,000, depending on the benefit group and intensity of needs. (Exceptions to the annual expenditure cap are available for individuals with exceptional medical or behavioral needs up to the comparable cost of institutional care.)

Despite the advantages of Employment and Community First CHOICES, some issues have arisen, as described in **Finding 2**.

Finding 2 – Concerns emerged before, during, and after the launch of Employment and Community First CHOICES

The State of Tennessee closed the Department of Intellectual and Developmental Disabilities' Medicaid waivers to new enrollments on June 30, 2016, and launched the Employment and Community First CHOICES program the following day.[21] The Division of TennCare has contracted with the department to administer certain aspects of the Employment and Community First CHOICES program, namely the intake and enrollment process, critical incident management, quality monitoring, and provider training.

Although the new program filled previous service gaps in the state's service delivery system, launch was not seamless. Specifically, in evaluating Employment and Community First CHOICES' first year of operations, we determined that

- the department did not transmit key information to TennCare;
- the initial program correspondence relayed by TennCare was confusing; and
- the program did not reach its first-year target enrollment.

Program Enrollment

Based on our discussions with the department's Deputy Director of Intake and Case Management and TennCare's Chief and former Deputy Chief of Long Term Services and Supports, individuals on the waiting list were not automatically considered for enrollment in Employment and Community First CHOICES. Instead, all individuals, including former waiting list members, must complete a self-referral form on TennCare's website to apply for the program.

TennCare's Chief of Long Term Services and Supports explained that the self-referral form is necessary to identify qualified applicants because the focus of the Employment and Community First CHOICES program is so different from the Medicaid waivers. For example, the self-referral form for Employment and Community First CHOICES includes questions about the individual's job history and employment goals (see **Figure 9** on page 48), whereas these factors did not affect qualification for Medicaid waiver services.

[21] We describe the transition from the Medicaid waivers to the Employment and Community First CHOICES program further in **Observation 1** on page 40.

Figure 9
Excerpt from Employment and Community First CHOICES Self-referral Form

Do you have a job now?:	(Please Select) ▼
Do you need services and supports so you can keep your job?:	(Please Select) ▼
This includes things like a job coach, transportation to and from work, or personal assistance to get ready for work or on the job.	
Do you have a job you could start if you could get services and supports to help you with your job?:	(Please Select) ▼
Have you recently lost a job and need services and supports to help you get or keep a new job?:	(Please Select) ▼

Source: https://tcreq.tn.gov/tmtrack/ecf/index.htm.

The Department Did Not Transfer Critical Waiting List Information to TennCare

Given that an individual must complete a self-referral form to apply for Employment and Community First CHOICES, we inquired with department and TennCare management about how the agencies prepared waiting list members and other interested parties for the new program. For the department, management and staff informed us that they provided case management services to individuals on the Medicaid waiver waiting list until the waivers closed to new enrollments. Our review of policies and procedures disclosed that case management services consisted of department personnel maintaining regular contact with individuals on the waiting list and helping individuals seek other services, such as state or federally funded programs and community resources.

We performed testwork to determine whether case managers informed and educated waiver waiting list members about the new Employment and Community First CHOICES program. We selected a haphazard, nonstatistical sample of 96 individuals from the population of 5,783 waiting list members as of June 30, 2016. Our sample comprised one waiting list member per category of need (crisis, urgent, active, and deferred) per case manager. We also haphazardly selected one waiting list member without an assigned case manager per region per category of need. After excluding 17 inapplicable individuals from our sample,[22] we tested 79 waiting list members in total.

Our testwork revealed that 53 of 79 individuals in our sample (67%) did not complete an Employment and Community First CHOICES self-referral form and had no documentation in their case file that the case manager discussed the program with the individual. Of the remaining 26 individuals in our sample, 9 individuals discussed Employment and Community First CHOICES with their case manager, 5 of whom proceeded to complete a self-referral form for the program. The other 17 did not discuss the program but independently completed a self-referral form for the program.

[22] We excluded from our sample 12 individuals who the department should have removed from the waiting list but did not; 3 individuals who were already enrolled in TennCare's CHOICES program for physical disabilities; and 2 individuals who were in the process of waiver enrollment as of June 30, 2016.

For 14 of the 53 individuals who did not complete a self-referral form or discuss the new program with their case manager, we observed case notes documenting circumstances that might have qualified the person for immediate enrollment in Employment and Community First CHOICES:

- Seven individuals had a note in their case file documenting their desire to work. One individual's relative told the case manager that her loved one could not live a meaningful life in the community because she could not accept a job offer without transportation assistance to get to and from work.
- Three individuals had a job or had held a job in the past.
- Four individuals were high school students, one of whom had expressed a need for supports to successfully transition from school to the workforce.

According to the Deputy Director of Intake and Case Management, the department transferred its Medicaid waiting list data to TennCare several weeks prior to the launch of Employment and Community First CHOICES. When we discussed these 14 individuals with the Deputy Chief of Long Term Services and Supports, however, TennCare remained unaware of their apparent suitability for the program.

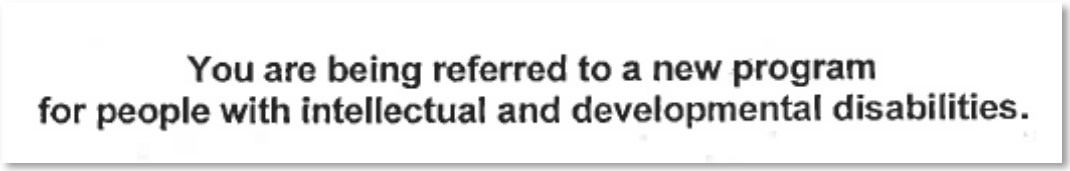
The department's management also asserted, and we agreed, that they were not contractually required to do anything regarding Employment and Community First CHOICES for TennCare until July 1, 2016.

TennCare's Initial Program Correspondence Was Confusing

TennCare's Chief of Long Term Services and Supports informed us that the division used the waiting list to create a "referral list" of individuals potentially eligible to receive services in the Employment and Community First CHOICES program. TennCare first officially communicated the changes in program service options to individuals on the referral list in a letter dated July 1, 2016, the same day the program launched and the division made the online self-referral program available.

Although TennCare management solicited feedback from both the department and the Tennessee Council on Developmental Disabilities before distributing the letter, family members of individuals on the former waiting list reported that they found the correspondence confusing. For example, the first page of the letter informed individuals they were being referred to a new program (see **Figure 10**).

Figure 10
Excerpt From Page 1 of Letter to Individuals on the Former Waiting List


You are being referred to a new program
for people with intellectual and developmental disabilities.

The top of the second page continued that individuals on the waiting list did not need to take any action because the referral was automatic (see **Figure 11**).

Figure 11
Excerpt From Top of Page 2 of Letter to Individuals on the Former Waiting List

What do you need to do?
To be on the referral list for the new Employment and Community First CHOICES program, you don't have to do anything. You will automatically be placed on the referral list.

The letter did not mention until the bottom of the second page, though, that individuals still needed to complete a self-referral form online to apply for the Employment and Community First CHOICES program (see **Figure 12**).

Figure 12
Excerpt From Bottom of Page 2 of Letter to Individuals on the Former Waiting List

Is one or more of the things above true for you? If so, tell us. How? Fill out a self-referral for the new program online at: http://tn.gov/tenncare. It will ask you to tell us about yourself. This will tell us if you're in one of the groups that may qualify to enroll in the new program first. Be sure you check the box that says you've been on a waiting list for the HCBS waivers. We will also use the facts DIDD already has for you.

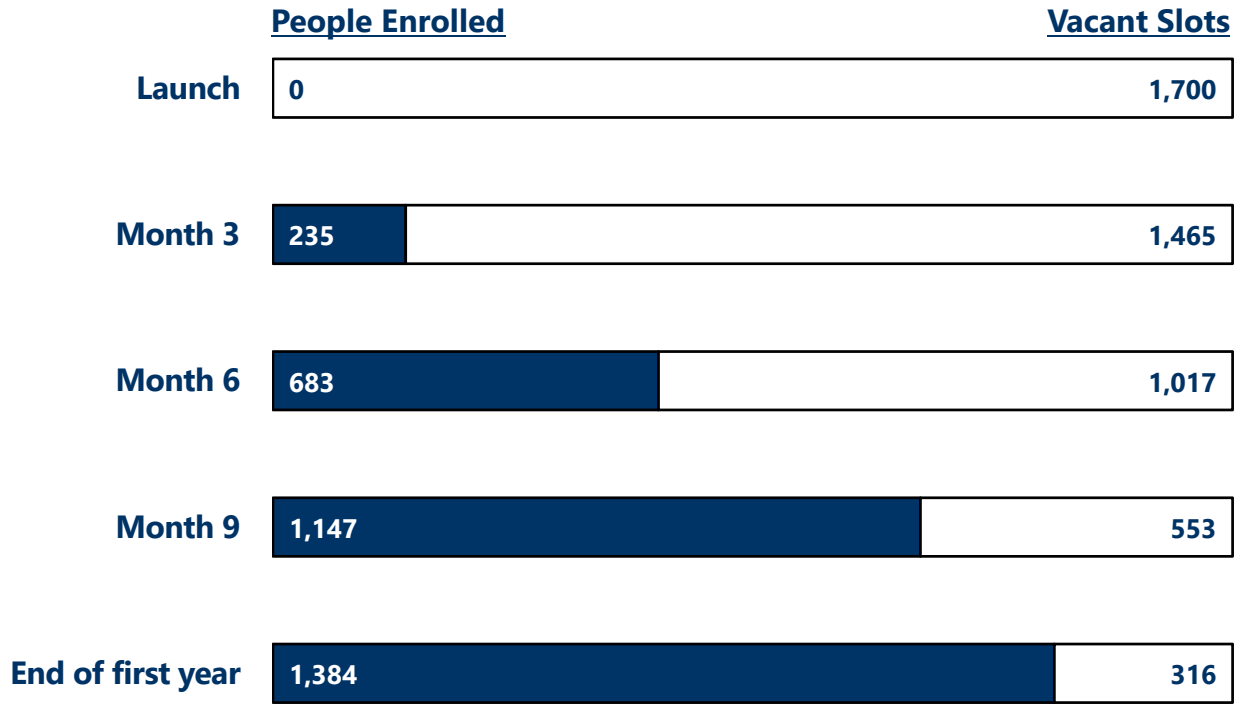
Following extensive consultation with advocacy groups and other stakeholders, TennCare sent a second letter to former waiting list members in early February 2017. The second letter was revised for clarity, contained detailed information about the program's priority enrollment categories (including new categories that had opened), and prominently displayed a link to the self-referral form and a telephone number to call for assistance.

Program Slots Remained Unfilled at the End of the First Year of Operations

For years, Tennessee's disability community has implored the state to reduce the waiting list for services and expand eligibility to individuals with developmental disabilities, yet our analysis revealed the program designed to fill these critical gaps was underutilized. Based on Employment and Community First CHOICES enrollment data for the year ending June 30, 2017, TennCare did not hit its first-year enrollment target of 1,700 individuals (see **Figures 13** and **14**).

As of June 30, 2017, **7,428** individuals were on the Employment and Community First CHOICES referral list.

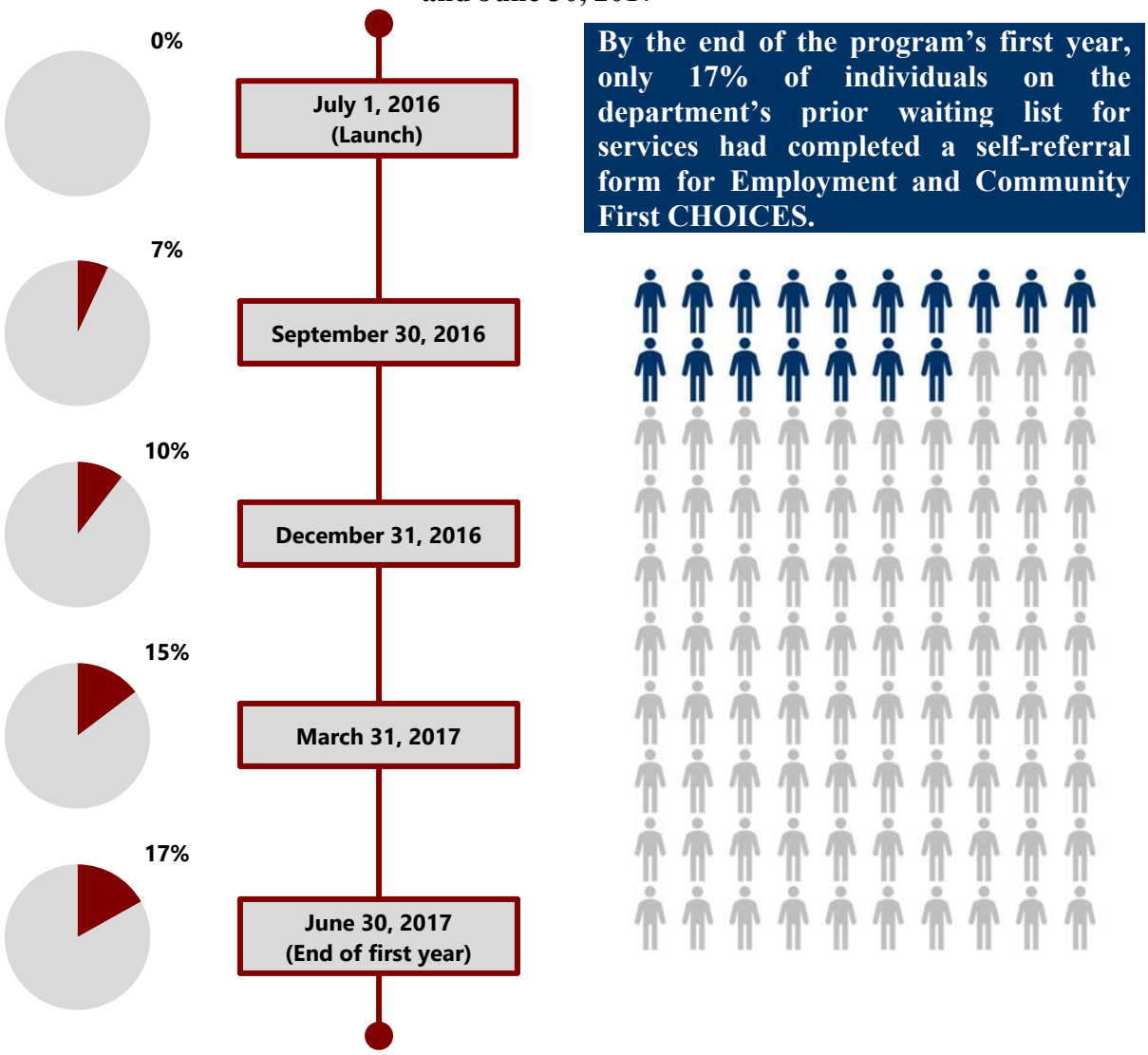
Figure 13
Employment and Community First CHOICES Enrollments and Vacant Slots
July 1, 2016 Through June 30, 2017



The under-utilization of Employment and Community First CHOICES was especially apparent during our review of waiting list program data obtained from TennCare. We determined that only 17% of former waiting list members had completed a self-referral by the end of the program's first year of operations. At an August 17, 2016, meeting, an advocacy group representative member of the department's Statewide Planning and Policy Council described the rate of self-referrals to Employment and Community First CHOICES by former waiting list members as "shockingly low," given the disability community's long campaign to expand state-funded services in Tennessee. She added, "It seems that people who were on the waiting list are actually having a more difficult time becoming engaged than people who are completely new to being eligible for services."

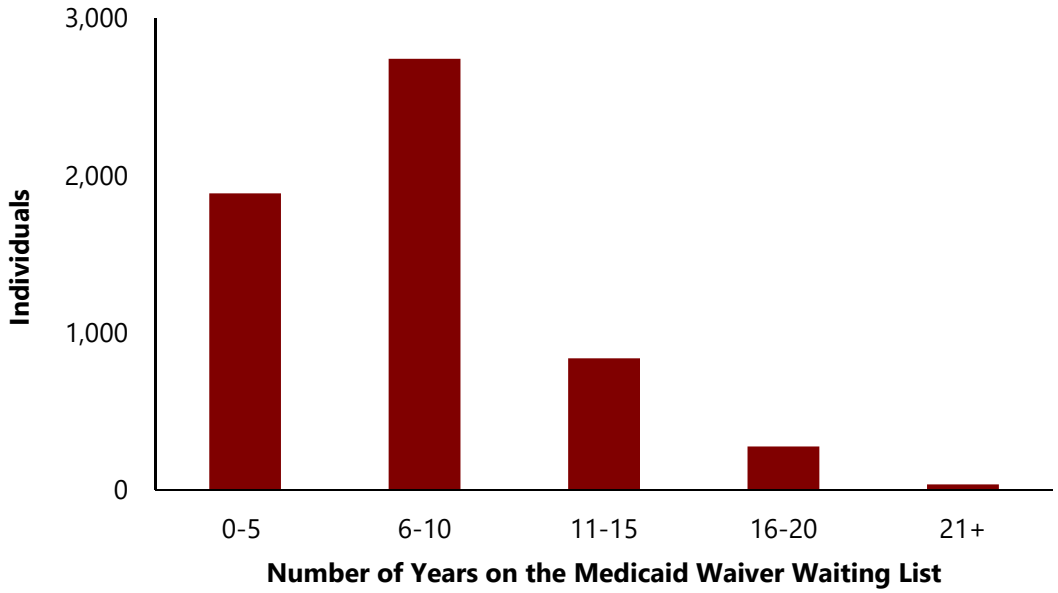
> **"It seems that people who were on the waiting list are actually having a more difficult time becoming engaged than people who are completely new to being eligible for services."**

Figure 14
Proportion of Individuals on the Former Waiting List Who Completed an Employment and Community First CHOICES Self-Referral Form Between July 1, 2016 and June 30, 2017



Our analysis of the waiting list as of June 30, 2016, disclosed that most of its 5,783 occupants had waited for services for at least 6 years, with individuals waiting an average of 8 years and 36 individuals waiting between 21 and 28 years (see **Figure 15**).

Figure 15
Length of Time on the Medicaid Waiver Waiting List



Department's Explanation

We then attempted to identify the reasons for open Employment and Community First CHOICES slots remaining at the end of first year of operations. With regard to communication, the department's management said it was unrealistic to expect case managers to tell every individual on the waiting list separately about the new program, even though its internal policy required annual contact. Management again pointed out, and we agreed, that the contract between the department and TennCare made no provision for the department to prepare waiting list members for Employment and Community First CHOICES.

Management started receiving inquiries about Employment and Community First CHOICES after Governor Haslam announced the program in his State of the State and Budget Address on February 1, 2016. That month, the Director of Communications requested from her counterpart at TennCare informational materials to help department staff answer questions from the public. Because members of the public often directed these inquiries to the central office rather than to the regional case management units, the department's Director of Communications developed and distributed internally additional talking points, including specific information for individuals on the waiting list, as well as for individuals with developmental disabilities other than intellectual disabilities who would be newly eligible for services. Department management also designated a lead person in each region to field advanced questions about the program. In May and June 2016, TennCare provided the department additional informational material, which department management distributed to the regional offices.

We evaluated the department's use of social media to promote Employment and Community First CHOICES. Based on our review of the department's Facebook page, only two posts about Employment and Community First CHOICES appeared before the program's launch

(see **Figure 16**). These two posts referenced advocacy groups—The Arc and Tennessee Works—but did not provide a program launch date or other specific information.

Figure 16
DIDD's Facebook Posts About the Employment and Community First CHOICES Program

The eight tweets the department made about Employment and Community First CHOICES prior to launch did not include specific details either. The department's management emphasized that since Employment and Community First CHOICES is a TennCare program, the department could not issue official communications about the program without TennCare's approval.

The department's Director of Communications also ensured that the department's website included a prominent banner link to the self-referral form as soon as TennCare published the link on July 1, 2016.

The Director of Communications elaborated that during the week of the program's launch, she had inquired with her TennCare counterpart about issuing a press release on July 1. TennCare declined to issue a press release on launch day and instead opted to wait to gauge initial interest before conducting further publicity. TennCare subsequently drafted an announcement for inclusion in the department's weekly *Open Line*[23] newsletter on July 25, 2016, and shared that post on its Facebook page.

Regarding other communications about the new program, the Director of Communications stated that department representatives attended stakeholder meetings, disability conferences, and job fairs throughout the state to educate waiting list members and the public. The department further published and distributed brochures at these events detailing state programs, including Employment and Community First CHOICES, available for individuals with intellectual and developmental disabilities.

[23] *Open Line* is published on the department's Tumblr social media website.

The Deputy Commissioner of Program Operations explained that both the department and TennCare were cautious not to over-publicize the program in order to avoid an overwhelming volume of applications at launch. Moreover, the agencies wanted to ensure that individuals with developmental disabilities other than intellectual disabilities, newly eligible for services, had an equal chance to apply for enrollment.

TennCare Explanation

The TennCare Chief of Long Term Services and Supports echoed the department's language about the strategy to "level the playing field" between those on the Medicaid waiting list and those newly eligible for services. She added that it would have been inappropriate to mail letters in advance of the program's start date because if certain slots had filled up quickly, it would have given significant advantage to individuals on the previous waiting list.

Furthermore, according to TennCare, expecting every individual on the waiting list to submit a new online referral would have resulted in a large volume of referrals for individuals not in any Employment and Community First CHOICES priority group or in any group for which reserve capacity slots were held. Members of TennCare management decided to prioritize and target limited resources for intake activities to those individuals most likely to enroll in the new program in its first year.

TennCare management also believed that no budget authority existed to commence operation of the new program prior to July 1, 2016. Management told us that only beginning July 1, 2016, and subject to the budget authority provided under the 2016-2017 Appropriations Act, could TennCare begin paying managed care organizations and the Department of Intellectual and Developmental Disabilities to perform intake and enrollment functions. TennCare management said that sending letters in advance of program launch would have resulted in the submission of referrals with no ability to respond, which would have been frustrating for potential applicants.

Upon our questioning, TennCare added that neither its management nor the department's management, who worked with stakeholders to design Employment and Community First CHOICES, received supplemental funding. This work was performed in addition to ongoing program leadership and management responsibilities.

TennCare established an Employment and Community First CHOICES Advisory Group that first met on October 11, 2016. Management said that based on recommendations from this advisory group, TennCare created a Communications Workgroup to assist in further development of outreach materials. The workgroup first met on July 5, 2017. Additionally, TennCare has established, and significantly expanded, Employment and Community First CHOICES information on both its own and the department's websites.

TennCare provided us with data showing that the Employment and Community First CHOICES first-year target enrollment was reached on September 12, 2017.

Recommendation

Although the department's role in the Employment and Community First CHOICES service model has changed compared to its role in the Medicaid waivers, the department remains the state's authority on serving individuals with intellectual and developmental disabilities. The department should continue to collaborate with TennCare to identify and execute new strategies to build interest and enrollment in Employment and Community First CHOICES, both among former waiting list members and populations previously ineligible for state-funded long-term services. These strategies should include the department transferring to TennCare information about the 14 individuals identified in our testwork who might be a good fit for the program, as well as similar case notes for other former waiting list members. TennCare (or the division's designee) should then follow up with the individuals to further assess their suitability for Employment and Community First CHOICES.

For future program launches, TennCare should ensure that its initial correspondence contains clear and thorough instructions regarding program enrollment.

Managements' Comments

Department of Intellectual and Developmental Disabilities

We do not concur.

The department respectfully disagrees with the audit finding being associated with DIDD's [the department's] sunset audit, as our role in the program is limited. First, individuals on the previous waiting list for the Section 1915(c) waivers, including the 14 individuals referenced in the recommendation, were notified in July 2016 regarding the implementation of Employment and Community First CHOICES. Then in February 2017, as noted by the auditors, a second letter was sent by TennCare to former waiting list members. This mailing also included the 14 individuals referenced in the recommendation. Among other improvements over the first letter, this second letter included a link to the self-referral form and a telephone number to call for assistance.

Secondly, the auditors took fault with the department's social media posts for not "provid[ing] a program launch date or other specific information." The auditors also stated the "eight tweets . . . did not provide specific information either." The lengthy content of the information to be conveyed in the TennesseeWorks blog and stakeholder meetings made it inadvisable for a social media post; rather, DIDD provided a link on its Facebook page to sites with specific information to increase awareness about these important opportunities for stakeholder education. The use of shared links is in keeping with the social media team's practice regarding lengthy articles, including its own press releases. As regards the eight tweets, the 140 character limit inherent to this form of social media speaks for itself. As with our Facebook posts, several tweets were designed to draw attention to the Employment and Community First CHOICES program and point to the specific information found in the TennesseeWorks blog or inform people of the Arc of Tennessee stakeholder meetings.

The department continues to promote the program on its social media pages. DIDD recently produced an employment success video distributed on Facebook and the NewsChannel 5+ program, "Inside Workforce Development," featuring a young lady who receives supports through the program. She is not identified as an Employment and Community First CHOICES enrollee as DIDD's employment videos focus on the success of a person, regardless of how or where they receive supports.

DIDD will continue its longstanding collaboration with the Division of TennCare. In this regard, information about Employment and Community First CHOICES has already been significantly expanded on both the TennCare and DIDD sites. Also, as suggested, the Deputy Director of Intake and Case Management transmitted information about the 14 individuals identified by the auditors to TennCare for their consideration and follow up on November 14, 2017. Due to staffing constraints, we do not foresee there being sufficient resources to perform a retroactive review of all case files pertaining to a waiting list that has not been in existence for more than a year. Even if resources were available, the benefit of such a review is doubtful, in light of the fact that two written notices have already been provided to every former waiting list member. We do recognize the benefit of, and need for, ongoing outreach. As a participating member of TennCare's Employment and Community First CHOICES Advisory Group, DIDD will certainly collaborate with any future outreach efforts as directed by the Division of TennCare.

Division of TennCare

We concur in part and disagree in part with the proposed finding.

TennCare concurs that with any implementation of this magnitude, there will always be concerns. Employment and Community First CHOICES is an innovative new program, the first of its kind in the country. With this kind of transformational change, a "perfect" implementation, while desirable and diligently planned for, is nearly impossible. In that regard, TennCare has continued to work closely with stakeholders, listening to individuals, families, advocates, providers, and other stakeholders to continue to make program improvements. For example, as noted above, we identified additional priority groups and reserve capacity criteria which were implemented in the program's first year, conducted additional outreach activities, and launched a Communications Workgroup to continue outreach strategies. While we recognize that the launch was not perfect, it is not the result of any failure by TennCare or DIDD to prepare or take appropriate actions.

We further concur that enrollment in the program did not reach the maximum first year enrollment target of 1,700 until September 12, 2017, a couple of months after the end of the first fiscal year. It should be noted, however, that TennCare, working in partnership with contracted MCOs and DIDD, successfully enrolled the largest volume of people with intellectual disabilities to be enrolled into services in a single year in recent history, and for the first time in the history of this state, substantial numbers of individuals with other kinds of developmental disabilities. In the July-September 2017 quarter alone, overall enrollment increased 36%, with more than 90% of new enrollees entering the program through one of the seven employment-related priority groups.

TennCare respectfully disagrees that DIDD failed to transmit key information to TennCare. DIDD was not expected to transmit information in its case files to TennCare. It would not have been practical to expect DIDD to review every case file in order to identify information relevant to the new prioritization criteria for enrollment into Employment and Community First CHOICES. Moreover, it is unlikely that such information, even if relevant, would have been sufficient for TennCare to proceed with enrollment activities. Because priority groups were substantively different than the categorization schema that had previously existed under the Section 1915(c) waivers, TennCare needed additional information in order to determine whether persons might qualify to enroll in these groups. The information needed to be specific, and accurately reflect current circumstances, and was best submitted by the person or someone acting on their behalf once the program was opened for enrollment.

TennCare further respectfully asserts that individuals on the previous waiting list for the Section 1915(c) waivers were properly and timely notified regarding the implementation of Employment and Community First CHOICES, including actions they could take to submit additional information to TennCare (through an online portal) if they believed they might qualify in an open priority category or in any of the groups for which reserve capacity slots were held.

Notification was made via a letter that was developed with review and input from DIDD and the Council on Developmental Disabilities. The letter was mailed on July 1, 2016, the day the Employment and Community First CHOICES program was implemented. In advance of the mailing, TennCare reached out to all of the key advocacy groups, including the Tennessee Council on Developmental Disabilities, The Arc Tennessee, the Tennessee Disability Coalition, Disability Rights Tennessee (the State Protection and Advocacy organization), and the Statewide Independent Living Council to provide copies of the letter, talking points, and guidance in assisting individuals and families.

In addition, TennCare partnered with The Arc Tennessee to conduct family forums across the state at various times and locations, leading up to the program's implementation. TennCare provided an outreach presentation, and The Arc staff met with individuals and families in their communities to inform them about the new program. Invitations were distributed through The Arc Tennessee membership (3000+), Tennessee Disability Coalition (10,000+), Vanderbilt Kennedy Center Monday Morning Message, DD Council, and DIDD *Open Line* via email. It was also posted on The Arc website and went out several times via their Facebook page.

It is not surprising that the volume of individuals on the 1915(c) waiting list submitting online referrals during the program's first year represented only about 17% of people on the list. While Tennessee was the first state in the nation to establish an "Employment First" policy, like most states, Tennessee has struggled to change expectations regarding competitive integrated employment for people with intellectual and developmental disabilities, including among persons with I/DD [disabilities] themselves and their families. The notion of working in the community, earning a competitive wage, and living with greater independence is a paradigmatic shift from the future that many individuals and their families had envisioned for themselves or their loved one. Thus, in the beginning, many individuals on the previous Section 1915(c) waiver waiting list and their families believed the program not to be "for them."

In addition, DIDD had worked diligently to address the needs of most people in the "crisis" category on the Section 1915(c) waiver waiting list, such that most people who might have met criteria for reserve capacity slots in Employment and Community First CHOICES had already been enrolled into a Section 1915(c) waiver.

In February 2017, a second mailing to persons on previously on the Section 1915(c) waiting list who had not submitted an online referral yielded a relatively small number of additional online referrals from persons previously on the 1915(c) waiting list during the weeks following its mailing, even though the primary purpose of the mailing was to announce new priority groups and reserve capacity criteria. While we sought additional feedback in modifying the letter used in the initial mailing, including from members of the Employment and Community First CHOICES Stakeholder Advisory Group, the letter's primary messages were very consistent, advising people to submit an online referral only if they believed they might quality in an open priority group or based on reserve capacity criteria.

While enrollment has steadily increased, based on recommendations from the ECF Stakeholder Advisory Group, TennCare has established a Communications Workgroup to assist in further development of outreach materials. Further, we have established, and significantly expanded, Employment and Community First CHOICES information on both the TennCare and DIDD sites. That said, there is no proven efficacy as to using social media, or evidence that this has or will increase the population served.

The number or percent of people previously on the DIDD waiting list who completed an online self-referral does not indicate how many people on the waiting/referral list understood the multiple mailings and other outreach activities that were conducted to ensure that all persons were informed about the new program. Not all persons needed or wanted services immediately, or, in some cases, the new benefits and expectations regarding employment and increased independence did not align with their preconceived notions or expectations regarding services. They thus chose not complete a self-referral in first year.

We believe that Employment and Community First CHOICES is a successful program that is having tremendous impact, and diligently continue our commitment to working collaboratively with stakeholders to improve the program and our processes in order to support more people with intellectual and developmental disabilities to live meaningful lives in the community, participate in integrated employment, increase their independence, and improve their quality of life.

Auditor's Comment

Although management disclaims responsibility for Employment and Community First CHOICES, Section 4-3-2701, *Tennessee Code Annotated*, obligates the department to promote services and supports available for its target population "through the public and private sectors in this state." The department did not fulfill this duty despite its standing as state authority on intellectual and developmental disabilities and sole owner of the waiting list for Medicaid services up until the launch of Employment and Community First CHOICES.

Regarding TennCare's statement about the practicality of reviewing every waiting list member's case file, department policy already required case managers to maintain at least annual contact with waiting list members (see **Finding 1**). Our finding identifies instances where case managers performing their routine duties failed to discuss the forthcoming Employment and Community First CHOICES program *even when individuals explicitly identified employment or post-education goals directly relevant to program eligibility*. We did not claim in our finding that TennCare would have been able to proceed with enrollment of these 14 individuals without obtaining further information. We specifically recommended "TennCare (or the division's designee) should follow up with the individuals to further assess their suitability."

As we noted in the finding, we did not identify instances where the department was noncompliant with its contractual agreement with TennCare. Instead, we highlighted missed opportunities for greater interagency cooperation to improve services for Tennesseans with disabilities. As stated in Section 33-2-102(c), *Tennessee Code Annotated*, "the general assembly finds as facts that the needs of persons . . . cannot be met by the department in isolation and that those persons need to receive services and supports that are integrated [and] have linkages between and among other human service agencies and programs."

Contrary to the department's statements—and as we explained to management—we did not take fault with the social media posts.

EMERGING ISSUE

Tennessee faces a critical shortage of caregivers for individuals with intellectual and developmental disabilities

Introduction

Tennessee, like other states, faces a crisis-level shortage of caregivers (also known as direct support professionals) for individuals with intellectual and developmental disabilities. In interviews and industry surveys, direct support professionals generally describe their work as fulfilling but physically and emotionally challenging, with low pay yet high levels of responsibility. The state's service providers and family members of individuals with disabilities conveyed to us and the Department of Intellectual and Developmental Disabilities tremendous difficulties recruiting and retaining these vital workers. The department and the Division of TennCare are taking action to expand the workforce capacity and reduce industry turnover, but the problem persists and may worsen as the demand for direct support professionals increases. The shortage threatens provider sustainability and impedes the quality of life of supported individuals and their families.

Background

Direct support professionals are the frontline workers in the state's service delivery system for individuals with intellectual and developmental disabilities. While their duties vary according to the unique needs and abilities of the supported individuals, they generally include

assistance with activities of daily living, such as eating, bathing, grooming, toileting, medication administration, health maintenance, employment supports, social engagement, and money management.

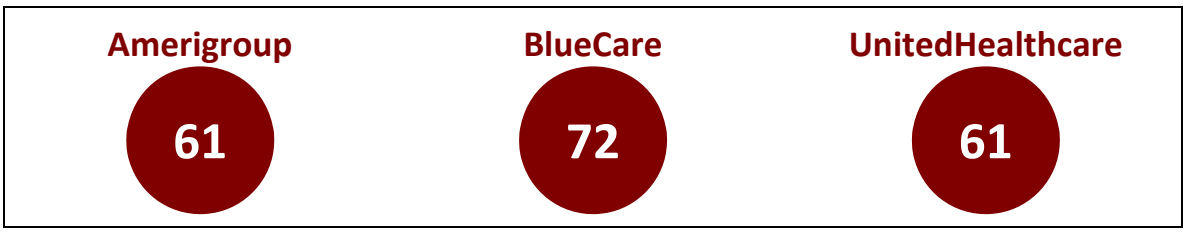
Role of Private Providers and Direct Support Professionals in Tennessee's Service Delivery System

Most individuals with intellectual and developmental disabilities who receive long-term state care are enrolled in either a home- and community-based services Medicaid waiver or the Employment and Community First CHOICES program. These are Medicaid programs subject to TennCare oversight and funded with a combination of state and federal dollars. Both programs rely on private provider agencies, who employ direct support professionals to deliver services to program participants in their homes or in community settings.

The relationship between the state and private provider agencies differs between the Medicaid waivers and the Employment and Community First CHOICES program. Through an interagency agreement, TennCare has delegated operation of the state's three home- and community-based services Medicaid waivers for individuals with intellectual disabilities to the department. The department contracts with over 400 provider agencies to support waiver enrollees in accordance with each individual's approved plan of care. Providers are responsible for hiring employees to deliver services to waiver participants. The providers then bill the department at the state's pre-determined rates for services rendered. The department approves provider billings and periodically transmits the authorized charges to TennCare for payment.

The Medicaid waivers closed to new enrollments on June 30, 2016, and the Employment and Community First CHOICES program launched the following day. In contrast to the waivers, Employment and Community First CHOICES operates under a managed care model. TennCare has contracted with three managed care organizations (MCOs) to administer the program: Amerigroup, BlueCare, and UnitedHealthcare. Program enrollees select one of the MCOs and receive long-term services from contracted providers in that organization's network (see **Figure 17**). The MCOs' contracted providers employ direct support professionals to deliver services. Employment and Community First CHOICES includes a participant-directed services option, allowing an enrollee to hire and supervise his or her direct support professionals and manage his or her own budget within program benefit limits.

Figure 17
Number of Contracted Providers by Managed Care Organizations for the Employment and Community First CHOICES Program



In addition to employees of private agencies contracted to deliver services for the Medicaid waivers and Employment and Community First CHOICES program, the state's direct support professional workforce includes

- employees directly hired by individuals with intellectual and developmental disabilities or their family members;
- department employees working in intermediate care facilities for individuals with intellectual disabilities; and
- employees of privately operated intermediate care facilities.

Direct support professionals also work with other populations, such as with individuals with physical disabilities and in aged care facilities and special education classrooms.

Tennessee's Direct Support Professional Workforce Crisis

According to a 2015 survey of the National Association of State Directors of Developmental Disabilities Services and the Human Services Research Institute, Tennessee lacks a sufficient supply of direct support professionals, who are crucial to the health and welfare of individuals with disabilities. Factors driving the industry shortage include low wages, economic recovery from the Great Recession, and the physical and emotional difficulty of the work. Without reliable and consistent caregivers, individuals with intellectual and developmental disabilities suffer diminished quality of care and risk losing access to life-sustaining services. The workforce crisis also puts pressure on the viability of private provider agencies, which are a key component of the state's service delivery system for individuals with disabilities.

