



Provider Manual

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INTEGRAL CARE

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Introduction

In order to ensure choice for the people served ("Covered Individuals") and an effective and comprehensive system of care, Austin Travis County Mental Health and Mental Retardation Center dba Integral Care (referred to throughout this Provider Manual as "Integral Care") has developed an integrated network of providers ("Provider Network", and each member of the Provider Network, a "Provider"). We are very pleased that you have become a member of Integral Care's Provider Network.

The purpose of this Provider Manual is to give you information you will need in order to provide services under your provider contract with Integral Care. Your provider contract incorporates the contents of this Provider Manual (both in its current version and as it is updated from time to time) as part of the terms that govern your relationship as a Provider with Integral Care.

All Providers must sign and return the "Integral Care Provider Manual Acknowledgement" before they will receive a final contract with Integral Care to provide services to Covered Individuals ("Covered Services"). If you have questions about any section of this Provider Manual, contact the Integral Care Contract Manager, as shown in the Key Contacts list contained in this Provider Manual. The most recent version of the Provider Manual can be found online at www.IntegralCare.org, under "Resources" in the "Provider" section.

Critical procedural information covered in this Provider Manual includes, but is not limited to, the following:

- Service Delivery Guidelines
- Authorization and Utilization Management Procedures
- Invoicing (Claims) Procedures and Billing and Reimbursement Guidelines
- Required Documentation
- Reporting of Abuse, Neglect and Other Incidents of a Serious Nature
- Confidentiality
- Covered Individual's Record Maintenance

Integral Care History

Founded in 1967, Integral Care prides itself on providing innovative, quality services for individuals residing in Travis County who have intellectual disabilities and/or brain-based disorders (including, but not limited to, major depression, bi-polar disorder and schizophrenia), and those who also have a (combined) diagnosis of chemical dependency and/or who may be homeless.

Various demographic and geographic data assist Integral Care's Board of Trustees, staff and Integral Care Advisory Committees to plan. Local planning, community, consumer and family input are utilized in Provider Network development and management, and in determining best value processes. Covered Individuals often have severe disabilities or persistent mental illnesses. Services and resources are targeted for the following populations:

- Priority and target populations as defined by DSHS, DADS, and DARS.
- Other populations, as determined by Integral Care's funders and/or its Board of Trustees to meet the needs of the community.
- Single diagnosis substance abuse, as defined by a funder contracting for services.
- HIV Services, as defined by a funder contracting for services.



- Priority and target populations (Mental Health / Intellectual and Developmental Disabilities) with co-occurring substance abuse diagnosis.
- Children with multiple needs who are part of the multi-agency Children's Integrated Funding Initiative.
- Other disabled or in need populations as part of demonstration projects or other study groups to acquire and/or demonstrate information about best practices.

Vision

A caring and healthy community that supports individuals and families in achieving self-reliance and self-determination.

Mission

To improve the lives of people affected by behavioral health and developmental and/or intellectual challenges.

Values

People: Integral Care's greatest strength is people – consumers, family, staff and the community – by promoting a culture built on trust, respect, teamwork, communication, creativity and collaboration in an environment that strives for equal opportunity.

Integrity: Integral Care delivers on its promises and is accountable for performance by working towards open and honest dialogue with consumers and staff, while cooperating within and across organizations to deliver the most positive outcomes. Transparent communication is critical to integrity.

Excellence: Integral Care is committed to excellence by providing services using evidence-based best practices in the most cost-effective, timely, safe and collaborative manner. This involves performance improvement, serving with dignity and respect and exceeding stakeholder expectation.

Leadership: Integral Care courageously confronts challenges through advocacy to increase public awareness and by building support for a community that meets the behavioral health and IDD needs of individuals and families. This is closely linked to ensuring comprehensive and targeted public policy that serves consumer needs.

Intake, Eligibility and Access to Covered Services

Integral Care is organized into four services divisions, each of which provides services to the distinct populations as defined below:

Behavioral Health Services Division ("BHS")

Adult Mental Health (MH) Priority Population - Adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.

Adult MH Target Population - Adults who have a diagnosis of schizophrenia, bipolar disorder, or severe major depression.

This division also serves adult individuals with serious mental illness who also have a diagnosis of substance abuse and/or other co-occurring disorders. Determinations of eligibility for service are established via an intake assessment, and resources are managed through a managed care delivery system using internal staff and Providers licensed to provide evaluation, treatment and intervention services.

