INCLUSA

Residential Scope of Service Training

- 1-2 Bed Adult Family Home (AFH)
- 3-4 Bed Adult Family Home (AFH)
- 5-8 Bed Community Based Residential Facility (CBRF)

Presented By: Community Resources and Provider Relations (CR/PR)

Scope of Service Training Agenda

01 Introductions

02 Purpose of the Scopes

03 Scope of Service Sections

04 Implementation Process

05 Additional Information

06 Questions/Comments

Scope of Service Purpose and Unification

Unification Process

- Comparison of Three Scopes/Expectations/Appendix 2
- Data Analysis
- Provider Engagement

Purpose

- Ensuring consistency in expectations of Inclusa and provider
- Best Practice
- High Quality Care and Service

Facility Definitions

1-2 Bed AFH: facilities in which the operator provides care, treatment, support, or services above the level of room and board to up to two adults. Services typically include supportive home care, personal care and supervision. Services may also include transportation and recreational/social activities, behavior and social supports, daily living skills training and transportation if provided by the operator or designee of the operator. It includes homes which are the primary domicile of the operator or homes which are controlled and operated by a third party that hires staff to provide support and services.

3-4 Bed AFH: facilities that are licensed under DHS 88 of the Wisconsin Administrative code and are places where 3-4 adults who are not related to the licensee reside, receive care, treatment or services above the level of room and board, and may include up to seven hours per week of nursing care per resident. Services typically include supportive home care, personal care and supervision. Other services provided may include behavior and social supports, daily living skills training and transportation performed by the operator or designee of the operator.

5-8 Bed CBRF: a place where five (5) or more adults, and in cases of persons with an intellectual disability up to 8 adults, who are not related to the operator or administrator reside and receive care, treatment, support, supervision and training.

- This training will provide an overview for the 5-8 bed expectations within scopes
- CBRF Scope of Service includes 5-8 Bed and > 8 Bed Facilities

Inclusa Interdisciplinary Team (IDT) Definition

The Inclusa Interdisciplinary Team (IDT) is composed of the following:

- **Community Resources Coordinator (CRC)** – The Inclusa CRC is responsible for identifying member service needs using the RAD process and authorizing the service(s) needed to meet the member's long-term care outcomes. The CRC ensures the member has the necessary furnishings and supplies for independent living and coordinates moving the member's belongings and medications at member move-in and in the event of the member moving out. The Inclusa CRC is the provider agency's main point of contact for member-specific or related questions, concerns, or information.

- **Health and Wellness Coordinator (HWC)** – The Inclusa HWC is a nurse that has ongoing responsibility to assess and review how the member is doing clinically and educate the member on health-related issues. Inclusa HWCs do not provide direct care services, supervision of agency direct care staff, or supervisory visits of direct care workers for nurse-delegated tasks. Inclusa HWCs do not delegate tasks to personnel from any provider agency or self-directed support. All nursing delegation must be provided by a registered nurse employed or subcontracted by the contracted provider agency.

The IDT may also be referred to as "Inclusa Team" or "Care Management Team."

Standards of Service

Provider must follow the standards for certification through their certifying agency for 1-2 bed AFH(s) or licensure through the State of Wisconsin, Division of Quality Assurance (DQA) for 3-4 bed AFH(s) and Community Based Residential Facility (CBRF).

The Scope of Service reflects Inclusa policies and procedures.

Services must be provided in a manner which honors member's rights such as consideration for member preferences (scheduling, choice of provider, direction of work), and consideration for common courtesies such as timeliness and reliability.

Standards of Service

Influencing Member Choice

Inclusa subcontracted providers of long-term care services are prohibited from influencing members' choice of long-term care program, provider, or Managed Care Organization (MCO) through communications that are misleading, threatening or coercive. Inclusa and/or the WI Department of Health Services may impose sanctions against a provider that does so.

Per DHS, any incidents of providers influencing member choice in a Family Care program must be reported to DHS immediately.

Service Descriptions

Services are billed with the indicated SPC and procedure code at the daily rate as defined in Appendix A of the Subcontract Agreement and Residential Rate Agreement.

The daily rate paid to the residential provider is comprised of two portions:

- room & board
- care & supervision

The room and board portion of the daily rate is based on county HUD rates. Care and supervision rates are established by Inclusa using the regression model which incorporates member acuity and type of facility.