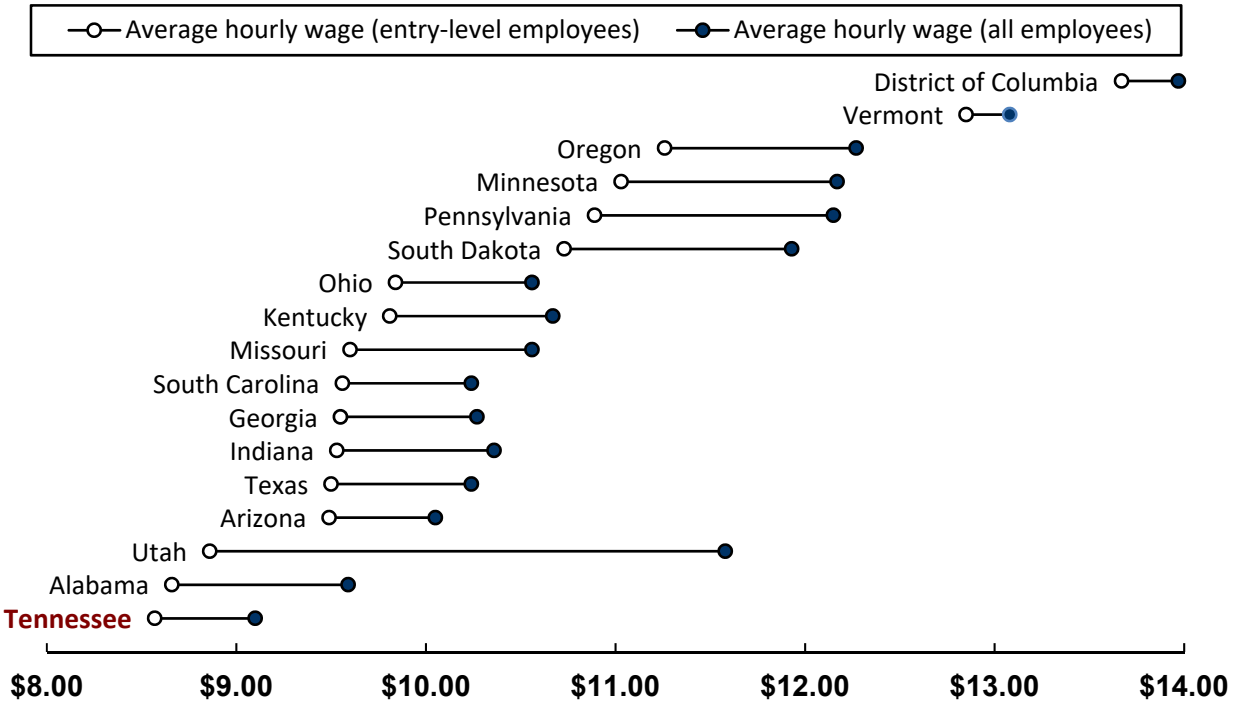
Medicaid Waiver Reimbursement Rates

Based on our interviews with both department and provider management and on supporting documentation provided by those parties, providers cited low wages as the primary cause of the direct support professional shortage. Under the Medicaid waiver service delivery model, the department reimburses its contract providers at fixed rates to support individuals with disabilities in the community. The department calculates the rates to allow for providers' costs, such as wages, benefits, and overhead. For services that direct support professionals administer (such as day services, supported living, and employment supports), the department reimburses providers based on an hourly direct support professional wage of $9.15.[24] The hourly wage component of the department's rate calculation has remained stagnant relative to inflation, increasing by just $0.65, from $8.50 to $9.15, over the past 10 years, while providers report their operational costs have escalated during that same time.

[24] The department does not require providers to pay direct support professionals the calculated hourly wage of $9.15. Providers may pay their employees more or less, but must at least pay them the federal minimum wage rate of $7.25 per hour.

While direct support professional wage stagnation is a nationwide problem, Tennessee ranked last among 16 states and the District of Columbia in a 2015 survey of average hourly wages for both entry-level and experienced direct support professionals, faring worse than socioeconomically comparable states like South Carolina, Alabama, and Kentucky (see **Figure 18**).

Figure 18
Average Hourly Direct Support Professional Wages by State in 2015



Source: National Core Indicators 2015 Staff Stability Survey Report.

Noting the apparent disparities between Tennessee's and other states' provider pay rates, TennCare conducted a rate study. The study compared Tennessee's Medicaid waiver reimbursement rates to those of other states and found that Tennessee paid providers similar (and, in some cases, higher) reimbursement rates than other southeastern states paid Medicaid agencies (see **Table 8**). Providers, however, emphasized that Tennessee's waiver program includes strict compliance requirements, which increases operating costs and reduces funding available for labor costs.

The providers we interviewed cited training, incident response, and financial accountability reviews as some of waiver providers' costly compliance requirements.

Table 8
Selected Data From TennCare's Study of Southeastern States' Medicaid Waiver Reimbursement Rates (Unaudited)

	Tennessee	Alabama	Arkansas	Florida	Georgia	Kentucky	Louisiana	Mississippi	Virginia	West Virginia
Personal Assistance (per 15 minutes)	$3.79	$3.90	No data	$3.82	No data	$5.54	$3.61	$5.72	$3.36 – 3.95	$5.01
Respite Care (per 15 minutes)	$3.72	$3.12	No data	No data	$3.00	$2.77	$3.26	$3.68	$3.36 – 3.95	$2.50 – 5.01
Day Services (per 15 minutes)	$1.31 – 5.40	$1.94 – 4.85	No data	$1.22 – 3.94	$3.04 – 7.26	$4.00 – 8.00	$1.79	$3.93	$2.15 – 6.50	$1.35 – 4.98
Individual Job Coaching (per 15 minutes)	$3.33 – 5.51	$5.00	$3.59	No data	$1.80 – 7.26	$10.25	$2.51	$7.16	No data	$5.01
Supported Living (per day)	$43.08 – 743.00	No data	$176.00 – 391.95	$38.80 – 370.80	$138.09 – 155.56	$79.00 – 172.46	$39.58 – 118.82	$60.64 – 136.50	No data	No data

Based on our discussions with both department and provider management and our review of various news articles, we learned that Medicaid waiver providers struggle to recruit and retain caregivers within the constraints of stagnant wages and high operating costs. Providers statewide are challenged to attract employees because they cannot compete with entry-level wages offered by fast food restaurants and retail stores—a problem that providers say has worsened as the entry-level labor pool shrinks following recovery from the Great Recession, with Tennessee reporting its lowest unemployment rate in recorded history in June 2017. One provider described the costly "endless human resources cycle" of filling and re-filling his organization's perpetually vacant direct support professional positions. Another provider advertised a direct support professional vacancy for two months to receive just five qualified applicants, none of whom appeared for his or her interview appointment. Providers say they invest substantial time and money training their new hires to safely and effectively support people with disabilities, yet they do not realize the return on their investment when employees quit as soon as they identify opportunities for greater compensation with less responsibility in other sectors.

Recognizing the struggle of waiver providers, the Statewide Planning and Policy Council, an entity established to advise and assist the department with policy, has repeatedly urged the department to address the caregiver crisis. In its Annual Reports to the Governor in 2012, 2013, 2015, and 2016, the council recommended rate increases for providers in the department's budget.

Figure 19
Direct Support Professional's Perspective

Elizabeth gets along well with her co-workers and has received glowing remarks from her supervisors each year on her job performance reviews. She has formed very close relationships with the people she supports. Since all of her biological family, with the exception of her son, lives out of state, the people she supports are like family to her, and she cares very deeply for them. She and her son often spend personal, non-working hours with them.

Her job is not the highest-paying one she has ever had, but the emotional rewards are so much greater, and this is what she feels she is called to do in life. Since securing her current position six years ago, she has received only a very minimal increase in pay that has not even kept up with the inflation rate. She knows the agency is doing the best it can with its increasing costs, but Elizabeth has difficulty paying her bills with what she makes, particularly since having her son. The past couple of years, she has started a second part-time job just to pay for necessities. Luxuries are not an option. Often, other DSPs she works with leave for higher-paying jobs, and she has to assume additional responsibilities while the search is on for their replacement. Lately, it is taking her agency longer to find people to fill these positions. This rapid turnover in staff is also difficult for the people she supports.

Elizabeth is often very tired and stressed about what she will do if she experiences some kind of financial emergency. She hopes she never has to face this dilemma, but she worries it may happen one day.

Source: http://www.tennesseeworks.org/.

Employment and Community First CHOICES Designed to Alleviate Workforce Problems

Before launching Employment and Community First CHOICES, the department and TennCare engaged stakeholders to make recommendations for the new program's design. Providers and supported individuals and their family members consistently ranked staffing as both important and an area in need of improvement in the Medicaid waiver system. In their *Home and Community Based Services for Individuals with Intellectual and Developmental Disabilities: Stakeholder Input Summary*, the department and TennCare stated:

> For individuals receiving waiver services and their families, consistent, well trained, quality staff is key—both in terms of services for the individual and supports for the family. They, along with providers, strongly recommended targeted investments in direct care staff pay in order to recruit and retain high quality staff.

Based on this stakeholder input, the department and TennCare designed Employment and Community First CHOICES with higher provider reimbursement rates and fewer administrative barriers (for example, less burdensome critical incident management requirements) than the waiver program. The agencies intended for these changes to both increase provider income and reduce their operating costs. TennCare management disclosed, however, that the direct support professional shortage remains a problem in the Employment and Community First CHOICES program. They explained that almost all providers in the MCOs' networks are also waiver providers and, thus, have carried over old staffing attitudes and practices that are incompatible with the new program's design. For example, many providers continue to seek full-time staff when only part-time employees may be needed, due to the program's increased emphasis on reliance on natural supports.[25]

Effect of Direct Support Professional Shortage on Stakeholders

The absence of a stable direct support professional workforce threatens the sustainability of contract providers, which in turn impacts access to critical services for individuals with intellectual and developmental disabilities. In interviews, some providers disclosed they are so understaffed that they must pay significant overtime or use managerial employees to cover unfilled direct support professional positions, at great financial and operational detriment to their business. Other providers are forced either to cease offering services that are too difficult to manage at prevailing reimbursement rates, or to close entirely. Furthermore, providers say they are reluctant to accept clients with the most intensive needs because maintaining the required staff is too difficult. One waiver participant's parent we consulted has searched for nearly two years for a service provider to agree to support her child with significant behavioral challenges. Meanwhile, her child resides in a temporary care facility that is inappropriate for his needs, and he is isolated from his family and unable to participate in community life.

[25] Natural supports are services that flow from people or places in an individual's community rather than from a waiver or Employment and Community First CHOICES service provider.

The workforce shortage also affects individual employers of direct support professionals, including state-funded program enrollees who direct their own services. We interviewed the parent of an Employment and Community First CHOICES participant, who spent seven months trying to recruit an employee to transport her adult child to and from work. She eventually supplemented her child's transportation allowance with personal funds to offer enough compensation to attract a suitable candidate. As a result, the supplemental funds were no longer available for their intended purpose: to pay for other activities that improve her child's quality of life. The parent added that she will be unable to afford to continue supplementing her child's travel allowance when she moves from the family home into an independent living arrangement.

Individuals who rely solely on their personal income to pay for their own or a loved one's care share the burden of the workforce crisis as well. One parent related to us the financial and emotional toll of hiring a direct support professional to assist her adult son without support from the state. She disclosed that while the family offers its direct support professionals an above average wage for the field, recruiting and retaining an employee remains a challenge when local fast-food restaurants offer better compensation for less responsible work. Furthermore, whenever an employee gets sick or quits, she or her husband must stay home from work to care for their child until the employee returns to work or a replacement is found.

One parent we interviewed remarked that her local school district pays its special education direct support professionals a competitive wage to work with younger and sometimes less behaviorally challenging populations than adults with intellectual and developmental disabilities. She asked,

"If you had a choice, would you rather work with a 45-pound 5-year-old with behavior issues for $11.25 an hour or a 205-pound 25-year-old with behavior issues for $9 an hour?"

Increasing Demand for Direct Support Professionals

While the state struggles to meet its current need for direct support professionals, governmental and industry experts anticipate demand to increase over time. The U.S. Department of Labor's Bureau of Labor Statistics attributes projected growth to a range of factors, including the aging baby-boom population and individuals with disabilities increasingly choosing to receive care in home or community settings rather than in a nursing home. Moreover, the Centers for Disease Control and Prevention has identified the increasing prevalence of autism spectrum disorder, which affected nearly 15% of school-age children in 2012, compared to approximately 7% of school-age children in 2000. One parent we interviewed identified her adult son with autism spectrum disorder as the "leading edge of the tsunami" because today's children with the diagnosis will come of age within the next 10 years, and many of them will require the services of direct support professionals in adulthood.

In *Addressing the Disability Services Workforce Crisis of the 21st Century*, the American Network of Community Options and Resources reported that an impending federal policy change will increase demand for direct support professionals without increasing funding. The federal Centers for Medicare and Medicaid Services has promulgated a new "settings rule" that raises standards for individual choice, control, and community integration in Medicaid-funded long-term care programs. For example, one new provision requires an individual to control his or her schedule, including access to food, at all times. This will increase labor costs as providers must

ensure adequate direct support professional staffing to accommodate individuals' choices to participate in planned and unplanned activities. Tennessee's Medicaid waivers and the Employment and Community First CHOICES program must demonstrate compliance with this rule by March 17, 2022; failure to do so could jeopardize the state's federal Medicaid funding for home- and community-based services.

State Action to Address the Crisis

Medicaid Waiver Rate Increases

Department management has demonstrated its commitment to address the direct support professional crisis by attempting to follow Statewide Planning and Policy Council recommendations to raise provider reimbursement rates. Based on our review of the department's annual budget presentations to the Governor from 2012 to 2016, the department requested cost increases to improve its provider reimbursement rates for fiscal years 2015, 2017, and 2018 (see **Table 9**).

Table 9
Summary of the Department's Medicaid Waiver Reimbursement Rate Increase Requests

Fiscal Year	Rate Increase Requested?	Rate Increase Granted?	Amount of Rate Increase
2014	✗	✓	0.9%
2015	✓	✓	1%
2016	✗	✗	-
2017	✓	✓	1%
2018	✓	✓	1%

In 2012 and 2014, department management proposed rate reductions to comply with the Governor's request for state agencies to make base budget reductions. Upon presenting a proposed 5.1% across-the-board rate reduction for fiscal year 2014, the former Commissioner stated:

> These next reductions are the most difficult on me personally, as I believe it has the greatest impact on the department. . . . If implemented, the rate reduction will be extremely hard on all our providers, taking into consideration that these providers have not received a rate increase since March of 2006, while inflation has increased by 14% over the same period of time. These agencies not only

> provide critical services, but they also contribute to Tennessee's workforce by supplying approximately 26,000 jobs.

Lawmakers ultimately rejected the Commissioner's proposal to reduce reimbursement rates and instead granted a 0.9% across-the-board rate increase for the department's waiver providers beginning in fiscal year 2014.

When the department's current Commissioner presented her fiscal year 2016 budget proposal in November 2014, she included a provider rate reduction of 2.75%, but stated,

> Over the last two fiscal years, we have implemented two rate increases totaling 1.9%, primarily to address the problem of low pay for direct support professionals. This reduction will more than take back these increases. . . . This reduction will be very difficult for our providers.

Although lawmakers rejected the Commissioner's proposal to reduce reimbursement rates for providers in fiscal year 2016, they did not grant an increase either.

While the department has received budget increases to raise provider reimbursement rates for both fiscal years 2017 and 2018, management acknowledged that the department has no guarantee that lawmakers will approve future requests. The Deputy Commissioner of Program Operations explained that the department is exploring service delivery methods that reduce reliance on direct support professional labor, such as real-time remote monitoring technologies.

Workforce Development

TennCare has demonstrated leadership in addressing the direct support professional shortage. In response to stakeholder concerns, TennCare allocated state innovation model grant funding[26] to launch an initiative to expand the workforce. TennCare and its stakeholders identified the most important non-monetary factors influencing direct support professionals' recruitment, retention, and job satisfaction: training and education, support, and career development. TennCare's initiative proposes to partner with institutions of higher education to allow direct support professionals to earn certifications and college credit for completing competency-based industry education and training. These credentials will function as a career path for direct support professionals, facilitating access to more advanced job opportunities and higher compensation. Based on discussion with TennCare's Chief of Long Term Services and Supports, pilot testing of the initiative begins in fall 2017, and full rollout is anticipated in 2018.

Learning Community

In addition to its workforce development initiative, TennCare management is creating a web-based learning community for individuals receiving services and their family members; providers; direct support professionals; and other stakeholders. TennCare management envisions

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[26] The federal Centers for Medicare and Medicaid Services awarded states innovation grants to develop strategies to transform health care payment and service delivery methods.

that the learning community will provide "an accessible forum for the exchange of ideas and information, and creative problem solving that will help us continue to move HCBS [home and community-based services] programs forward." The community will facilitate access to content, training, and discussion that will help stakeholders address problems such as hiring staff for an individual with irregular support needs. To help design and implement the learning community, TennCare has engaged a nationally recognized expert in the field of workforce development and community supports for individuals with developmental disabilities.

Conclusion

The direct support professional workforce crisis in Tennessee poses serious implications for the quality of life of individuals with intellectual and developmental disabilities, as well as the viability of provider agencies that enable people with disabilities to live at home or in community settings. The department, in conjunction with TennCare, is taking action to address this pressing challenge. The agencies should continue to work together to explore innovative solutions, as workforce demands will only increase in years to come.

Finding 3 – Although the department has made improvements since the prior audit, it did not properly develop or review Individual Support Plans in some instances

Federal guidelines prescribe the development of a "plan of care" for all individuals receiving Medicaid waiver services. The Department of Intellectual and Developmental Disabilities fulfills this requirement via the Individual Support Plan (ISP). Our October 2013 audit report found problems with the involvement of the Circle of Support in ISP development; the propriety of the goals and outcomes included in the ISP; and the accuracy of the service types and service rates in the cost plan and payments compared to the ISP. Management did not concur with this finding, stating, "While there are continued opportunities for improvement with respect to the development of outcomes and action steps, we disagree that the Individual Support Plans (ISP) were not properly developed."

In our current audit, we found no issues regarding Independent Support Coordinator services for partial months or cost plan and payments and noted improvement in goals and outcomes (the error rate decreased from 28% to 17%). Nonetheless, the department still did not ensure all ISPs were properly developed. We also noted new problems with staff not reviewing ISPs or performing visits with individuals as required. Due to these deficiencies, we were unable to determine if services, paid for by the State of Tennessee, were sufficiently provided to individuals with intellectual disabilities to fulfill their vision of a desired life.

Background

The department is the state agency responsible for administering services to Tennesseans with intellectual and developmental disabilities. The department has an agreement with the federal government, called the home- and community-based services Medicaid waiver, to provide services to eligible individuals in the community rather than in an institution. Tennessee has three programs under the Medicaid waiver: comprehensive aggregate cap, statewide, and

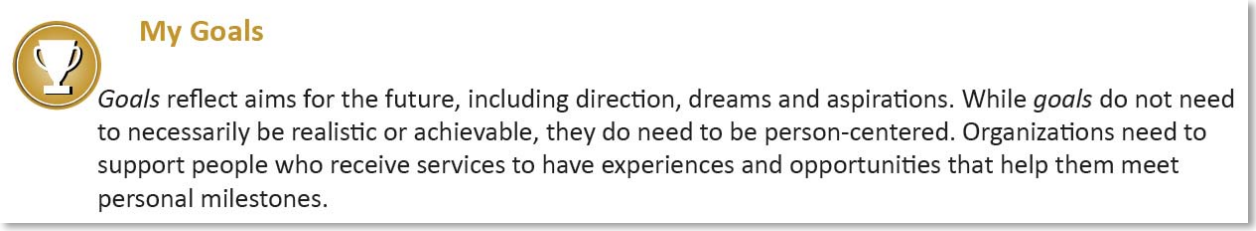
self-determination. Department staff coordinate with other parties to develop an ISP for each individual enrolled in waiver services.

Goals and Outcomes

According to the department's *Provider Manual*, the ISP is "a person-centered document that provides an individualized, comprehensive description" of the person supported, along with guidance for "achieving quality and person-centered outcomes that are important to and for the person in achieving a good quality of life."

In addition, the Council on Quality and Leadership, the department's accrediting body,[27] established "goals" as one of its five Personal Outcome Measures:

Figure 20
Council on Quality and Leadership's Description of Goals



Source: https://c-q-l.org/files/2017Documents/CQL-Personal-Outcome-Measures-Validation-Report-2017.pdf.

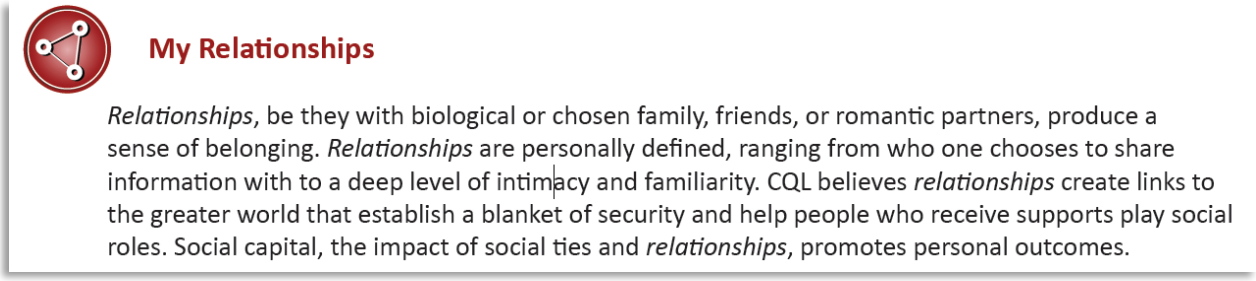
Circle of Support

The individual supported and a group of trusted people, such as his or her family members, conservator, and support staff, form the Circle of Support. An Independent Support Coordinator or a Case Manager facilitates the development of the ISP with the Circle of Support. Independent Support Coordinators assist individuals on the comprehensive aggregate cap waiver and the statewide waiver, while Case Managers assist individuals on the self-determination waiver.

The Council on Quality and Leadership's Personal Outcome Measures also include relationships:

[27] For more information about the department's accreditation, see the Achievements section of this report on page 16.

Figure 21
Council on Quality and Leadership's Description of Relationships



Source: https://c-q-l.org/files/2017Documents/CQL-Personal-Outcome-Measures-Validation-Report-2017.pdf.

Timelines for ISPs

According to the department's *Provider Manual*, for new enrollees, the initial ISP must be developed within 60 calendar days from the date the person is enrolled in services. Furthermore, the ISP must be amended when there are changes in goals and outcomes; services or service providers; or significant service and support needs, or if the individual makes a major change to his or her preferred lifestyle.

The ISP is considered to be expired after 365 days and must be reviewed and updated before that time; the Independent Support Coordinator and Case Manager document their review on the Annual ISP Review and Update Documentation Form.

Monitoring Implementation of the ISP

Contact is an essential way for the department to determine if the ISPs reflect the supported individuals' preferred vision of life. To ensure that the individuals are satisfied with the services and that they identify any need for ISP amendments, the department's *Provider Manual* and Policy 80.3.4 stipulate that Independent Support Coordinators and Case Managers must review the ISP no less than once each calendar month and must document each review on the Monthly Documentation Forms with a dated signature. The *Provider Manual* requires Independent Support Coordinators to perform one face-to-face visit with the individual served each calendar month and to document the visits on the Monthly Documentation Forms. Case Manager requirements differ slightly—they must complete at least one face-to-face visit each quarter with self-determination waiver participants, unless the ISP specifies more frequent visits.

Quality Review Panel

The Quality Review Panel was established in 1997 in response to the requirements of the Clover Bottom Developmental Center Settlement Agreement.[28] The panel is an outside entity that helps monitor the agreement by conducting annual system reviews of class members living in developmental centers and class members living in the community. The Quality Review Panel reviewed 54 provider agencies and visited 180 individuals in 2012; reviewed 53 provider

[28] We provide more information about this settlement agreement in the Achievements section on page 16.

agencies and visited 175 individuals in 2013; and reviewed 53 provider agencies and visited 179 individuals in 2014.

Testwork Results

Sample Methodology

To determine if the department corrected the prior finding, we selected a nonstatistical, random sample of 60 waiver participants from a population of 8,324 during calendar year 2016 and examined their ISP, including the narrative, action plan, services, and planning meeting signature sheets; their approved cost plans; and the payments for waiver services in calendar year 2016. In addition, to evaluate the department's compliance with the review and visitation sections of its policies, we examined the same 60 waiver participants' Support Coordination and Case Management Monthly Documentation Forms and Annual Individual Support Plan Review and Update Documentation Forms in calendar year 2016.

Goals and Outcomes –Repeated Issue

Based on our review of the ISP, we identified that the goals and outcomes for 10 of 59[29] individuals (17%) did not appear appropriate or measurable and would not lead to them acquiring new skills or enhancing existing skills, as detailed in **Table 10** on page 74. The Assistant Commissioner of Accreditation and Person Centered Practice agreed with us that these goals and outcomes should be strengthened.

Circle of Support –Repeated Issue

The Circle of Support meets to develop the ISP and must sign a Planning Meeting Signature Sheet that describes the attendees' names and their relationship to the individual served. We found that

- for 3 of the 60 individuals' Planning Meeting Signature Sheets reviewed (5%), at least one Circle of Support attendee did not include his or her affiliation.

The Assistant Commissioner of Accreditation and Person Centered Practice stated that the Independent Support Coordinators and Case Managers focus on making sure that Circle of Support members sign the signature sheet and do not focus on making sure the members consistently list their affiliation. We believe that the absence of accurate and complete ISP planning documentation could lead to the provision of inappropriate services.

[29] One individual in our sample enrolled in the Medicaid waiver on November 18, 2016, and her ISP was developed in January 2017. Since the scope of the testwork was from January 1, 2016, to December 31, 2016, some aspects of our testwork were not applicable for this individual.

Table 10
Inappropriate Goals and Outcomes That Impair Individuals' Abilities to Achieve Their Vision of a Preferred Life

Individual	Outcome	Action	Problem Noted
1	Individual 1 wants to help others when or where needed.	Individual 1 will complete tasks for others.	The outcome should specify the type of help. Additional and more specific action steps are needed.
2	Individual 2 wants a job that she enjoys.	1. Individual 2 will create a resume. 2. Individual 2 will fill out an application for employment that interests her.	The outcome should specify the type of job. Additional action steps are needed.
3	Individual 3 would like to earn money so that he can purchase personal items.	Individual 3 will continue to work on contracts.	The contract work is one way to earn money, but additional action steps can be developed to explore other ways to earn money.
4	Individual 4 wants to attend appointments to ensure her hearing aids are in good working order and that she has appropriate amplification.	Individual 4 will attend hearing aid follow-up appointments as scheduled.	The outcome should include more action steps that outline the significance of hearing aids being operational.
5	Individual 5 wants to stay busy during the day so that he is not bored at home.	Individual 5 will go to Bass Pro Shops once a month.	Additional action steps are needed to demonstrate how the outcome will be achieved.
6	Individual 6 wants to stay mentally and physically healthy so that he can enjoy life to the fullest extent possible.	Individual 6 will complete volunteer activities.	Additional action steps are needed to demonstrate how the outcome will be achieved.
7	Individual 7 wants to do various activities so she can enjoy herself.	Individual 7 will participate in social, recreational, or leisure activities at the day program.	Additional action steps are needed to demonstrate how the outcome will be achieved.
8	-	-	Individual 8 was approved for and received facility-based services from January 17, 2016, to January 16, 2017, but no outcomes or actions for this support were listed in his ISP.
9	-	-	Individual 9 was approved for and received community-based day services from August 13, 2016, to August 12, 2017. but no outcomes or actions for this support were listed in her ISP.
10	Individual 10 wants to practice skills that would make her more independent.	Individual 10 will brush her hair.	The ISP narrative did not address Individual 10 brushing her hair, although it did list actions important for her preferred vision of life such as swinging, volunteering at the animal shelter, and handing out water at marathons.

Monthly Documentation Forms and Face-to-Face Visits–New Issue

As part of the current audit, we also reviewed the Monthly Documentation Forms to determine if the Independent Support Coordinators and Case Managers ensured the ISPs helped implement the individual's preferred vision of life. We found issues with 24 of 60 ISPs tested (40%) and, as a result, were unable to evaluate the propriety of services provided. Details are included in **Table 11**.

Table 11
Deficiencies Involving Monthly Documentation Forms and Face-to-Face Visits

Nature of Errors	Number of ISPs With Errors
The Independent Support Coordinator and the Case Manager did not review the ISP monthly.	5
No Monthly Documentation Forms were provided.	4
Monthly Documentation Forms did not have a dated signature.	8
The Independent Support Coordinator and the Case Manager did not sign and/or date the Monthly Documentation Forms *until we informed them*.	8
The Case Manager did not perform the face-to-face visit in accordance with department policy or as specified in the ISP.	4
The visit details were completed *after we communicated this problem*.	2
The Case Manager signed the Monthly Documentation Forms *prior to the face-to-face visits*.	1
The Case Manager used an Annual Review Form to document *both* the annual review and the monthly face-to-face visits.	1
Total errors	**33***

*Some ISPs contained multiple deficiencies.

Annual ISP Review Form – New Issue

Although the Assistant Commissioner of Accreditation and Person Centered Practice provided us with ISPs effective for calendar year 2016, she did not relay the corresponding Annual Individual Support Plan Review Forms for 2 of 59 individuals (3%). Therefore, for these 2 individuals, we were unable to determine if the ISP had been updated before it expired.

Reason for Testwork Errors

The Assistant Commissioner of Accreditation and Person Centered Practice simply stated that these problems were due to human error.

Quality Review Panel Annual System Reviews

After we completed our testwork, we read the Quality Review Panel's Annual System Reviews for 2012, 2013, and 2014 and saw that the panel identified similar problems:

- The ISPs do not clearly describe individuals' vision of a desired life.

- Outcomes designed to help individuals become more independent and achieve their vision of a desired life were not present.
- Independent Support Coordinators and provider agencies did not consistently assess progress related to individuals achieving outcomes and ultimately their vision of a desired life.

Figure 22
Excerpt From 2014 Quality Review Panel Report

> The Panel found problems with ISPs across almost every class member reviewed in 2014. Relying in large part on the description of service and support needs described in the ISP to direct its inquiry during reviews, the Panel looked at the ISP to understand what services should be in place for a class member and how those services should be delivered. It follows that if the ISP is poorly written, incomplete, or erroneous, this impacts the review. Scores were low across the board for Individual Support Planning and Achieving ISP Outcomes. Where agencies achieved higher scores, the Panel found quality service delivery was present in spite of the poorly written ISP. In other words, providers used other information to augment, correct or replace the information in the ISPs. The two examples below illustrate how ISPs that contain incorrect information or omit important facts can lead to numerous problems with how services are delivered and evaluated:

The Quality Review Panel stated the following in its 2012 and 2013 reports: "[The department] has acknowledged the inconsistencies between the ISPs developed for [the individuals] and the expectations set forth in ISP and Outcomes training."[30]

Consequences for Underdeveloped ISPs and Lack of Reviews

The individuals the department serves through the Medicaid waiver may need continuous assistance with basic daily activities, such as dressing, eating, and grooming. The only way for these individuals to communicate their desires may be through their ISP. If the ISP is poorly written, incomplete, or erroneous, it detrimentally impacts the delivery of services needed to achieve the individual's vision of a preferred life. Additionally, since these individuals are more at risk and vulnerable than the general population, ISP reviews are necessary to determine if their needs change.

Recommendation

Goals and Outcomes

The Assistant Commissioner of Accreditation and Person Centered Practice should continue to advocate for improvement in the development of ISPs, especially the goals and outcomes.

Circle of Support

The Independent Support Coordinators and the Case Managers should ensure Circle of Support attendees add their affiliation to the individual on the Planning Meeting Signature Sheet.

[30] The department was not required to respond to the 2014 Quality Review Panel report.

Monthly Documentation Forms and Face-to-Face Visits

The Independent Support Coordinators and the Case Managers should review the ISPs monthly and perform face-to-face visits as required. Management should ensure these reviews are documented on the appropriate forms with a dated signature from the Independent Support Coordinator and the Case Manager.

Annual ISP Review Form

The Assistant Commissioner of Accreditation and Person Centered Practice should ensure forms are maintained and reviews are adequately documented.

Management's Comment

We concur with the finding. With regard to the above recommendations, we offer the following responses.

Goals and Outcomes

We concur. DIDD [the department] will work towards continuous improvement of goals and outcomes via the accreditation process and in collaboration with ISC/Case Manager leadership. As regards the ten (10) Individual Support Plans (ISP) identified within this report, the Assistant Commissioner of Accreditation and Person Centered Practice will personally review them and follow up with each respective Individual Support Coordinator (ISC) agency and request a formal review of each plan identified, and will have them submit their plan of remediation.

Circle of Support

We concur. The Assistant Commissioner of Accreditation and Person Centered Practice will modify the ISP Planning Meeting Signature Sheet to include affiliation to the individual supported, and will distribute the revised sheet to all ISC agencies and Case Manager leadership.

Monthly Documentation Forms and Face-to-Face Visits

We concur. The Assistant Commissioner of Accreditation and Person Centered Practice will work with leadership on creating training for Individual Support Coordinators and Case Managers that covers best practice with documentation and monthly visits.

Annual ISP Review Form

We concur. The Assistant Commissioner of Accreditation and Person Centered Practice will work with Individual Support Coordinator/Case Manager leadership on training regarding documentation of forms.

Observation 2 – The department actively participates in federal and state integrated employment initiatives but has only recently begun collecting comprehensive data to evaluate its success

Federal Lawsuit

In *Olmstead v. L.C.*, the U.S. Supreme Court decided in 1999 that mental illness is a form of disability and that "unjustified isolation" of a person with a disability constitutes discrimination under Title II of the Americans with Disabilities Act. The ruling required states to eliminate unnecessary segregation of individuals with disabilities and to ensure that population receives services.

In 2009, the U.S. Department of Justice's Civil Rights Division launched an effort to enforce the Supreme Court's decision in *Olmstead v. L.C.*

Eight named individuals, along with United Cerebral Palsy of Oregon and Southwest Washington, filed a class action lawsuit (*Lane v. Kitzhaber*, later renamed *Lane v. Brown*) in January 2012 on behalf of themselves and other individuals with intellectual and developmental disabilities who were either in or had been referred to sheltered workshops, in which individuals receive subminimum pay in segregated settings.

In June 2012, the U.S. Department of Justice issued a findings letter to Oregon's Attorney General that stated:

> The State [Oregon] plans, structures, and administers its system of providing employment and vocational services in a manner that delivers such services primarily in segregated sheltered workshops, rather than in integrated community employment. Sheltered workshops segregate individuals from the community and provide little or no opportunity to interact with persons without disabilities, other than paid staff.

State Reaction

In response to these national trends, on June 19, 2013, Governor Haslam signed Executive Order No. 28, *An Order Establishing the Tennessee Employment First Initiative to Expand Community Employment Opportunities for Tennesseans With Disabilities*. The order directs state agencies to coordinate efforts to increase opportunities for integrated and competitive employment for Tennesseans with intellectual and developmental disabilities, mental illnesses, substance abuse disorders, and other disabilities.

The Department of Intellectual and Developmental Disabilities is responsible for convening an Employment First Task Force with the following focus areas as listed in the executive order:

1. Identify state agency policies and procedures that create barriers and disincentives for employment of people with disabilities and develop recommendations to reduce or eliminate those barriers and disincentives to better meet the needs of individuals who desire employment;
2. Best practices, effective partnerships, sources of federal funds and opportunities for shared services among state agencies;
3. Recommendations from the U.S. Office of Disability and Employment Policy (ODEP); and
4. Training on disability employment for state and provider agencies, individuals with disabilities and their families to raise awareness about effective strategies for successful employment.

As the leader of the Employment First Task Force, the department has been actively participating in the following ODEP initiatives:

- ODEP sponsored an initiative to design an Integrated Employment Toolkit, which creates an accessible collection of critical resources. The assembled information allows the department to access, and in some cases adapt, the resources they need to implement integrated employment.
- ODEP created the Employment First State Leadership Mentor Program (EFSLMP), which assists the department in aligning policies, regulations, and funding priorities to encourage integrated employment as the primary outcome for individuals with significant disabilities. To initiate increased access to peer mentoring and other support opportunities among local and government officials, ODEP established the EFSLMP State Ambassadors Network in 2015. Of the eight individuals ODEP selected as state ambassadors, two were on the Tennessee Employment First Task Force. Of those two, one was the department's former Director of Employment and Day Services.

EMPLOYMENT FIRST SUCCESS STORIES
(https://www.tn.gov/didd/topic/employment-first)

Anthony loves working in a school and interacting with teachers and students.

Kellye's an important part of Tennessee's tourism industry, and she couldn't be happier!

Jared's fun-loving personality shines as he takes plants from seed to market in his job at a farm.

- In 2017, for the fifth consecutive year, the department secured federal support in the form of technical assistance for Tennessee's work to increase competitive, integrated job opportunities for people with disabilities. Tennessee's recognition means several more disability service providers will receive training as they transition from segregated workshops to community-based employment. This transition has the potential to impact more than 500 people the department currently supports.

Data Collection

Department's Prior Efforts

The department began collecting employment data in 2007 in response to the *United States v. State of Tennessee (Arlington)* lawsuit. This data collection effort involved places of employment, positions held, average hours of employment per week, and wages earned per hour. In 2012, the department commenced the compilation of data focusing specifically on competitive wage consideration and targeted toward tracking indicators of sheltered work. The data tool the department launched required all provider agencies to submit monthly data indicating supported individuals' places of employment and also requested wage per hour information.

Post-launch of the 2012 employment data collection tool, and acting on adjustments derived from management's identification of the need for additional data, the department developed and launched a new collection system in 2015. While this iteration produced more accurate and focused data, the department continued to refine its collection process.

Department's Current Efforts

One of the recommendations the Employment First Task Force made in its 2014 report to the Governor was to strengthen both the quality and the scope of data that state agencies compiled about employment of individuals with disabilities. As a result, the department hired a State Director of Employment and Day Services on August 1, 2016.

On May 1, 2017, the department officially implemented and launched a new employment data collection tool to capture a comprehensive data set—including employment status, type, wage, hours, and industry—for individuals enrolled in its Medicaid waivers. The department designed this tool to address specific challenges in eliciting full participation from providers using previous methodologies. As the Employment First Task Force states in its 2017 report, "This achievement represents an important milestone because DIDD [the department] can now establish an accurate employment baseline, highlight success areas, direct resources to areas of need, set goals and benchmarks for the state to achieve, and track progress at the state, regional, provider, and individual levels."[31]

[31] We noted in a finding in the State of Tennessee's 2016 *Single Audit Report* that the Department of Human Services did not comply with Vocational Rehabilitation earmarking requirements, resulting in the failure to provide $17,200,626 in pre-employment transition services to Tennessee students with disabilities.

In the next audit, we will review the department's data collection methodologies and results.

National Efforts

In addition to its own data collection efforts, the department participates in the National Core Indicators Survey, a joint venture between the National Association of State Directors of Developmental Disabilities Services and the Human Services Research Institute that helps states target human services spending to practices that work. National Core Indicators provides state-specific data brief updates on the status and outcomes of individuals with intellectual and developmental disabilities in integrated employment that are then compiled into national updates.

The department first participated in a state-specific survey in 2013-2014. For that year, the Vanderbilt Kennedy Center collected data on 436 randomly selected individuals over the age of 18 receiving at least one service from the department. For 2014-2015, the Vanderbilt Kennedy Center's study encompassed 580 randomly selected individuals whom the department served. The percentage of individuals reporting a paid job in the community was 15.1% for 2013-2014 and 18.8% for 2014-2015.

Of the 31 participating states in the 2014-2015 national update, Tennessee ranked 13th. The top 4 states had 30.8% to 41.7% in integrated employment, while the lowest 6 states all fell under 10% in integrated employment.

Finding 4 – The Office of Risk Management and Licensure did not perform annual reviews of problematic areas identified in our prior two audits, leading to nine repeated findings

Within the Office of Risk Management and Licensure, the Risk Management Unit

- responds to allegations of financial impropriety and conducts investigative audits of both provider agencies and Department of Intellectual and Developmental Disabilities offices as the situation demands;
- performs the standard internal audits of the department's three regional offices and the central office; and
- assists the department's audit committee (the Commissioner's executive and senior management teams) in conducting the department's annual risk assessment to evaluate internal controls with regard to *Tennessee Code Annotated* requirements and responsibilities.

Our testwork revealed that

1. the Risk Management Unit did not perform the annual reviews described in management's corrective action plan for our April 2013 and October 2013 audit findings; and

2. although management noted in its risk assessments that controls were operating effectively, we are repeating more than half of the prior findings.

Lack of Reviews

The department had 7 findings in our April 2013 audit report and 10 findings in our October 2013 audit report, for a total of 17 findings. After following up on the status of all 17 prior findings, we determined that 10 (59%) contained unresolved deficiencies. See **Table 12** for details.