Crisis Services Division (“CSD”)

This division serves individuals who are experiencing a psychiatric crisis by providing psychiatric assessments, crisis intervention services, crisis respite services, crisis residential services and links to physician services and community resources. The Crisis Services Division is comprised of the following:

- 24/7 Crisis Hotline 512-472-HELP (4357) – Callers have access to mental health professionals, with all crisis calls to assist individuals experiencing a crisis.
- Crisis Chat: IntegralCare.org/content/crisis-chat – Integral Care offers emotional support using online, text-based communication at CrisisChat.org, an innovative way to connect with people who may otherwise not reach out for help.
- Psychiatric Emergency Services (PES) – PES is a walk-in psychiatric Emergency service open 24 hours a day, 7 days a week.
- Mobile Crisis Outreach Team (MCOT) – MCOT is designed to immediately respond to individuals experiencing psychiatric distress at the site of crisis and is available 7 days a week, 10 a.m. – midnight, with 24/7 on-call availability.
- Assertive Community Treatment (ACT) Team – A self-contained program that provides treatment, rehabilitation and support services to individuals who have a history of multiple hospitalization treatments.
- The Inn – The Inn is a sixteen-bed facility providing adults with short-term psychiatric residential care.
- Next Step - Provides crisis respite care based on life coaching, providing short-term psychiatric services to adults who are recovering from a psychiatric crisis.

Inpatient Services funded through Central Health

Eligible Client – An eligible client is defined as any person who on the date of the request for service:

- Has a household income of less than 200% of the latest Federal Poverty Income Guidelines that are applicable to a household with the same number of persons as his/her household.
- Is covered by no other applicable insurance or other third-party payer for full coverage of needed services, nor is individual eligible for other third-party payer programs.
- Is a bona fide resident of Travis County, which is determined by his/her address of residency or his/her stated intention to remain in Travis County for an indefinite period of time if homeless.

Eligibility Screening - To document if a person is an Eligible Client, the private hospital requesting authorization will be required to complete and submit the Eligibility and Consent Form. (Form attached). Once admitted to a private hospital facility, UM will review the Eligibility and Consent Form received from the private hospital prior to issuance of the authorization. This form verifies the client’s eligibility for Central Health funding as well as providing initial clinical information at the time of admission. UM will verify the information on the Eligibility and Consent Form, enter an updated demographic in the electronic record, enter a clinical admission note, and informational note regarding Medical Necessity and eligibility. The authorization letter will be issued by UM containing a standard disclaimer regarding



authorization and payment.

Intellectual and Developmental Disabilities Division ("IDD")

This division serves individuals with intellectual disabilities, autism and other pervasive developmental disabilities who access services from Integral Care's integrated network of internal staff, Providers, START Services and a single identified Service Coordinator using a Person-Directed Planning approach to service delivery.

Child and Family Services Division ("CFS")

This division serves children and adolescents with developmental delays, Severe Emotional Disturbances ("SEDs") or mental illnesses, developmental disabilities, and also serves children/adolescents At-Risk for juvenile justice involvement, and their families with multiple service needs. The CFS division is comprised of:

- Integral Care's Infant Parent Program ("EPI"), which serves children ages 0-3 with developmental delays;
- Integral Care's Children's Mental Health Program ("CMH") for children with SED or mental illness ages 3-18, and children with developmental disabilities who need intensive Service Coordination;
- Services funded through The Children's Partnership ("CP"), an interagency program initiative using the Wraparound process for children with complex needs and SED; and
- Services funded through the Youth and Family Assessment Center ("YFAC"), a prevention and intervention program for youth with multiple psychosocial needs and their families, using the Wraparound process.

Authorizations/Utilization Management/Resource Allocation

Integral Care's staff establishes or confirms Covered Individual eligibility for Covered Services delivered through its Provider Network for the Behavioral Health, Intellectual and Developmental Disabilities, Child and Family Services and Crisis Services Divisions, and for Integral Care's Managed Services Organization ("MSO") Managed Care Department.

Non-Emergency Authorizations

It is the Provider's responsibility to obtain initial verbal and subsequent written authorization for all non-Emergency Covered Services for Covered Individuals from the appropriate Integral Care Utilization Manager ("UM") or Resource Allocator ("RA"), each referred to separately as "UM/RA" throughout this Provider Manual.

Utilization Manager: A licensed RN, RN-APN, PA, PhD psychologist, LCSW, LPC, LMFT, or MD who approves authorization requests submitted by Providers, as defined by Texas Department of Insurance (TDI) regulations.

Resource Allocator: A Bachelor's level individual who authorizes, manages and coordinates resources consistent with the Wraparound or Person-Directed Planning service delivery models.