Member-specific rates will be documented through a Residential Rate Agreement. The signed Residential Rate Agreement must be returned to Inclusa within seven (7) business days of receipt. Inclusa will then fully execute the agreement and return a signed copy back to the provider for their records.

Service Descriptions

Physical Environment *(Room and Board)*

1. Physical Space
2. Furnishings
3. Equipment
4. Housekeeping services
5. Building Maintenance
6. Grounds Maintenance
7. Building Protective Equipment
8. Building Support Systems
9. Fire and Safety Systems
10. Food
11. Telephone and Media Access

Service Descriptions

Program Services (*Care and Supervision)*

1. Supervision
2. Personal Emergency Response Systems (PERS)
3. Socialization and access to community activities
4. Health Monitoring
5. Medication Management and Administration
6. Individualized Service Plans
7. Facility Supplies and Equipment
8. Personal Protective Equipment (PPE)
9. OSHA and Infection Control Systems
10. Hoyer/EZ Stand Lifts

*Hoyer/EZ Stand Lifts: On a member specific basis, Inclusa may purchase a Hoyer or EZ Stand for members residing in homes that are four (4) beds or less. Training regarding the use of this equipment is required and is the responsibility of the provider.

Service Descriptions

Behavior Support Planning and Implementation:
If a member requires a Behavior Support Plan, providers will develop/write behavior support plans in partnership with the IDT. It is the expectation that providers will comply with all aspects of implementation, documentation, communication, reporting and timelines when behavior support plans are in place for a member receiving services.

Service Descriptions

Costs incurred by individual member or Inclusa

The following costs are *not provided* by a facility and are costs incurred by the individual member(s) or the MCO:

- Co-payments for medication and medical/dental care
- Personal hygiene supplies
- Member clothing
- Costs associated with community recreational activities

The following costs are usually paid by Inclusa in addition to the residential rate:

- Personal incontinence products related to a diagnosis
- Respiratory/oxygen products/equipment
- Durable medical equipment and supplies for a specific individual
- Sleep apnea related products/equipment

Service Descriptions

Transportation

Facility should provide or arrange all regular and routine transportation needed to meet member outcomes as part of care and supervision services. Provider agencies and Inclusa are encouraged to coordinate with natural supports for transportation whenever possible.

The definition of “Regular and Routine” is defined for each member as a collaborative partnership between the provider and Inclusa and will be defined for each member at admission to a residential placement and/or during annual and six (6)-month reviews or upon member change in condition.
Regular and routine transportation may include but is not limited to:

- Social/Leisure/Community Outings or Availability to participate in community outings. Outings can be group in nature. Providers are responsible to provide options but not individual specific outings.
    - Examples include but are not limited to shopping, going out to eat, going to the movies, attending a community fair, etc.
- Religious Services
    - Religious services that are provided at the facility can meet this expectation if determined to be in accordance with member outcomes.

Service Descriptions

Transportation

Transportation for scheduled medical appointments (medical transportation) and employment, prevocational services, and/or day services, etc. (non-medical transportation) are included in care and supervision up to the first 100 miles per member per month. Starting at mile 101, the provider could be reimbursed for this service outside of the care and supervision rate.

This transportation will be reimbursed at $0.41 per mile.

Wheelchair Accessible Transportation

Wheelchair accessible transportation will only be reimbursed if the member requires it. Starting at mile 101, the provider could be reimbursed for this service outside of the care and supervision rate. This would be a authorization to the residential provider.

Wheelchair accessible transportation will be reimbursed at $0.70 per mile.

Service Descriptions

Requirements for mileage authorizations per member per month are as follows:

1. The Inclusa team will estimate appropriate mileage authorization after first 100 miles with input from the member and residential provider
2. Mileage authorizations will be for a one-month period, unless IDT deems it necessary to update the authorization mid-month.
3. Retroactive adjustments to mileage authorizations are not possible. Providers, members, and the Inclusa team must plan ahead for anticipated miles related to residential services as outlined above.
4. Provider may only bill for mileage incurred up to the mileage authorization. A provider may not charge for miles that were not needed.
    a. For example, Community Resource Coordinator authorizes 60 miles per month as it is estimated the member needs 160 miles per month. Provider only documents 140 miles per member per month. The residential provider may only bill for the 40 miles (above the initial 100), not the full 60 miles as authorized.
5. Providers must track the full miles per member per month.
6. Inclusa will conduct random audits to verify documentation to support mileage reimbursement.

Provider may use an outside vendor for transportation. Residential Provider would be reimbursed for member mileage and use this authorization/payment to reimburse the outside vendor.