Table 12
Prior Audit Findings With Unresolved Deficiencies

April 2013 Report
1. resident property (see **Finding 10**),
2. Resident Trust Fund accounts (see **Finding 11**),
3. information system controls A (see **Finding 14**),[32] and
4. information system controls B (see **Finding 14**).
October 2013 Report
5. departmental employee background checks (see **Finding 5**),
6. departmental volunteer background checks (see **Finding 6**),
7. waiting list category of need (see **Finding 1**),
8. Individual Support Plan development (see **Finding 3**),
9. Quality Assurance monitoring (see **Finding 8**), and
10. trust funds for deceased and transferred residents (see **Finding 13**).

After seeking an explanation for the high percentage of repeated findings, we ultimately discovered that for six of the findings, the Risk Management Unit did not complete the annual audits or assessments of the regional offices and the central office that management referenced in its corrective action plan. Specifically, we found the following:

- The unit did not perform any audit work for two of the findings (department employee background checks and department volunteer background checks).
- We identified an additional four findings (resident property, Resident Trust Fund accounts, information system controls B, and trust funds for deceased and transferred residents) for which the unit had only performed and released one review instead of the annual reviews described. The unit released audit reports for the West, Middle, and East regions on March 4, 2014, and for the central office on October 20, 2014. Each audit covered the period March 1, 2013, through April 30, 2013.

To explain the lack of reviews, management pointed to the limited resources available to the Risk Management Unit and the high number of fraud, waste, and abuse allegations it

[32] In the April 2013 audit report, we had two findings related to information system deficiencies. Due to a change in the way we present information system findings, we have combined the two prior findings into one finding for this report.

received. Staff with audit responsibilities consist of four full-time monitors, along with an Administrative Assistant and a Director (both of whom also have licensure responsibilities). Management added that since June 2013, the unit has issued 95 allegation reports and received 126 additional allegations, for a total of 221.

Based on our calculations, we agree with management that the internal monitors experience heavy caseloads when only considering the allegation component of their work. See **Table 13** for details.

Table 13
High Average Allegation Caseload per Internal Monitor

Calendar Year*	Total Allegation Count	Number of Internal Auditors	Average Caseload per Monitor
2014	75	4	19
2015	51	4	13
2016	56	4	14
Totals:	**182**		**15**

*We only included the full calendar years within our audit period.

Management added, and we agreed, that for budget reductions dating back to 2007, the department has made repeated cuts to administrative functions rather than directly to programmatic areas. We noted, however, that the department's administrative cuts were so severe that they harmed operations—the nature of our repeated findings is one illustration.

Management also asserted that when we concluded our fieldwork on June 30, 2017, additional internal audits of the regional offices and the central office were near finalization. As of October 30, 2017, the unit had released all of those reports, shown in **Table 14.**

Table 14
Internal Audits Finalized After Our Fieldwork Concluded

Report Topic	Period Covered	Fieldwork Began	Report Released
West Region	6/1/2014 – 7/31/2014	8/8/2016	7/31/2017
West Region	2/1/2016 – 3/31/2016	8/8/2016	10/31/2017
Middle Region	6/1/2014 – 7/31/2014	8/29/2016	8/11/2017
Middle Region	2/1/2016 – 3/31/2016	8/29/2016	10/25/2017
East Region	6/1/2014 – 7/31/2014	8/8/2016	7/31/2017
East Region	2/1/2016 – 3/31/2016	8/8/2016	10/23/2017
Central Office	6/1/2014 – 7/31/2014	8/29/2016	9/8/2017
Central Office	2/1/2016 – 3/31/2016	8/29/2016	10/12/2017

As we describe in the repeated findings throughout our report, the unit's results matched ours in multiple instances.

Issues With Risk Assessments

According to management, the department additionally assesses the status of prior findings through the annual risk assessment required under Section 19-18-102, *Tennessee Code Annotated*. This passage, known as the Financial Integrity Act of 1983, establishes that

> The objectives of the annual risk assessment are to provide reasonable assurance of the following:
>
> (1) Accountability for meeting program objectives;
>
> (2) Promoting operational efficiency and effectiveness;
>
> (3) Improving reliability of financial statements;
>
> (4) Strengthening compliance with laws, regulations, rules, and contracts and grant agreements; and
>
> (5) Reducing the risk of financial or other asset losses due to fraud, waste and abuse.

Upon analyzing the department's risk assessments for 2015 and 2016, we saw that management reported that controls were operating effectively for two findings we are repeating from the April 2013 audit report and all six findings we are repeating from the October 2013 report.

Management explained this inconsistency by again referring to the limited number and heavy workload of the internal monitors. Because of these factors, the monitors could only test small samples (five or six items) covering a limited period (one or two months).

In preparation for the risk assessment due in December 2017, the Risk Management Unit sponsored a two-day retreat to

a) familiarize the audit committee and other management staff with the U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book) and the Committee of Sponsoring Organizations' approach to enterprise risk management; and

b) collaboratively design the department-specific toolkit to be used during this year's risk assessment.

Conclusion

According to Principle 17, "Evaluate Issues and Remediate Deficiencies," of the Green Book,

> **17.06** Management completes and documents corrective actions to remediate internal control deficiencies on a timely basis. These corrective actions include resolution of audit findings. Depending on the nature of the deficiency, either the oversight body or management oversees the prompt remediation of deficiencies

by communicating the corrective actions to the appropriate level of the organizational structure and delegating authority for completing corrective actions to appropriate personnel. The audit resolution process begins when audit or other review results are reported to management, and is completed only after action has been taken that (1) corrects identified deficiencies, (2) produces improvements, or (3) demonstrates that the findings and recommendations do not warrant management action. Management, with oversight from the oversight body, monitors the status of remediation efforts so that they are completed on a timely basis.

The Risk Management Unit serves as the department's primary monitoring tool to ensure the implementation of an effective internal control system. Because the unit lacks the resources to follow up on prior findings, through internal audits as well as risk assessment tests, the department continues to place at risk the health and welfare of individuals with intellectual and developmental disabilities.

Recommendation

Management informed us that in the upcoming budget, they anticipate requesting additional full-time audit positions for the Risk Management Unit.

Furthermore, effective October 1, 2016, the General Assembly passed, and the Governor signed, legislation creating the position of Executive Internal Auditor to oversee the state's internal audit shops. We recommend that the department continue cooperating with the Executive Internal Auditor and his team to develop plans and implement other suggestions to improve the unit's effectiveness and efficiency.

Management's Comment

We concur.

Since the auditors concluded their fieldwork on June 30, 2017, and as an interim measure, additional resources from other units were made available to assist the Risk Management Unit with investigative audits. The relief provided allowed the Risk Management Unit to:

- finalize and issue the outstanding internal audits of the regional offices and the Central Office as noted by the auditors, and
- begin the fieldwork for the fiscal year 2017 & 2018 internal audits. This fieldwork is well underway and we anticipate that corresponding reports will be finalized and issued within the first quarter of calendar year 2018.

As regards to resource limitations and the need for additional full-time audit positions:

- A vacant position in another unit was successfully converted into a new Auditor 4 position. This new position was filled effective October 22, 2017, and is primarily

responsible for DIDD's [the department's] Risk Assessment process which will include ongoing monitoring of management's efforts to address findings identified by external sources, such as the Comptroller's Office, as well as internal Risk Assessment efforts. The resulting vacancy within the Risk Management Unit will be filled with a Program Monitor 4. Interviews to fill that position will be held in November 2017 and, once filled, the Program Monitor 4 will report to the "Risk Assessment Auditor 4" and assist her with the ongoing monitoring of management's efforts to address the findings identified by the auditors in this report.

- In addition to the above, 3 new Auditor positions for the Risk Management Unit were included in DIDD's budget presented to Governor Haslam in November 2017. If approved, these positions will be added effective July 2018 and filled as soon as possible.

We also concur with the auditor's recommendation to continue to cooperate with the Executive Internal Auditor and his team as we continue to benefit from that relationship. Our efforts in that regard have led to the decision to purchase and implement TeamMate, which is an internal audit management software solution that is utilized by several state departments and agencies, including the Comptroller's Office. This effort will allow the Risk Management Unit to adopt an integrated, paperless strategy for managing audits. This will increase the Risk Management Unit's efficiency and productivity across the entire internal audit process, including scheduling, planning, review, and report generation.

SAFETY OF SUPPORTED INDIVIDUALS

Non-negotiable human and civil rights

1. People are safe
2. People are free from abuse and neglect
3. People have the best possible health
4. People experience continuity and security
5. People exercise rights
6. People are treated fairly
7. People are respected

Source: *The Council on Quality and Leadership, Personal Outcome Measures – My Human Security,* https://c-q-l.org/the-cql-difference/personal-outcome-measures

The Department of Intellectual and Developmental Disabilities has established a Protection from Harm system to ensure the safety of individuals supported in state-run and privately-operated facilities and in its network of home- and community-based services providers. The foundation of the Protection from Harm system has been in place since 2005, and the department strives for alignment with the Council on Quality and Leadership's Personal Outcome Measures for individuals with intellectual and developmental disabilities (see sidebar). The Protection from Harm system includes incident management, investigations, and abuse registry reporting components.

The department has established specific requirements to ensure the protection and safety of individuals served in its developmental centers, community homes, and Harold Jordan Center—which is "a primary mission of the Department" according to internal policy. The

department's Policy 100.1.7, "Ensuring Coverage and Scheduling Overtime," sets forth procedures to maintain adequate staffing at state-operated facilities, while Policy 100.1.1, "Protection from Harm," applies to all employees, contract staff, and volunteers who provide services and support to individuals residing in the department's facilities. We focused our testwork on the department's employees and volunteers.

The department licenses providers to operate facilities and offer supports within its service delivery system. Providers must abide by licensure rules regarding minimum environmental and safety standards, including personnel and staffing requirements. Furthermore, the department's *Provider Manual* identifies specific criteria intended to achieve and maintain the safety and protection of all individuals supported by the provider network. The department requires the timely reporting of allegations of abuse, neglect, and exploitation, which are then turned over to the Investigations Unit.

Employee Checks

Section 33-2-1201, *Tennessee Code Annotated*, requires department employees and volunteers whose function includes direct contact with or direct responsibility for individuals served to submit to a criminal background check. Furthermore, the department developed Policy 10.1.2 to cover background checks and also require

- sex offender registry, abuse registry, felony offender information list (FOIL), list of excluded individuals/entities (LEIE), and substantiated investigations records inquiry (SIRI) checks; and
- checks of work history and references, academic records, and professional credentials and certifications.

- FOIL – Contains information about Tennessee felony offenders who are or have been in the custody of the Tennessee Department of Correction.
- LEIE – Contains information about individuals and entities excluded from federally funded health care programs.
- SIRI – Contains the names of individuals substantiated for abuse, neglect, or exploitation of an individual supported by the department.

We published a finding in our October 2013 audit that the department did not establish a uniform, statewide employee background check policy until we brought it to management's attention and did not incorporate best practices into its existing policies, which resulted in employees beginning work before the department obtained background check results.

As of September 22, 2016 (when we obtained employee lists), department staff who had direct contact with or direct responsibility for individuals served were located at the Greene Valley Developmental Center; the East, Middle, and West Tennessee Homes; and the Harold Jordan Center. The department had 1,001 employees in a direct-contact or direct-responsibility position on this date. Greene Valley officially closed on May 26, 2017.[33]

[33] We present more information about the Greene Valley closure in the Achievements section of our report on page 16.

Volunteer Background Checks

In addition to employees, the department allows volunteers to enhance the lives of individuals served by providing companionship and entertainment. The department subjects its volunteers to the same criminal background, registry, and work checks as its employees.

We reported a finding in our October 2013 audit that the department had not performed background checks on volunteers or implemented an adequate volunteer tracking system.

Incident Management

As defined by the department's Policy 100.1.1, reportable incidents include, but are not limited to, the following:

- physical, sexual, or emotional/psychological abuse;
- neglect;
- exploitation;
- serious injury of unknown cause;
- suspicious injury, whether minor or serious;
- death of a supported individual;
- property destruction exceeding $100;
- any 911 calls or visits to an urgent care facility or hospital;
- intervention of law enforcement or the fire department; and
- any reasonable suspicion that a supported individual has committed a crime or has probable cause of criminal conduct.

The department's Incident Management personnel process, categorize, and record all reported incidents in the Incidents and Investigations data collection system. During the 3 years and 7 months between June 1, 2013, and December 31, 2016, the department logged 16,118 reports in its Incidents and Investigations information system, as shown in **Table 15**.

Table 15
Incident Reports by Category, June 2013 Through December 2016

Incident Type	Number of Reports[34]
Staff misconduct[35]	4,983
Neglect (alleged)	3,820
Serious injury	2,914
Physical, sexual, and emotional/psychological abuse (alleged)	2,796
Death	731
Exploitation (alleged)	486
Criminal conduct by person supported	388
Total:	**16,118**

The department uses two levels to classify substantiated investigations:

- Level 1 – With these incidents, the risk of harm or harm sustained is more than minimal. The department's Incident Management Coordinator and the Facility Administrator receive notice of the incident, and the coordinator submits a typed report to the central office.
- Level 2 – With these incidents, the risk of harm or harm sustained is minimal. The Incident Management Coordinator and the Facility Administrator receive notice of the incident, but the central office does not.

Investigation Review Committee

A provider, department Facility Administrator, or supported individual (or his or her legal representative) may request a review of a final investigation report based on the availability of new evidence, evidence not considered during the investigation, or concerns about the integrity of the investigative process. The department's Investigation Review Committee considers these requests and determines whether to uphold, modify, or overturn the original conclusions of a final investigation report.

Between June 2013 and December 2016, the Investigation Review Committee substantiated the conclusions of **56** reports.

Our October 2013 performance audit report included a finding that the department's former Deputy Commissioner acted outside his authority and overturned or modified the substantiated investigations into the deaths of two supported individuals. As a less significant matter, we reported that the department's files omitted some relevant information.

[34] A single event sometimes generates multiple incident reports—for example, if more than one person is affected, or if the incident type spans multiple categories. Table 33 on page 169 presents average annual incident rates at the department's developmental centers and community homes, with each incident involving multiple individuals counted as a single event.

[35] The department's *Provider Manual* defines reportable staff misconduct as "actions or inactions . . . that are contrary to sound judgement and/or training. . . . Staff misconduct includes incidents that do not rise to the level of abuse, neglect or exploitation, and do not result in injury or adverse effect, and the risk for harm is minimal."

Abuse Registry

Investigators submit substantiated Level 1 investigations to the department's Abuse Registry Review Committee, which reviews the final investigation report and determines whether to refer the individual for placement as a perpetrator on the Tennessee Department of Health's Abuse Registry. The abuse registry is a public database of individuals who have abused, neglected, or exploited a vulnerable person. Perpetrators may request an administrative hearing to appeal their placement on the registry within 60 days of written notice of the committee's decision.

Between June 2013 and August 2017, the department placed **224** perpetrators on the state's abuse registry.

Death Reviews

The Office of Health Services oversees reviews of unexplained and unexpected deaths in the department's service delivery system to minimize preventable deaths and improve safety for all supported individuals. A Death Review Committee, consisting of health professionals, provider management, and a staff member familiar with the decedent, convenes to examine the individual's autopsy report, medication history, death certificate, investigation report, and other pertinent documentation. The committee then prepares recommendations for improvement for the appropriate provider agency or facility. In addition to its internal death reviews, the department contracts with an external organization to conduct periodic independent trend analyses of mortality in its service delivery system.

Quality Review Panel

Following a federal lawsuit critical of living conditions at Tennessee's developmental centers for individuals with intellectual disabilities, in 1997 the state entered into a settlement agreement to improve the safety and quality of life for supported individuals. The court appointed an independent Quality Review Panel[36] to conduct annual assessments of the state's compliance with the settlement agreement's terms. The panel published its findings and recommendations for improvement in an annual report. The panel documented 12 recommendations in its 2014 Annual System Review—the last such report the panel issued before the department entered a plan to exit the lawsuit and the related settlement agreement.[37]

Audit Results

1. Audit Objective: Did management correct the October 2013 finding involving departmental employee background checks?

Conclusion: We identified noncompliance with both state law and department policy in this area (see **Finding 5**).

[36] We will refer to the Quality Review Panel as the court-appointed monitors in our objectives.

[37] We discuss the department's resolution of its federal lawsuits in the Achievements section on page 16.

2. **Audit Objective:** Did the department comply with departmental employee sex offender registry, abuse registry, felony offender information list (FOIL), list of excluded individuals/entities (LEIE), and substantiated investigation records inquiry (SIRI) search requirements?

   Conclusion: Based on our testwork, the department did not follow the registry requirements established in its own policy (see **Finding 5**).

3. **Audit Objective:** Did the department obtain from prospective employees authorization forms agreeing to the release of all investigative records from any source?

   Conclusion: We found that the department did not always obtain the authorizations required by state law (see **Finding 5**).

4. **Audit Objective:** Did the department check work records; references; academic records; and professional licenses and/or certifications prior to employees commencing work?

   Conclusion: According to our testwork results, the department violated its own work check requirements (see **Finding 5**).

5. **Audit Objective:** Did the department correct the October 2013 finding involving volunteer background checks?

   Conclusion: We again found issues with volunteer background checks (see **Finding 6 and Observation 3**).

6. **Audit Objective:** Did the department check the sex offender registry, abuse registry, FOIL, LEIE, and SIRI for its volunteers?

   Conclusion: Our testwork revealed that the department did not conduct the registry checks mandated by its internal policy (see **Finding 6**).

7. **Audit Objective:** Did the department check work records; references; academic records; and professional licenses and/or certifications prior to volunteers commencing work?

   Conclusion: The department did not comply with its policy provisions involving work checks (see **Finding 6**).

8. **Audit Objective:** Did management correct the October 2013 finding involving overturned Protection from Harm cases?

   Conclusion: We determined that management corrected this finding.

9. **Audit Objective:** Did Investigation Review Committee members sign conflict-of-interest forms?

Conclusion: The department did not have a policy requiring committee members to sign conflict-of-interest forms (see **Observation 4**).

10. **Audit Objective:** Did the department implement the court-appointed monitors' recommendation to obtain death reviews from an outside agency?

Conclusion: Based on our testwork, beginning March 1, 2015, the department contracted with an outside agency to conduct quality assurance on its death reviews.

11. **Audit Objective:** Did the department implement the court-appointed monitors' recommendation to conduct a comprehensive review of every death in group homes, not just those initially deemed suspicious, unexplained, or unexpected?

Conclusion: No, but we found that the department is not required to implement the monitors' recommendations. If the plaintiffs want a recommendation implemented that the department does not, they would have to either obtain an agreed order or a court order to force compliance.

12. **Audit Objective:** Did the department ensure compliance with its death review policy?

Conclusion: We noted untimely submission of various death review documents (see **Finding 7**).

13. **Audit Objective:** Did department personnel properly notify conservators of allegations of harm at state-run facilities and the results of their internal investigations?

Conclusion: Our testwork results disclosed that personnel properly notified conservators of the allegations and the results of their investigations.

14. **Audit Objective:** Did department personnel properly notify law enforcement of allegations of harm at state-run facilities and the results of their internal investigations?

Conclusion: According to our testwork results, personnel properly notified law enforcement of allegations and the results of their internal investigations. The department has a memorandum of understanding to report criminal acts to the Greene County District Attorney and has publicized its willingness to establish similar agreements with other district attorney's offices across the state.

15. Audit Objective: Did the department report instances of employees' drug convictions, physical abuse, neglect, and exploitation to the Office of the Comptroller of the Treasury?

Conclusion: No; however, state statute does not require the department to report these instances to the Office of the Comptroller of the Treasury.

16. Audit Objective: Did the department appropriately handle misconduct by Protection from Harm employees?

Conclusion: Based on our testwork, the disciplinary actions taken against Protection from Harm employees appeared reasonable.

17. Audit Objective: Did the department appropriately handle misconduct by employees who had direct contact with or direct responsibility for supported individuals?

Conclusion: Our testwork revealed that for this employee population, the department followed its Drug Free Workplace policy and Abuse Registry Referral Form protocols.

18. Audit Objective: Did the department develop written policies for staffing community home and developmental center cottages, including shift assignments?

Conclusion: We identified written policies for staffing community home and developmental center cottages that included shift assignments.

Finding 5 – For its employees directly caring for individuals with intellectual disabilities, the department did not perform background checks; sex offender, abuse, and other registry checks; and work history and credentials checks timely or at all

In order to maintain safe conditions, the Department of Intellectual and Developmental Disabilities is legally required to obtain a criminal background check on any employee whose function would include direct contact with or direct responsibility for individuals with intellectual and developmental disabilities.

Department employees with direct contact or direct responsibility duties provide assistance with activities including

- bathing,
- toileting,
- eating, and
- medicating.

When testing compliance with employee background check requirements during our October 2013 audit, we found that the department

a. lacked a uniform statewide policy until we brought the matter to their attention, causing each of the community homes and developmental centers to perform background checks differently; and

b. completed the majority of its direct-contact employee background checks under more relaxed standards and time frames, resulting in new employees starting work before the department obtained their completed criminal history results.

In response to the prior finding, management did not concur and stated, "At no time did the Department operate out of compliance with state law." Management did commit to updating its uniform background check policy to ensure that it fully complied with statutory requirements and was consistently applied.

Effective October 22, 2013, the department implemented Policy 10.1.2, "Background Checks For Department Of Intellectual And Developmental Disabilities (DIDD) Employees, Contract Workers And Volunteers," which required employees with direct-care and direct-responsibility functions to obtain completed criminal background checks before they could commence work. Furthermore, the policy added requirements to check

- the sex offender registry, abuse registry, felony offender information list (FOIL), list of excluded individuals/entities (LEIE), and substantiated investigations records inquiry (SIRI); as well as
- work history and references, academic records, and professional credentials and certifications.

The department's central office has delegated the responsibility of hiring employees to the applicable regional office. As part of the hiring process, regional office staff must check criminal backgrounds; sex offender, abuse, FOIL, LEIE, and SIRI registries; and work histories and credentials.

We incorporated these additional checks into our testwork for employees who began working after the policy's effective date. The policy also establishes a review process (which we tested) for prospective employees with a record or report of a charge, arrest, indictment, or conviction on their criminal background check.

Our current testwork results revealed that the department

- did not obtain the following checks prior to allowing employees to commence work or else did not obtain them at all:
  - criminal background;
  - sex offender registry, abuse registry, FOIL, LEIE, and SIRI; and
  - work history and references, academic records, and professional credentials and certifications;

- did not follow its own review process for prospective employees with a record or report of a charge, arrest, indictment, or conviction on their background check; and

- did not gather authorizations from employees prior to conducting background checks.

During our testwork, we also noted an inconsistency between state law and department policy.

The department has a duty to ensure that it hires only suitable applicants to provide care for individuals enrolled in its services. By not following state law or internal policy, the department potentially jeopardizes the safety of this vulnerable population.

Our Testwork Methodology

To determine if the department conducted the required criminal background checks, we selected a random, nonstatistical sample of 60 departmental employees from a population of 178 employees who have direct contact with or direct responsibility for supported individuals and who were hired from June 1, 2013, through June 30, 2016. For each employee selected, we performed testwork to determine if the department obtained the required authorization and performed the background check. Of the 60 employees in our random sample, 50 commenced work after the effective date of the department's Policy 10.1.2. We examined all 50 employees' files to evaluate whether staff performed the additional registry and work checks required by policy. We additionally tested each employee for compliance with check timeliness and background check review requirements.

Problems Found and Explanations Provided

Employees Commenced Work Before Criminal Background Checks Were Completed

Section 33-2-1201(a)(2), *Tennessee Code Annotated*, establishes that prospective employees should, "[s]upply a fingerprint sample for the conduct of a criminal background investigation by the Tennessee bureau of investigation."

We determined that for 5 of 60 employees (8%), the regional offices did not conduct criminal background checks prior to the employees commencing work. Of these cases,

- the department hired 4 of the employees before implementing Policy 10.1.2 on October 22, 2013, performing their checks between 7 and 834 days after the hire date; and
- for the 1 employee who was hired after the new policy went into effect, the department conducted the check 3 days after the hire date.

None of the 5 employees had criminal records listed on their background checks.

When we discussed our testwork results with management, they did not provide comments. The error rate for our current testwork (8%) represents a slight improvement from the error rate for our prior audit testwork (10%).

Registry Checks Not Performed Timely or At All

According to the department's Policy 10.1.2, departmental employees, contract workers, and volunteers must

> Submit to the following types of background checks which, for prospective employees, contract workers or volunteers, shall constitute a preliminary screening:
>
> a. Tennessee Sexual Offender Registry
>
> b. Department of Health Abuse Registry
>
> c. Tennessee Felony Offender Registry
>
> d. Office of Inspector General (OIG) List of Excluded Individuals/Entities
>
> e. Substantiated Investigation Records Inquiry (SIRI).

Based on our testwork, prior to employing individuals who will have direct contact with or direct responsibility for individuals with disabilities, the regional offices did not perform the required registry checks timely or at all (see **Table 16**).

Table 16
Breakdown of Registry Check Errors

	Sex Offender	Abuse	FOIL	LEIE	SIRI
Error Rate	25 of 50 employees (50%)	19 of 50 employees (38%)	33 of 50 employees (66%)	30 of 50 employees (60%)	11 of 50 employees (22%)
Not in File	16	11	19	25	8
Number Performed Late	9 (between 2 and 130 days late)	7 (between 2 and 16 days late)	13 (between 2 and 206 days late)	5 (between 6 and 539 days late)	3 (between 11 and 130 days late)
Other	-	1 performed using the wrong Social Security number, rendering the check ineffective	1 undated	-	-

We performed the missing sex offender registry, abuse registry, FOIL, and LEIE checks ourselves and did not identify any matches. We were unable to conduct the missing SIRI checks, as we do not have access to that system.

Management concurred with our testwork results. According to management, one of the regional offices was checking the registries but not keeping proper documentation by printing and maintaining the results in the employee file. Management added that they "confirmed that

employees in all regions were aware of the requirement but not all employees were aware of the mandatory nature of the requirement for these checks to be conducted pre-employment."

Work Checks Not Performed Timely or At All

The department's Policy 10.1.2 states, "In addition to criminal background checks, checks shall be conducted of the work history and references of prospective employees . . . who will have direct contact with, or direct responsibility for, persons served. Checks of academic and professional credentials or certifications shall also be conducted if deemed necessary."

We found that for 42 of 50 employees (84%), the regional offices did not perform checks of work records; references; academic records; and professional licenses and/or certifications prior to the employees commencing work (see **Table 17**).

Table 17
Breakdown of Work Check Errors

	Work History	Personal References	Professional Licenses	Academic Records	Total Errors
Number Performed Late	23 (ranging from 1 to 39 days late)	12 (ranging from 1 to 46 days late)	2 (ranging from 85 to 338 days late)	-	37
Undated	2	7	-	-	9
Not in File	7	13	2	6	28
Total Errors	**32**	**32**	**4**	**6**	**74**[38]

Management agreed with our testwork results, explaining that staff were unaware that the work checks must be performed prior to start dates.

Background Check Review Process Not Followed

In accordance with department policy, when a record or report of a charge, arrest, indictment, or conviction appears on a criminal background check, regional offices must obtain approval from the central office's Human Resources Division and the Legal Division prior to the employee commencing work. The department documents this approval on a Background Investigation Qualifying Report. We discovered noncompliance with the established review process for 5 of 6 employees with a record or report on their background check (83%) and found that

- 2 employee files did not contain evidence of the Human Resources and Legal review; and

[38] We identified multiple deficiencies for some employee files.

- for the remaining 3 employees, the Human Resources and Legal divisions performed the review between 290 and 770 days after the hire date.

Additionally, we were unable to assess the reasonableness of the department's decision to approve 3 of the 6 employees (50%), because 2 files did not contain evidence of a review and 1 file lacked an explanation of how the Human Resources and Legal divisions reached a decision for approval.

Management did not agree with the errors concerning the Background Investigation Qualifying Report. According to management, since the items on the criminal background check did not disqualify the applicants from employment, a review was not required. The department's background check policy, though, mandates a review for a "record or report of any charge, arrest, indictment or conviction." Management did not comment further on the file lacking an explanation for the approval.

Authorization for Release of Information Not Obtained

Section 33-2-1201(a), *Tennessee Code Annotated*, stipulates that department employees must "[a]gree to the release of all investigative records about the person from any source, including federal, state and local governments." We identified deficiencies with authorizations for 19 of 60 employees (32%):

- the department did not have authorizations on file for 10 employees; and
- for the remaining 9 employees, the department obtained the authorizations between 1 and 963 days late.

Management agreed with our testwork results, alluding to human error as the cause.

Department Policy Inconsistent With State Law

The department's Policy 10.1.2, "Background Checks For Department Of Intellectual And Developmental Disabilities (DIDD) Employees, Contract Workers And Volunteers," contains provisions that are inconsistent with Sections 33-2-1201 and 33-2-1202, *Tennessee Code Annotated*. Specifically, we noted the following:

- Section VI.A of the policy states, "For an individual who has resided in Tennessee for less than five (5) years, a nationwide criminal background check is required." Section 33-2-1201, *Tennessee Code Annotated*, does not mention a set requirement for years of residency in the state, instead requiring a national criminal history check on applicants if no disqualifying record is identified.
- Section VI.F.1 of the policy states, "Current employees, contract workers, and volunteers whose position does not entail direct contact with, or direct responsibility for, a person served shall have a criminal background check conducted within ten (10) days of a change of responsibilities or position that includes direct contact with,

or direct responsibility for, persons supported." Section 33-2-1202, *Tennessee Code Annotated*, deleted the "ten (10) days" as part of an amendment effective April 28, 2016.

Management acknowledged the information regarding the update to *Tennessee Code Annotated* and stated they will review the policy for necessary revisions.

Recommendation

1. The Human Resources Division should conduct a comprehensive review to ensure that all existing direct-contact departmental employees have completed background, registry, and work check results on file. Thereafter, the division should perform regular reviews of new employees to ensure proper completion and documentation of background, registry, and work checks.
2. Department management said they centralized human resource operations during calendar year 2013. Regarding the applicable regional office being responsible for the hiring process, it appears that the department only centralized in theory and not practice. The Director of Human Resources should consider transferring the responsibility for background, registry, and work checks to the central office.
3. As an alternative to transferring this responsibility to the central office, the Director of Human Resources should meet with the East, Middle, and West regional office Directors to ensure that they understand the statewide background check policy requirements and that they should communicate these requirements to the staff responsible for hiring new employees in a direct-contact or direct-responsibility position. Furthermore, the Director of Human Resources should emphasize to each regional director the importance of recordkeeping and maintaining complete personnel files, including required checks and authorizations.
4. The department should ensure its policies match state law.

Management's Comment

We concur with the finding.

With regard to the above recommendations, we offer the following responses:

1. We concur. The DIDD [department] HR Division has already begun the process of obtaining the missing criminal background checks, registry checks, and work history checks.

2 & 3. We concur. The Director of Human Resources, along with the Regional Human Resources Managers, will begin reviewing procedures and make any changes needed to address the risk associated with this internal control. The Director of Human Resources will work with the DIDD Risk Management Unit to make sure the annual risk assessment accurately reflects any risk associated with this internal control deficiency. HR staff have been tasked with implementing an enterprise-wide check list and a monitoring plan to ensure compliance.

4. We concur. DIDD's HR Director and Office of General Counsel are reviewing DIDD's policy for compliance with *Tennessee Code Annotated*. They are also reviewing the policy as it pertains to the review process for prospective employees with a record or report of a charge, arrest, indictment, or conviction on their background check.

Finding 6 – The department did not keep track of who volunteered at its facilities; performed criminal background, sex offender registry, abuse registry, and work history checks late or not at all; and accessed sensitive information about volunteers without permission

The Department of Intellectual and Developmental Disabilities provides services to some of the state's most vulnerable citizens. The department uses both employees and volunteers to enhance the lives of those individuals served at its community homes and developmental centers. State law outlines certain requirements these volunteers must meet. When testing compliance with these requirements during our October 2013 audit, we reported a finding that the department

a. did not obtain criminal background checks for Clover Bottom Developmental Center and West Tennessee Homes volunteers;

b. obtained the wrong type of background check for Greene Valley Developmental Center volunteers;

c. did not maintain accurate and complete Greene Valley volunteer records; and

d. gathered sensitive information about volunteers without their authorization.

Management concurred that the department's volunteer tracking system needed improvement.

Subsequent to the conclusion of our prior audit, the department implemented an internal policy requiring its staff to conduct a series of registry and work checks prior to volunteers commencing service. We included these additional checks in our testwork for volunteers who commenced service following the policy's implementation.

For our current testwork, we found that the department

a. lacked an effective mechanism to track and maintain information on volunteers, resulting in at least one undisclosed program providing services; and

b. for the three disclosed volunteers,

- did not conduct a criminal background check on one individual until nearly three years after he began volunteering;

Volunteers directly interacted with individuals with intellectual disabilities alone without criminal background checks; sex offender registry, abuse registry, felony offender information list (FOIL), list of excluded individuals/entities (LEIE), and substantiated investigation records inquiry (SIRI) checks; and work history and reference checks on file.

- did not conduct registry or work checks on the one individual who began volunteering following implementation of the new internal policy; and
- accessed sensitive information about two individuals without their permission.

Failing to conduct even one criminal background check; sex offender, abuse, or other type of registry check; or work check—or conducting those checks after the volunteer already gained unsupervised access to an individual supported by the department—could pose significant safety hazards resulting in abuse, neglect, or exploitation.[39]

Background Information

Requirements for Checks

State law and internal policy govern the requirement for the department to obtain criminal background checks for volunteers. In addition, the department's Policy 10.1.2, "Background Checks For Department Of Intellectual And Developmental Disabilities (DIDD) Employees, Contract Workers And Volunteers," describes requirements for various registry and work checks. This policy became effective October 13, 2013.

- Section 33-2-1201(a), *Tennessee Code Annotated*, states,

  To help the department determine the suitability of a person for volunteer services or employment and verify the accuracy of information submitted in support of an application to work for the department, any person who applies to work for the department as an employee, or any volunteer, whose function would include direct contact with or direct responsibility for persons with mental illness, serious emotional disturbance, or developmental disabilities shall:

  (1) Agree to the release of all investigative records about the person from any source, including federal, state and local governments; and

  (2) Supply a fingerprint sample for the conduct of a criminal background investigation by the Tennessee bureau of investigation. If no disqualifying record is identified, the bureau shall send the fingerprints to the federal bureau of investigation for a national criminal history record check.

[39] Under the U.S. Government Accountability Office's *Government Auditing Standards*, we are obligated to report all errors involving criminal background, registry, and other work checks because of their significance to the department's mission. Specifically, Section 6.04 defines "significance" as the relative importance of a matter within the context in which it is being considered, including quantitative and qualitative factors. Such factors include the magnitude of the matter in relation to the subject matter of the audit; the nature and effect of the matter; the relevance of the matter; the needs and interests of an objective third party with knowledge of the relevant information; and the impact of the matter on the audited program or activity.

- Additionally, the department's Policy 10.1.2 lists the following requirement as part of "[d]etermining the qualifications or suitability" for prospective or current volunteers:

  > C.2. Submit to the following types of background checks which, for prospective employees, contract workers or volunteers, shall constitute a preliminary screening:
  >
  > a. Tennessee Sexual Offender Registry
  >
  > b. Department of Health Abuse Registry
  >
  > c. Tennessee Felony Offender Registry [FOIL]
  >
  > d. Office of Inspector General (OIG) List of Excluded Individuals/Entities [LEIE]
  >
  > e. Substantiated Investigation Records Inquiry (SIRI).
  >
  > D. In addition to criminal background checks, checks shall be conducted of the work history and references of . . . volunteers who will have direct contact with, or direct responsibility for, persons served. Checks of academic and professional credentials or certifications shall also be conducted if deemed necessary.

Volunteer Tracking

Human resources personnel within the department's central office are responsible for ensuring the East, Middle, and West regional offices follow the established guidelines for volunteers. When we requested a list of all volunteers serving at the department's facilities since June 1, 2013, however, the central office was unable to provide it. The central office had to contact each regional office to obtain volunteer information.

The regional offices responded that during the period under review, the following facilities had no volunteers: Clover Bottom Developmental Center, Harold Jordan Center, West Tennessee Homes, Middle Tennessee Homes, and East Tennessee Homes. The East regional office divulged that three individuals had volunteered at Greene Valley between June 1, 2013, and February 2, 2017.

Since the central office lacked a process for tracking and maintaining information on volunteers, we were unable to verify the completeness of the population provided by the regional offices. Due to our concerns, we performed Google searches in an attempt to identify any undisclosed volunteers who had direct contact with or direct responsibility for individuals with intellectual disabilities. We found material about a Foster Grandparent Program that provided services to certain individuals at Greene Valley.

According to the Director of the Foster Grandparent Program, foster grandparents had been serving at Greene Valley for more than 30 years. The foster grandparents ordinarily worked with children, but they were allowed to continue working with their assigned individual once he or she reached adulthood. Each foster grandparent had a plan specific to his or her

assigned individual to work on skills like communication, mobility, and socialization. As of March 2, 2017, the Director stated that 6 foster grandparents were assigned to Greene Valley.

We reviewed the Individual Support Plan[40] for each individual with a foster grandparent. Based on our review, the foster grandparents were allowed direct, unsupervised contact with their assigned individual (for example, taking the individual for walks outside).

Once we learned the names of the foster grandparents, we ran sex offender, abuse, FOIL, and LEIE checks.[41] For one foster grandparent, we identified a potential name match on the FOIL. We were unable to definitively determine whether the foster grandparent was the same person due to the lack of information about her.

Management considered the current system of tracking volunteers at the facility level to be appropriate, asserting that it allowed for a closer relationship between the facility director and volunteer. Nonetheless, management acknowledged that volunteer programs at each facility might function a little differently and that they would take under advisement the need for a formal process of centrally tracking and keeping records on all volunteers.

Furthermore, we discovered that management knew little about the Foster Grandparent Program. After researching the program, management concurred that the foster grandparents were volunteers. They added that although the program completes its own background checks, those checks do not meet the standards promulgated by the department's policy.

Disclosed Volunteers

Late Criminal Background Check

Based on our review of documentation, the department did not conduct a criminal background check on 1 of the 3 disclosed Greene Valley volunteers (33%) before he commenced service. The check was 1,045 days (nearly 3 years) late. The department was fortunate that this volunteer's background check results did not show any criminal records—the results could have easily turned out differently.

Management concurred that the background check was conducted late. They explained that the absence of the background check was discovered during an internal file review following the release of our October 2013 audit report.

No Registry and Work Checks

For the one volunteer who commenced work after the new background check policy became effective, the department did not conduct a sex offender registry, abuse registry, FOIL, LEIE, or SIRI check. We did not identify any

[40] For more information about Individual Support Plans, see the Service Delivery System Operations section of our report on page 25.
[41] We were unable to conduct SIRI checks, as we do not have access to that system.

matches on the sex offender registry, abuse registry, FOIL, or LEIE checks ourselves.[42] In addition, the department did not check the volunteer's work history or references. We could not assess whether a check of academic records would be required due to the lack of information maintained by the department.

Management agreed with the problems we noted but did not provide a cause.

Accessed Without Permission

For two of the three disclosed Greene Valley volunteers (67%), the department did not obtain documentation showing the volunteers agreed to the release of all investigative records from any source.

When we discussed our testwork results with management, they did not specifically comment on this deficiency.

Risks

By not keeping track of volunteers and not running the required criminal background checks; sex offender, abuse, FOIL, LEIE, and SIRI registry checks; and work history and reference checks, the department might inadvertently allow unsuitable people to volunteer. The resulting direct, unsupervised interaction might jeopardize the safety of the vulnerable population the department serves. As a matter of less concern, by obtaining background checks without first seeking permission, the department breached the volunteers' right to privacy.

Recommendation

Although the department closed the Clover Bottom and Greene Valley Developmental Centers during our audit period, the Harold Jordan Center and the West, Middle, and East Tennessee Homes remain open. The appropriate regional office should immediately obtain the criminal background checks, registry checks, and work checks we identified as missing.

Going forward, the department should develop standard procedures to identify and maintain records about volunteers at its facilities. Central office Human Resources personnel should exercise more stringent oversight over their regional office counterparts to ensure they understand and execute the required checks before the volunteers commence service. In addition, Human Resources personnel should ensure that signed investigative record authorizations are on file before initiating background checks on volunteers.

[42] We do not have access to SIRI and were therefore unable to determine whether there were any name matches for that check.

Management's Comment

We concur. The DIDD [department] HR Division has already begun the process of obtaining the missing criminal background checks, registry checks, and work history checks. The Director of Human Resources, along with the Regional Human Resources Managers, will begin reviewing procedures and make any changes needed to address the risk associated with this internal control. The Director of Human Resources will work with DIDD Risk Management Unit to make sure the annual risk assessment accurately reflects any risk associated with this internal control deficiency. HR staff have been tasked with implementing an enterprise-wide checklist and a monitoring plan to ensure compliance.

Observation 3 – Department policy does not clearly differentiate between volunteers and visitors

As part of the Department of Intellectual and Developmental Disabilities' closure of its developmental centers and simultaneous opening of community homes, more friends and natural supports[43] are interacting with individuals served. Department management categorizes these people as visitors to the home rather than volunteers.

During our review, we noted that the department's Policy 10.1.2, "Background Checks For Department Of Intellectual And Developmental Disabilities (DIDD) Employees, Contract Workers And Volunteers,"

- only offers a brief definition of a volunteer: "a person who is eighteen (18) years or age or older, who provides service to the Department, or to persons served by the Department, without compensation";
- does not define "visitor"; and
- does not distinguish between a visitor and a volunteer.

As we discussed in **Finding 6**, the department requires volunteers to undergo criminal background checks as well as sex offender, abuse, and other registry checks. "Visitors" would not be subject to these checks.

Since individuals (typically four) reside in a community home together, the likelihood of someone coming to see one resident also encountering another resident is high. If the "visiting" person has a criminal record or otherwise appears on a registry, he or she may jeopardize the safety of other community home residents, as well as the host resident.

[43] The department's *Staff Development Plan/Training Resources Guide* describes "natural supports" as "family members and close (constant, stable, steady, long-lasting, and established) friends of the person using services. . . . Natural supports are not paid by [the department] or by contracted providers."

As stated in the U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government*, best practices include providing guidance to management for identifying, analyzing, and responding to significant changes that could impact the internal control system. According to Principle 9, "Identify, Analyze, and Respond to Change,"

> **9.04** As part of risk assessment or a similar process, management analyzes and responds to identified changes and related risks in order to maintain an effective internal control system. Changes in conditions affecting the entity and its environment often require changes to the entity's internal control system, as existing controls may not be effective for meeting objectives or addressing risks under changed conditions. Management analyzes the effect of identified changes on the internal control system and responds by revising the internal control system on a timely basis, when necessary, to maintain its effectiveness.

We recommend that the department update Policy 10.1.2 to clearly and comprehensively differentiate between volunteers and visitors. Management told us they would take our concerns under advisement.

Finding 7 – The department and its providers did not complete required death reviews timely

The Department of Intellectual and Developmental Disabilities conducts systematic reviews of the deaths of individuals with intellectual disabilities receiving care in its own facilities (developmental centers and community homes), as well as through private facilities and community-based providers. According to the department's Policy 90.1.2, "Death Reporting and Review," the purpose of these reviews is "to identify factors which may have contributed to the death; to recommend necessary preventive measures; and to improve supports and services for all persons in the system."

Based on testwork performed, we determined that the department and its providers did not complete required death reviews within deadlines specified by its internal policy. Untimely reviews delay the deceased's family and friends from gaining closure on the death of their loved one. Furthermore, the more time passes between an individual's death and the death review, the greater the risk that evidence will be lost or compromised.

Background

The department requires the facilities it operates, private facilities, and community-based providers to notify the applicable regional office of the death of an individual with intellectual disabilities. If the individual received residential services, the residential provider must submit to the regional office an Initial Agency Death Review identifying the events surrounding the death and any known or likely conditions that contributed to the death (such as delayed emergency medical response or neglectful staff conduct).

The applicable regional office performs a Preliminary Death Review to determine whether the death was unexpected or unexplained (meaning the death did not result from typical progression of a known medical condition or disease). For deaths classified as unexpected or unexplained, or if the decedent was a class member,[44] a nurse employed by either the department or an independent entity prepares a Clinical Death Summary containing information about the circumstances surrounding the individual's death.

Each of the department's three regions (West, Middle, and East) has its own Death Review Committee. The committees use the Initial Agency Death Review, Preliminary Death Review, and Clinical Death Summary reports in analyzing facts relevant to the death and in developing recommendations for improvement.

Requirements for Death Reports and Reviews

The department's Policy 90.12, "Death Reporting and Review," specifies completion time frames for the Initial Agency Death Review, Preliminary Death Review, Clinical Death Summary, and Death Review Committee meeting.

Initial Agency Death Review

According to Section VI.D.3 of Policy 90.12, "The Initial Agency Death Review shall be completed within five (5) business days of the individual's death."

Preliminary Death Review

Section VI.B.2 of Policy 90.12 states, "Within five (5) business days of receipt of a Notice of Death, the Preliminary Death Review Team shall conduct a Preliminary Death Review to determine if the death meets criteria for Unexpected or Unexplained."

Clinical Death Summary

Under Section VI.C.2 of Policy 90.12,

> The Clinical Death Summary shall be completed within thirty (30) calendar days of the death by the DIDD [department] Regional Nurse (registered) or a qualified, independent registered nurse. This time period may be extended for good cause with the approval of the Central Office (CO) Director of Nursing.

[44] A class member is an individual represented in prior litigation against the department, specifically in either *People First of Tennessee v. the Clover Bottom Developmental Center* or *United States v. State of Tennessee (Arlington).* We discuss these lawsuits in more detail in the Achievements section of the report on page 16.

Death Review Committee

Pursuant to Section VI.E.2 of Policy 90.12,

> Death Reviews shall be conducted [by the Death Review Committee] within forty-five (45) business days of the individual's death. However, this time period shall be automatically extended for thirty (30) business days when the autopsy report or investigation report is not completed. Any extensions beyond thirty (30) business days shall require approval of the DIDD Commissioner or designee.

Testwork Methodology

We obtained the population of 731 deaths of individuals receiving care through departmental facilities, private facilities, and community-based providers for the period June 1, 2013, through December 31, 2016. We selected a random, nonstatistical sample of 60 deaths to determine whether the department complied with its death reporting and review policy.

Problems Found and Explanations Provided

Our review disclosed that the department's providers did not submit Initial Agency Death Reviews timely. We also determined that the department did not complete Clinical Death Summaries or Death Review Committee reviews within the time frames specified by policy (see **Table 18**).

Table 18
Breakdown of Forms Completed Late

Form Completed Late	Error Rate	Range of Days Late
Initial Agency Death Reviews	3 of 54[45] (6%)	Between 3 and 7 days late, with an average of 5
Clinical Death Summaries	11 of 28[46] (39%)	Between 5 and 20 days late, with an average of 11
Death Review Committee Reviews	2 of 26[47] (8%)	Between 32 and 65 days late, with an average of 49

Management concurred that these reports were not completed timely. The Interim Director of Nursing explained that providers are responsible for completing the Initial Agency Death Review, and in some instances the provider violates policy and does not notify the department of an individual's death until several days later.

[45] Of 60 deaths tested, 6 did not require an Initial Agency Death Review because the decedents did not receive residential services.
[46] Of 60 deaths tested, the department's Preliminary Death Review did not classify 32 as unexpected or unexplained; therefore, the department was not required to prepare a Clinical Death Summary.
[47] Of 60 deaths tested, 34 deaths were not unexpected or unexplained, or the decedent was not a class member; therefore, the Death Review Committee was not required to perform a review.

The Interim Director of Nursing attributed the untimely Clinical Death Summaries and Death Review Committee meetings to filing errors. He was confident that the regional offices requested extensions, which he then granted; however, he could not locate documentation to prove the extensions were filed and approved. Without this documentation, we could not verify that the extensions existed and were processed according to policy. The Interim Director of Nursing stated he has implemented a new filing system to prevent loss of documentation in the future.

Departmental Internal Reviews

The department's Office of Risk Management and Licensure personnel also noted deficiencies in death review timeliness in their regional office audit reports for 2014, 2015, and 2016:

- A 2014 audit of the West regional office (released March 4, 2014) found that the department did not complete 3 of 5 Clinical Death Summaries (60%) timely. Management concurred and resolved to dedicate additional human resources to completing the summaries timely during periods of high demand.
- A 2014 audit of the Middle regional office (released March 4, 2014) found that for 1 of 5 deaths examined (20%), the Death Review Committee did not record the correct date of death in its minutes. Management concurred and proposed to complete quarterly internal audits of its death reviews to ensure accurate recording of information.
- A 2015 audit of the Middle regional office (released August 11, 2017) disclosed that personnel did not complete Clinical Death Summaries timely for 2 of 5 deaths examined (40%). The internal auditors also identified incomplete Death Review Committee document packets and a Clinical Death Summary that were not returned to a provider timely. Management concurred and proposed to track the Clinical Death Summaries' due dates and extension dates.
- A 2016 audit of the Middle regional office (released October 25, 2017) again identified an incomplete Death Review Committee document packet and untimely distribution of a Clinical Death Summary to a provider. Management concurred and proposed to track the Clinical Death Summaries' due dates and extension dates.

Risks Resulting From Problems Noted

The department's death review and reporting requirements exist to protect the health and safety of supported individuals by identifying the causes of unexpected and unexplained deaths, and establishing recommendations to avoid similar occurrences. If the department and its providers do not meet report and review deadlines, harm could come to other vulnerable citizens if a preventable problem is not detected and communicated timely.

Recommendation

The Commissioner and applicable regional office personnel should ensure that all death review and reporting procedures are followed. The Director of Nursing should retain all extension requests and approvals.

Management's Comment

We concur. As noted in the body of the finding, a new filing system has been implemented to minimize the risk of human error leading to the loss of documentation.

Additionally the Death Reporting and Review Policy will be revised to address the potential conflict between the timeframes in which the agency is made aware of the death and submits the Notice of Death and when the Initial Agency Death Review is required to be submitted.

Observation 4 – The department lacks a conflict-of-interest policy for Investigation Review Committee members

Based on our testwork, the Department of Intellectual and Developmental Disabilities does not have a policy requiring Investigation Review Committee (IRC) members to sign forms disclosing potential conflicts of interest with cases under review. The committee—which upholds, modifies, or overturns investigators' decisions to substantiate or not substantiate allegations of harm—includes both department employees and non-department employees. The committee consists of 11 members, 6 department employees and 5 non-department employees (representatives from the Department of Human Services, a service provider, two advocacy groups, and the Tennessee Council on Developmental Disabilities). The Commissioner appoints a department employee to serve as the committee's chairperson.

Despite establishing a conflict-of-interest policy that applies to its own employees,[48] the department has no such policy for committee members from outside entities. Because of this deficiency, IRC members could potentially vote on cases in which they have a vested interest and/or influence other members' votes, which may in turn jeopardize accountability for a provider that compromised the safety of a supported individual.

Procedural Background

Pursuant to Section 33-1-305, *Tennessee Code Annotated*, the department's Commissioner is authorized to "[i]nvestigate complaints by a service recipient [also called a supported individual] or anyone on behalf of a service recipient." The Commissioner has delegated this power to the department's Protection from Harm Division, which takes the following steps:

1. The division's investigators examine all allegations and reports of abuse, neglect, or exploitation the department receives.
2. The investigators produce and issue the Final Investigation Report, which documents all of the information surrounding the incident, including whether the allegations were substantiated or unsubstantiated.

[48] For more information about the conflict-of-interest policy for departmental employees, see the Department Finances and Inventory section of our report on page 177.

3. The division allows the service provider, supported individual, and supported individual's representative to request a review of the Final Investigation Report's accuracy. The department only grants such reviews based on the availability of new or additional information and questions about the integrity of the investigative process.
4. The IRC reviews the Final Investigation Report. Once the IRC closes a case, its decision is final and may not be overturned or modified by any department employee.

Testwork Catalyst

We identified concerns with potential conflicts of interest while attending the April 27, 2016, IRC meeting, which was presided over by another department employee in the regular chairperson's absence. Members discussed two cases:

- For the first case, two non-department employees disclosed that they had previously treated the supported individual involved; these were the only committee members who voted against substantiating the exploitation allegation. One of the employees had asked whether he should recuse himself from voting, but another member responded there was not a need for him to do so based solely on his previous treatment of the supported individual.
- For the second case, the provider representative removed herself from the discussion because the case involved her agency.

Recommended Changes

The department should develop a policy requiring all IRC members to complete conflict-of-interest disclosure forms at least annually in order to document any potential conflicts that may surface due to Final Investigation Report review requests. The acknowledgement of such conflicts on signed disclosure forms is a best practice.

SERVICE DELIVERY SYSTEM MONITORING

The Department of Intellectual and Developmental Disabilities contracts with approximately 400 agencies (providers) responsible for providing services to individuals with intellectual disabilities. To increase providers' awareness of the basic requirements to deliver quality services, the department issues the *Provider Manual* (see **Figure 23**). Each provider participating in a state- or federally funded service delivery program must have an executed provider agreement that requires compliance with this manual.

Figure 23
Introduction to the Department's *Provider Manual*

IN.1. Welcome.

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

The department's Office of Quality Management evaluates compliance with the *Provider Manual* and provider agreements by conducting Fiscal Accountability Reviews and Quality Assurance monitoring.

Fiscal Accountability Reviews

Providers receiving more than $500,000 from the department undergo annual Fiscal Accountability Reviews. The objectives of these reviews are to

a) test whether billed costs were appropriate and allowable;
b) obtain reasonable assurance that the provider will be able to continue operations for the foreseeable future;
c) assess the reliability of internal controls;
d) verify contractual compliance; and
e) ensure that the provider has met Title VI requirements (prohibiting discrimination in programs receiving federal financial assistance).

Additionally, when applicable, these reviews satisfy the requirements of the Department of General Services' Policy 2013-007, "Subrecipient Monitoring."

In our May 2008 and April 2013 audit reports of the department, we included a finding that the department had not updated the *Provider Manual* with the most current information or properly conducted Fiscal Accountability Reviews.

Quality Assurance Monitoring

The department conducts Quality Assurance monitoring to evaluate providers' compliance with performance standards in 10 distinct areas, called domains:

Figure 24
Quality Assurance Domains

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

Source: https://www.tn.gov/assets/entities/didd/attachments/Quality_Assurance_Overview.ppt.

Providers generally undergo annual monitoring, except independent clinical service providers who do not employ additional staff. The department surveys these clinical service providers every two to three years. Furthermore, the department monitors less frequently the providers that demonstrate ongoing high levels of performance.

We focused our testwork on the department's monitoring of the Safety and Security domain. We published a finding in our October 2013 audit that Quality Assurance monitors

- failed to identify that provider employees had disqualifying records on their criminal background checks, presenting a potential danger to supported individuals; and
- incorrectly recorded the dates of background checks, abuse registry checks, and sex offender registry checks, resulting in the monitors' improper assessment of the timeliness of required checks.

Monitoring Overall

We included an observation in our April 2013 report that the department could strengthen follow-up actions on monitoring reviews. Specifically, we found that the department did not issue sanctions[49] for repeat findings discovered through the Fiscal Accountability Review

[49] As noted in the April 2013 audit report, sanctions are measures imposed on a provider for noncompliance with TennCare/Medicaid or departmental regulations or policies. In addition to financial sanctions, the department may

monitoring process or exercise the recoupment[50] option for Quality Assurance reviews for problems found with staff qualifications and training.

Background Check Exemptions

Although federal law does not prohibit employers from asking about a person's criminal history, the U.S. Equal Employment Opportunity Commission (EEOC) does prohibit employers from discriminating when they use this information. In response to the EEOC's guidance, the department allows providers to request an exemption for employees with criminal records on their background check results. The department implemented Policy 30.1.6, "Exemption Process," to ensure consistency among providers when granting exemptions.

Audit Results

1. **Audit Objective:** Did the department correct the *Provider Manual* portion of the April 2013 finding?

   Conclusion: We found that the department corrected this portion of the prior finding.

2. **Audit Objective:** Did the department correct the Fiscal Accountability Review portion of the April 2013 finding?

   Conclusion: Based on our testwork results, the department corrected this portion of the prior finding.

3. **Audit Objective:** Did the department resolve the October 2013 finding involving Quality Assurance monitoring of provider employee background checks and monitoring of the sex offender registry; the abuse registry; the Tennessee Felony Offender Information List; and the Office of Inspector General's List of Excluded Individuals and Entities?

   Conclusion: No, the department's Quality Assurance monitoring contained deficiencies involving provider employee background checks and other registry checks (see **Finding 8**); additionally, the monitoring tool was populated incorrectly (see **Observation 5**).

impose non-monetary sanctions, including written warnings to correct deficiencies; mandated technical assistance; a moratorium on providing services to anyone other than existing supported individuals; a moratorium on providing additional services or expanding the provider's service area; termination of the department's provider agreement for cause or for convenience; and the department's assumption of management responsibility and control directly or through a department-designated entity.

[50] The *Provider Manual* in effect at the time of the prior audit defined "recoupment" as "recovery of money paid to a provider due to the provider's failure to comply with TennCare or [department] requirements for service provision or documentation of such."

4. **Audit Objective:** Did the department address the issues noted in the April 2013 observation regarding strengthening follow-up actions on monitoring reviews?

   Conclusion: We determined that the department did strengthen its follow-up actions.

5. **Audit Objective:** Did the department grant provider background check exemptions in accordance with its internal policy?

   Conclusion: The department violated its own policy when granting background check exemptions (see **Finding 9**).

6. **Audit Objective:** Was the department's provider background check exemption policy reasonable?

   Conclusion: We found that the department should strengthen its policy regarding provider background check exemptions (see **Finding 9**).

Prior Audit Deficiencies

Current Audit Deficiencies

Finding 8 – Continued weaknesses exist within the system the department designed to ensure that individuals with intellectual disabilities receive high-quality care

The Department of Intellectual and Developmental Disabilities' Quality Assurance (QA) section monitors contracted providers in order to safeguard the health and welfare of supported individuals residing in community settings. We noted in our prior report dated October 2013 that the QA monitors sometimes did not

a. identify convictions included in background check results that would have prevented provider employees from working directly with supported individuals; or

b. accurately conclude on the timeliness of background, sex offender registry, and abuse registry checks performed by the provider.

In response to the prior finding, management concurred and said that employees involved in the errors had been counseled and

retrained. They added, "All components of the [department's] Quality Assurance survey process will continue in their endeavor to exhibit the highest standards of data evaluation, recording, and reporting."

For our current testwork, we

- discovered a new problem where we disagreed with the monitors about whether the providers had even performed checks of the abuse registry, sex offender registry, Tennessee Felony Offender Information List (FOIL), and the Office of Inspector General's List of Excluded Individuals and Entities (LEIE);[51]
- observed that monitors still inaccurately assessed the timeliness of the various checks performed by providers; and
- found that a monitor missed a criminal record listed on the background check of 1 of the 309 provider employees we tested.

Background Information

As part of the QA surveys, the department's monitors perform tests to determine provider compliance with requirements contained in *Tennessee Code Annotated*, as well as the department's *Provider Manual*; provider contracts; and the QA survey instrument, described on page 113. The monitors review qualifications (background and registry checks) for all provider employees hired since the previous review. The monitors examine tenured employees' files for compliance with training requirements but not with qualifications, since that information would have been captured during the monitoring period in which the provider hired the employee.

On March 15, 2014, the department released its updated *Provider Manual*, which expanded the number of checks providers must perform. Along with the background, sex offender registry, and abuse registry checks, providers must now perform FOIL and LEIE checks before hiring an employee. We included these additional checks in our current testwork.

Requirements for Checks

Section 33-2-1202, *Tennessee Code Annotated,* requires criminal background checks and abuse registry checks to be performed on all employees and volunteers who will be in direct contact with or have direct responsibility for supported individuals.

The department's *Provider Manual* establishes that staff with direct contact with or direct responsibility for service recipients must not be listed on the abuse registry, sex offender registry, FOIL, or LEIE.

[51] This list provides information to the health care industry, patients, and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs.

Requirements Specifying Hiring and Employment Restrictions

The department enters into a contract, called a provider agreement, with each of its provider agencies. In the 2010–2014 provider agreement, the department prohibited the provider from hiring or retaining employees whose background check results identified certain convictions if those employees would have direct contact with or direct responsibility for supported individuals. The department's current provider agreement includes additional provisions for employees who have been convicted and steps the provider can take to still hire that employee.[52]

Requirements Involving Check Timeliness

In addition to stipulating hiring limitations, the department requires providers to conduct checks within a designated time period prior to employment or before a change in duties that results in the employee's direct contact with or direct responsibility for supported individuals.

- Section 5.2.c of the *Provider Manual* specifies, "Background checks must be completed prior to, but no more than 30 days in advance of, employment or reassignment to direct service."
- The department's QA survey instrument contains timeliness criteria as well, indicating that checks should be "completed prior to, but no more than 30 days in advance of, employment or a change in assignment to direct support."

Our Testwork Methodology

To determine whether our conclusions matched those of the QA monitors, we selected a random, nonstatistical sample of 10 provider surveys from a population of 137 performed during either the 2015 monitoring cycle or during the 2016 monitoring cycle through April 29, 2016. For each QA survey selected, we examined documentation for background, abuse registry, sex offender registry, FOIL, and LEIE checks for each provider employee that the department's monitors had tested. In total, we reviewed the records of 309 provider employees.

Problems Found and Explanations Provided

Checks Not Performed

For 46 of 309 provider employees tested (15%), we found that the monitor reached the incorrect conclusion on whether the provider performed the required checks. See **Table 19** for details.

[52] We discuss the department's exemption process further in **Finding 9** on page 123.

Table 19
Auditors' Disagreement With Monitors' Conclusions on Check Performance

Type of Check	Number of Provider Employees for Whom the QA Monitor Reached the Incorrect Conclusion
Abuse registry	4
Sex offender registry	3
Felony offender information list (FOIL)	7
List of excluded individuals and entities (LEIE)	39
Total	**53**[53]

- For 36 employees, the provider did not give us documentation showing the check had been performed. The QA monitors visited the providers to recheck our work and agreed that the provider did not currently have the check documentation available.
- For the remaining 17 employees, the provider gave us documentation; however, upon closer inspection, we discovered the provider had used the incorrect first name, last name, or both. These errors render providers' background and registry checks useless.

  When we performed our own registry checks for these 53 provider employees, we did not identify any matches.

Overall, we disagreed with the monitors' conclusions for 6 of the 10 providers tested (60%). We did not identify this problem in the prior audit.

Management did not believe that our testwork results suggested systemic problems with the QA monitoring process. They acknowledged that assessing checks was a detailed process and cited monitor error for some of the issues, but they emphasized that other issues we found could be attributed to the provider's inability to produce original documentation from the QA survey (for example, one provider could not locate documentation subsequently archived in a storage building, and another provider had changed human resources personnel three times since the original QA survey).

Based on our analysis, 33 of the missing checks involved the provider experiencing human resources turnover.

- Provider representatives informed us they had not run checks for 31 of the sampled employees, specifically stating that (after last running a check on September 29, 2014) the earliest checks had been run on September 11, 2015.
- We further observed that the monitors had entered the exact same information for LEIE checks as they had for the background checks.

[53] For some provider employees, we found errors with multiple checks.

Therefore, it does not appear that the problems we found are solely attributable to the provider's failure to maintain documentation given to the QA monitors during their survey.

Management added, and we agree, that the QA system for review did not require monitors to maintain original documentation to support their conclusions.

Inaccurate Assessment of Check Timeliness

For 38 of the 263 employees with properly completed checks (14%), we disagreed with the monitors' conclusion regarding check dates, as shown in **Table 20.**

Table 20
Auditors' Disagreement With Monitors' Conclusions on Check Dates

Type of Check	Number of Provider Employees for Which the QA Monitor Reached the Incorrect Conclusion
Criminal background	11
Abuse registry	22
Sex offender registry	7
Felony offender information list (FOIL)	26
List of excluded individuals and entities (LEIE)	25
Total	**91**[54]

Our overall results showed that the QA monitors recorded incorrect check dates for 7 of the 10 providers tested during the current audit (70%).

Because the monitors incorrectly recorded the check dates, they also misapplied criteria included in their QA survey instrument:

- The monitors erroneously assessed 23 of the 91 checks as timely when the provider actually performed the check more than 30 days in advance of the employee's start date, in violation of QA survey instrument criteria.
- For 25 checks, we were unable to reach a conclusion on timeliness because the checks did not have a date on them.
- For the remaining 43 checks, based on our comparison of the correct check date with the employee's start date, we found that the monitors still made accurate conclusions about check timeliness even though they used incorrect check dates.

When we discussed our testwork results with management, they concurred that the QA monitors incorrectly assessed some dates during their original review, apparently due to human error.

[54] For some provider employees, we found errors with multiple checks.

In the prior audit, we identified problems with the check dates recorded for 14 of 67 provider employees tested (21%). Therefore, for this condition, the current error rate (14%) is an improvement from the prior audit.

Criminal Record Not Recognized

For 1 of 309 provider employees we tested (0.3%), the QA monitor failed to identify a record on the criminal background check that would have precluded the person from assuming a position involving direct contact with or direct responsibility for supported individuals unless the provider had received an exemption from the department. In this instance, the provider employee's background check results showed two misdemeanor records from September 13, 2013 (see **Figure 25**).

Figure 25
Background Check Results

Count:	1	**Severity:**	Misdemeanor
Offense Date:	09–13–2013	**Disp. Date:**	03–05–2014
Offense:	SIMPLE POSSESSION OF MARIJUANA		
Disposition:	DIVERSION		
Sentence:	PROBATION FOR 11 MONTHS AND 29 DAYS, FINES/COSTS OF $1,777		
Count:	2	**Severity:**	Misdemeanor
Offense Date:	09–13–2013	**Disp. Date:**	03–05–2014
Offense:	DRUG PARAPHERNALIA		
Disposition:	DIVERSION		
Sentence:	PROBATION FOR 11 MONTHS AND 29 DAYS, FINES/COSTS OF $1,777		

The provider employee received a diversion,[55] which had not been completed prior to the date of hire. We further noted that the provider obtained the criminal background check more than 30 days prior to the employee's date of hire, which did not meet the department's requirements. We were unable to determine if the provider employee was still under diversion or if the charge had been updated to a conviction.[56]

Management concurred that the monitor did not note the criminal record. The omission appeared to be an oversight. While the specific record that the monitor missed involved drugs, such an oversight could have involved physical harm charges instead.

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[55] Based on our review of the criminal background checks, a diversion allows a charge to be diverted once the defendant completes the terms of the probation. If the defendant does not meet these terms, then a conviction is entered.

[56] The absence of criminal record documentation relates to **Finding 9** involving the department's background check exemption policy.

Since in the prior audit we documented an error rate of 3% (2 of 67 employees tested) for this condition, the current audit results demonstrate improvement.

Risks Resulting From Problems Noted

When the department fails to properly perform criminal background, abuse registry, sex offender registry, FOIL, and LEIE checks, the care of supported individuals could be compromised. Furthermore, by not recognizing that providers conducted registry searches too early, the department exposes supported individuals to the risk that the provider employees committed offenses that will remain undetected.

Recommendation

1. The Quality Management Assistant Commissioner and the Deputy Director of Quality Assurance should remind the QA monitors of the importance of thoroughly analyzing background check results and correctly recording the dates of background, abuse registry, sex offender registry, FOIL, and LEIE checks.
2. After identifying the QA monitors who made the errors we noted, management should offer them more intensive training and take any necessary disciplinary actions.
3. The department should notify its providers of the importance of recordkeeping and maintaining complete personnel files, including documenting required checks.
4. QA monitors should begin spot-checking the files of some tenured provider employees in order to ensure appropriate documentation retention.
5. Management should consider performing a cost-benefit analysis of obtaining the resources to scan documents and should maintain the provider documentation the QA monitors review.

Management's Comment

We concur with the finding.

With regard to the above recommendations, we offer the following responses.

1. Regional Administrators for Quality Assurance have discussed the need for a thorough analysis of the results of the background/registry check reviews with the surveyors assigned to perform these reviews. This discussion included stressing the need to correctly record all information for the various checks as well as re-checking their work for accuracy. At an upcoming meeting with regional QA leadership and the three surveyors who have this specific responsibility, the Assistant Commissioner for Quality Management and the Deputy Director for Quality Assurance will discuss what specific steps need to be taken to prevent future occurrences of incorrect recording of information.
2. Regional Administrators for Quality Assurance and Regional Quality Assurance Coordinators will review the most recent finding as noted in this audit and specifically

discuss it with the surveyors responsible for the finding. Disciplinary action will be taken as deemed appropriate by the Regional Administrator for Quality Assurance. In the Middle Tennessee Region, steps have been taken to identify a surveyor dedicated solely to the background and registry check reviews and to train that surveyor as to the performance requirements. In the future, each region will assume responsibility for spot-checking a sample of background and registry checks that were reviewed on survey. Central Office Quality Management staff will perform a quarterly random check of these reviews. Reliability checks across regions will also be conducted.

3. In an upcoming edition of *Open Line,* the department's weekly communication to department staff, providers, and other stakeholders, the Office of Quality Management will provide information to reinforce to providers the current DIDD [department] requirements for maintenance of staff personnel records as well as the importance of accurate record keeping.
4. Maintenance of provider records is important because it provides evidence of compliance with departmental requirements and a demonstration of best practices in provider operations. The Office of Quality Management will amend its current background and registry check process to include review of a small sample of tenured employee records as a verification that records exist to support original survey findings as they pertain to background and registry check documentation.
5. Central Office Quality Management staff, Regional Administrators for Quality Assurance, and Regional Quality Assurance Coordinators will discuss and evaluate feasible options that provide a means of preserving evidence of background and registry check performance by providers for future reference. Following consultation with the Commissioner about these possible options, a procedure will be established that addresses this issue.

Observation 5 – Since its monitoring tool was populated incorrectly, the department runs the risk of incorrectly assessing a provider as either compliant or noncompliant

When performing a survey, the department's Quality Assurance (QA) monitor tests all new provider employees hired since the last review. The QA monitor requests that the provider submit certain pre-survey information. The QA monitor then enters information into a Qualified Provider Review workbook, which automatically calculates provider compliance or noncompliance.

We selected a random, nonstatistical sample of 10 provider surveys to test from a population of 137 performed during either the 2015 monitoring cycle or during the 2016 monitoring cycle through April 29, 2016. Based on our testwork, QA monitors populated 5 of the 10 workbooks (50%) with inaccurate information. Specifically, we determined the following:

1. For 2 workbooks, the "N/A" (not applicable) boxes were incorrectly marked under various registry checks, causing the "Overall Compliance" boxes to also show an "N/A" result. This deficiency affected a total of 10 provider employees.

Management explained that the workbook populates registry check applicability based upon whether the employee performs direct support services. By default, the department set the workbook to record "NA" for the various checks if the employee is listed as "Clinical." The QA monitors completing the workbooks re-marked the checks as "N/A" after initially recording a "Y" (yes), apparently due to human error.

2. Five[57] workbooks had provider employee names entered incorrectly, meaning that any registry search run on those names would be ineffectual. We identified a total of 15 misspelled names.

   Management asserted that the misspelled names typically arose because the provider misspelled those names on the pre-survey documentation submitted to the QA monitor and the monitor did not correct this information in the workbook. Management commented, and we agreed, that the provider performed searches on the correct name.

Overall, management did not agree that the problems we found were systemic.

As stated in the U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government*, best practices include providing guidance to management on the need for using quality information to support the internal control system. According to Principle 13, "Quality information is appropriate, current, complete, accurate, accessible, and provided on a timely basis."

When QA monitors report inaccurate data, they may assess a noncompliant provider as compliant or vice versa. Therefore, department management should emphasize the importance of the monitors populating the workbook with correct data and then double-checking their work to ensure accuracy. They should also reconsider using automation to eliminate the types of errors we identified.

Finding 9 – The department's policy for granting exemptions for people with criminal records to work with vulnerable individuals contains both design and implementation flaws

As a result of guidance issued by the federal Equal Employment Opportunity Commission (EEOC), the Department of Intellectual and Developmental Disabilities updated its policies and procedures to allow providers a route to hire people with criminal records—including those involving physical harm, monetary theft, and drug/alcohol misuse—to directly care for individuals with intellectual and developmental disabilities. Our testwork revealed that the department

- omitted critical elements in its background check exemption policy, including
  - not maintaining sources for crafting policy;
  - not researching other states' interpretation of EEOC guidance;

[57] Two Qualified Provider Review workbooks contained both types of errors.

- not tracking exemption requests;
- not requiring its staff to perform abuse, sex offender, and other registry checks; and
- not monitoring expired exemptions; and

- has not followed provisions currently present in the policy, including
  - not properly approving exemption requests; and
  - not meeting timeliness requirements.

The result? The department approved an assault exemption for a person to directly care for vulnerable individuals at a provider agency and then later placed that same person on the abuse registry for physical abuse. Furthermore, the department approved two people to work at a provider without first gaining awareness of their felony convictions.

Wrongly approving even one criminal background check exemption request jeopardizes the safety of supported individuals, and we believe that harm to even one individual is unacceptable.[58] The department possesses a responsibility to ensure that its exemption request policy is as stringent as possible while complying with federal guidelines.

Background

Equal Employment Opportunity Commission Guidance

Source: http://www.aauw.org/.

The EEOC enforces Title VII of the Civil Rights Act of 1964, which prohibits employment discrimination based on race, color, religion, sex, or national origin. Upon analyzing 20 years of data, the EEOC identified a significant increase in the number of working-age Americans with criminal records, with African Americans and Hispanics arrested two to three times their proportion of the general population.[59]

In response to this trend, the EEOC issued updated guidance on April 25, 2012, focusing on employment discrimination based on race and national origin. According to the guidance, "An employer's use of an individual's criminal history in making employment decisions may, in some instances, violate the prohibition against employment discrimination under Title VII of the Civil Rights Act of 1964, as amended." The EEOC offered the following best practices for employers who are considering criminal record information when making employment decisions:

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[58] Under the U.S. Government Accountability Office's *Government Auditing Standards*, we are obligated to report all errors involving criminal background check exemption requests because of their significance to the department's mission. Specifically, Section 6.04 states, "Significance is defined as the relative importance of a matter within the context in which it is being considered, including quantitative and qualitative factors. Such factors include the magnitude of the matter in relation to the subject matter of the audit, the nature and effect of the matter, the relevance of the matter, the needs and interests of an objective third party with knowledge of the relevant information, and the impact of the matter to the audited program or activity."

[59] Source: EEOC Enforcement Guidance Number 915.002.

Figure 26
Equal Employment Opportunity Commission Best Practices

General

- Eliminate policies or practices that exclude people from employment based on any criminal record.
- Train managers, hiring officials, and decisionmakers about Title VII and its prohibition on employment discrimination.

Developing a Policy

- Develop a narrowly tailored written policy and procedure for screening applicants and employees for criminal conduct.
    - Identify essential job requirements and the actual circumstances under which the jobs are performed.
    - Determine the specific offenses that may demonstrate unfitness for performing such jobs.
        - Identify the criminal offenses based on all available evidence.
    - Determine the duration of exclusions for criminal conduct based on all available evidence.
        - Include an individualized assessment.
    - Record the justification for the policy and procedures.
    - Note and keep a record of consultations and research considered in crafting the policy and procedures.
- Train managers, hiring officials, and decisionmakers on how to implement the policy and procedures consistent with Title VII.

Questions about Criminal Records

- When asking questions about criminal records, limit inquiries to records for which exclusion would be job related for the position in question and consistent with business necessity.

Confidentiality

- Keep information about applicants' and employees' criminal records confidential. Only use it for the purpose for which it was intended.

Policy and Procedure Revisions

The department enters into a contract, called a provider agreement, with each of its provider agencies. Prior to the issuance of the new EEOC guidance, the department prohibited the provider from hiring or retaining employees whose criminal background check results identified certain convictions if those employees would have direct contact with or direct responsibility for individuals using services.

In addition, the department's *Provider Manual* lists the requirements a provider must follow for employee background checks:

- 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 [OIG LEIE].
- Background checks must be completed prior to, but no more than 30 days in advance of, employment or reassignment to direct service.

Following the issuance of EEOC's guidance, the department amended its instructions to providers to include additional provisions for applicants with criminal convictions and steps the providers can take if they still wish to hire that applicant:

> Providers shall not have a blanket policy of not hiring applicants with prior felony or misdemeanor convictions' [*sic*]. 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 [the department] 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
>
> (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 ten (10) 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.

Under the leadership of its Office of Policy and Innovation, the department additionally implemented Policy 30.1.6, "Exemption Process," effective May 5, 2012. This policy establishes a process for providers to request exemptions from department policies and procedures, including those involving criminal background check requirements. Since the beginning of our audit period, the department has revised the policy three times, with effective dates of January 15, 2014; January 1, 2016; and December 28, 2016.

Background Check Exemption Requirements

The steps for obtaining an approved exemption have changed under each new version of the department's "Exemption Process" policy (see **Figure 27**).

Figure 27
Exemption Process Policy Changes From May 2012 to December 2016

Regional Office Review

Policy Effective Date	Requirements for the Regional Office (RO) Review
May 5, 2012 (original)	The RO Director must route the exemption request (along with a recommendation for approval or denial) to the department's Office of Policy and Innovation (OPI) within 14 days of receipt.
January 15, 2014	The RO Director must route the exemption request to the OPI within 5 business days of receipt.
January 1, 2016	Same requirements as the January 15, 2014, policy.
December 28, 2016	The RO Director is not required to route the exemption request to the OPI within a certain time frame.

Office of Policy and Innovation Review

Policy Effective Date	Requirements for the Office of Policy and Innovation (OPI) Review
May 5, 2012 (original)	The OPI must review the exemption request and inform the provider in writing within 14 days if the exemption request is approved or denied.
January 15, 2014	The OPI must inform the provider within 5 business days if the exemption request is approved or denied.
January 1, 2016	Same requirements as the January 15, 2014, policy.
December 28, 2016	Same requirements as the January 15, 2014, policy.

Executive Level Review

Policy Effective Date	Requirements for the Executive Level Review
May 5, 2012 (original)	The policy specifies a team of four individuals to whom the OPI is to route the exemption request for review. No specified time frame is required to review the exemption request.
January 15, 2014	The Commissioner's Executive Team is required to review the exemption request at the next regularly scheduled meeting.
January 1, 2016	The Commissioner's Executive Team is required to review the exemption request at the next regularly scheduled meeting or on an ad hoc basis.
December 28, 2016	A Policy Exemption Review Committee is required to review the exemption request at the next regularly scheduled meeting.