Service Descriptions

Transportation for Multiple Members in One Vehicle
In the event a residential provider is transporting multiple Members, who will be delivered to an end destination, the provider would be expected to split the mileage between the Members who are sharing the ride. Residential providers should not bill for each Member individually in these instances. This expectation would not apply to Members who are in the vehicle due to no supervision at home or if they are in the vehicle for their community outing or any other regular and routine transportation as defined above.

Example:
Provider transports 2 members, one is going to day services and the other to their place of employment. Total one-way trip is 20 miles. It is 12 miles to the day services and an additional 8 miles to the place of employment.
Day services member would have 6 miles of transportation (half of 12 miles), and the employment member would have 14 miles of transportation (half of 12 miles + 8 miles where they are the only member in the vehicle).

Service Descriptions

Transportation Exceptions
Medical transportation needed for dialysis, chemotherapy, or a short-term acute need such as post-surgical trips would be considered an exception and could be funded outside of transportation as outlined previously to another vendor or to the provider if available.

These trips would not count towards the 100 miles, and could be reimbursed at mile one (1) either to the provider or another vendor.

Units of Service and Reimbursement Guidelines

Units of service will be made based on **DAYS** authorized in the facility. A DAY includes the day of admission, but not the day of discharge. Day of disenrollment of a Family Care member is not a paid service day. Disenrollment includes death, incarceration, loss of financial/functional eligibility, failure of member to pay cost share, move to an IMD, and/or move out of the MCO service area. Voluntary or otherwise determined by MCO.

Member absence from residential care

Residential providers are required to complete a member absence notification form if a member will temporarily be gone from a facility. Providers would coordinate with the IDT regarding reimbursement during this period.
This would not include visits with family, vacations, or camp attendance that is less than 14 calendar days. Providers would continue to receive regular care and supervision and room and board payment in these situations.

Substitute Care

Substitute Care (provider respite) cost is the responsibility of the residential provider and is included within the care and supervision rate.

Units of Service and Reimbursement Guidelines

Planned and Unplanned Termination of Placement

Planned Termination of Placement
A written 30-day notice is required by the MCO/member or residential provider (whoever is initiating the termination) to terminate a placement. Payment will be made up to, but not including the date of the member's move out of the home. Failure by provider/MCO to meet 30-day notice requirement may result in a financial penalty up to, but not exceeding the number of days left in provider/MCO's 30-day service commitment, unless an earlier date is mutually agreed upon by both parties.

Unplanned Termination of Placement
When an unplanned termination is due to reasons involving health and/or safety concerns a 30-day notice may not be required. The residential provider will coordinate an appropriate discharge plan with the IDT. Payment will be made up to, but not including the date of the member's move out of the facility.
If the unplanned termination is due to disenrollment of a member, 30-day notice would not be required. Disenrollment includes death, incarceration, loss of financial/function eligibility, failure of member to pay cost share, move to an IMD, and/or move out of the MCO service area, voluntary or otherwise determined by MCO. Payment would be made up to the last day of enrollment, but does not include the date of disenrollment.

Staff Qualifications and Training

Providers will comply with all applicable standards and/or regulations related to caregiver background checks as well as comply with the ***Inclusa Provider Policy on Caregiver Background Checks***.

Staff that provide services shall complete required training within six months of beginning employment unless training is needed before the staff can safely provide the service.

Provider agency must orient and train their staff on the Family Care Program, Inclusa, and Commonunity™, the trademarked care management model of Inclusa. Support materials regarding the Family Care Program and Commonunity™ are available on the Inclusa website at www.inclusa.org.

It is recommended providers utilize additional resources, as needed, in the community in order to work with the target population effectively.
It is expected the provider train all staff per DHS requirements. For a list of suggested requirements, please review Scope of Service.

Providers shall comply with DHS regulations in regard to employing anyone under the age of 18.

Supervision and Staff Adequacy

Providers will follow all regulatory requirements for staffing patterns as stated by DHS.

Residential category of provider also outlines staffing pattern. Inclusa's residential rate methodology utilizes category assignments for each provider. Categories are determined based on target group, average acuity of members served, staffing model, overnight care, and behavioral/medical specialties. There are five (5) provider categories.

Providers must have an acceptable back up procedure when scheduled staff is not available.