Exemption Durations

Policy Effective Date	Requirements for Exemption Durations
May 5, 2012 (original)	Approved exemptions are only effective a maximum of one year from the approval date and will automatically expire. It is the provider's responsibility to request a continuation of the exemption.
January 15, 2014	Same requirements as the original (May 5, 2012) policy.
January 1, 2016	Approved exemptions for staff background checks shall be effective for the employee's duration of employment with the requesting provider. When an exemption is approved, the provider must conduct subsequent background checks at a minimum of every three years for the duration of the person's employment.
December 28, 2016	Approved exemptions for staff background checks are effective for the employee's duration of employment with the requesting provider. The provider must perform an updated background check upon the discovery of any new convictions.

Document Maintenance

Policy Effective Date	Requirements for Document Maintenance
May 5, 2012 (original)	Providers must maintain a copy of the approved exemption to be available for inspection by any department review team.
January 15, 2014	Providers must maintain a copy of the approved exemption request and the approval letter to be available for inspection by any department review team.
January 1, 2016	Same requirements as the January 15, 2014, policy.
December 28, 2016	Providers must maintain a copy of the approval letter to be available for inspection by any department review team.

Our Testwork Methodology

In addition to reviewing each version of the "Exemption Process" policy in place during our audit period, we selected a nonstatistical, random sample of 60 provider employees from a population of approximately 216[60] who had an approved background check exemption from June 1, 2013, through April 14, 2016 (the date we requested the exemption list from the department). Due to concerns that arose, we then tested all exemption requests (approximately 218) approved from June 1, 2013, to September 7, 2016, to detect the presence of an approved provider employee on the abuse registry; the sex offender registry; the Tennessee Felony Offender Information List (FOIL); or the Office of Inspector General's List of Excluded Individuals and Entities (LEIE).

Design Flaws

While performing testwork, we identified multiple flaws in the design of the department's "Exemption Process" policy that may compromise the safety of the individuals served.

Sources for Crafting Policy Not Maintained

When we requested information about the initial development of the exemption policy, management was unable to provide it, noting that the policy's creator had since ended his state employment. Keeping records of consultations and research is an EEOC best practice. Without this information, we could not assess the reasonableness of the department's original policy.

No Research on Other States

Moreover, we determined through inquiry with management that the department had not researched other states' interpretation of EEOC's new guidance when revising its policy. Based on our own limited comparison, the department's "Exemption Process" policy was less stringent than other states' policies and procedures for criminal background check exemptions, as described in **Table 21.**

[60] Since we identified issues with population completeness, described later in the finding, we were unable to definitively determine the number of exemption requests in the testwork populations.

Table 21
Department Exemption Policy in Comparison to Other States' Policies

State	Policy Requirements
Florida	The *applicant* must • obtain all arrest reports, court dispositions, probation information, etc., or a letter stating that none of these exist anymore; and • provide the following: o explanation in a signed statement; o a letter of recommendation from their most recent employer; and o character references.
California	The *applicant* must • obtain a copy of all police reports or a letter stating that they no longer exist; and • provide the following: o explanation in a signed statement; and o character references.
Hawaii	The *agency* obtains the state name check, which must show conviction. The *applicant* must provide • explanation in a signed statement; • proof of employment or participation in therapy, education, etc.; and • professional references.
Tennessee	*Providers* must submit supporting documentation (if applicable).

Source: State policies available online.

We identified multiple instances, which we forwarded to the department, where the provider did not submit supporting documentation. Management did not respond to our forwarded information.

Management disagreed that researching other states' policies is a necessary component of policy development, asserting the sufficiency of the department's current policy without any additional revisions. We, however, believe that since the department serves such a vulnerable population, it has the responsibility to make its exemption policy as strong as possible while complying with the EEOC's guidelines.

While performing sample testwork, we found that the department approved one employee's exemption on February 20, 2014, but then placed this same employee on the abuse registry on February 25, 2016, for physical abuse. The provider told us that the employee had been terminated on July 15, 2015. When we reviewed the supporting documentation the department used in deciding to approve the exemption, we noted the absence of details (including arrest records and police reports) of the employee's 2005 conviction for misdemeanor assault.

Complete Population of Exemption Requests Not Maintained

The department's exemption policy did not establish a way for staff to keep track of the exemption record requests, and our sample testwork disclosed that the department maintained multiple sets of records, none of which appeared complete. When we initially asked management for a complete list of all exemption requests, the Office of Policy and Innovation provided us with its central office exemption tracking form. Our comparison of exemption supporting documentation with the tracking form, however, revealed several errors:

- incorrect recording of the date the provider submitted the exemption request;
- incorrect recording of the type of exemption request (background check or other);
- final disposition showing approved rather than denied;
- exemptions omitted from the tracking form; and
- duplicate entries for the same exemption.

We asked management about these discrepancies; they responded that we should instead use the exemption tracking forms from the West, Middle, and East regional offices. Of the 60 items we selected for testwork, we found 2 instances where the central office exemption tracking form and the applicable regional office tracking form contained conflicting dates. We also identified an instance of inconsistent name spelling.

The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book), Principle 13, emphasizes the importance of quality information, stating, "Management uses the quality information to make informed decisions and evaluate the entity's performance in achieving key objectives and addressing risks."

We met with management, and they speculated that the difference in dates between the exemption tracking forms arose from instances when the provider sent the exemption request directly to the central office and bypassed the regional office. Additionally, for the central office exemption tracking form, management explained that two or three different individuals had been entering data.

Registry Checks Not Performed by the Department

Based on our review, the department did not check the abuse registry, sex offender registry, FOIL, or LEIE—and the "Exemption Process" policy did not require staff to check these registries—before approving the background check exemption requests. We attempted to perform the registry checks ourselves and found that for one approved exemption, the provider employee's name did not appear on either the exemption tracking form or other documentation retained by the department. Management attributed this issue to poor recordkeeping on the department's part. Although management told us that it did not appear that an exemption was required because the potential employee only had charges, not a conviction, they did not provide us with proof of their claim. They further admitted that a background check, which would determine if the charge led to a conviction, was not available.

We also identified 17 potential FOIL and LEIE matches, but we were unable to determine if the individuals were a match to the registries based on the exemption documentation we received from the department. We had to obtain additional documentation from the provider showing the employees' birthdates and Social Security numbers.

Using the documentation we received directly from the provider, we identified two employees who matched the FOIL registry. Based on the department's background check exemption request documentation, though, the approvals were for misdemeanor convictions—we found no references to felonies.

After we brought this matter to the department's attention, management gathered additional information about the felony convictions from the Department of Correction. This documentation revealed that both employees had felony judgment orders that were entered before the Commissioner's Executive Team approved the exemption requests. See **Table 22**.

Table 22
Description of Two Employees' Felony Convictions

	Employee 1	Employee 2
Felony Judgment Order Entered	August 27, 2015	October 27, 2015
Exemption Request Approved	June 8, 2016	June 8, 2016
Specific Convictions	• Felony, possession of schedule II drugs with intent to sell, methamphetamine • Felony, failure to appear	• Felony, evading arrest • Misdemeanor, resisting arrest • Misdemeanor, failure to maintain financial responsibility
Department's Explanation	The background check performed by the licensed private investigation company failed to detect the employee's felony convictions.	The felony conviction occurred after her date of hire. The background check was performed at the time of hire, which is the statutory requirement. Therefore, the approved exemption was appropriate. It was the employee's responsibility to inform her employer of her change in status.
Our Response	We agree with the explanation for this employee. State law allows the provider to use a licensed private investigation company to perform criminal background checks.	We disagree with the department's explanation. The Commissioner's Executive Team approved the exemption even though the background check was completed 10 months before the exemption request. A background check cannot be completed more than 30 days before the employee's date of hire, in accordance with Section 5.2.c of the department's *Provider Manual*. Additionally, we disagree that the employee was placed on the FOIL registry after her hire date. Our review shows that the employee was placed on the list prior to this date.

Figure 28
Employee 1 Felony Judgment Orders

On the 27 day of Aug, 20 15, the defendant: FRANKLIN COUNTY, TN

☒ Pled Guilty ☐ Dismissed/Nolle Prosequi
☐ Pled Nolo Contendere
☐ Pled Guilty – Certified Question Findings Incorporated by Reference

Is found: ☒ Guilty ☐ Not Guilty
☐ Jury Verdict ☐ Not Guilty by Reason of Insanity
☐ Bench Trial

Indictment: Class (circle one) 1st A (B) C D E ☒ Felony ☐ Misdemeanor
Indicted Offense Name AND TCA §: Felony Poss Sch II, 5 grams or more
Amended Offense Name AND TCA §: Poss Sch II w/ intent to Sell 39-17-417 39-17-417
Offense Date: 1-31-13 County of Offense: Franklin
Conviction Offense Name AND TCA §: Poss Sch II w/ intent to Sell 39-17-417
Conviction: Class (circle one) 1st A B (C) D E ☒ Felony ☐ Misdemeanor
Is this conviction offense methamphetamine related? ☒ Yes ☐ No
Sentence Imposed Date: 8-27-15

On the 27 day of Aug, 20 15, the defendant: FRANKLIN COUNTY, TN

☒ Pled Guilty ☐ Dismissed/Nolle Prosequi
☐ Pled Nolo Contendere
☐ Pled Guilty – Certified Question Findings Incorporated by Reference

Is found: ☒ Guilty ☐ Not Guilty
☐ Jury Verdict ☐ Not Guilty by Reason of Insanity
☐ Bench Trial

Indictment: Class (circle one) 1st A B C D (E) ☒ Felony ☐ Misdemeanor
Indicted Offense Name AND TCA §: Felony Failure To Appear
Amended Offense Name AND TCA §:
Offense Date: 6-24-13 County of Offense: Franklin
Conviction Offense Name AND TCA §: Felony Failure To Appear
Conviction: Class (circle one) 1st A B C D (E) ☒ Felony ☐ Misdemeanor
Is this conviction offense methamphetamine related? ☐ Yes ☒ No
Sentence Imposed Date: 8-27-15

Figure 29
Employee 2 Felony Judgment Order

On the 27th day of October, 2015, the defendant:

☒ Pled Guilty ☐ Dismissed/Nolle Prosequi
☐ Pled Nolo
☐ Pled Guilty – Certified Question Findings Incorporated by Reference

Is found: ☒ Guilty ☐ Not Guilty
☐ Jury Verdict ☐ Not Guilty by Reason of
☐ Bench Trial

Indictment: Class (circle one) 1st A B C D E ☒ Felony ☐ Misdemeanor
Indicted Offense Name AND TCA §: 39-16-603 – FELONY EVADING ARREST
Amended Offense Name AND TCA §:
Offense Date: 01/11/2015 County of Offense: FAYETTE
Conviction Offense Name AND TCA §: Same
Conviction: Class (circle one) 1st A B C D (E) ☒ Felony ☐ Misdemeanor
Is this conviction offense methamphetamine related? ☐ Yes ☒ No
Sentence Imposed Date: 10-27-15

Overall, management does not believe there is a systemic issue to address because we identified issues with "only" 3 of 218 approved exemptions, or 1.4%. Three may be a small number, but our focus is on quality not quantity—even one wrongly approved exemption request places supported individuals in harm's way and elevates the department's risk level.

As stated in Principle 10 of the Green Book, best practices include management designing control activities to achieve objectives and respond to risks.

Expired Exemptions Not Monitored

Our review further disclosed that the exemption policy did not require the department to perform monitoring to ensure providers requested a continuation when the original exemption expired after one year. As a result, 6 of the 8 exemptions that expired (75%) had no continuation on file.

When we met with management to discuss the issue, they questioned if the approval letters had expiration dates and if the employee still worked for the provider. We noted that in both instances the letters contained an expiration date and that the employee in question was

working for the provider at the time the exemption expired. Management then added that the burden should be placed on the provider to monitor and report any change in the status of its employees.

The Green Book says that monitoring is a key component of internal control. Without performing this monitoring, the department may inadvertently allow an employee with new convictions to continue to work with a vulnerable population.

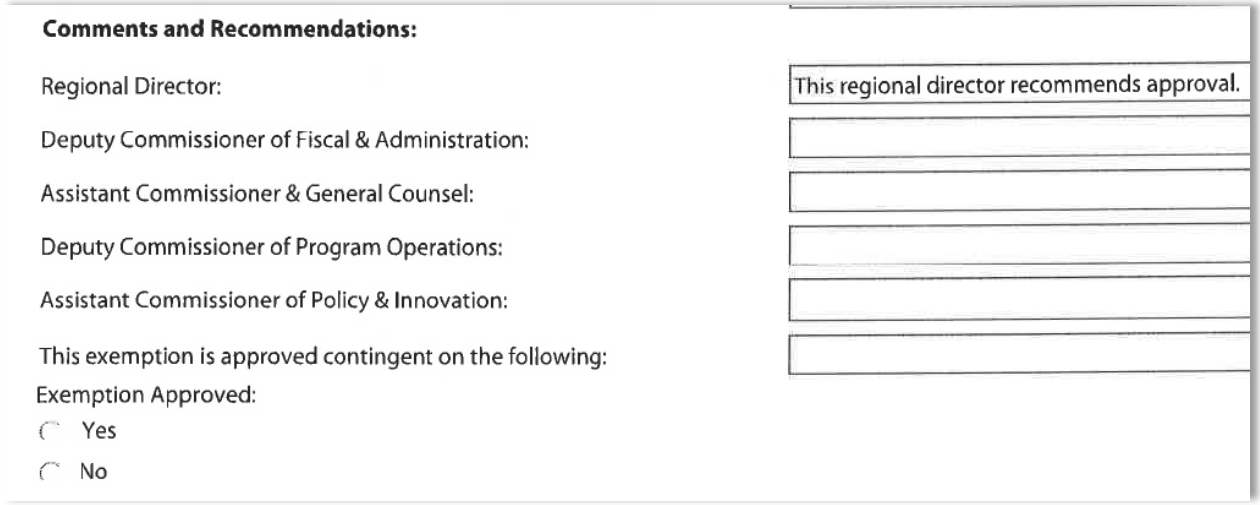
Implementation Flaws

The second part of our testwork involved assessing the department's compliance with existing policy provisions. We again found multiple deficiencies.

Exemption Requests Not Properly Approved

The department's exemption request form has a place for 5 members of the Commissioner's Executive Team to sign for approval. Based on our review of the forms and the approval letters sent to the provider, the department did not properly approve 34 of 60 provider employee background check exemption requests (57%). We found that 25 forms only had 1 signature, which was the same signature on the approval letter. The remaining 9 forms contained no signature indicating approval (see **Figure 30**).

Figure 30
Example of Exemption Request Form With Incomplete Approvals



Comments and Recommendations:

Regional Director:	This regional director recommends approval.
Deputy Commissioner of Fiscal & Administration:	
Assistant Commissioner & General Counsel:	
Deputy Commissioner of Program Operations:	
Assistant Commissioner of Policy & Innovation:	
This exemption is approved contingent on the following:	

Exemption Approved:
- ◯ Yes
- ◯ No

Principle 10 of the Green Book lists "authorizations and approvals" as internal control activities.

Management responded that all the Executive Team members may not have been at a meeting to sign the approved exemption and that approvals may have been handled through email due to time constraints. However, management was unable to provide us evidence of any email approvals.

By not following its own policy, the department risks approving a person who has not been properly vetted to provide direct care to supported individuals.

Timeliness Requirements Not Met

The department did not meet a series of timeliness requirements promulgated in its exemption policy:

Table 23
Description of Steps Performed Late

Steps	Error Rate
Original[61] – The regional office Director did not review the exemption request and route it to the Office of Policy and Innovation (OPI) within the 5-business-day time frame required by the department's internal policy.	22 of 60 (37%)
Revised – The regional office Director did not review the exemption request and route it to the OPI within the 5-business-day time frame required by the department's internal policy.	25 of 60 (42%)
The Commissioner's Executive Team did not review the request at the next regularly scheduled meeting.	22 of 60 (37%)
The OPI did not inform the provider in writing of the final disposition within the required 5 business days.	8 of 60 (13%)

Management additionally stated that the exemption policy includes a provision that the Commissioner's Executive Team may review exemption requests on an ad hoc basis. We were unable to determine when the ad hoc meetings were held because the department did not maintain any documentation of these meetings. Furthermore, the ad hoc review included only those exemption requests submitted for the policy revision effective January 1, 2016. Of the 22 exemption requests that the department did not review at the next regularly scheduled meeting, only 5 fell under this policy provision.

If the department does not process exemption requests timely, then individuals with disabilities may not get the care they need. We discuss the provider workforce shortage crisis further in the **Emerging Issue** on page 60.

Providers Did Not Receive Approval Documentation

For 52 of 53[62] exemption requests (98%), the department did not ensure the provider had a copy of the approved exemption request and/or the approval letter.

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[61] We performed our testwork based on the central office tracking form provided by management. After communicating our error results to the department, management requested that we re-perform our testwork using the East, West, and Middle regional office tracking forms.

[62] We excluded 7 of the items in our sample for this part of our testwork because the individual never commenced work with the provider after the exemption was approved; therefore, the provider did not retain the documentation of the approved exemption.

- Six of the providers stated that the department did not return the approved exemption and they only received the approval letter.
- Our review of the approved exemptions showed that 4 contained restrictions in order for the employee to work for the provider.
    - While the department notified 3 of the providers of the restriction in the approval letter, they did not notify 1 provider of a restriction imposed on its employee.
    - This uncommunicated restriction would have prevented the provider employee from accessing the checking accounts of the individuals served.

Management ultimately agreed that providers most likely did not receive the approved exemption request, because the provider did not need to know the regional office Director's recommendation or see the notes department staff added to the form. In response to our comments, management revised its policy effective December 28, 2016, to require providers to only maintain the approval letter, not the approved exemption request.

This policy revision also removed the requirement that providers conduct new background checks for exempted employees at a minimum of every three years. The department believes that it is the employee's responsibility to provide notification of subsequent convictions. Relying on employees to act against their interest and communicate with the providers seems to set an unrealistic expectation that could result in the supported individuals interacting with dangerous employees.

Recommendation

The Assistant Commissioner of Policy and Innovation, together with the Legal Division, should

1. research exemption policies enacted by other states and consult with the EEOC in order to make the department's policy as strong as possible while complying with legal requirements;
2. implement a system to ensure the completeness and accuracy of the population of exemption requests maintained by both the central office and the regional offices;
3. perform abuse registry, sex offender registry, FOIL, and LEIE checks for each person for whom a provider requests an exemption and then re-perform those checks at least annually;
4. ensure that a minimum of three members of the Policy Exemption Review Committee sign the exemption form to record approval or denial, in accordance with the department's current policy;
5. ensure that providers requesting exemptions supply documentation (for example, background checks, arrest reports, court dispositions, letters of recommendation, and signed statements of explanation) that is accurate and current, and ensure that providers run regular registry checks on approved employees; and

6. closely monitor exemption request processing time frames to determine if the department should again require each step to be completed within a set number of days.

Management's Comment

We concur in principle with the nature of the finding but we respectfully disagree with portions of the recommendations. With regard to the above recommendations, we offer the following responses.

1. We do not concur.

   Each state has specific statutory requirements regarding timeliness of background checks which should impact their exemption policies. The EEOC has provided all states with guidance which DIDD [the department] has followed in development of its policy. The department believes the current exemption process provides all the necessary information, including a written statement from the applicant, to make an informed decision regarding the background of the applicant.

   We did review the other states' policies as recommended by the auditors. Our review noted that since DIDD's 2017 implementation of changes to Policy 30.1.6, Exemption Process, the average turnaround time for a decision by DIDD is now 10 days. This timeframe is much shorter than the turnaround time of the other states noted, which range from 30 to 75 days. As reflected in other sections of this report, the nation is facing a Direct Support Professional (DSP) shortage. A process which requires providers to wait 30 to 75 days for a disposition of whether they will be allowed to hire a DSP would be detrimental to the hiring of the applicant, therefore potentially jeopardizing supports to persons with disabilities.

2. We concur.

   A system for maintaining exemption requests has been implemented in the Central and Regional offices.

3. We do not concur.

   3.1. The obligation to perform these checks is on the provider per the department's *Provider Manual* and *Provider Agreement*. The provider must show proof that abuse registry, sex offender registry, FOIL, and LEIE checks were performed as either a part of the background check or as separate checks performed by the provider. As stated in the emerging issues sections of this report, "DIDD contracts with over 400 provider agencies to support waiver enrollees in accordance with each individual's approved plan of care. Providers are responsible for hiring employees to deliver services to waiver participants."

   3.2. Likewise, providers have their own internal policies regarding staff reporting any new convictions to the provider agency. For the department to perform these checks at the time of the exemption and annually would place

an undue burden on the department that is not required by either rule or statute.

4. We concur.

   As stated, this is a component of the Policy 30.1.6, Exemption Process, that has been implemented in 2017 by the department.

5. We concur in part.

   5.1. We concur regarding certain documentation providers who are requesting exemptions should submit with a background exemption request. The department requires that providers submit background checks, registry checks, and statements of explanation for convictions. If the background check does not include a final disposition of charges, the provider is also required to submit a final court disposition as part of the exemption packet.

   5.2. We do not concur providers should provide arrest reports with the exemption request. Because EEOC guidelines stipulate only convictions can be reviewed in reference to hiring practices, providers are not required to submit arrest reports. A decision not to hire cannot be based upon an arrest only; there must be a conviction.

   5.3. We do not concur providers should submit letters of recommendation with an exemption request. Providers may submit a letter of recommendation that will be considered but is not required and will not be determinative of whether the exemption is approved. Weight will be given to the type of conviction, length of time since conviction, and the applicant's own statement of events.

We do not concur providers should run regular registry checks on approved employees. There is no statutory or legal basis to require providers to continue to run registry checks on approved employees. As stated above, DIDD relies on providers' own policies regarding staff reports on future convictions. This is the same standard the state requires of its employees. To require additional checks of providers' employees is unduly burdensome and holds providers to a higher standard than the state.

Auditor's Comment

Some of management's specific comments are inaccurate.

1. We did not recommend that the department implement other states' time frames for approving exemptions. Instead, in our recommendation 6, we recommended that the department closely monitor its exemption request processing to assess the necessity of re-implementing deadlines to perform interval steps. While we understand about the DSP shortage, it would also be detrimental for department management to approve the hiring of an inappropriate worker, which we already found that they did in at least one instance—placing a DSP on the abuse registry only two years after approving his exemption.

3. We did not recommend that the obligation of performing background checks and other registry checks be taken away from the providers or state that the department was violating any current regulation by not performing registry checks. Our recommendation was for the department's policy to include a requirement for its staff to verify providers' information by performing their own checks. We do not agree that this would cause an "undue burden" because these registry checks are *only* for the employees going through the exemption process, which totaled 218 exemption requests approved from June 1, 2013, to September 7, 2016. It took us less than a minute to complete each registry check. Furthermore, performing these registry checks is **free**.

5. We identified multiple instances where the provider did not submit the required supporting documentation (such as registry checks and statements of explanation) that department management mention in their comment. We forwarded these instances to the department and received no response back. As we explained earlier, running registry checks is not burdensome. The benefits of protecting a particularly vulnerable population would outweigh the limited "cost" of provider employee time.

RESIDENT TRUST FUND ACCOUNTS AND PROPERTY

The Department of Intellectual and Developmental Disabilities operates intermediate care facilities throughout the state to provide 24-hour residential support to individuals with intellectual disabilities. These facilities include 37 four-person community homes integrated in typical residential neighborhoods. During our audit period, the department also operated three institutions for individuals with intellectual disabilities:

- Greene Valley Developmental Center;
- Clover Bottom Developmental Center; and
- the Harold Jordan Center, a specialized forensic and behavioral stabilization facility.

As part of its efforts to support individuals in community settings rather than institutions, the department closed Clover Bottom in November 2015 and Greene Valley in May 2017. The Harold Jordan Center remained operational as of June 30, 2017, the end of our audit period.

The department's facilities are home to the individuals who live there on a long-term basis until they discharge from state care or transfer. Accordingly, the department has instituted policies and procedures to ensure that residents experience the same sense of safety, control, and security that people should expect to feel in their own homes. This includes policies to safeguard residents' personal property and their personal funds.

Personal Property

Personal property encompasses all items belonging to an individual, whether purchased by the person or given to him or her as a gift. Personal property includes the individual's clothing and jewelry, grooming implements, toys, equipment, and other material possessions. Department policy requires that residents have as much involvement as possible over the selection, care, and control of their property and that their personal property is maintained, inventoried, and monitored.

Our April 2013 audit report disclosed a finding related to the department's management of residents' personal property at Clover Bottom and the Harold Jordan Center. Specifically, we noted that department staff did not always account for residents' personal inventory items properly, did not perform regular inventories or audits of residents' belongings, and could not find specific items of inventory.

Resident Trust Fund

Residents of the department's intermediate care facilities may receive income and other financial assets from employment, government benefits, donations, gifts, stipends, and inheritances. Residents may opt to deposit their personal funds in an individual checking account at a bank of their choosing, or in a trust fund account the department maintains. One type of trust fund account is a personal fund account.

The department helps residents manage their money by

- serving as a representative payee for residents who receive Social Security benefits;
- reconciling monthly statements with account balances, purchase receipts, and cash on hand;
- maintaining personal funds cash in each facility to make available to residents upon request for their needs or for leisure activities; and
- ensuring proper disposition of trust fund monies upon a resident's death, discharge, or transfer from a department facility.

We have noted deficiencies in controls over Resident Trust Fund accounts in prior audits dating back to 2003. Our April 2013 audit report cited problems with the handling of unspent funds and verification of resident purchases at Clover Bottom and the Harold Jordan Center. The report also described inadequate safeguards over residents' personal funds at Greene Valley. Furthermore, our October 2013 audit report described improper trust fund disposition for deceased, discharged, and transferred residents.

Federal Eligibility Monitoring

Residents of department facilities are subject to income and asset limits to retain eligibility for Medicaid and Social Security benefits. Department policy requires fiscal staff to

monitor residents' trust fund accounts and alert the applicable intermediate care facility Administrator when a resident's balance reaches 75% of the maximum allowed.

Special Fund Account

The department's Administrative Office manages a Special Fund Account for accepting gifts or donations for the benefit of the department's intermediate care facility residents.

Audit Results

1. Audit Objective: Did management resolve the April 2013 finding involving personal property in the Middle region, and did management adhere to relevant guidance involving tracking personal property in the East and West regions?

Conclusion: Based on our review, management did not resolve the prior finding involving personal property in the Middle region, and management did not adhere to the guidance involving tracking personal property in the East and West regions. (see **Finding 10**)

2. Audit Objective: Did the department correct the April 2013 Resident Trust Fund finding for the Middle and East regions, and did management comply with applicable regulations when handling Resident Trust Fund accounts for the West region?

Conclusion: Management corrected the April 2013 Resident Trust Fund finding for the East region, but not the Middle region. Furthermore, we identified new issues with Resident Trust Fund accounts in the East and West regions (see **Finding 11**).

3. Audit Objective: Did management remedy the October 2013 Resident Trust Fund finding by properly disposing of account balances for deceased, discharged, and transferred residents?

Conclusion: We determined that management still did not properly dispose of Resident Trust Fund account balances (see **Finding 12**).

4. Audit Objective: Did the department comply with other aspects of its Resident Trust Fund policy, including individual bank account set-up and federal eligibility monitoring?

Conclusion: According to our testwork results, the department did not comply with federal eligibility monitoring for the Middle, East, and West regions (see **Finding 13**).

5. **Audit Objective:** For each region, did fiscal staff perform monthly personal property audits in accordance with the department's internal guidelines?

   Conclusion: We found that fiscal staff did not perform monthly personal property audits in accordance with internal guidelines for the East, Middle, and West regions (see **Finding 10**).

6. **Audit Objective:** For each region, did fiscal staff perform the required monthly bank reconciliations?

   Conclusion: Our testwork revealed that fiscal staff performed the required monthly bank reconciliations.

7. **Audit Objective:** In each region, did staff adhere to the department's internal policy regarding personal fund accounts for residents?

   Conclusion: Although East region staff adhered to internal policy, Middle and West region staff did not (see **Observation 6**).

Finding 10 – As noted in findings for the last 14 years, the department did not implement the internal controls necessary to keep track of the belongings of individuals under its care

Like those with typical cognitive abilities, individuals with intellectual disabilities own personal property, including clothing, toys, DVDs, and pictures. The Council on Quality and Leadership, the Department of Intellectual and Developmental Disabilities' accrediting body, has adopted the following standard: "People experience continuity and security." In accordance with internal policy, department staff are responsible for maintaining and monitoring the personal property of individuals residing in its facilities in the West, Middle, and East regions. Since 2003, however, we have identified deficiencies in this area. See **Table 24** for details.

Table 24
Personal Property Problems Noted in Prior State Audit Reviews

Review Type	Dates Covered	Testwork Results
Department of Finance and Administration[63] financial and compliance audit	July 1, 2003, through March 31, 2005	In the Middle region, staff did not update personal property records. Additionally, some personal property was either missing or located in suspicious locations (such as staff's vehicles).
Department of Finance and Administration financial and compliance audit	April 1, 2005, through May 31, 2007	In the Middle region, staff did not update personal property records. Additionally, some personal property was missing.
Department of Finance and Administration, Division of Mental Retardation Services follow-up review	June 1, 2007, through July 28, 2010	In the Middle region, staff did not maintain accurate or complete personal property records. Additionally, some personal property was missing, and staff did not conduct regular inventories.
Department of Intellectual and Developmental Disabilities performance audit	January 15, 2011, through July 17, 2012	In the Middle region, staff did not update personal property records. Additionally, some personal property was missing, and neither cottage nor trust fund staff performed the monthly inventories required by department policy.

Management concurred with our prior testwork results.

Our current testwork results disclosed similar problems as those noted in prior reviews. Specifically,

- department staff did not maintain a complete list of individuals' personal property;
- department staff did not follow established guidelines for inventorying individuals' personal property; and
- department management did not establish an appropriate tone at the top, which was displayed when we communicated that some individuals' personal property could not be located.

The individuals the department supports are a vulnerable population who are now located in 33 four-person community homes across the state and who rely on department management and staff to establish and maintain a control process to track their personal property. The individuals' personal property—which includes items of strong emotional attachment as well as items of necessity—is important to them as these are their only possessions.

[63] Prior to January 15, 2011, the department was a division under the Department of Finance and Administration.

Complete Population of Personal Property Inventory Not Maintained

During our testwork, we identified multiple threats to the completeness of individuals' personal property lists, and we confirmed cases where the department did not have accurate and complete lists on file.

1. For each region, the department maintained individuals' personal property lists on a shared drive, allowing multiple staff to make edits to and remove items from the lists without management providing oversight and ensuring staff were accountable for changes to the lists. At the time of our testwork, 17 staff members at the West region had access to the shared drive, 11 at the Middle region, and 23 at the East region.

   Management explained that they desired to allow staff to update the inventory records for individuals under their care on as-needed basis. Paragraphs 10.03 and 11.14 of the U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book) emphasize the importance of limiting user access "to help reduce the risk of errors, fraud, misuse, or unauthorized alteration."

   While performing our sample testwork, the risks involving staff's unrestricted access to personal property lists came to fruition. The department's Office of Investigations reported on November 10, 2016, that an East Tennessee Homes staff member exploited an individual by deleting clothing from his personal property list and then transferring that clothing to her own home. The investigative memorandum noted, "There was a state audit that took place at [the individual's East Tennessee Home] on 8/8/16 which is in direct correlation with the personal property that should have been on the log."

   An East Tennessee Homes staff member stole clothing from a resident and then covered it up by deleting the items from his personal property list.

2. According to the department's Policy 100.1.5, "A personal property inventory shall be completed on the date the person supported moves into or out of their home."

   - Department staff did not conduct initial inventories for any of the 36 individuals we selected for sample testwork in the Middle region (the only Harold Jordan Center resident admitted with personal items and the 35 individuals admitted to community homes). In addition, for 2 Middle Tennessee Home residents, community home managers still did not have an inventory list available, rendering us unable to perform our sample testwork. Staff told us they relied on previous providers to conduct inventories shortly before the individuals moved into the homes. For the 2 individuals without an inventory list, staff were unable to locate the list from the previous provider.

   - For 13 of 14 individuals we tested in the West region (93%), staff could not provide us with documentation confirming that they had performed initial personal property inventories. According to management, staff were unaware of the department's policy requirements.

3. Policy 100.1.5 states, "The personal property inventory shall be updated as new items are purchased, acquired, or discarded. . . . If personal items are outgrown, lost/misplaced, destroyed, discarded, or stolen, the disposition of the items shall be documented on the personal property."

    - Based on our review of personal property lists and discussion with management, we determined that the department did not maintain any documentation to support dispositions of items when individuals were transitioning from developmental centers to the Middle Tennessee Homes. According to management, individuals at Clover Bottom Developmental Center were moving into the community in phases as new homes were completed. Management added that when the transition actually occurred, the individuals' Circle of Support collectively decided what items should be discarded and what items the individuals could take with them, operating on the rationale that individuals would have a "fresh start" at a new home.
    - We also discovered during our sample testwork that staff had discarded a total of 30 items for 5 individuals in the Middle region without documenting the reason for doing so or the date of the action. As an explanation for this deficiency, management cited staff's difficulties in transitioning from using paper personal property lists to an electronic format.
    - At management's request, we followed up on our testwork results from the beginning of the audit where we had identified missing personal items at the Middle Tennessee Homes locations. We observed that staff had made significant changes to some individuals' personal property lists by discarding or adding items since our initial review.
        - Based on our follow-up, we determined that staff had originally provided us with inaccurate personal property lists for 25 of 33 individuals tested (76%).
        - The number of items that were either discarded or not originally added ranged from 1 to 107 (a total of 870 items).

<u>Regular Inventories Not Performed</u>

Based on our discussions with various management and staff, the department's key controls for ensuring the accuracy and completeness of personal property lists are inventories performed by both home and fiscal staff. The department's Policy 100.1.5 mandates the following for home staff: "Inventories shall be monitored quarterly, at a minimum." At the same time we attempted to physically locate items on the personal property lists, we found instances in each region where home staff were unable to provide us with conclusive evidence that they had conducted the required inventories (see **Table 25**).

Table 25
Quarterly Inventories Not Performed by Home Staff

Region	Number of Inventories Not Performed	Department's Explanation
Middle	45 of 45 individuals tested (100%, 12 at Harold Jordan Center and 33 at Middle Tennessee Homes)	For the Harold Jordan Center, management was unaware that shift supervisors were not conducting inventories as required. For the Middle Tennessee Homes, the home staff stated they had performed inventories on one of the following bases: monthly, quarterly, or annually. They added, however, that the policy did not provide specific instructions on documenting the inventories.
East	4 of 82 individuals tested (5%, all residing in 1 East Tennessee Home)	Home staff claimed that inventories had been conducted as required, but they were unable to provide us with legible documentation supporting their assertion. Management also remarked on the recent hiring of some home staff.
West	10 of 47 individuals tested (21%)	Home staff were unaware of the procedures to follow for conducting the quarterly inventories or were not maintaining complete and accurate documentation showing they had conducted the required inventories.

The fiscal staff's required monthly personal property inventories are governed by the department's *Guidelines for Monthly Cottage and Home Audits for Persons Supported*. The guidelines state, "Always check for DVD's and CD's to determine if you find the approximate number of items listed on the inventory. You should select at least 5% of the titles and locate those specifically." Central office fiscal staff select additional categories of personal property (such as clothing and toys/games/books) each month for regional fiscal staff to inventory.

As with the home staff's inventories, we detected deficiencies with the fiscal staff's inventories in the Middle, East, and West regions (see **Table 26**).

Table 26
Problems With Fiscal Staff's Monthly Inventories

Region	Testwork Scope	Problems Identified	Department's Explanation
Middle	Monthly audits for the Middle Tennessee Homes and the Harold Jordan Center for July 1, 2014, through March 31, 2016	Regional fiscal staff did not • perform 324 of 823 monthly personal property inventories (39%); • follow up on discrepancies identified during 80 of 89 inventories (90%); • inventory the categories selected by central office staff during 2015; and • achieve consistent results when separate staff performed audits at the same community home [items could not be located for 26 of 433 audits (6%), and in the other audits no discrepancies were identified].	Regional fiscal staff said they were unaware of the department's *Guidelines for Monthly Cottage and Home Audits for Persons Supported*.
East	Monthly audits for the East Tennessee Homes and the Greene Valley Developmental Center for July 1, 2014, through February 29, 2016	Regional fiscal staff did not adhere to guidelines for 336 of 406 monthly personal property inventories (83%). Specifically, staff did not • inventory the categories selected by the central office in 21 instances; and • check for DVDs or CDs in 323 instances.	Management disagreed that a problem existed, claiming that the categories selected by the central office and the guidelines' instruction to always inventory DVDs and CDs were a suggestion and not a requirement.
West	Monthly audits for the West Tennessee Homes for July 1, 2014, through February 29, 2016	Regional fiscal staff did not adhere to guidelines for 200 of 240 monthly personal property inventories (83%). Specifically, staff did not • inventory the categories selected by the central office in 12 instances; • check for DVDs or CDs in 194 instances; and • perform inventories timely in 4 instances.	Management repeated its East region response.

We ultimately concluded that fiscal staff's personal property inventories were ineffective.

Personal Property Not Located

We obtained the personal property lists on file for individuals in the department's Middle, East, and West regions and attempted to locate a nonstatistical, random sample of items. For each region, we selected five items per individual to verify. If department staff could not locate any of the initially selected five items, we then randomly selected extra items until we were able to verify five for each individual.[64]

Besides the missing items we identified, supported individuals had an unknown number of other missing personal property we were unable to recognize due to the incomplete lists management provided to us.

As with prior audits, our testwork results revealed that some individuals' personal property was missing: 17 of 250 items for the Middle region (7%), 11 of 421 items for the East region (3%), and 4 of 115 items for the West region (3%).[65] The department's Policy 100.1.5, "Personal Property," establishes, "The personal property inventory shall be updated as new items are purchased, acquired, or discarded."

Department management concurred with our Middle region testwork results, citing inadequate oversight, simple human error, and the complexities surrounding Clover Bottom's closure and the subsequent opening of the Middle Tennessee Homes. For the East region, management pointed out that several staff were involved in keeping track of personal property, which could lead to communication gaps about updating property lists. Furthermore, staff could be distracted by other responsibilities. For the West region, management either believed the property had been discarded but the list had not been updated or could not provide an explanation for the missing item.

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[64] Our specific sampling methodology for each region was as follows:

- Middle – We obtained the population of Harold Jordan Center residents as of March 14, 2016, and the population of Middle Tennessee Homes residents as of March 31, 2016. Of the 14 Harold Jordan Center residents, we tested 11; we did not test personal property for the remaining 3 residents due to safety concerns. We tested all 33 Middle Tennessee Homes residents with available personal property list. Therefore, we tested a combined total of 49 residents in the Middle region. We attempted to physically locate items between April 4, 2016, and April 8, 2016.
- East – We obtained the population of 62 Greene Valley Developmental Center residents as of May 16, 2016, and the population of 61 East Tennessee Homes residents as of February 29, 2016. We selected for testwork the entire population of 62 Greene Valley residents and selected a random, nonstatistical sample of 5 of 16 East Tennessee Homes residents, with 4 residents per home, for a total of 20 residents. We tested a combined total of 82 residents for the East region. We attempted to physically locate items between May 16, 2016, and May 25, 2016.
- West – We obtained the population of 47 West Tennessee Homes residents as of February 13, 2017. We selected a nonstatistical, random sample of 6 of the 12 West Tennessee Homes and tested each resident (a total of 23). We attempted to physically locate items between March 13, 2017, and March 16, 2017.

[65] We list the specific personal property not located in Appendix 3 on page 208.

Management's Overall Response

Although management agreed with us that some regular inventories were not performed and some individuals' personal property was missing, they dismissed the overall importance of our testwork results. We believe that to safeguard each individuals' personal property, it is imperative that management have the proper control process in place to ensure the accuracy of personal property lists. The Chief Administrative Officer and other administrative management told us on numerous occasions, though, that the regular inventories performed by fiscal staff were out of courtesy and not a requirement.

Moreover, the Chief Administrative Officer and other administrative management repeatedly expressed their belief that the missing personal property should be evaluated on a quantitative basis. In other words, if the item cost $5, losing it is not important. We, however, considered both qualitative and quantitative measurements. Items on the personal property lists represent all of the individuals' material possessions. Even if an item is relatively inexpensive, it may be an individual's favorite possession, and losing it could cause him or her distress.

Management's attitude toward an individual's personal property inevitably trickles down to staff. The Green Book emphasizes, "The control environment is the foundation for an internal control system." Management should "establish and maintain an environment throughout the entity that sets a positive attitude toward internal control" and should "demonstrate a commitment to integrity and ethical values."

Recommendation

The Commissioner should ensure that both central office and regional office management and staff accept full responsibility for the personal property of supported individuals. In addition, the department should

1. ensure that home staff maintain complete and accurate personal property lists on each individual;
2. avoid providing unnecessary edit access to personal property lists and implement a system that allows updates on the electronic lists to be traceable to specific staff;
3. add a functional level of reviewing and approving discarded items separate from the home staff;
4. ensure that home staff conduct initial inventories upon each individual's admission and then the required quarterly inventories thereafter;
5. ensure that fiscal staff conduct monthly inventories in accordance with established guidelines or, if management opts to revise the guidelines, that fiscal staff inventory every item on an individual's personal property list at least once throughout the year;
6. design a system to ensure that inventories conducted by home staff and fiscal staff are properly documented (including the dates of inventories, the names of staff conducting them, and the results);

7. take the appropriate disciplinary action (if needed) against home and fiscal staff; and
8. ensure the central office provides each regional office with improved training on accounting for personal property.

Management's Comment

We concur that the internal controls for personal property management need to be strengthened. The department is in the process of implementing an information technology solution to track the personal property of each resident. This solution will identify system users, dates, and times of each entry made into the personal property inventory. In addition, the solution will catalog all discarded property and allow users to provide a justification for the disposal of each item. DIDD [department] Central Office staff and Regional Office staff are conducting training sessions with the homes staff to ensure that initial property inventories are completed accurately and maintained for the duration of a resident's stay.

The department is in the process of revising the guidelines for our monthly audit process to incorporate current departmental structures, updated audit practices, and recommendations set forth in this audit report. The revisions envisioned by the department will allow for an increased focus on qualitative measurements while also maintaining a focus on quantitative values. Specifically, the revisions will allow for the flexibility to audit items that are most important to the residents, and focus on the items with the highest monetary value.

Central Office staff will continue to issue audit reports that outline property management issues discovered. These identified issues will continue to be tracked until resolved. Implementing this practice will give Central Office and Regional Office staff an additional tool to ensure compliance with policy and a metric to evaluate the effectiveness of departmental practices.

Finding 11 – Since 2003, the department has lacked adequate internal controls over the use of Resident Trust Fund accounts to make purchases

Resident Trust Fund accounts are equivalent to personal bank accounts.

Department of Intellectual and Developmental Disabilities regional office staff are responsible for administering Resident Trust Fund accounts, which are established for the individuals served through the department's developmental centers and community homes. These individuals receive money from the Social Security Administration, relatives, jobs, and other sources that is deposited into their Resident Trust Fund. Individuals with sufficient account balances may purchase items or services or have items or services purchased on their behalf, such as Christmas presents, haircuts, and life insurance payments.

We have reported findings with the department's handling of Resident Trust Fund accounts for the past 14 years. Specifically, in our April 2013 audit, we cited the department because staff did not

- return unspent funds promptly to the accounting office at the Clover Bottom Developmental Center and Harold Jordan Center after the purchase/event;
- properly secure unspent funds at the Clover Bottom and Greene Valley Developmental Centers and the Harold Jordan Center;
- properly document that items purchased matched the related receipts at Clover Bottom and the Harold Jordan Center; and
- retain the logs showing the movement of money at the East Tennessee Homes.

Management concurred with our finding and informed us that in December 2012, all of the department's Fiscal Offices were consolidated into one central Fiscal Office to ensure uniformity among policies and practices and to increase oversight.

For the current audit, we found that although the weaknesses involving the security of unspent funds and retaining logs had been resolved,

- receipts containing the purchase of physical items could not be matched to individuals' personal property lists;
- individuals did not get to take advantage of the membership points or rewards their purchases generated; and
- unspent funds were still returned late to the accounting office.

Testwork Background and Methodology

The department formalized its instructions for processing supported individuals' money through Policy 100.1.11, "Trust Fund Accounts," which became effective November 8, 2013. The department uses Request for Funds forms to document the chain of custody for individuals' money. In addition, the department maintains a personal property list for each individual showing his or her belongings.

For the Middle region (Middle Tennessee Homes), we tested a nonstatistical, random sample of 60 Request for Funds forms from a population of 1,745 for the period November 8, 2013, through February 29, 2016. For the East region (Greene Valley Developmental Center and East Tennessee Homes), we tested a nonstatistical, random sample of 60 checks from a population of 5,037 for the period November 1, 2013,[66] through April 26, 2016. For the West region (West Tennessee Homes), we obtained a check register for the period November 8, 2013, through December 31, 2016, which we then filtered for the checks involving Request for Funds forms. From the population of 417 checks involving Request for Funds forms, we selected a nonstatistical, random sample of 60 to test.

[66] The department provided us with monthly check registers for the East region.

Unsubstantiated Personal Property

For both the East and West regions, we identified several instances where items purchased could not be traced to supported individuals' personal property lists.[67]

Table 27
Unsubstantiated Personal Property

Region	Problems Identified	DIDD's Explanation
East	For 10 of 60 Request for Forms tested in the East region (17%), items listed on receipts as purchased were not included on the individual's current personal property listing. This condition involved a total of 29 items costing $336.	Staff had recorded 19 of the items on a prior personal property listing but could not provide documentation as to the subsequent fate of the item. Management said that a lot of the items may have been discarded because some supported individuals are rough on their clothing. Furthermore, we found inaccurate information on the prior listings—prices higher than and quantities lower than those on the receipts. Staff did not record 10 of the purchased items on any personal property listing.
West	For 11 of 60 Request for Forms tested in the West region (18%), items listed on receipts as purchased were not included on the individual's current personal property listing. This condition involved a total of 70 items costing $1,035.	Management explained that 40 items were purchased prior to the region's switch on July 1, 2014, to an Excel system to track personal property. Staff did not record 14 of the purchased items on any personal property listing. For the remaining 16 items, staff recorded fewer items purchased than was shown on the receipt, or else we could not determine the status of the item.

We also identified one Request for Funds form in the East region and one form in the West region with unreadable receipts attached, as well as one form in the West region where the receipt attached was not the original (lacked the store's logo).

According to the department's Policy 100.1.5, "Personal Property," "The personal property inventory shall be updated as new items are purchased, acquired, or discarded." Additionally, Paragraph 10.03 of the U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* states the following:

[67] See **Finding 10** on page 143 for further deficiencies we identified with personal property.

> Transactions are promptly recorded to maintain their relevance and value to management in controlling operations and making decisions. This applies to the entire process or life cycle of a transaction or event from its initiation and authorization through its final classification in summary records. In addition, management designs control activities so that all transactions are completely and accurately recorded.

Misapplied Membership Benefits

Based on our testwork for the East and West regions, supported individuals' purchases generated membership points and rewards, but the department was unable to provide us with documentation showing that the individual received those benefits.

- For the East region, this condition involved 2 of 60 Request for Funds forms (3%) and 3 receipts. The membership benefits generated consisted of department store "cash" and points.
- For the West region, this condition involved 6 of 60 Request for Funds forms (10%) and 8 receipts. The membership benefits generated consisted of department store points.

The department's Policy 80.4.3, "Personal Funds Management," establishes,

> Providers and their employees, representatives, subcontractors and paid conservators shall not illegally obtain, misappropriate or otherwise misuse personal funds. Prohibited practices include, but are not limited to, the following . . . b. Using a person's personal funds for staff benefit . . . h. Using a person's personal funds for purposes that do not benefit the person-supported, except as specified above.

Management did not believe this was a concern that needed to be addressed.

Unspent Funds Returned Late

Our testwork revealed that staff in the Middle and West regions did not turn in unspent funds to the accounting office in accordance with internal standards. The department's Policy 100.1.11, "Trust Fund Accounts," stipulates, "All DIDD [department] employees designated to negotiate checks written from trust fund accounts shall return unspent cash and submit receipts to the Fiscal Office within three (3) business days following the activity or event for which the disbursement was approved." Error details are as follows:

Table 28
Unspent Funds and/or Receipts Returned Late

Region	Request for Funds Forms	Problems Identified	Days Late	Department's Explanation
Middle	27 forms including shopping trips	For 17 of these 27 forms (63%), staff did not turn in purchase receipts and/or unspent money timely to the accounting office.	Ranged from 1 to 7 and averaged 1	Based on discussion with management, staff only violated internal policy due to extraordinary circumstances, such as an unplanned hospital visit with an individual. We were not provided with evidence of these extraordinary circumstances, however.
West	48 forms including shopping trips	For 4 of these 48 forms (8%), staff did not turn in purchase receipts and/or unspent money timely to the accounting office.	Ranged from 1 to 2 and averaged 2	Management believes these funds should have been returned within 3 business days from the event. Management also stated that since these errors were from 2014 and since there were no other errors noted of this type, no further action is required.

Departmental Internal Reviews

During the Office of Risk Management and Licensure's review of Resident Trust Fund accounts, internal monitors also identified problems. In the fiscal year 2014-2015 report, published on September 8, 2017, for the period June 1, 2014, through July 31, 2014, the Office of Risk Management and Licensure had a *finding* that internal controls over disbursements needed improvement. Specifically, monitors found errors in all three regions with late returns of unspent cash and receipts (see **Table 29**).

Table 29
Late Returns of Unspent Cash and Receipts Identified During Internal Reviews

Region	Late Return Details	Department's Response
Middle	4 of 22 checks written (18%)	Management concurred with the Office of Risk Management and Licensure's testwork results.
East	8 of 20 checks written (40%)	Management concurred with the office's testwork results.
West	6 of 10 checks written (60%)	Management concurred with the office's testwork results.

Resulting Consequences

Department management and staff possess a fiduciary duty to ensure proper protection of and reasonable access to Resident Trust Fund accounts. Because of the deficiencies we noted, the department faces a heightened risk of failing to safeguard supported individuals' money. Theft or other loss may result.

Recommendation

Department management should ensure staff

1. accurately and completely record purchased items on the applicable individual's personal property list;
2. document discarded items;
3. maintain proof that membership benefits were used on the supported individual;
4. return unspent funds to the accounting office timely; and
5. in the central office, perform regular reviews of the problem areas we identified at the regional offices.

Management's Comment

We concur with the majority of this finding with a few exceptions. As in the previous finding, the department agrees that the internal controls for personal property management should be strengthened. The previously mentioned information technology property management solution coupled with additional training should assist staff in accurately recording purchased items and documenting discarded items on personal property listings.

The department maintains that membership benefits directly benefited individuals supported, as evidenced by the audited receipts, through the purchase of items at a discounted price. The intent of utilizing a membership card is to assist a supported individual in the conservation of personal funds not to benefit staff.

Although the department has made improvement since the previous audit period, we concur that controls related to the timely return of unspent funds can be strengthened. Currently, the department is developing mechanisms for reporting and documenting extraordinary circumstances that may prevent the timely return of unspent funds. Additional training concerning returning funds in a timely manner is also being provided.

Finding 12 – As noted in our October 2013 audit, the department did not ensure that the money belonging to individuals who died at, or were otherwise transferred from, its facilities ended up with the appropriate parties

Our October 2013 audit report disclosed that the Department of Intellectual and Developmental Disabilities failed to comply with federal and state guidelines for disposition of Resident Trust Fund balances—equivalent to bank account balances—for deceased and transferred residents. This noncompliance resulted in the routing of money to parties to whom it did not actually belong. Management concurred with our finding. For the current audit, we identified similar problems with Resident Trust Fund accounts.

Background

Regional office staff are responsible for administering Resident Trust Fund accounts, which are established for the individuals served through the department's developmental centers and community homes (known as intermediate care facilities for individuals with intellectual disabilities). The money individuals receive from various sources, such as the Social Security Administration, relatives, and jobs, is deposited into their Resident Trust Fund, and individuals with sufficient account balances may purchase items or have items purchased on their behalf for their personal use. When an individual transfers to another facility or dies, regional office staff follow the department's Policy 100.1.11, "Resident Trust Funds"; state law; and the Social Security Administration's 2014 *Guide for Organizational Representative Payees* to close the Resident Trust Fund.

Disposition of Resident Trust Fund Accounts

According to the department's Policy 100.1.11, Section VI.B.1.h:

> Funds remaining in the person's personal bank account or trust fund account shall be transferred with the person to his/her new residence. The Fiscal Office shall return any unspent Social Security or SSI [Supplemental Security Income] funds, including interest, to the Social Security Administration in accordance with Social Security Administration rules and regulations. If a person supported is discharged from the ICF/IID [intermediate care facility] due to death, the Fiscal Office shall perform a full and final accounting of funds. At the discretion of DIDD [the department], funeral expenses may be paid with the person's remaining funds if the funeral bill exceeds the amount of any burial trust. Additional monies and property left by the deceased person shall be distributed according to TCA [*Tennessee Code Annotated*] 33-4-109(b)(c)(e). The Fiscal Office shall ensure that individual bank accounts belonging to discharged persons are closed.

Furthermore, Section 33-4-109(b)(c)(e), *Tennessee Code Annotated*, states

> Notice to an administrator, executor or personal representative shall be directed to the probate court of the county in which that person is qualified to administer the estate of the deceased. . . . The chief officer shall keep the deceased or discharged person's personal property for six (6) months if it is not claimed. The chief officer shall then sell the property, with the approval of the commissioner, and deposit the proceeds in a fund, maintained under the supervision of the chief officer, for the benefit of needy service recipients.

Purpose of Benevolent Fund

In addition to the Resident Trust Fund accounts, department policy describes the regional office staff's administration of the Benevolent Fund, a community fund consisting of donations from residents' family and friends or other donors. These fund donations are used to pay for residents' activities as well as memorials for past residents.

Testwork Results

We obtained a population of the 91 deceased or transferred residents from the West, Middle, and East regions during the period June 21, 2013, through December 31, 2016. We tested a nonstatistical, random sample of 60 Resident Trust Fund accounts for deceased or transferred residents. Due to the problems noted for residents from the Middle region, we reviewed all deceased and transferred residents in that region (an additional 6 residents), for a total of 66 tested.

Original Testwork

Based on our review, the department did not ensure the proper disposition of the Resident Trust Fund accounts for 12 of 60 individuals tested (20%), as detailed in **Table 30.**

Table 30
Improper Dispositions of Resident Trust Fund Accounts – Original Testwork

Problem	No.	Region	Resident's Status	Amount in Question
After the account balance went unclaimed for six months, the department should have followed Section 33-4-109(b)(c)(e), *Tennessee Code Annotated,* referenced in Policy 100.1.11, by transferring the money to the Benevolent Fund and then closing the Resident Trust Fund account. Instead, the Resident Trust Fund account remains open.	1	West	Deceased on 6/19/2015	$344.33
	2	West	Deceased on 12/25/2013	$691.91
According to state law and the appropriate probate court, the department should have transferred the remaining account balance to the individual qualified to administer the estate of the deceased. The department, however, wrote a check for the amount directly to the conservator.	3	Middle	Deceased on 8/10/2014	$224.43
	4	Middle	Deceased on 3/19/2016	$1,705.83
	5	Middle	Deceased on 11/10/2014	$18.30
	6	Middle	Deceased on 2/28/2015	$767.97
	7a*	East	Deceased on 7/28/2013	$462.92
After the department wrote a check for the account balance to the conservator, the Resident Trust Fund received an interest allocation. The department transferred the interest amount to the Benevolent Fund without waiting the six months required by state law.	7b*	East	Deceased on 7/28/2013	$0.07
	8	East	Transferred on 7/10/2013	$0.07
	9	East	Transferred on 8/6/2013	$0.51
	10	East	Deceased on 11/1/2013	$0.19
	11	East	Transferred on 3/18/2014	$0.03
	12a*	East	Deceased on 10/13/2014	$0.01
The funeral home refunded an amount to the department. Rather than waiting the six months required by state law, the department transferred the amount to the Benevolent Fund.	12b*	East	Deceased on 10/13/2014	$13.37
Total Amount Improperly Disposed:				**$4,229.94**

*The disposition consisted of two separate transactions.

We found that the error rates for the current audit testwork and the prior audit testwork were both 20%.

Management stated that the West and East region errors occurred while the department was revising and implementing Policy 100.1.11. The department implemented Policy 100.1.11 on November 8, 2013, with a revision effective July 21, 2016. Due to the problems we identified in our original sample, we performed additional testwork to evaluate the breadth of the department's noncompliance. We expanded our sample specifically for the Middle region after considering the error rate from this region and department management's comment to us that the Middle region trust fund staff knew the policy but acted against it.

Expanded Testwork

We tested the remaining six Middle region individuals included in our population and discovered that Resident Trust Fund accounts for an additional four individuals were not properly disposed (see **Table 31**).

Table 31
Improper Dispositions of Resident Trust Fund Accounts – Expanded Testwork

Problem	No.	Region	Resident's Status	Amount in Question
According to state law, the department should have transferred the remaining account balance to the probate court.	1	Middle	Deceased on 6/30/2015	$539.19
The department, however, wrote a check for the amount directly to the conservator.	2	Middle	Deceased on 8/6/2013	$889.11
The department transferred the interest amount to the Benevolent Fund without waiting the six months required by state law.	3a*	Middle	Deceased on 10/3/2014	$20.85
	4a*	Middle	Deceased on 6/20/2014	$24.89
The department reimbursed the conservator for funeral expenses without obtaining receipts for those expenses.	3b*	Middle	Deceased on 10/3/2014	$350.00
	4b*	Middle	Deceased on 6/20/2014	$300.00
Total Amount Improperly Disposed:				**$2,124.04**

*The disposition consisted of two separate transactions.

Prior Audit Errors

We performed a follow-up on the seven individuals from the October 2013 audit report to determine if the regional office staff made the appropriate corrections for disposition of the Resident Trust Fund accounts. Based on the follow-up, we determined that for four individuals (57%), staff did not perform the necessary procedures. Specifically, we found the following:

- For one uncorrected error, West regional trust fund staff did not attempt to follow up with Social Security Administration (SSA) for $1,073.63 erroneously returned in July 2011. Since staff did not immediately follow up

with SSA, the opportunity to receive the erroneously returned funds has likely passed.

- For two uncorrected errors, Middle regional trust fund staff believed that since the amount in the residents' account was less than $1.00, the amount would not have been transferred with the resident and would have instead been moved into the Benevolent Fund. The staff was unable to verify this information because the accounting information was maintained in a previous system and is no longer accessible.
- For one uncorrected error, East regional trust fund staff moved the funds that remained as the account balance directly into the Benevolent Fund without notifying the conservator.

Departmental Internal Reviews

The Office of Risk Management and Licensure's internal auditors also performed reviews of deceased individuals' Resident Trust Fund accounts:

- In the fiscal year 2014-2015 report, published on September 8, 2017, for the audit period June 1, 2014, through July 31, 2014, the Office of Risk Management and Licensure had a *repeat finding* for an individual whose account balance was not handled timely. In this case, the internal auditors found that after the individual's death, a notification letter was mailed, but a subsequent follow-up was not performed until a year and a half later. Management concurred and stated that division staff would continue to receive training on policy and procedures.
- In the fiscal year 2016 report, published on October 12, 2017, for the audit period February 1, 2016, through March 31, 2016, the office had a *repeat finding* for five individuals whose account balance was not handled timely. The internal auditors found that after the individual's death, follow-up on these accounts did not occur until seven months to a year and a half later. Management concurred and stated that they would provide refresher training for trust fund staff and ensure that timely notification was given to applicable staff.

Risks Resulting From Problems Noted

Because the department did not ensure the proper disposition of Resident Trust Fund account balances for deceased and transferred residents, the department deprived the parties legally entitled to the money.

Recommendation

The Chief Administrative Officer should ensure regional office staff ensure the proper disposition of Resident Trust Fund accounts upon death or transfer of an individual in accordance with the established laws, SSA guidelines, and the department's policies and procedures. She should also ensure that staff remedy the errors we noted.

Management's Comment

We concur that policy was not followed, particularly in the Middle Tennessee Region, concerning the disbursement of funds related to the death of a resident. The department has implemented additional training to ensure all staff follow proper procedures as set forth in *Tennessee Code Annotated* 33-4-109 and Policy 100.1.11. The department would like to note that the two improper dispositions for West Tennessee Region (as noted in Table 30) have been resolved.

As to the prior uncorrected audit errors, the item related to the West Tennessee Trust Fund staff was discovered during the prior October 2013 audit report. At that time, this item was over two years old and the department concurs that the opportunity to recoup those funds expired. The department admits that, even four years later, the opportunity to receive these funds has expired. Staff has been trained to address these types of situations in the future. As to the other previous findings, the department's general counsel has provided guidance on how to address returned interest and other funds in accordance with applicable policies and law. This guidance will be applied to returned funds in the future and should reduce the risk of findings of this nature in the future.

Finding 13 – Because of the department's inadequate monitoring, some individuals' account balances exceeded the maximum allowable amount, risking loss of Medicaid eligibility

Per the Social Security Administration's regulations, an individual's monthly account balance should not exceed $2,000 except in cases where the individual receives back payments. Individuals whose account balance exceeds the maximum allowable amount may lose their Medicaid eligibility and, thus, their place in the department's facilities.

The department tracks the money of individuals residing at its facilities by establishing Resident Trust Fund accounts.

During our testwork at the Department of Intellectual and Developmental Disabilities, we found instances where staff failed to comply with internal policy for monitoring Resident Trust Fund accounts, and as a result, some individuals exceeded the Social Security Administration's $2,000 account balance limit.

Testwork Methodology

We selected for testwork individuals residing at the department's facilities in each region:

- Middle – 14 residents at the Harold Jordan Center as of March 14, 2016, and 35 residents at Middle Tennessee Homes as of March 31, 2016, for a total of 49. We tested the entire population.

- East – 61 residents at East Tennessee Homes as of February 29, 2016, and 62 residents at Greene Valley Developmental Center as of May 16, 2016, for a total of 123 residents. We tested a nonstatistical, random sample of 60 residents.
- West – 47 residents at West Tennessee Homes as of February 13, 2017. We tested the entire population.

For the residents tested, we recalculated their monthly account balances from June 1, 2013 (or their move-in date), through our testwork date.

Testwork Results

The department's Policy 100.1.11, "Trust Fund Accounts," states, "The Fiscal Office shall monitor the accumulation of personal funds for persons supported to prevent the loss of benefits (e.g. Social Security or Medicaid) due to excessive accumulation."

Department staff use monthly Quicken reports to monitor supported individuals' account balances. For our audit period, 75% of the maximum allowable account balance equaled $1,500. Upon reaching this threshold, department staff should send notifications to the applicable regional office Director. If the balance is over the $2,000 threshold, department staff should send an email or fax to the Department of Human Services until September 2016 and the Division of TennCare going forward.

Our testwork disclosed problems with Medicaid eligibility monitoring in all three regions.

- Middle – We determined that staff did not monitor 44 of 49 (90%) Resident Trust Fund accounts for the 75% threshold. The Accountant 3 explained that she believed she was only required to track the account balances of the 5 individuals who received Supplemental Security Income.[68] Management agreed with us that all Resident Trust Fund accounts should have been monitored for Medicaid eligibility.

  Because of inadequate monitoring, 14 individuals reached 75% of the maximum allowable account balance but were not reported to the regional office Director. Four of these individuals' exceeded the $2,000 limit for 30 days or more. In the most egregious instance, an individual's account remained over the limit for 11 months and reached $8,707.
- East – For 12 of the 60 Resident Trust Fund accounts we tested (20%), staff were unable to provide us with documentation showing that they had notified the regional officer Director once the account reached 75% of the maximum allowable balance. Based on discussion with management, since 5 of the accounts involved the same

[68] According to https://www.ssa.gov/ssi/, "Supplemental Security Income (SSI) is a Federal income supplement program funded by general tax revenues (*not* Social Security taxes):

- It is designed to help aged, blind, and disabled people, who have little or no income; and
- It provides cash to meet basic needs for food, clothing, and shelter."

month, this was a matter of a lost document. Management told us that staff did not notify the Director for the other 7 accounts "for good reason." Specifically, staff were aware that the individuals were about to incur a liability that would reduce their account balances below $1,500.

- West – We found that for 9 of 47 individuals (19%), staff did not notify the regional office Director that the account balance was greater than 75% of the maximum allowable limit. Two individuals' account balances exceeded the $2,000 limit for more than 30 days. One of these individuals reached a balance of $4,441 and remained over the account limit for 8 months. Management attributed the errors we noted to missing documentation. As in the East region, management asserted that West region staff were aware that some individuals would incur a liability that would drop their balances below the reporting threshold.
- All – Management's comments on the East and West region errors revealed that the department's policy did not establish a mechanism for calculating the individual's account balance to determine if it had exceeded the maximum allowable amount. Additionally, department policy did not establish a time of the month to report to the regional office Director or the Department of Human Services/Division of TennCare the individuals whose account balances exceeded the maximum allowable amount of $2,000 for 30 days or more.

Recommendation

Department management should ensure that staff in each region monitor all the Resident Trust Fund balances and notify the regional office Director once the $1,500 threshold is reached, as well as notify the Division of TennCare once the balance is over the $2,000 threshold. Management should ensure staff retain complete and accurate documentation of this notification. Furthermore, management should develop policies and procedures on how to calculate and when to report the individuals whose account balances exceed the $2,000 limit for 30 days or more.

Management's Comment

We concur that monitoring individual account balances needs to be enhanced and strengthened. The department agrees that Regional Trust Fund staff should notify the ICF/IID Directors when a resident's balance reaches $1,500. The department is in the process of conducting additional training of staff to ensure that needed notices are sent to the appropriate parties on a monthly basis and that these notices are retained to document transmission. In addition, a new Trust Fund Procedures for Reporting on Medicaid Eligibility is being developed to ensure that all staff are aware of the procedures for reporting resident balances over $2,000.

Observation 6 – The Middle and West Tennessee regions did not have adequate internal controls in place when handling the personal funds of individuals residing in community homes

Individuals who reside in the Department of Intellectual and Developmental Disabilities' East, West, and Middle Tennessee Homes and the Harold Jordan Center have personal funds available onsite for daily use such as shopping or eating out. The funds are maintained in a secured repository (such as a safe, lock box, or locked drawer) with a separate record of available cash for each person for whom money is held. Each transaction is recorded on the Individual Accounting Form.

We found the Middle and West Tennessee Homes did not follow best practices or have adequate internal controls in place over the individuals' personal funds. We noted the following problems:

1. one individual did not have personal funds available;
2. staff did not fill out the Individual Accounting Form correctly;
3. home managers did not adequately segregate duties when handling individuals' personal funds; and
4. staff were inconsistent in the type of Individual Accounting Form used to record the personal fund transactions;

Middle Tennessee Homes

We reviewed Individual Accounting Forms for all 48 individuals presently residing at the Middle Tennessee Homes and the Harold Jordan Center for the 5 most current months at the time of our testwork (December 2015 through April 2016). Based on our testwork, we determined that 1 of 48 individuals (2%) did not have personal funds available and the home manager did not communicate the personal fund request to the accounting office in a timely manner. Specifically, the individual in question moved into the home on March 15, 2016; however, the home manager had not notified the accounting office of the need for personal funds for that individual as of April 4, 2016.

West Tennessee Homes

We reviewed the Individual Accounting Forms for 47 individuals residing at the West Tennessee Homes as of February 13, 2017, and found that for 35 individuals (74%), the department did not ensure adequate controls were in place pertaining to the individuals' personal funds. Specifically, we noted the following:

- For 7 of the individuals tested, the home managers did not complete the Individual Accounting Form correctly. We noted that the home managers did not complete the date, source, amount of funds received/returned, and/or signature column. In addition, one form contained a calculation error that was not identified when fiscal staff performed their monthly audits.

- For 32[69] of the individuals tested, the home manager did not adequately segregate duties when handling individuals' personal fund transactions. We found home managers did not obtain a second signature when an individual's personal funds were being received or returned.

Individual Accounting Forms

Based on our review of the Individual Accounting Forms for the 47 individuals residing in the West Tennessee Homes, we found the home managers were using a version of the form that appeared to be outdated in comparison with the Middle region. The Trust Funds Account Operations Manager for the central office provided us with the current version of the form used by the Middle region as of March 2016. The form contained a total of 11 columns with additional spaces for signatures of staff handling the individual's personal funds. The form used by the West region contained 8 columns, with the additional spaces for staff signatures removed. The Chief Administrative Officer at the central office told us that the form with 8 columns is the new version of the form and that fiscal staff sent the new form to the West region in August 2016. After we brought this issue to her attention, the Chief Administrative Officer then stated that the West region had already switched from the 11-column form to the 8-column form prior to the department officially deploying the new form. Based on this information, we were unable to determine when the regions should have started using the new form.

Conclusion

When the department does not ensure adequate internal controls are in place when handling an individual's personal funds, the risk for misappropriation increases. If the home manager does not communicate in a timely manner a request for an individual's personal funds, the individual may be unable to purchase things that he or she needs or wants. When an individual's funds are disbursed or received but not recorded completely and accurately and there is no second verification of the cash transaction, the possibility of errors may result in incorrect and unreliable accounting information. Furthermore, if community home managers do not maintain the most current version of the Individual Accounting Form, staff may inadequately document transactions for information that may prove helpful should an error or a misappropriation occur. By using different versions of the Individual Accounting Form, the uniformity principle in the accounting function is not applied.

Recommendation

1. The department should reconsider implementing written guidelines that provide a reasonable time frame for home managers and accounting personnel to request and process personal funds for new residents. The guidelines should clearly state responsibilities and duties of each staff member involved in the process.
2. The department should ensure that the home managers and staff are filling out the Individual Accounting Form for each resident completely and accurately.

[69] For some individuals, we found both types of errors present.

3. The department should ensure that community home managers and their staff adequately segregate and document their duties. This activity includes obtaining two signatures showing verification of the cash count when an individual's personal funds are being received or returned.
4. The department should ensure that all of its facilities use the most current version of the Individual Accounting Form to document individuals' personal fund transactions.

TRANSITIONS FROM DEVELOPMENTAL CENTERS TO COMMUNITY HOMES

Beginning in 1923, the State of Tennessee operated developmental centers to provide 24-hour residential care to citizens with intellectual disabilities. Industry best practices and public attitudes evolved over time to favor supporting people with disabilities in integrated community settings rather than institutions, and by the early 1990s, litigation alleged civil rights violations and subpar conditions at the state's developmental centers. The Department of Intellectual and Developmental Disabilities resolved to settle the lawsuits and improve its service delivery by closing the developmental centers and transitioning residents to community homes. Community homes are certified intermediate care facilities for individuals with intellectual disabilities (ICF/IID), house up to four individuals, and are located in typical residential neighborhoods to promote community integration. (See **Table 32** for a comparison of developmental centers to community homes.)

The department began transition efforts with Arlington Developmental Center residents in 2007 and completed the endeavor when the final residents of Greene Valley Developmental Center moved into their new homes in May 2017. Because the department was constructing each of the 38 community homes (16 in East Tennessee, 10 in Middle Tennessee, and 12 in West Tennessee) to meet ICF/IID certification standards, the time frame to transition an individual to a community home took up to two years. The department created an Individual Support Transition Plan for each resident, detailing the continuity of services and supports from the developmental center to the community home. In addition, department monitors conducted a minimum of five post-placement visits with each community home resident to ensure satisfaction of key indicators specified in the plan. After the final post-placement visit, the department continues to monitor residents' quality of life through the Individual Support Plan development and review process.[70]

The department's YouTube page features a video of the last Clover Bottom resident transitioning to a community home in November 2015: **https://www.youtube.com/watch?v=u1ButZqg7AU.**

We focused our audit work on quality of care following resident transitions to community homes from the Clover Bottom and Greene Valley Developmental Centers, both of which closed during our audit period.[71]

[70] We present additional information about Individual Support Plans in the Service Delivery System Operations section of the report on page 25.

1. **Audit Objective:** Was the rate of incidents (abuse, neglect, exploitation, and death) at community homes comparable to that of developmental centers?

   Conclusion: Based on the analytical procedures we performed, the rate of incidents at community homes was slightly lower than that of developmental centers (see **Table 33** for the rates of abuse, neglect, and exploitation).

2. **Audit Objective:** Did the department establish an adequate process for documenting and responding to complaints lodged by community home residents and other interested parties?

   Conclusion: We determined that the department's Protection from Harm system provided an adequate process for documenting and responding to complaints.

Table 32
Comparison of Developmental Centers to Community Homes

	Clover Bottom Developmental Center	Greene Valley Developmental Center	Community Homes
Date Opened	1923	1960	2010–2017
Date Closed	November 2015	May 2017	-
Space	363 acres	450 acres	4,000 square feet
Number of Beds	20 (as of June 30, 2015)*	62 (as of June 30, 2015)*	4 per home
Average Daily Cost per Person (2015)	$1,856	$1,000 / $1,366**	West: $933–$1,387 Middle: $932–$1,266 East: $659–$994

* The number of beds at Clover Bottom and Greene Valley continued to decline as individuals transitioned to community care. At their peak in the 1960s, Clover Bottom housed approximately 1,500 individuals and Greene Valley housed approximately 1,100 individuals.

** The first rate represents the average daily cost per person for "high personal care" services. The second rate represents the average daily cost per person for "medical treatment" services.

[71] We present additional information about the closure of Clover Bottom and Greene Valley, including pictures, in the Achievements section of the report on page 16.

Table 33
Average Annual Incidents of Abuse, Neglect, and Exploitation per 100 Residents at Developmental Centers and Community Homes Between June 1, 2013, and December 31, 2016[72,73]

	2013 (June 1–December 31)	2014	2015	2016
Clover Bottom Developmental Center	0.27	0.50	0.33	Closed
Greene Valley Developmental Center	0.11	0.37	0.45	0.35
Middle Tennessee Homes	No residents	0.20	0.27	0.25
East Tennessee Homes	0.19	0.17	0.27	0.13

INFORMATION SYSTEMS

The Department of Intellectual and Developmental Disabilities uses information systems to support its mission-critical business functions. The state's centralized computer service bureau, Strategic Technology Solutions (STS), manages the department's network access and email; hosts most of the department's file and application servers; and administers Edison, the state's enterprise resource planning system. The department's Information Technology division was responsible for supporting internal applications and implementing new hardware technologies until July 2016, when this function transitioned to STS as part of Tennessee's NextGen Information Technology improvement initiative.

We focused our audit work on two aspects of the department's computing environment: information systems controls and systems development.

Information Systems Controls

Information systems controls broadly describe measures to ensure the security, accuracy, and reliability of hardware and software. Our April 2013 audit report included two findings relating to the department's information systems controls, one of which was repeated from the prior two audits.

[72] We calculated average annual incident rates per 100 residents by dividing the total number of incidents reported at a facility in a calendar year by the facility's average monthly census for the year, and multiplying the result by 100. We calculated each facility's average monthly census by adding the facility's monthly population counts in a calendar year and dividing the result by 12.

[73] For the purposes of our calculation, we counted incidents involving multiple residents as a single incident.

Systems Development

The department relies on an array of computer systems and manual processes to

- keep track of individuals enrolled in departmental services;
- pay contract service providers timely and accurately; and
- manage incidents affecting the health and welfare of supported individuals.

We published a finding in our October 2013 audit documenting the department's 19-year struggle to replace its critical Community Services Tracking system.

Audit Results

1. **Audit Objective:** Did management correct the two April 2013 findings involving state information systems security policies and industry best practices?

   Conclusion: No, the department did not comply with state information systems security policies and industry best practices (**see Finding 14**).

2. **Audit Objective:** Did the department correct the October 2013 finding by making adequate progress in replacing its outdated Community Services (CS) Tracking system?

   Conclusion: We found that despite further setbacks and missed deadlines, the department had progressed toward replacing the CS Tracking system (**see Observation 7**).

Finding 14 – The department did not provide adequate internal controls in five specific areas

The Department of Intellectual and Developmental Disabilities did not provide adequate internal controls in five specific areas, related to seven of the department's systems. For three of the five areas, we are reporting internal control deficiencies that were repeated from the prior audit because corrective action was not sufficient. Ineffective implementation of internal controls increases the likelihood of errors, data loss, and inability to continue operations. The details of this finding are confidential pursuant to Section 10-7-504(i), *Tennessee Code Annotated*. We provided the department with detailed information regarding the specific conditions we identified, as well as the related criteria, causes, and our specific recommendations for improvement.

Recommendation

Management should ensure that these conditions are remedied by the prompt development and consistent implementation of internal controls in these areas. Management

should implement effective controls to ensure compliance with applicable requirements; assign staff to be responsible for ongoing monitoring of the risks and mitigating controls; and take action if deficiencies occur.

Management's Comment

We concur. For one of the three areas that was a repeat deficiency, the new (current) STS Executive IT Director developed the necessary controls, pushed them into production, and demonstrated their effectiveness to the auditors before the conclusion of their fieldwork. For the remaining four areas, department and STS staff have already assigned respective responsibilities and begun work on developing and implementing the needed controls.

Observation 7 – After 23 years and over $18 million spent, the department has progressed toward replacing its antiquated Community Services Tracking system, despite suffering additional setbacks and missed deadlines since our last audit

The Department of Intellectual and Developmental Disabilities has attempted to replace its outdated Community Services (CS) Tracking system since 1994. The department uses CS Tracking to house information about individuals enrolled in the department's Medicaid waiver programs. A finding published in our October 2013 audit report disclosed that the department anticipated implementing Project Titan, its third attempt to replace CS Tracking, by June 2014.