Provider agency will ensure:

- Staff are supervised and assessed to assure they are working effectively and collaboratively with members by conducting adequate on-site supervision and review.
- Performance issues with staff are addressed promptly and Inclusa teams are kept informed about significant issues that affect the Inclusa member.
- Supervisory staff are involved in assessment, goal planning and tracking, and supervision for Inclusa members.
- Provider staff are working collaboratively and communicating effectively with Inclusa staff.

Service Referral and Authorization

The Inclusa team will communicate to the provider agency expected outcomes, amount, frequency and duration of services to be provided
Residential providers will receive a rate agreement from Inclusa that must be signed and returned to indicate acceptance of the terms of a member's placement.

Authorizations for Member Services
The Inclusa Provider Portal is used by providers to obtain information about current authorizations. In addition, the provider must use the portal to acknowledge all new authorizations.

For authorization needs such as new authorizations, additional units, or missing authorizations, during normal Inclusa business hours (8:00 a.m. to 4:30 p.m.) the provider should contact the Inclusa team (Community Resource Coordinator or Health and Wellness Coordinator).

If your authorization request is an emergent need impacting the member's health and safety and you cannot reach the Inclusa team:

- During Inclusa business hours – contact Inclusa's general number for assistance at 1-877-622-6700
- After Inclusa business hours – contact the After-Hours Authorization Line at 1-800-285-6425

Communication, Documentation, and Reporting Requirements

Inclusa communicates with providers regularly in the following formats:

- Vendor forums
- Mass notifications via email, fax, or mail
- Notices for expiring credentialing

Notices are sent to providers via email when the provider has email available to ensure timeliness of communication.

Providers can update their information by submitting the Provider Contact Information Form at www.inclusa.org/providers/resources, or by contacting Provider Relations at 888-294-7451 or ProviderRelations@inclusa.org.

The provider agency shall report to the Inclusa team whenever:

1. There is a change in the member's needs or abilities
2. The member is not available to attend scheduled services as defined on the member's ISP

Providers will notify Inclusa of formal complaints or grievances received from Inclusa members within 48 hours of receipt. Written notification of completed complaint investigations will be forwarded to the Inclusa interdisciplinary team.

Communication, Documentation, and Reporting Requirements

Member Incidents

Providers will communicate and report all incidents involving an Inclusa member to the Inclusa Interdisciplinary Team (IDT) – the Community Resource Coordinator (CRC) or the Health and Wellness Coordinator (HWC) within **24 hours** via phone, fax or email.

If the reporter is unable to reach the CRC or HWC, they may leave a message reporting details of an incident that has been resolved and did not result in serious harm or injury to the member.

If the incident is not yet resolved or resulted in serious harm or injury to the member, the provider must attempt to contact the IDT via phone. If unsuccessful, call 1-877-622-6700 and ask to speak to a Member Support Manager or Regional Operations Senior Manager to immediately make a report. If a manager is unavailable, the provider will speak with the receptionist to be redirected or leave a message**.**

All reported incidents will be entered into the Inclusa Incident Management System and reported to DHS in accordance with MCO contract requirements. Providers may be asked to provide any additional information or details necessary to complete the investigation of reported incidents. The provider will inform Inclusa when notifying their regulatory authority of incidents. A copy of the report may be submitted as a form of notification.

Both Inclusa and contracted providers must comply with all state regulations and rules as outlined in the ***Provider Incident Reporting Policy and Training*** document, available on the Inclusa website at www.inclusa.org.

Communication, Documentation, and Reporting Requirements

The provider agency must maintain the following documentation; and make available for review by Inclusa Staff upon request.

- Provider meets the required standards for applicable staff qualification, training and programming
- Verification of criminal, caregiver and licensing background checks as required.
- Policy and procedure related to supervision methods by the provider agency including frequency, intensity and any changes in supervision.
- Policy and procedure for responding to complaints, inappropriate practices or matters

Communication, Documentation, and Reporting Requirements

Communication: What Provider Can Expect from MCO

A strength-based, collaborative relationship with providers is one of the most effective means to achieve positive outcomes for Inclusa members. To ensure a true partnership with Inclusa providers, Inclusa staff expectations are listed within the Scope of Service

Inclusa IDT shall inform Provider within five (5) business days if/when there is a change in the assigned Community Resource Coordinator or Health & Wellness Coordinator for a member.

Quality Assurance

Purpose

Inclusa quality assurance activities are a systematic, departmental approach to ensuring and recognizing a specified standard or level of care expected of subcontracted providers. These methodologies are established to review and inspect subcontracted provider performance and compliance.