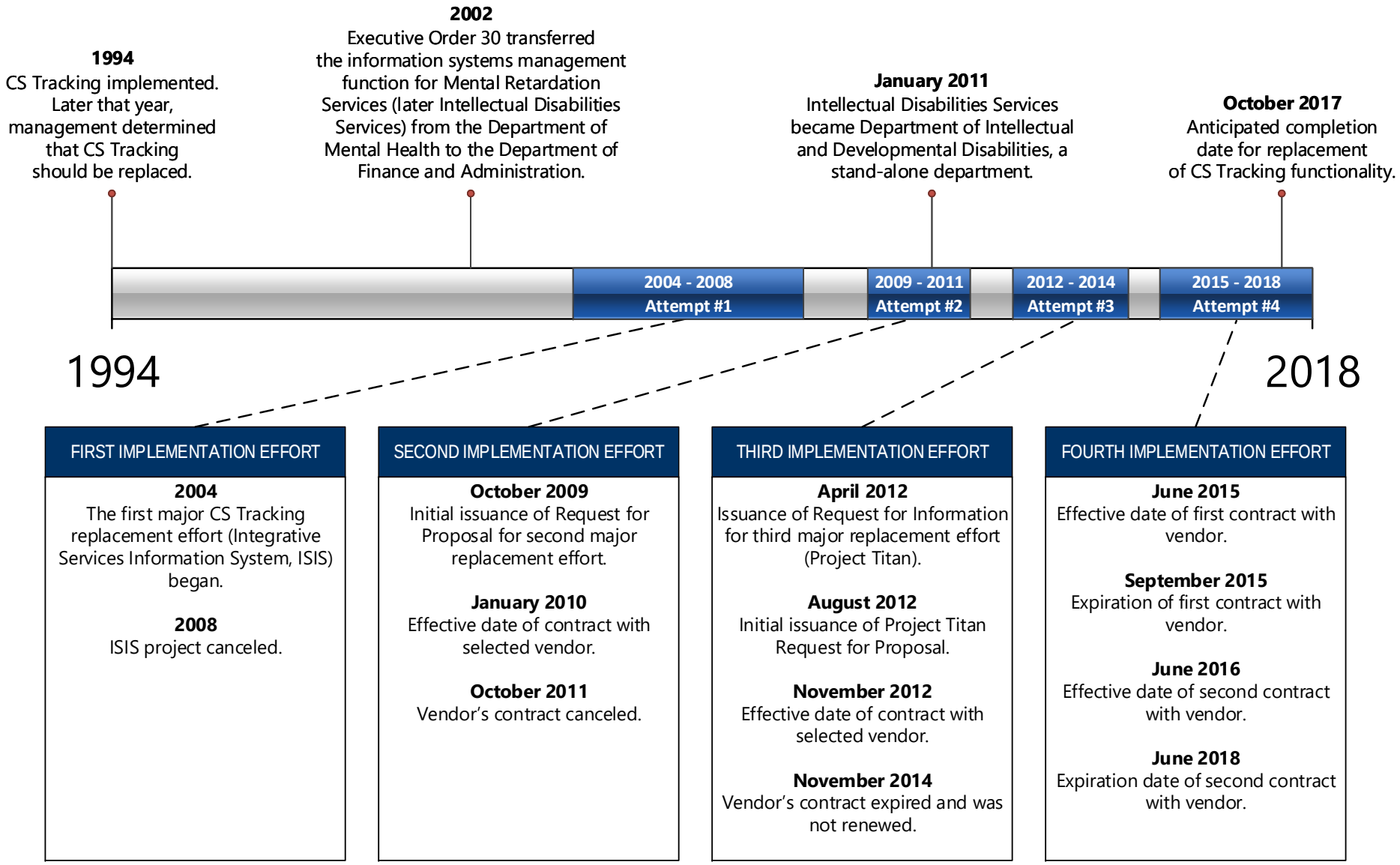
During our current audit, we discovered that the department's implementation vendor did not meet the June 2014 deadline, and its contract with the state expired later that year. In mid-2015, the department embarked on its fourth attempt to replace CS Tracking, contracting with a new vendor to complete the project. As of June 2017, the vendor has achieved critical contracted milestones, and it expects to retire CS Tracking in spring 2018.

History of CS Tracking Replacement Efforts

We published a finding in our October 2013 audit report detailing the department's three major attempts to replace CS Tracking over the 19 years between 1994 and 2013. We summarize those efforts below.

The department implemented CS Tracking in 1994 as a short-term solution to manage one month's payment processing and had intended to replace it with a more robust system the following month. In the 10 years immediately following CS Tracking implementation, department staff focused on enhancing the existing system to meet their needs rather than developing an entirely new system.

Figure 31
CS Tracking System Replacement Timeline



Source: Discussions with department staff and review of applicable documentation.

First Major Implementation Effort

The department's first major CS Tracking replacement effort began in 2004 with the Integrated Services Information System project, an in-house solution. The project encountered numerous obstacles and was eventually cancelled in 2008 due to missed deadlines.

Second Major Implementation Effort

In January 2010, the department contracted with a vendor to customize an off-the-shelf solution to the department's needs. The department canceled the contract in October 2011, citing the vendor's inability to meet project deadlines and fulfill critical deliverables.

Third Major Implementation Effort

The department embarked on its third major implementation effort, Project Titan, in 2012. In an effort to address issues that caused previous projects to collapse, the department enlisted assistance from the Department of Finance and Administration's Business Solutions Delivery Group, a centralized state resource to guide the execution of complex information systems projects. Following a competitive procurement process, the department engaged a second implementation vendor to tailor the 2011 edition of Microsoft's Customer Relationship Management (CRM) platform to the department's specifications. When we released our prior audit report in October 2013, the department anticipated reaching the first Project Titan milestone by mid-summer 2013 and completing the project by June 2014.

When we inquired about the status of Project Titan in April 2016, the former Chief Information Officer[74] disclosed that the vendor implemented Phase 1A of the project, covering the department's Intake and Waiting List functions, in spring 2014. Despite the Business Solutions Delivery Group's involvement in the project, the vendor did not complete work on the remaining phases before its contract expired in November 2014. The department opted not to renew its contract with the vendor.

Fourth Major Implementation Effort

Following the expiration of the second implementation vendor's contract, management, in conjunction with Strategic Technology Solutions (STS), entered into a three-month contract with another firm to optimize the prior vendor's Phase 1A code and design the remaining Service Planning and Protection From Harm modules of Project Titan. The new contractor assessed the prior vendor's code and proposed strategies to improve system design, efficiency, and security. The vendor's recommendations included upgrading Project Titan from the now-outdated 2011 CRM platform to the 2015 CRM.

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[74] The department transitioned its Information Systems function to Strategic Technology Solutions (STS), the state's centralized computer service bureau under the Department of Finance and Administration, in July 2016. The department's Chief Information Officer resigned from state service in October 2016; STS assigned an Executive Information Technology Director to the department in January 2017.

Over the initial contract period, the contractor's developers had difficulty making the prior vendor's code compatible with the 2015 CRM. The vendor determined that rebuilding Project Titan afresh on the new CRM 2016 framework would be less time-consuming than rewriting the prior vendor's code. The department agreed and entered into a second contract to complete Project Titan, this time expanding the scope of Project Titan to encompass additional business processes.

Successes, Setbacks, and Risks of the Fourth Implementation Effort

Department and STS management described significant events in the fourth implementation effort through June 2017.

Phases 1 and 2 Developed

The vendor implemented Phase 1 of Project Titan, supporting the department's intake and referral functions, in August 2016. Department management initially anticipated the phase would be completed by July, but data migration issues delayed the original schedule. The vendor completed development and user acceptance testing of Phase 2 of Project Titan in January 2017. The department intends to implement this part of the system at the same time as Phase 3.

Phase 3 Scope Modified and Delayed

Phase 3 is the part of Project Titan that replaces CS Tracking functionality; its other features include service planning for individuals. The initial project schedule showed work on Phase 3 beginning in October 2016, with deployment anticipated by October 2017. At its February 2017 meeting, however, the project's steering committee elected to split Phase 3 into two sub-phases:

- Phase 3A, which includes the functionality required to replace CS Tracking; and
- Phase 3B, which includes the remaining features initially included in Phase 3.

The committee decided to complete Phase 3A first to decommission CS Tracking early—in September instead of October as initially planned—and defer Phase 3B to Phase 4. The project schedule as of May 2017, however, showed that STS did not expect Phase 3A to conclude until October 2017. The Executive IT Director attributed the delayed schedule to the complexity of the department's business requirements covered by Phase 3A.

Consequently, the time frame for the vendor to develop the remaining Phases 3B and 4 through 7 is compressed, with each phase overlapping the next. This increases the risk that Project Titan will be unfinished when the department's contract with the vendor expires in June 2018. The department's contract with the vendor states that all deliverables must be met within specified timelines and that the state's maximum liability is $4,561,016. If the work is unfinished when the contract expires, the state may have to expend resources to enforce the contract if the vendor demands more money or refuses to complete the work. Moreover, the department will lack an operational computer system.

Staffing Issues

Through our discussions with the Executive IT Director and the Enterprise Senior Project Manager and our examination of the project's steering committee meeting minutes, we also learned that the timely progression of Project Titan was stymied by staffing problems. These included

- changes to key department, STS, and contractor personnel assigned to the project, resulting in loss of institutional knowledge and experience; and
- staffing disparities between the vendor and the state, with the vendor having greater personnel resources to assign to Project Titan, increasing the risk that the state will be unable to match the vendor's development pace, especially when project phases overlap.

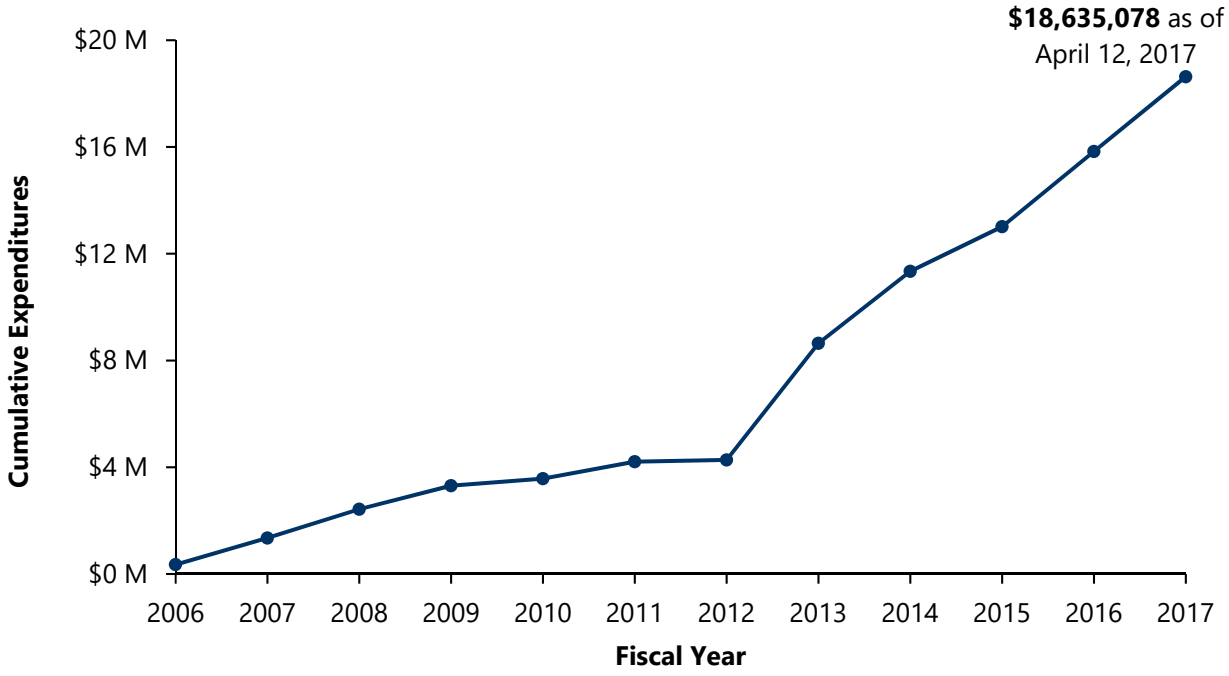
Configuration and Customization Risks

Based on our review of project meeting minutes, we noted the vendor advocating a configuration approach to Titan's development. This entails adapting existing CRM tools to the department's needs, rather than writing custom code to build desired features within the CRM. If the department and the vendor later determine that the CRM cannot be configured to suit the department's business requirements, there will be significant delays, expenses, and complexities to make necessary customization. Furthermore, state employees may encounter difficulty maintaining any vendor-created customizations after the development contract expires.

Cost of CS Tracking Replacement

Since fiscal year 2006, the department has invested over $18.5 million in contract and in-house development costs to replace CS Tracking. **Figure 32** illustrates the department's cumulative spending on this project through April 12, 2017.

Figure 32
Cumulative CS Tracking Replacement Expenditures
for July 1, 2005, Through April 12, 2017



As of April 27, 2017, the department had approximately $4 million budgeted to complete Project Titan.

Lack of Independent Steering Committee Voting Members

Based on our review of meeting minutes, we noted the project's steering committee lacked independent voting members. The committee's purpose is to oversee and guide Project Titan, make executive-level decisions, remove barriers, resolve conflicts, and issue final approval of project deliverables. The committee includes representation from non-departmental stakeholders, but its voting membership consists of members of the department's executive management team and the STS Executive IT Director assigned to the department (who was a department employee until the department's IT function transferred to STS in July 2016). The lack of independent voting members on the committee increases the risk that serious problems—such as unrealistic deadlines or unacceptable deliverables—will pass through the committee unchallenged.

Conclusion

Despite additional setbacks, the department, in conjunction with STS and its implementation vendor, has made strides toward replacing CS Tracking and its other obsolete legacy systems since our last report. While this effort has cost the state more than $18 million, it appears that Project Titan will improve efficiency of the department's business processes; facilitate adaptability to changing program regulations; and promote the department's mission to

become the nation's most person-centered and cost-effective state support system for individuals with intellectual and developmental disabilities.

DEPARTMENT FINANCES AND INVENTORY

In calendar year 2013, the Department of Intellectual and Development Disabilities centralized its accounting, human resources, and procurement functions. Prior to this time, the department relied on decentralized operations in the East, Middle, and West Tennessee regions. The regional offices now implement policies and procedures developed by the department's central office, promoting consistency and efficiency by using the same policies, procedures, forms, and contracts throughout the state.

We focused our audit work on a selection of the department's accounting, human resources, and procurement activities.

Medicaid Cost Reports

For each of its developmental centers and community homes with a status of intermediate care facility for individuals with intellectual disabilities, the department's central office can submit cost reports in order to receive reimbursement for allowable patient care and administration expenditures from the state's TennCare program. The Division of TennCare, in turn, obtains reimbursement from the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services. In our April 2013 audit report, we cited department management in a finding for failure to establish controls governing the preparation of the Clover Bottom Developmental Center and Greene Valley Developmental Center cost reports. Specifically, we found that fiscal staff

- made typographical errors,
- inappropriately used preliminary expenditures rather than final expenditures, and
- omitted review of the cost reports prior to official submission.

Travel Expenditures

Department employees may receive reimbursement for travel expenditures in accordance with the Department of Finance and Administration's Policy 8, "Comprehensive Travel Regulations." During our audit period, department employees traveled for purposes such as conducting and attending training and performing reviews.

Conflict-of-Interest Forms

One responsibility of regional office staff consists of ensuring that all employees sign a disclosure form in accordance with the department's Policy 101, "Conflict of Interest." This policy defines "conflict of interest" as "[w]hen a person is in a position of trust and gives, or is in a position to give, preferential treatment to someone and/or attempts to influence public decisions in exchange for personal gain and in a manner which actually or potentially compromises the public interest." Our October 2013 audit report contained an observation that the department neither required all employees to sign conflict-of-interest forms nor updated its conflict-of-interest policy and related form to reflect recent organizational changes.

Pharmacy and Supply Inventories

At the Greene Valley Developmental Center, the department operated both a warehouse to store supplies (soap, wheelchairs, food products, etc.) and a pharmacy to administer medication to center residents. In our April 2013 audit report, we published a finding that management had not mitigated the risks associated with inadequate controls over the center's pharmacy and supply inventories. Both pharmacy and supply physical counts differed from inventory lists; in addition, supply inventory duties were inadequately segregated.[75]

Audit Results

1. **Audit Objective:** Did the department correct the April 2013 finding by properly preparing its Medicaid cost reports?

   Conclusion: We found that the department corrected the prior cost report finding.

2. **Audit Objective:** Were department employees' travel expenditures reimbursed in accordance with statewide regulations and also reasonable and necessary?

   Conclusion: Based on the random, nonstatistical sample we tested, employee reimbursements followed applicable regulations, and travel expenditures were reasonable and necessary. According to an Office of Risk Management and Licensure investigative report released on June 29, 2017, however, two former department employees engaged in double-dipping (requesting and receiving reimbursement from both the State of Tennessee and an outside employer). Management plans to recoup $877 for travel reimbursements from the employees. These travel expenditure reimbursements were not part of our sample.

[75] The department closed Greene Valley on May 26, 2017. As a result, department representatives notified the Board of Pharmacy on July 25, 2017, that it had closed the pharmacy. See the Achievements section on page 16 for more information about the developmental center closure.

3. **Audit Objective:** To correct the October 2013 observation, did the department require all employees to sign conflict-of-interest forms?

   Conclusion: Not all department employees signed conflict-of-interest forms (see **Observation 8**).

4. **Audit Objective:** To correct the October 2013 observation, did the department update its conflict-of-interest policy and related form?

   Conclusion: The department did not update its conflict-of-interest policy and related form (see **Observation 8**).

5. **Audit Objective:** Did the department correct the portion of the April 2013 finding involving pharmacy inventories?

   Conclusion: Our testwork results disclosed that the department corrected this portion of the prior finding.

6. **Audit Objective:** Did the department correct the portion of the April 2013 finding involving supply inventories?

   Conclusion: Based on our testwork, the department corrected this portion of the prior finding.

Observation 8 – The department still did not require all employees to sign conflict-of-interest forms and did not update its conflict-of-interest policy

An essential method of maintaining public trust in and ensuring the proper performance of government involves disclosing potential conflicts of interest. In our October 2013 audit, we reported that Department of Intellectual and Developmental Disabilities management did not ensure that employees consistently signed conflict-of-interest forms or that Policy 101, "Conflict of Interest," had been updated to reflect the department's transition to a stand-alone entity. We found identical problems with our current audit testwork.

Conflict-of-Interest Disclosure Requirements

Both state law and the department's own policies codify conflict-of-interest disclosure requirements.

State Law

Section 33-2-1301, *Tennessee Code Annotated*, states the following about conflicts of interest:

IF

(1) (A) a person is an officer or employee of the department, OR

(B) a person is an officer or employee of a licensee of the department,

AND

(2) (A) the person or the person's spouse, parent, grandparent, brother, sister, or child has an ownership interest in a residential facility that is not publicly held or an ownership interest in a business that is not publicly held that owns or manages a residential facility that provides mental health or developmental disabilities services or supports, OR

(B) the person or combination of persons named in subdivision (2)(A) has an ownership interest of at least thirty-five percent (35%) in a residential facility that is publicly held that provides mental health or developmental disabilities services, OR

(C) the person or combination of persons named in subdivision (2)(A), has an ownership interest of at least thirty-five percent (35%) in a business that is publicly held that owns or manages a residential facility that provides mental health or developmental disabilities services,

THEN

(3) the person shall disclose the interest to the department or licensee, AND

(4) the person may not serve in a capacity of decision making or influence or responsibility for the direct referral or placement of persons to any residential facility that provides mental health or developmental disabilities services or supports.

Department's Conflict-of-Interest Policy

The department has also developed its own conflict-of-interest policy, Policy 101. The purpose of the policy, which supplements *Tennessee Code Annotated* requirements, is "[t]o establish standards for employees of the Division of Intellectual Disabilities Services (DIDS) [now DIDD] for avoiding conflicts of interest to assure the public trust and best interest of DIDS are not compromised." According to the Definitions section of the policy, conflicts of interest arise whenever "an employee is in a position of trust and gives, or is in a position to give, preferential treatment to someone and/or attempts to influence public decisions in exchange for personal gain and in a manner which actually or potentially compromises the public interest." The conflict-of-interest policy also specifies in section E.7 that

> DIDS employees must sign the Acknowledgement and Disclosure Statement Form [conflict-of-interest form] to confirm they have read and agree to comply with the DIDS Conflict of Interest Policy. The signed form will be maintained in the DIDS Human Resources Office.

Figure 33
Excerpt From the Department's Conflict-of-Interest Form

Disclosure Information

According to policy, I am disclosing below my involvement and/or interest in, and/or my family member's interest in, any organization that may be deemed as a conflict of interest with my DIDS employment. As a condition of my employment with DIDS, I agree to abide by the decision of DIDS which is noted below.

Name of Business: _____ **Type of Involvement:** _____

DIDS Employee Signature: _____ **Date:** _____

DIDS Approval: _____ **DIDS Disapproval:** _____

Reason for Disapproval: _____

DIDS Supervisor Signature: _____ **Date:** _____

DIDS Human Resources Signature: _____ **Date:** _____

The department's policy became effective October 13, 2010. According to the former Director of Human Resources during our prior audit, when the department implemented the policy, the Human Resources Division required existing employees, along with newly hired employees, to complete a conflict-of-interest form. This action should have resulted in all department employees signing the form for their personnel file.

Testwork Results

Conflict-of-Interest Forms Not on File for Some Employees

From the population of 1,675 department employees employed as of September 22, 2016 (derived from Edison, the state's accounting system), we selected a random, nonstatistical sample of 60 to determine if they had a signed conflict-of-interest form on file. We obtained copies of the forms from the Director of Human Resources, who said he had gathered them from the applicable regional office in East, Middle, or West Tennessee. After identifying high-risk factors related to discrepancies between the conflict-of-interest forms we received from management and our employee list from Edison, we expanded our sample to include 25 more randomly selected employees, for a total of 85. We then traveled to every regional office and attempted to locate the original conflict-of-interest forms for all 85 employees tested.

Our testwork disclosed the following results:

- Five of 85 employees (6%) did not have a signed conflict-of-interest form on file. All 5 of the missing forms originated from our expanded sample. While the department provided evidence that these employees completed annual conflict-of-interest training, we do not consider the training an acceptable replacement for employees

affirmatively declaring that no conflicts exist. The Director of Human Resources stated that the conflict-of-interest forms might have been lost during one of the regional offices' various moves.

- Of the four employees who disclosed potential conflicts, department management did not show approval or disapproval for two (50%). The Director of Human Resources was unable to provide an explanation for these omissions, one of which predated the beginning of his tenure as director in October 2015.
- Furthermore, we identified two instances where the employee name listed on the conflict-of-interest form differed from records in Edison. The Director of Human Resources stated that his staff added the married name to help identify the individual; however, we determined that staff did not initial or date their additions.

Conflict-of-Interest Policy and Form Not Updated

Another deficiency we observed is that management had not taken the time to update the conflict-of-interest policy and the accompanying form to show that the department became an independent department on January 15, 2011. As demonstrated in the policy citations above, the policy and form repeatedly refer to the department as a division under the Department of Finance and Administration. The Human Resources Director said that the department had overlooked the outdated references in prior policy reviews; however, management had initiated a new review in October 2016, following the commencement of our testwork.

Investigative Report

On June 29, 2017, the department's Office of Risk Management and Licensure released an investigative report that identified conflict-of-interest concerns related to a current employee and two former employees. Specifically, the department was unable to find the required conflict-of-interest forms that showed approval for these three individuals' work at an outside entity.

In addition, when one of the former employees received a promotion, department policy prohibited her from maintaining the outside employment arrangement, but she continued to do so. The department's policy states, "DIDS employees cannot receive compensation or gifts from a DIDS Contractor or Provider in exchange for acting as an officer, agent, employee, subcontractor, or consultant of the Contractor or Provider if the employee is in a state executive position."

Conclusion

If department management does not maintain and review signed conflict-of-interest forms for all employees, then they may remain unaware of potential conflicts. Furthermore, failing to update the conflict-of-interest policy and form leads to inconsistency among official forms and the impression that management possesses a lackadaisical attitude about correcting previously identified deficiencies.

The Director of Human Resources should ensure that all employees, retroactively or on their hire date, sign the conflict-of-interest form. Applicable management should additionally

- review and approve or disapprove employees' potential conflict-of-interest disclosures;
- update the conflict-of-interest policy to incorporate the department's transition from a division under the Department of Finance and Administration to a stand-alone entity;
- ensure that Human Resources staff initial and date any modifications to employees' forms; and
- prioritize the correction of deficiencies identified during the course of the audit, whether or not they rise to the level of a finding.

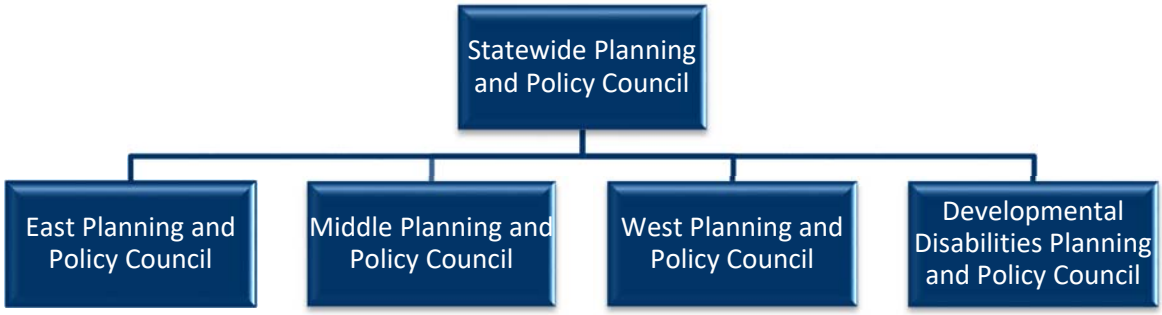
PLANNING AND POLICY COUNCILS

Upon making the Department of Intellectual and Developmental Disabilities an independent entity in 2011, the General Assembly also created the Statewide Planning and Policy Council for the purpose of assisting and advising the department. Section 33-5-602, *Tennessee Code Annotated*, requires the council to focus on the following:

1. identifying common areas of concern to be addressed by the service areas;
2. identifying the needs of supported individuals who are children or elderly and of supported individuals with combinations of intellectual or developmental disabilities and other conditions;
3. evaluating needs assessment, service, and budget proposals;
4. reconciling policy issues among the service areas; and
5. annually reviewing the adequacy of Title 33, *Tennessee Code Annotated*, to support the service systems.

To help the Statewide Planning and Policy Council fulfill its duties, the department established the East, Middle, and West Regional Planning and Policy Councils, as well as the Developmental Disabilities Planning and Policy Council, pursuant to Section 33-2-202, *Tennessee Code Annotated*.

Figure 34
Depiction of Planning and Policy Councils



State law defines the membership composition of the Statewide Planning and Policy Council and each of the four sub-councils. The composition of the council and four sub-councils is designed to represent all stakeholders—supported individuals, family members of supported individuals, service providers, and advocacy groups. *Tennessee Code Annotated* additionally stipulates that the Statewide Planning and Policy Council should consist of not less than 11 members and should meet quarterly.

While state law prohibits council members from receiving additional compensation for their services, they may receive reimbursement for travel expenditures in accordance with statewide policy.

Audit Results

1. **Audit Objective:** Did the Statewide Planning and Policy Council fulfill the duties specified in Section 33-5-602, *Tennessee Code Annotated*?

   Conclusion: We determined that the council fulfilled these required duties.

2. **Audit Objective:** Did the Statewide Planning and Policy Council and four sub-councils meet the membership composition requirements described in Sections 33-5-601 and 33-2-203, respectively?

   Conclusion: Based on our audit work, each council met the specified membership composition requirements.

3. **Audit Objective:** Did the Statewide Planning and Policy Council satisfy the meeting frequency requirements promulgated in Section 33-5-601?

   Conclusion: While the council convened quarterly as required, some members did not attend at least half of the scheduled meetings in any one-year period between 2013 and 2016 (see **Observation 9**).

4. **Audit Objective:** Were council members' travel expenditures reasonable, necessary, and reimbursed in accordance with statewide regulations?

Conclusion: Our testwork revealed that travel expenditures were reasonable and necessary and that reimbursements followed applicable regulations.

Observation 9 – Infrequent meeting attendance by some Statewide Planning and Policy Council members might lead to the voices of the membership category they represent remaining unheard

Section 33-5-601, *Tennessee Code Annotated*, states,

> (d) The statewide planning and policy council shall meet quarterly at a place designated by the chair and may meet more often upon the call of the chair or a majority of the members. . . .
>
> (f) The appointing authority may remove a member for failure to attend at least one half (1/2) of the scheduled meetings in any one-year period or for other good cause.

The Statewide Planning and Policy Council operates on a calendar year basis. State law names the Governor, Speaker of the Senate, Speaker of the House of Representatives, and the Department of Intellectual and Developmental Disabilities' Commissioner as appointing authorities for the council. Also under *Tennessee Code Annotated*, council membership categories should include, but are not limited to, the following: supported individual or supported individual's family member; child representative; service provider; elderly supported individual representative; at-large representative; representative for others affected by intellectual and developmental disability issues; and legislator.

When we examined records for council meetings conducted from August 21, 2013, through November 16, 2016, we found that some council members did not attend at least half of the scheduled meetings in a one-year period. A breakdown of the members not meeting this attendance criteria is as follows:

Table 34
Overview of Members Who Failed to Attend At Least Half of the Scheduled Meetings

Year	Total Members	Number in Noncompliance	Percentage in Noncompliance
2013	11	2	18%
2014	12	8	67%
2015	13	1	8%
2016	11	6	55%

See **Table 35** for additional information.

Table 35
Details of Council Members' Noncompliance

Year	Member	Member Category	Number in Member Category	Appointing Authority	Average Attendance
2013*	Member 1	Child Representative**	1	Commissioner	0%
	Member 2	Other Affected Representative	1	Commissioner	0%
2014	Member 1	Supported Individual	2	Commissioner	50%
	Member 2	Supported Individual	2	Commissioner	25%
	Member 3	Child Representative**	1	Commissioner	0%
	Member 4	Service Provider	1	Commissioner	50%
	Member 5	Elderly Representative	1	Commissioner	50%
	Member 6	At-large Representative	1	Commissioner	25%
	Member 7	Legislator	2	Speaker of the Senate	25%
	Member 8	Legislator	2	Speaker of the House of Representatives	0%
2015	Member 1	Legislator	2	Speaker of the House of Representatives	0%
2016	Member 1	Service Provider	2	Commissioner	0%
	Member 2	At-large Representative	2	Commissioner	50%
	Member 3	Legislator	2	Speaker of the House of Representatives	0%
	Member 4	Elderly Representative	1	Commissioner	25%
	Member 5	Supported Individual	2	Commissioner	50%
	Member 6	Family Member of Supported Individual	2	Commissioner	50%

*For 2013, we researched the two meetings occurring after our scope beginning date of June 1, 2013. We only counted those members who were absent during both meetings as noncompliant with the average attendance criteria.
**The Commissioner appointed the same individual to serve as the child representative for both the 2013 and 2014 calendar years.

We talked to department management about their decision to forego pursuing the removal of the consistently absent council members, even though *Tennessee Code Annotated* provisions

make that option available. They responded that they were aware of the attendance issue and were making decisions on a case-by-case basis. The department's Commissioner elaborated that she and other appointing authorities would have difficulty replacing some members due to the membership category they represent. Other members' qualifications are such that if they can just attend one meeting, their input is valuable. The Commissioner also said that although meetings are quarterly, work related to the council continues throughout the year.

The General Assembly designed state laws regarding the council's membership composition to promote input from a diverse range of people. When council members miss the quarterly meetings, the voices of the membership category they represent might remain unheard. Another consequence of low attendance rates is increased legislative scrutiny. The General Assembly factors in membership participation and attendance when considering recommendations to continue, restructure, or terminate an entity.

The Commissioner and other appointing authorities should ensure those they appoint to the council are willing and able to attend the quarterly meetings. Furthermore, they or their designee should contact the consistently absent council members and verify their continued interest in serving. If attendance issues persist, the Commissioner and other appointing authorities should initiate the removal process.

APPENDICES

APPENDIX 1
Methodology To Achieve Audit Objectives

SERVICE DELIVERY SYSTEM OPERATIONS

1. Audit Objective: Did the department correct the October 2013 finding by establishing sufficient services for individuals with developmental disabilities and adequately engaging in planning efforts to do so?

We interviewed key Department of Intellectual and Developmental Disabilities and Division of TennCare management. We reviewed Employment and Community First CHOICES planning and program documentation; statewide and department budget documentation for fiscal years 2014 through 2017; and Statewide Planning and Policy Council and Developmental Disabilities Planning and Policy Council minutes and reports.

We obtained the population of individuals served through the Employment and Community First CHOICES program as of April 26, 2017, and the population of individuals served through the Family Support Program. We then calculated the proportion of individuals in both programs who had a developmental disability.

We studied websites and program literature to evaluate services provided to individuals with developmental disabilities through other Tennessee state agencies, specifically the Department of Human Services; the Department of Education; the Department of Labor and Workforce Development; the Department of Mental Health and Substance Abuse Services; the Department of Treasury; the Council on Developmental Disabilities; the Tennessee Housing Development Agency; and the Tennessee Commission on Aging and Disability.

Additionally, we consulted memorandums of understanding between the Department of Intellectual and Developmental Disabilities and the Department of Human Services for the provision of employment services and between the Department of Intellectual and Developmental Disabilities, the Department of Human Services, the Department of Education, the Department of Labor and Workforce Development, and the Department of Mental Health and Substance Abuse Services regarding transition services for youth with disabilities.

2. Audit Objective: Did the department correct the October 2013 finding by working to reduce the number of individuals on the waiting list for Medicaid services?

We met with department and TennCare management. We reviewed internal operating guidelines; waiting list correspondence templates; internal waiting list audit working papers; waiver slots and budgets; and aging caregiver legislation fiscal notes.

We compiled the department's data management reports for June 2013 through June 2016 and compared waiting list additions and removals for each month in that period, as well as overall waiting list numbers at annual intervals.

3. Audit Objective: Did the department correct the October 2013 finding by maintaining the current needs status of all individuals served?

We interviewed department personnel and reviewed internal operating guidelines. We obtained the population of 1,019 individuals removed from the waiting list to a waiver during the period June 1, 2013, through June 30, 2016. We analyzed the list and calculated the number of individuals removed by each category of need. Using random, nonstatistical sample selection, we tested 60 of 62 individuals who were not in the "crisis" category of need but were enrolled in a waiver. We examined waiver enrollment documentation for each individual in our sample to determine whether they fell under the highest need category ("crisis") after all.

4. Audit Objective: Did department personnel adequately communicate with individuals on the waiting list?

5. Audit Objective: Were the workloads reasonable for case managers overseeing individuals on the waiting list?

The following methodologies apply to audit objectives 4 and 5. We inquired with applicable department and TennCare personnel. We examined internal operating guidelines and waiting list correspondence templates.

We obtained the department's waiting list for home- and community-based services as of June 30, 2016, the list's final day of operation. We calculated the caseload number for each case manager, averages for each region, and an overall department average. We contacted other states with comparable demographic characteristics and inquired about their intellectual and developmental disability waiver caseload numbers.

From the waiting list as of June 30, 2016, we selected a haphazard sample of 96 individuals, consisting of 1 individual per category of need per case manager and 1 individual with no assigned case manager per category of need per region. We reviewed each individual's case file and documented the date(s) the case manager contacted the individuals or their conservators/legal representatives and the nature of that communication.

Furthermore, we obtained a list of 973 individuals served by the department's Employment and Community First CHOICES intake function from July 1, 2016, through April 26, 2017. We selected a random, nonstatistical sample of 25 individuals for testwork, comprising 15 individuals who initiated intake but did not enroll in Employment and Community First CHOICES and 10 individuals who completed intake and enrolled in the program. We read intake documentation for each individual in our sample to determine whether department personnel completed intake steps within the time frame required by the department's interagency agreement with TennCare.

To evaluate case manager communication relative to aging caregiver legislation, we acquired TennCare's Employment and Community First CHOICES referral list as of April 26, 2017, and joined it to the department's waiting list as of June 30, 2016. We applied date of birth and enrollment status filters to the joined lists to identify 562 individuals aged 50 and older, by waiting list category of need, who were not enrolled in either a Medicaid waiver or the Employment and Community First CHOICES program. We also obtained a spreadsheet dated June 23, 2016, of caregiver age information the department maintained for 896 of the 5,783 individuals on the waiting list. We calculated the percentage of individuals on the waiting list for whom the department maintained caregiver age data. We identified individuals who appeared to qualify for waiver or equivalent services pursuant to aging caregiver legislation and inquired with management why those individuals were not enrolled in those services.

6. Audit Objective: Did the department fill empty Medicaid waiver slots as soon as practicable?

We met with department and TennCare management. We reviewed *Rules of the Tennessee Department of Intellectual and Developmental Disabilities*; *Rules of the Tennessee Department of Finance and Administration Division of TennCare*; and Title 42, *Code of Federal Regulations*, Part 441, Subpart G.

7. Audit Objective: Did the state fill empty Employment and Community First CHOICES program slots as soon as practicable?

We interviewed applicable department and TennCare personnel. We reviewed Statewide Planning and Policy Council meeting minutes and Employment and Community First CHOICES waiting list recruitment letters. We also obtained and analyzed quarterly Employment and Community First CHOICES enrollment data for the period July 1, 2016, through June 30, 2017.

8. Audit Objective: Are Tennessee's waiting list numbers comparable to other states' numbers?

We obtained state waiting list numbers from the Kaiser Family Foundation's *Medicaid Home and Community-Based Programs 2013 Data Update* and state population numbers from the U.S. Census Bureau. To compare waiting list numbers between Tennessee and other states, we used ArcGIS (mapping software) to map each state's numbers relative to its population.

9. Audit Objective: Did the department address the state's shortage of caregivers (known as direct support professionals)?

We interviewed service providers and family members of individuals supported by the Medicaid waiver and the Employment and Community First CHOICES program.

We reviewed the following reports: the National Association of State Directors of Developmental Disabilities Services and Human Services Research Institute's *2015 Staff Stability Survey Report*; Tennessee Community Organizations' 2016 *Direct Support Provider Wage Crisis*; the American Network of Community Options and Resources' 2017 *Addressing the*

Disability Services Workforce Crisis of the 21st Century; and the department's Statewide Planning and Policy Council's Annual Report to the Governor for calendar years 2013 through 2015.

We read meeting minutes from June 1, 2013, through May 10, 2017, for the department's Statewide Planning and Policy Council; Developmental Disabilities Planning and Policy Council; East Planning and Policy Council; Middle Planning and Policy Council; and West Planning and Policy Council. We also located various media articles about the direct support professional shortage.

We discussed the state's response to the direct support professional shortage with various department and TennCare personnel. We viewed the department's budget presentations to the Governor for fiscal years 2016 through 2018 and press releases relative to the Governor's fiscal year 2018 budget amendment.

10. Audit Objective: Did the department correct the October 2013 finding by properly developing Individual Support Plans for individuals receiving services through the Medicaid waiver?

11. Audit Objective: Did the department comply with the monthly and annual review and monthly visit requirements established in its Individual Support Planning policies?

The following methodologies apply to audit objectives 10 and 11. We interviewed key department personnel. We reviewed the department's *Provider Manual*; the department's Policy 80.3.4, "Authorization of Services," effective December 7, 2015; the Person Centered ISP Training presentation from September 1, 2015; the Independent Support Coordination Review Tool; and the Council on Quality and Leadership's Personal Outcome Measures.

We determined that there was a population of 8,324 Medicaid waiver participants during the period January 1, 2016, through December 31, 2016. We tested a nonstatistical, random sample of 60 waiver participants and reviewed their Individual Support Plans, including the narrative, action plan, services, and planning meeting signature sheets; their approved cost plans; and the payments for waiver services in calendar year 2016. In addition, we reviewed the 60 waiver participants' Support Coordination and Case Management Monthly Documentation Forms and Annual Individual Support Plan Review and Update Documentation Forms in calendar year 2016.

12. Audit Objective: Did the department correct the October 2013 finding by verifying data submitted by Family Support Program contract agencies?

13. Audit Objective: Did the department ensure that contract agencies used Family Support Program funds for approved purposes?

The following methodologies apply to audit objectives 12 and 13. We met with department management. We reviewed the *Tennessee Family Support Guidelines* (August 2016

and January 2017 editions); the Family Support Program Claims & Reporting Process User's Guide; the Family Support Program State Council minutes from August 2013 to November 2016; the Fiscal Accountability Review monitoring guidance, testing document, and report; the Family Support Program programmatic monitoring checklists and report; the contract for a Family Support Program contract agency; Family Support Program statute (Title 33, Section 5, *Tennessee Code Annotated*); the 2016 Family Support Program State Council report; the list of Family Support contract agencies; contract agency quarterly reports; and the Family Support Program 2016 statewide evaluation.

We tested a nonstatistical sample of 10 contract agencies, choosing the 5 agencies with the highest November 2016 reimbursement amount and randomly choosing 5 additional agencies, ensuring that at least 1 agency from each of Tennessee's 3 regions was in our sample. We chose to test the November 2016 reimbursement requests since that was the most recent month that had been submitted and reviewed by the department when we began testing the Family Support Program. From the November 2016 reimbursement request of each contract agency in our sample, we haphazardly chose 5 expenditure items that the Statewide Family Support Coordinator had reviewed and randomly chose 5 expenditure items that the Statewide Family Support Coordinator had not reviewed, for a total of 100 expenditure items tested. We also tested the eligibility information (proof of disability, proof of citizenship, and proof of residency) for each of the individuals associated with the expenditure item that was tested. We made field visits to each of the 10 contract agencies in our sample to review the necessary documentation.

We also performed testwork to determine if the department's population data for individuals receiving Family Support Program funds was complete and accurate by reconciling the department's information to documentation from each of the 10 contract agencies from the above sample. Each of the 10 agencies provided us with documentation for individuals who had been approved for Family Support Program funds. We reconciled each contract agency's documentation to reports we obtained from the department, and specifically verified individuals who had been newly approved for Family Support Program funding in November 2016 and each of the 10 individuals whose expenditure items we tested in our sample.

14. Audit Objective: Has integrated employment for individuals with disabilities increased?

We interviewed key department personnel. We obtained information from the U.S. Department of Labor's website, the department's Employment First website, Expect Employment Reports, National Core Indicators data updates, and various news articles.

15. Audit Objective: Did the Office of Risk Management and Licensure perform regular reviews of the risk areas identified as findings in the April 2013 and October 2013 audit reports?

We interviewed management. We compiled a list of findings with management's comments that referenced the Office of Risk Management and Licensure's reviews as part of planned corrective action; reviewed the internal audit plans submitted after June 1, 2013; and obtained the internal reports released since June 1, 2013. We analyzed the annual risk

assessments for the years 2015 and 2016 to determine the control activity the department implemented to ensure compliance in the responsible area and to determine if management agreed the control was or was not operating effectively.

SAFETY OF SUPPORTED INDIVIDUALS

1. **Audit Objective:** Did management correct the October 2013 finding involving departmental employee background checks?

2. **Audit Objective:** Did the department comply with departmental employee sex offender registry, abuse registry, felony offender information list (FOIL), list of excluded individuals/entities (LEIE), and substantiated investigation records inquiry (SIRI) search requirements?

3. **Audit Objective:** Did the department obtain from prospective employees authorization forms agreeing to the release of all investigative records from any source?

4. **Audit Objective:** Did the department check work records; references; academic records; and professional licenses and/or certifications prior to employees commencing work?

The following methodologies apply to audit objectives 1 through 4. We interviewed management. We read applicable *Tennessee Code Annotated* provisions, as well as the department's Policy 10.1.2, "Background Checks For Department Of Intellectual And Developmental Disabilities (DIDD) Employees, Contract Workers And Volunteers."

We selected a random, nonstatistical sample of 60 department employees from a population of 178 who had direct contact with or direct responsibility for supported individuals and who were hired between June 1, 2013, and June 30, 2016. For each employee selected, we examined the available criminal background checks and related authorizations.

For the 50 employees commencing work after Policy 10.1.2 became effective, we obtained available sex offender registry, abuse registry, felony offender information list (FOIL), list of excluded individuals/entities (LEIE), and substantiated investigations records inquiry (SIRI) checks. We also obtained available checks of work history and references; academic records; and professional credentials and certifications. We ran the missing sex offender, abuse, FOIL, and LEIE checks ourselves.[76]

5. **Audit Objective:** Did the department correct the October 2013 finding involving volunteer background checks?

[76] We were unable to conduct SIRI checks, as we do not have access to that system.

6. Audit Objective: Did the department check the sex offender registry, abuse registry, FOIL, LEIE, and SIRI for its volunteers?

7. Audit Objective: Did the department check work records; references; academic records; and professional licenses and/or certifications prior to volunteers commencing work?

The following methodologies apply to audit objectives 5 through 7. We met with key personnel. We requested lists of volunteers since June 1, 2013. For the three individuals Greene Valley Developmental Center disclosed through February 2, 2017, we tested for existing and timely criminal background checks, registry checks, work checks, and authorization forms.

We conducted Google searches to identify undisclosed volunteers. We identified individuals volunteering through the Foster Grandparent Program, and we interviewed the program's director. After the program's director revealed the names of the six foster grandparents as of March 2, 2017, we ran sex offender, abuse, FOIL, and LEIE checks.

For both the disclosed and undisclosed volunteers, we ran the missing sex offender, abuse, FOIL, and LEIE checks ourselves.

8. Audit Objective: Did management correct the October 2013 finding involving overturned Protection from Harm cases?

We inquired with applicable personnel and reviewed the updated *Provider Manual* and relevant departmental policies.

We obtained a list of cases substantiated by the Investigation Review Committee (IRC) and a list of substantiated death cases for the period June 1, 2013, through December 31, 2016. We performed reviews of both populations to determine if any of the cases had been subsequently overturned by anyone other than the IRC. We reviewed a total of 75 cases—19 substantiated death cases and 56 cases substantiated by the IRC.

We compiled committee meeting minutes for the period June 1, 2013, through December 31, 2016. We read a total of 31 sets of meeting minutes to determine if the minutes documented the position of each attendee; a list of the committee members, if any, who were absent from the meeting; the source of the factors considered in the decision-making process; and a breakdown of committee members' votes to either substantiate or reverse the regional investigators' findings.

9. Audit Objective: Did Investigation Review Committee members sign conflict-of-interest forms?

We inquired with management and staff. We reviewed the department's Policy 101, "Conflict of Interest," along with Policy 80.2.3, "Investigation Review Committee." Then we requested a list of Investigation Review Committee members from the period June 1, 2013,

through December 31, 2016. We tested the entire population of 20 members for the existence of conflict-of-interest forms.

10. Audit Objective: Did the department implement the court-appointed monitors' recommendation to obtain death reviews from an outside agency?

We interviewed key personnel. We reviewed the following:

- the department's Policy 90.1.2, "Death Reporting and Review Policy";
- the Quality Review Panel annual reports for 2012, 2013, and 2014;
- the Greene Valley Developmental Center Annual Exit Plan Provisions Review from June 21, 2016;
- the joint motion approving the exit plan and the agreed order; and
- the outside agency's contract with the department.

11. Audit Objective: Did the department implement the court-appointed monitors' recommendation to conduct a comprehensive review of every death in group homes, not just those initially deemed suspicious, unexplained, or unexpected?

We met with the appropriate departmental employees. We analyzed the department's Policy 90.1.2, "Death Reporting and Review," and Policy 100.1.1, "Protection from Harm."

12. Audit Objective: Did the department ensure compliance with its death review policy?

We conversed with multiple members of management. We reviewed the following documents:

- the department's Policy 90.1.2, "Death Reporting and Review";
- Policy 100.1.1, "Protection from Harm";
- the Quality Review Panel annual reports for 2012, 2013, and 2014;
- the department's *Provider Manual*;
- External Mortality Review Reports;
- the department's Annual Mortality Reports for fiscal years 2014 through 2016; and
- TennCare Death Review Reports from the fourth quarter of 2014 and the first quarter of 2017.

We acquired a population of the 731 individuals who had participated in programs operated by the department (funded by the State of Tennessee or by the Title XIX Medicaid program) and who died during the period June 1, 2013, through December 31, 2016. We

selected a nonstatistical, random sample of 60 individuals and tested compliance with various provisions of the department's death review policy.

13. Audit Objective: Did department personnel properly notify conservators of allegations of harm at state-run facilities and the results of their internal investigations?

14. Audit Objective: Did department personnel properly notify law enforcement of allegations of harm at state-run facilities and the results of their internal investigations?

The following methodologies apply to audit objectives 13 and 14. We interviewed department management. We reviewed incident reports (including death, exploitation, neglect, and abuse) for all of the department's developmental centers and community homes from June 1, 2013, to December 31, 2016, as well as final investigative reports and other investigation documents.

To ensure that the information listed in incident reports matched the information listed in the case files, we conducted data reliability testwork, testing a nonstatistical, random sample of 25 from a population of 403.

We also performed testwork to determine if and when the individual's conservator or primary contact and law enforcement was notified of the beginning of the investigation; if and when the individual's conservator or primary contact and law enforcement was notified of the conclusion of the investigation; and if and when an Abuse Registry Referral Form was completed. We performed this testwork for the population of 71 substantiated allegations and for a nonstatistical, random sample of 25 unsubstantiated allegations from a population of 189 items.

15. Audit Objective: Did the department report instances of employees' drug convictions, physical abuse, neglect, and exploitation to the Office of the Comptroller of the Treasury?

We held discussions with key personnel and studied Sections 8-19-501 and 8-4-119, *Tennessee Code Annotated.*

16. Audit Objective: Did the department appropriately handle misconduct by Protection from Harm employees?

We interviewed key personnel and reviewed multiple documents (including Policy 100.1.1, "Protection from Harm"; the department's Protection from Harm protocol and various other protocols; the department's Policy .05.100.30.01, "Drug Free Workplace/Employee Drug and/or Alcohol Testing"; and the Department of Human Resources' "Drug-Free Workplace Guidelines" and "Terminations and Designations for Rehire" policy."

Using Edison (the state's enterprise resource planning system), we compiled a list of the 52 Protection from Harm employees with administrative leave, leave without pay, suspensions, or terminations from June 1, 2013, through April 5, 2017. We obtained the employees' personnel files and documented the nature of their misconduct and subsequent disciplinary action, if any.

17. Audit Objective: Did the department appropriately handle misconduct by employees who had direct contact with or direct responsibility for supported individuals?

We interviewed key personnel and reviewed multiple documents (including Policy 100.1.1, "Protection from Harm"; the department's Protection from Harm Protocol and various other protocols; the department's Policy .05.100.30.01, "Drug Free Workplace/Employee Drug and/or Alcohol Testing"; and the Department of Human Resources' "Drug-Free Workplace Guidelines" and "Terminations and Designations for Rehire" policy."

We reviewed personnel files for 12 employees identified during a risk assessment and documented more details about the misconduct described, including dates. We also reviewed the Abuse Registry Review Committee minutes regarding the employees on this list who were determined to have physically abused supported individuals.

18. Audit Objective: Did the department develop written policies for staffing community home and developmental center cottages, including shift assignments?

We obtained and reviewed the department's Policy 100.1.7, "Ensuring Coverage and Scheduling Overtime," and the department's "Interpretive Guidelines - Intermediate Care Facilities for Individuals with Intellectual Disabilities." We also read the Centers for Medicare and Medicaid Services' *State Operations Manual* for intermediate care facilities for individuals with intellectual disabilities, as well as the department's staffing plan and pattern for the West Tennessee Homes, Middle Tennessee Homes, East Tennessee Homes, and the Greene Valley Developmental Center as of June 2016.

SERVICE DELIVERY SYSTEM MONITORING

1. Audit Objective: Did the department correct the *Provider Manual* portion of the April 2013 finding?

We interviewed key personnel and reviewed the updated *Provider Manual*, dated March 15, 2014, as well as relevant departmental policies.

2. Audit Objective: Did the department correct the Fiscal Accountability Review portion of the April 2013 finding?

We discussed Fiscal Accountability Review monitoring with applicable personnel. We also inspected various documentation related to this monitoring, including the Detail Review Guide, *Procedure Manual*, Report Template, and federal approval for in-home day services.

We obtained a list of the 371 monitoring reviews performed during the period June 1, 2013, through March 29, 2016. From the list, we selected 9 monitoring reviews (1 for each of the 8 Fiscal Accountability Review monitors active during our audit period and 1 monitoring review to provide representation of a provider in East Tennessee). We tested transactions for 3 clients at each provider. For each provider, we tested 1 client for whom the monitor had identified questioned costs; we selected the remaining 2 clients to test haphazardly. For every provider selected that had offices in multiple regions, we performed testwork in each of the 3 regions (East, Middle, and West). Overall, we tested 81 separate expenditure transactions, totaling $9,433.

3. Audit Objective: Did the department resolve the October 2013 finding involving Quality Assurance monitoring of provider employee background checks and monitoring of the sex offender registry; the abuse registry; the Tennessee Felony Offender Information List; and the Office of Inspector General's List of Excluded Individuals and Entities?

We interviewed management. We selected a random, nonstatistical sample of 10 providers from the population of 137 that either underwent Quality Assurance monitoring in calendar year 2015 or in 2016 through April 29, 2016. For the providers selected, we re-performed testwork (which consisted of viewing documentation of the following checks: criminal background, abuse registry, sex offender registry, the Tennessee Felony Offender Information List, and the Office of Inspector General's List of Excluded Individuals and Entities) on all 309 provider employees the department monitored.

4. Audit Objective: Did the department address the issues noted in the April 2013 observation regarding strengthening follow-up actions on monitoring reviews?

From a list of the 137 providers reviewed during fiscal year 2014, we tested 25 providers—the top 10 providers receiving the most departmental funds and 15 other haphazardly selected providers. We also examined recoupment and sanction documentation.

5. Audit Objective: Did the department grant provider background check exemptions in accordance with its internal policy?

We interviewed management. We selected a random, nonstatistical sample of 60 provider employees from a population of approximately 216[77] who had a background check exemption request approved from June 1, 2013, through April 14, 2016, to assess compliance

[77] As described in **Finding 9** on page 123, we identified problems with the completeness of the exemption request population.

with the approval and timeliness provisions contained in the department's "Exemption Process" policy.

We then expanded our testwork and reviewed all provider background check exemption requests that were approved from June 1, 2013, to April 14, 2016. Because we identified a potential match, we limited our testwork to evaluate whether any provider employee with an approved exemption was listed on the sex offender registry, the abuse registry, the Tennessee Felony Offender Information List, or the Office of Inspector General's List of Excluded Individuals and Entities.

6. Audit Objective: Was the department's provider background check exemption policy reasonable?

We held discussions with department management and staff. We reviewed each version of the department's exemption policy in effect during our audit period. In addition, we researched other states' background check exemption processes.

RESIDENT TRUST FUND ACCOUNTS AND PROPERTY

For all objectives in this section, we obtained training attendance records and training material provided to staff for resident's trust funds, personal property, and personal spending money. We reviewed copies of internal audit reports for findings relating to resident's trust funds, personal property, or personal spending money. We also obtained copies of the department's internal audit program.

1. Audit Objective: Did management resolve the April 2013 finding involving personal property in the Middle region, and did management adhere to relevant guidance involving tracking personal property in the East and West regions?

We reviewed Policy 100.1.5 – "Personal Property" and key personnel about controls over residents' personal property. We obtained listings of residents of the department's facilities as follows:

- 61 residents of the East Tennessee Homes as of February 29, 2016;
- 62 residents of the Greene Valley Developmental Center as of May 16, 2016; and
- 47 residents of the West Tennessee Homes as of February 13, 2017.

We selected for testwork the entire population of 62 Greene Valley Developmental Center residents, 14 Harold Jordan Center residents, and 35 Middle Tennessee Homes residents. We also selected a random, nonstatistical sample of 5 of 16 East Tennessee Homes and 6 of 12 West Tennessee Homes. Each home comprised 4 residents, for a total of 20 residents in the East region. For the West region, 5 homes comprised 4 residents and 1 home comprised 3 residents, for a total of 23 residents.

We acquired the personal property listing for each resident in our testwork. For each resident, we selected a random sample of five items of personal property from their inventory and asked community home or center staff (as applicable) to locate the item. If staff could not locate items within the first five selected items, we randomly selected extra items until we verified five items of personal property per resident. (For three residents at the Harold Jordan Center, we did not attempt to locate their personal property due to safety concerns.) Overall, we attempted to locate 421 items of personal property in the East Region; 260 items of personal property in the Middle region; and 122 items of property in the West region.

We used this same sample to determine if staff performed an inventory when individuals moved into or out of their home on or after June, 1, 2013, as well as if staff performed an inventory at least quarterly while the individuals resided at the department's facilities.

2. **Audit Objective:** Did the department correct the April 2013 Resident Trust Fund finding for the Middle and East Regions, and did management comply with applicable regulations when handling Resident Trust Funds for the West Region?

We interviewed applicable management and staff. We obtained the population of requests for funds in each region as follows:

- 1,745 Request for Funds forms issued for the Middle region between November 8, 2013, and February 29, 2016;
- 5,037 checks issued for the East region between November 1, 2013, and April 26, 2016; and
- 417 checks issued for the West region between November 8, 2013, through December 31, 2016.

We tested a nonstatistical, random sample of 60 items in each region.

3. **Audit Objective:** Did management remedy the October 2013 Resident Trust Fund finding by properly disposing of account balances for deceased, discharged, and transferred residents?

We interviewed management. We reviewed Policy 100.1.11 – "Trust Fund Accounts;"; Section 33-4-109, *Tennessee Code Annotated*; and the Social Security Administration's Guide for Organizational Representative Payees.

We obtained the population of 91 deceased or discharged/transferred residents from West, Middle, and East Tennessee during the period June 21, 2013, through December 31, 2016. We tested a nonstatistical, random sample of 60 deceased or discharged/transferred resident's trust fund accounts. Due to the problems noted for residents from the Middle region, we reviewed all deceased and discharged/transferred residents, for a total of 66 residents tested.

4. Audit Objective: Did the department comply with other aspects of its Resident Trust Fund policy, including individual bank account set-up and federal eligibility monitoring?

We obtained listings of residents of the department's facilities. See the methodologies for objective 1 for a breakdown of the residents by facility.

We reviewed the following items:

- the individuals' Quicken reports;
- the fiscal staff's notifications for account balances over the maximum limit;; and
- the fiscal staff's monthly interest allocations.

We tested the entire population of residents of the Middle Tennessee community homes and West Tennessee community homes and for the East region we tested a combined total of 82 Greene Valley Developmental Center and East Tennessee Homes residents to determine if the department complied with other aspects of its trust funds account policy, including individual bank account set-up and federal eligibility monitoring.

5. Audit Objective: For each region, did fiscal staff perform monthly personal property audits in accordance with DIDD's internal guidelines?

We reviewed Policy 100.1.5 – "Personal Property," and *Guidelines for Monthly Cottage and Home Audits for Persons Supported.* We observed personal property audits at a community home. We obtained the population of monthly personal property audit reports for each region as follows:

We obtained the population of monthly personal property audit reports for each region as follows:

- 823 monthly audits performed by individual for the Middle Tennessee Homes and the Harold Jordan Center for July 1, 2014, through March 31, 2016;
- 406 monthly audits for the East Tennessee Homes and the Greene Valley Developmental Center for July 1, 2014, through February 29, 2016; and
- 240 monthly audits for the West Tennessee Homes for July 1, 2014, through February 29, 2016.

We tested the entire population of the monthly personal property audits.

6. Audit Objective: For each region, did fiscal staff perform the required monthly bank reconciliations?

We obtained the population of monthly bank reconciliations for each region as follows:

- East region: 28 monthly bank reconciliations for November 1, 2014, through February 29, 2016;
- Middle region: 31 monthly bank reconciliations for July 1, 2014, through March 31, 2016; and
- West region: 39 monthly bank reconciliations for November 1, 2013, through January 31, 2017.

We tested each bank reconciliation to determine if fiscal staff performed a monthly bank reconciliation and if fiscal staff resolved any discrepancies found in the monthly bank reconciliations.

7. Audit Objective: In each region, did staff adhere to the department's internal policy regarding personal fund accounts for residents?

We reviewed Policy 80.4.3 – "Personal Funds Management," and a copy of the department's Individual Accounting Form. We interviewed several personnel about controls over residents' personal funds. We observed personal funds audits at a community home. We obtained the population of monthly personal fund audit reports for each region as follows:

- 1,157 monthly personal fund audits performed by individual for the Middle Tennessee Homes and the Harold Jordan Center for July 1, 2014, through March 31, 2016;
- 406 monthly audits for the East Tennessee Homes and the Greene Valley Developmental Center for July 1, 2014, through February 29, 2016; and
- 240 monthly audits for the West Tennessee Homes for July 1, 2014, through February 29, 2016.

We tested the personal fund accounts of

- all 14 residents of the Harold Jordan Center as of March 14, 2016;
- all 35 residents of the Middle Tennessee Homes as of March 31, 2016;
- all 62 residents of the Greene Valley Developmental Center as of May 16, 2016; and
- all 47 residents of the West Tennessee Homes as of February 13, 2017.

We also selected a random, nonstatistical sample of 5 of 16 East Tennessee community homes and tested the personal funds of all 20 residents of the homes selected (4 in each home). We tested each personal trust fund account to determine if each resident had cash available to them in the home, if the staff person in the home ensured the funds held for the residents were properly locked in the safe, and if the safe cash count agreed to the supporting documentation according to the department's policy.

TRANSITIONS FROM DEVELOPMENTAL CENTERS TO COMMUNITY HOMES

1. **Audit Objective:** Was the rate of incidents (abuse, neglect, exploitation, and death) at community homes comparable to that of developmental centers?

2. **Audit Objective:** Did the department establish an adequate process for documenting and responding to complaints lodged by community home residents and other interested parties?

The following methodologies apply to audit objectives 1 and 2. We interviewed applicable members of departmental management. We also reviewed the incident reports from June 1, 2013, to December 31, 2016; the population of individuals who transitioned out of Clover Bottom and Greene Valley Developmental Centers to a community home between June 1, 2013, and December 31, 2016; and the monthly census of individuals for the developmental centers and community homes between June 1, 2013, and December 31, 2016.

Next, we performed analytical procedures by comparing the number of incidents and deaths reported each month (by incident type, death, and overall incidents) to determine if there were significant differences between developmental centers' and community homes' incident rates and death rates. We also compared the number of incidents and deaths reported each month to the average monthly census of individuals at the developmental centers and community homes.

For individuals who transitioned from a developmental center to a community home and subsequently died between June 1, 2013, and December 31, 2016, we calculated the number of days between transitioning to the community home and the date of death.

INFORMATION SYSTEMS

1. **Audit Objective:** Did management correct the two April 2013 findings involving state information systems security policies and industry best practices?

We reviewed management's internal control activities to assess adherence to state information systems security policies and information systems industry best practices.

2. **Audit Objective:** Did the department correct the October 2013 finding by making adequate progress in replacing its outdated Community Services (CS) Tracking system?

We interviewed the former Chief Information Officer, as well as the Executive Information Technology Director and Enterprise Senior Project Manager. We reviewed project contracts, schedules, design documents, budgets, meeting minutes, and newsletters. We obtained a schedule of expenditures incurred to date to replace the CS Tracking system and traced the expenditure amounts to supporting journal vouchers. We also observed the Titan system, the department's projected replacement for the CS Tracking system, in operation.

DEPARTMENT FINANCES AND INVENTORY

1. **Audit Objective:** Did the department correct the April 2013 finding by properly preparing its Medicaid cost reports?

We conducted interviews and performed walkthroughs with key personnel responsible for compiling the cost reports and associated cost allocation plans. We also researched relevant cost report rules and regulations and read the U.S. Department of Health and Human Services' Office of Inspector General audit of the department's cost reports dated April 18, 2013.

We reconciled every departmental cost report for fiscal years 2013 to 2015 to supporting documentation (final versions[78] for fiscal years 2013 and 2014 and tentative versions for fiscal year 2015):

- fiscal year 2013 – Clover Bottom Developmental Center, Greene Valley Developmental Center, West Tennessee Homes, and East Tennessee Homes;
- fiscal year 2014 – Clover Bottom, Harold Jordan Center, Greene Valley, West Tennessee Homes, Middle Tennessee Homes, and East Tennessee Homes; and
- fiscal year 2015 – Clover Bottom, Harold Jordan Center, Greene Valley, West Tennessee Homes, Middle Tennessee Homes, and East Tennessee Homes.

2. **Audit Objective:** Were department employees' travel expenditures reimbursed in accordance with statewide regulations and also reasonable and necessary?

We reviewed the Department of Finance and Administration's Policy 8, "Comprehensive Travel Regulations." We also selected a random, nonstatistical sample of travel expenditures to test for the following periods:

Period	$ Amount Population	$ Amount Sampled	# of Items in Population	# of Items Sampled
June 1, 2013 – June 30, 2013*	$36,602	$1,090	911	25
July 1, 2013 – June 30, 2014	$482,018	$871	13,054	25
July 1, 2014 – June 30, 2015	$449,358	$883	12,098	25
July 1, 2015 – October 31, 2015	$133,838	$1,009	3,552	25
Total	$1,151,816	$3,853	29,615	100

*June was the only month from fiscal year 2013 that was included in our audit period.

In addition, we obtained the Office of Risk Management and Licensure's investigative report released on June 29, 2017.

[78] Under Chapter 1200-13-6.07 of the *Rules of the Tennessee Department of Health, Bureau of TennCare*, agencies must submit a tentative version of the cost reports within three months of their year-end. Agencies may submit a final version up to the due date of the next annual cost report. The final version of the fiscal year 2015 cost report was not due before we commenced testwork; therefore, we only tested the tentative version.

Audit Objective: To correct the October 2013 observation, did the department require all employees to sign conflict-of-interest forms?

We analyzed applicable *Tennessee Code Annotated* sections. We obtained a list of all 1,675 department employees who were currently employed as of September 22, 2016. We then selected a random, nonstatistical sample of 60 employees. After identifying high-risk factors related to discrepancies between the conflict-of-interest forms we received from management and our employee list from Edison (the state's accounting system), we expanded our sample to include 25 more randomly selected employees, for a total of 85 tested. In addition to verifying that the employee's conflict-of-interest form was on file, we determined whether management had approved any conflict disclosures. We also obtained the Office of Risk Management and Licensure's investigative report released on June 29, 2017.

3. **Audit Objective:** To correct the October 2013 observation, did the department update its conflict-of-interest policy and related form?

We inspected the latest version of the department's Policy 101, "Conflict of Interest," which became effective October 13, 2010.

4. **Audit Objective:** Did the department correct the portion of the April 2013 finding involving pharmacy inventories?

We interviewed key Greene Valley Developmental Center personnel. We analyzed the Office of Risk Management and Licensure's audit working papers for the pharmacy inventory dated September 5, 2013, as well as the Department of Health's Tennessee Board of Pharmacy Institutional Compliance report on the center dated December 2015. We also obtained examples of the various documentation used during the pharmacy ordering and distributing process and viewed a news article detailing pharmacy inventory regulations.

Furthermore, we accessed the Greene Valley Pharmacy Stock Status report as of April 28, 2016, which included 1,133 inventory items. We selected a random, nonstatistical sample of 60 items and attempted to physically locate them.

5. **Audit Objective:** Did the department correct the portion of the April 2013 finding involving supply inventories?

We conversed with applicable department personnel. We gathered documentation supporting the supply ordering and distributing process.

In addition, we obtained the Edison inventory list as of April 18, 2016, which included 400 items. We selected a random, nonstatistical sample of 60 items and attempted to physically locate them.

PLANNING AND POLICY COUNCILS

1. Audit Objective: Did the Statewide Planning and Policy Council fulfill the duties specified in Section 33-5-602, *Tennessee Code Annotated*?

In addition to reviewing minutes for the Statewide Planning and Policy Council meetings held from August 21, 2013, through November 16, 2016, we studied the council's 2013, 2014, and 2015 annual reports. We also interviewed all 12 council members as of August 2, 2016, along with the chairs of the East, Middle, and West Regional Planning and Policy Councils and the Developmental Disabilities Planning and Policy Council.

2. Audit Objective: Did the Statewide Planning and Policy Council and four sub-councils meet the membership composition requirements described in Sections 33-5-601 and 33-2-203, respectively?

We compared the requirements delineated in state law to the composition of the council and sub-councils for 2013 through 2016.

3. Audit Objective: Did the Statewide Planning and Policy Council satisfy the meeting frequency requirements promulgated in Section 33-5-601?

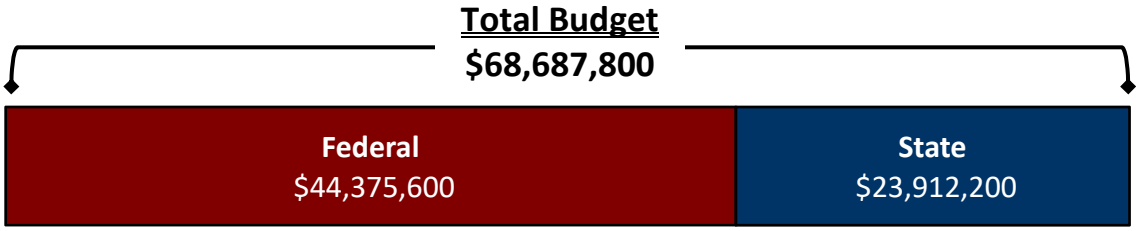
After researching *Tennessee Code Annotated*, we obtained available attendance records and minutes for meetings conducted from August 21, 2013, through November 16, 2016. We then calculated average annual attendance rates for each council member.

4. Audit Objective: Were council members' travel expenditures reasonable, necessary, and reimbursed in accordance with statewide regulations?

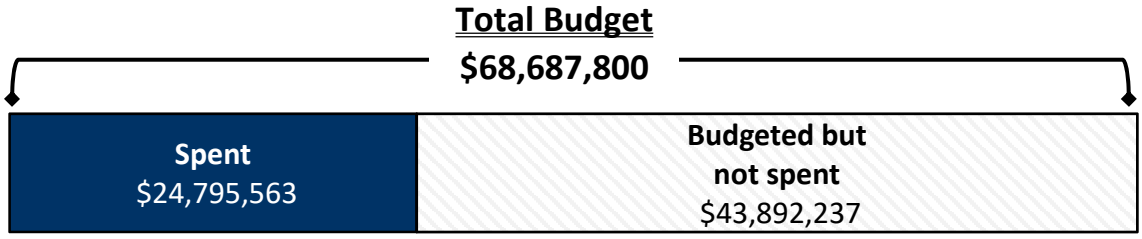
For the period June 1, 2013, through June 30, 2016, we compiled the population of travel expenditures reimbursed to members of the Statewide Planning and Policy Council and four sub-councils (a total of 95 transactions for $9,473). We then selected a random, nonstatistical sample of 25 expenditures, totaling $3,250, for testwork.

APPENDIX 2
Employment and Community First CHOICES Budget

Amount budgeted to support individuals in Employment and Community First CHOICES in Fiscal Year 2017



Amount spent to support individuals in Employment and Community First CHOICES in Fiscal Year 2017



APPENDIX 3
Personal Property Not Located

Region	Description of Missing Items
Middle	-9 shirts -4 pants -2 coats -1 stocking -1 underwear
East	-6 shirts -1 pants -1 dress -1 dinosaur toy -1 set of 2 CDs -1 socks
West	-3 shirts -1 face towel

APPENDIX 4
Glossary of Terms

abuse

The deliberate inflicting of injury, unreasonable confinement, intimidation, or punishment on a service recipient, resulting in physical harm, pain, or mental anguish to him or her.

abuse registry

The Tennessee Department of Health's public database of individuals who have abused, neglected, or exploited a vulnerable person. *See also* Abuse Registry Review Committee.

Abuse Registry Review Committee

A department committee established to review substantiated investigations of abuse, neglect, and exploitation and to determine whether to refer the perpetrator for placement on the abuse registry. *See also* abuse registry.

aging caregiver law

Legislation passed in 2015 and updated in 2016 to require enrollment of any person with intellectual disabilities in the self-determination waiver (or an equivalent assistance program) if the person's primary caregiver is age 75 or older (Section 33-5-112, *Tennessee Code Annotated*).

Benevolent Fund

A community account comprising donated funds, established to pay for activities and other benefits for residents of the department's intermediate care facilities.

category of need

A classification describing the immediacy of needs (crisis, urgent, active, or deferred) for individuals on the department's now-defunct Medicaid waiver waiting list. *See also* waiting list.

Centers for Medicare and Medicaid Services (CMS)

A federal agency within the U.S. Department of Health and Human Services, responsible for administering the Medicaid program. *See also* Medicaid.

Circle of Support

A group of trusted people, such as friends, family, legal representatives, and service providers, that helps an individual develop his or her Individual Support Plan (ISP).

Clover Bottom Developmental Center

A facility located in Nashville that provided 24-hour residential care to individuals with an intellectual disability (closed November 2015).

Council on Quality and Leadership (CQL)

An international accrediting agency dedicated to the definition, measurement, and improvement of quality in human service organizations and systems.

cost plan

A list of services authorized in an Individual Support Plan, including the service period, maximum units, and service rates. *See also* Individual Support Plan.

Death Review Committee

A department committee established to review deaths of service recipients to identify factors that may have contributed to the death and to recommend necessary preventive measures.

developmental centers

State-operated institutions, now closed, which offered long-term residential services, habilitative care, and training programs for individuals with intellectual disabilities. *See also* Clover Bottom Developmental Center *and* Greene Valley Developmental Center.

Developmental Disabilities Planning and Policy Council

See Statewide Planning and Policy Council.

developmental disability

A physical and/or mental impairment that begins before age 22 and inhibits an individual's capacity to perform activities of daily living, such as self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency.

direct support professional

A caregiver who assists an individual with intellectual or developmental disabilities with activities such as eating, grooming, bathing, medication administration, community interaction, and transportation.

East Regional Planning and Policy Council

See Statewide Planning and Policy Council.

East Tennessee Homes

A group of 16 state-run, 4-person homes that serve former residents of developmental centers, located in Greene County.

Employment and Community First CHOICES

A Medicaid program offering long-term services and supports to individuals with intellectual and developmental disabilities, focused on promoting competitive, integrated employment and independent community living.

Employment First Task Force

A task force established by Governor Haslam's Executive Order 28 and convened by the department to explore strategies to increase integrated and competitive employment for Tennesseans with disabilities.

exploitation

Actions including but not limited to the deliberate misplacement, misappropriation, or wrongful temporary or permanent use of belongings or money with or without the consent of a service recipient.

Felony Offender Information List (FOIL)

A public database containing information about Tennessee felony offenders who are or who have been in the custody of the Tennessee Department of Correction.

Greene Valley Developmental Center

A facility located in Greeneville that provided 24-hour residential care to individuals with an intellectual disability (closed May 2017).

Harold Jordan Center

A 28-bed facility located in Nashville that serves individuals with an intellectual disability who have severe behavioral challenges or who have been charged with a crime.

home- and community-based services waiver

A Medicaid-funded program that provides long-term care to individuals in their homes and the community instead of in an institution or nursing home. The department operates three home- and community-based services waivers for individuals with intellectual disabilities: the comprehensive aggregate cap waiver, the statewide waiver, and the self-determination waiver.

Independent Support Coordinator (ISC)

A case manager contracted by the department to assist a person supported in identifying, selecting, obtaining, coordinating, and accessing services.

Individual Support Plan (ISP)

A federally required plan of care for an individual receiving waiver services. The plan must provide a comprehensive description of the person supported and the services required to meet his or her needs. *See also* Circle of Support *and* cost plan.

intellectual disability

Below-average cognitive ability that manifests before age 18 and is characterized by an intelligence quotient of 70 or below, along with significant limitations in the ability to adapt to and carry on everyday life activities.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

Facilities that have four or more beds and are certified by the Centers for Medicare and Medicaid Services to provide health or rehabilitative services to individuals with intellectual disabilities.

Investigation Review Committee

A committee composed of department employees and representatives of outside entities, established to review final investigation reports of allegations of abuse, neglect, or exploitation and to make decisions to uphold, modify, or overturn the original conclusions.

List of Excluded Individuals and Entities (LEIE)

The U.S. Department of Health and Human Services' Office of the Inspector General's database of individuals and entities excluded from participating in federal health care programs due to Medicaid fraud, patient abuse, or other health-care-related offenses.

Medicaid

A program jointly funded by states and the federal government to provide health coverage to individuals and families with limited resources.

Middle Regional Planning and Policy Council

See Statewide Planning and Policy Council.

Middle Tennessee Homes

A group of nine state-owned, four-person homes serving former residents of developmental centers, located in Davidson and Wilson Counties. Another home is state-owned but privately operated.

neglect

The failure to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness, which results in injury or probable risk of serious harm to a service recipient.

Office of Disability Employment Policy (ODEP)

An office within the U.S. Department of Labor that is responsible for developing and promoting policies to increase employment of people with disabilities.

People First of Tennessee v. Clover Bottom Developmental Center

A 1995 lawsuit filed against the state on behalf of residents of the Clover Bottom Developmental Center, Greene Valley Developmental Center, and Nat T. Winston Developmental Center, alleging neglect, abuse, and civil rights violations at those facilities.

People First of Tennessee v. State of Tennessee

A 1991 lawsuit filed against the state on behalf of residents of the Arlington Developmental Center, alleging neglect, abuse, and civil rights violations at that facility.

Provider Manual

A guide for the department's providers that outlines the principles and requirements for the delivery of quality services to individuals with intellectual disabilities.

Quality Review Panel

A court-appointed monitor established in 1997 to assess the state's compliance with a federal lawsuit settlement agreement. *See also People First of Tennessee v. Clover Bottom Developmental Center*.

regional offices

The department's local offices, located in the three grand regions of the state: East, Middle, and West Tennessee.

Resident Trust Fund

A bank account, managed by the department, that contains money belonging to residents of the department's intermediate care facilities.

Substantiated Investigations Records Inquiry (SIRI)

A departmental database containing the names of individuals substantiated for abuse, neglect, or exploitation of a person supported.

Statewide Planning and Policy Council

A council the Tennessee General Assembly established in 2011 to assist and advise the department in planning, developing, and evaluating services and supports for individuals with intellectual and developmental disabilities. The council includes four subcouncils: the Developmental Disabilities Planning and Policy Council, the West Regional Planning and Policy Council, the Middle Regional Policy and Planning Council, and the East Regional Planning and Policy Council.

Title XIX of the Social Security Act

See Medicaid.

waiting list

A list, maintained by the department until July 1, 2016, that identified individuals who had requested home- and community-based waiver services from the department. *See also* category of need.

waiver

See home- and community-based services waivers.

West Regional Planning and Policy Council

See Statewide Planning and Policy Council.

West Tennessee Homes

A group of eight state-run, four-person homes serving former residents of developmental centers, located in Shelby and Fayette counties. Another four homes are state-owned but privately operated.

APPENDIX 5
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