Inclusa will measure a spectrum of outcomes against set standards to elicit the best picture of provider quality.

Inclusa provider quality assurance practices:

1. Establish the definition of quality services;
2. Assess and document performance against these standards; and
3. Detail corrective measures to be taken if problems are detected.

It is the responsibility of providers and provider agencies to maintain the regulatory and contractual standards as outlined in this section. Inclusa will monitor compliance with these standards to ensure the services purchased are of the highest quality.

Quality Assurance

Quality Performance Indicators

- Legal/Regulatory Compliance- evidenced by regulatory review with no deficiencies, type of deficiency and/or effective and timely response to Statement of Deficiency
- Education/Training of staff- Effective training of staff members in all aspects of their job, including handling emergency situations. Established procedures for appraising staff performance and for effectively modifying poor performance where it exists.
- Performance record of contracted activities-
  - tracking of number, frequency, and outcomes of Inclusa Incident Reports related to provider performance
  - tracking of successful service provision (member achieving goals/outcomes, increased member independence and community participation, etc.)
- Contract Compliance- formal or informal review and identification of compliance with Inclusa contract terms, provider service expectation terms, applicable policies/procedures for Inclusa contracted providers
- Availability and Responsiveness- related to referrals or updates to services, reporting and communication activities with Inclusa staff.

Quality Assurance

Inclusa Sources and Activities for Measuring Provider Performance

- Member satisfaction surveys
- Internal or external complaints and compliments
- Onsite review/audits
- Statement of Deficiency (SOD)- state regulated entities
- Quality Teams- as assigned based on significant incidents, trend in quality concerns or member-related incidents, or issued Statement of Deficiency.
- Tracking of performance and compliance in relation to the subcontract agreement and appendices
- Statistical reviews of time between referral and service commencement

Quality Assurance

Expectations of Providers and Inclusa for Quality Assurance Activities

- **Collaboration**: working in a goal oriented, professional, and team based approach with Inclusa representatives to identify core issues to quality concerns, strategies to improve, and implementing those strategies
- **Responsiveness**: actions taken upon request and in a timely manner to resolve and improve identified issues. This may include submitted documents to Inclusa, responding to calls, emails, or other inquiries, keeping Inclusa designated staff informed of progress, barriers, and milestones achieved during quality improvement activities.
- **Systems perspective toward improvement**: approaching a quality concern, trend, or significant incident with the purpose of creating overall improvements that will not only resolve the issue at hand, but improve service and operations as a whole
- **Member-centered solutions to issues**: relentlessly striving to implement solutions with the focus on keeping services member-centered and achieving the goals and outcomes identified for persons served

Inclusa is committed to interfacing with providers to collaboratively and proactively discuss issues identified with processes and assist with implementing improvements and reviewing the impact of the changes as a partner in the mission to serve members.

Implementation and Training

Implementation

- Scopes of Service will be effective 1/1/2019
- Changes will not be made to current member's until the time of their MCP or a change of condition
- All new referrals after 1/1 will follow unified Scope of Service

IDT Training

- Teams are being trained 10/31, 11/7, and 11/15

Authorization Updates

- Providers will see service line entries for transportation mileage reimbursement

Commonunity® is Inclusa's approach to everything we do. So central to our operations, Commonunity® is a trademarked model of managed care that places emphasis on the importance of full citizenship and what it means to be an active participant in everyday life. Explored through both a collective and individual approach.

Commonunity® is the belief in the strengths of everyone and the commitment to support the common good for all.

Commonunity® is a way of living which brings together the basics—connection to community, opportunity to work, a place to call "home," ability to get where I need to go—to create the life of my choosing.

In every day practice, Commonunity® explores the importance of full citizenship by supporting the development of meaningful connections between members and their communities through the thoughtful exploration of five component areas: Community Connections, Self-Determination, Community Living, Integrated Employment, and Mobility.

Rate Changes in 2019?

Inclusa will not be adjusting our Residential Rate Methodology for 2019.

In instances in which Member acuity is over 899 or the Member has a care and supervision rate greater than 200% above the residential rate methodology, Inclusa IDT will partner with providers to assure members are being supported in the most appropriate setting, with the appropriate level of care. We would like to review if staffing patterns can be reassessed, or other changes can be made to the programming that allows the Member to reside in the least restrictive and most inclusive setting possible. This approach can lead to helping the long-term sustainability for providers and Inclusa.

Inclusa is not making adjustments to Room and Board rates in 2019.

Questions?

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