The Utilization Management / Resource Allocation functions are performed as follows:

DIVISION	PROGRAM	UM/RA
Behavioral Health	Resiliency and Disease Management Program (RDM)	Utilization Manager
	External Contract Substance Abuse Providers (MSO and non-MSO)	Utilization Manager
	External and Internal Contract Providers (non-MSO)	Program/Contract Manager and Utilization Manager
Intellectual and Developmental Disabilities	All IDD services Internal and External Contracted Providers	Service Coordinator and Utilization Manager
Child and Family Services	CP-program for SED youth	Care Coordinator
	YAFAC-program for At-Risk youth	Care Coordinator
	ECI-program for children 0-3 with developmental delays	Service Coordinator
	External and Internal Contract Providers who serve Integral Care children/adolescents with SED	Utilization Manager
Crisis Services	Resiliency and Disease Management (RDM)	Utilization Manager
Crisis Services	Resiliency and Disease Management (RDM), Psychiatric Emergency Services Contract (PESC) External Contracted Providers	Utilization Manager

For BHS, CSD and CFS Providers, the Resiliency and Disease Management Programs (RDM) are available on the Department of State Health Services website at <http://www.dshs.state.tx.us/mhprograms/RDMClinGuide.shtm>. The RDM Program Manual is available at <http://www.dshs.state.tx.us/mhprograms/rdm.shtm>. Providers who provide RDM Covered Services must receive RDM training prior to providing those services.

For CFS and IDD Providers, the Wraparound and Person-Directed Planning models are considered best practice and Providers are encouraged to participate in this training.

Before a Provider provides Covered Services, the designated UM/RA will contact that Provider to review the Covered Individual's Plan and to authorize needed Covered Services. The UM/RA is limited to arranging for ONLY the Covered Services at the rates stated in the Provider's then-current contract. After initial authorization of Covered Services by the UM/RA, the Provider receives written authorization to provide the UM/RA-approved Covered Services. The Provider should review the written authorization for accuracy of the type of Covered Service, number of units, begin and end dates and service/CPT or procedure codes, consistent with the prior, initial verbal authorization or written approval given by the UM/RA. It is the Provider's responsibility to ensure that a written authorization has been received for all requested Covered Services prior to service delivery.



Integral Care IS NOT REQUIRED TO PAY FOR ANY COVERED SERVICE THAT IT DOES NOT AUTHORIZE IN WRITING PRIOR TO THE PROVISION OF THE COVERED SERVICE THROUGH THE APPROPRIATE UM/RA IDENTIFIED BELOW.

However, authorization is not a guarantee of payment (see reasons for denial or adjustment of submitted Claims / Invoices in the “Claims / Invoice Submission, Request, Processing and Payment” section, above).

The Provider must immediately notify the UM/RA when the Covered Individual’s need for services/treatment changes, or when the Covered Services are discontinued for any reason during the course of treatment or program involvement.

For BHS, CSD and CFS Providers:

Data elements needed by the UM/RA to authorize Covered Services include, but are not limited to:
<ul style="list-style-type: none">identifying information concerning the Covered Individual and the Covered Services he/she will receive must be provided (Name, Date of Birth, Social Security Number, including that of the Covered Individual’s legally authorized individual (LAR) or primary caregiver, if applicable and the following:<ul style="list-style-type: none">Current diagnostic reviewCurrent assessmentCurrent Plan<ul style="list-style-type: none">the Plan objective(s) that was the focus of the service;the progress or lack of progress in achieving treatment plan goals;Verification that the Provider providing the service and a notation as to whether he/she is an LPHA, a QMHP-CS, a pharmacist, a CSSP, an LVN, a peer provider or otherwise authorized and credentialed, as required for that service.

For CFS and IDD Providers:

Upon accepting referrals, Providers should obtain at least the following information from the UM/RA:
<ul style="list-style-type: none">Authorization NumberName of Covered Individual and/or service recipient (i.e. family member)Covered Individual’s date of birthCovered Individual’s needs and strengthsGoals and objectives in providing Covered ServicesOther relevant information for service provisionDiagnosis, if relevant to service provision

Ongoing Review for Authorizations

Authorizations for continuing care are given by the UM/RA after a brief review of the Covered Individual's Plan or interaction with the Provider regarding the Covered Individual's response to Covered Services,



justification for continuation of Covered Services and Plan modifications and/or recommendations. Together, the UM/RA and the Provider will agree upon an Individualized Plan that is consistent with the UM Plan or Service Delivery Model, although the actual name of the Plan may differ depending on which Covered Services are provided.

It is the Provider's responsibility to obtain written authorization from the appropriate UM/RA for any Covered Service prior to the provision of that Covered Service, except for situations defined as an Emergency in this Provider Manual. The Provider must deliver Covered Services according to the schedule, duration and frequency specified in the Covered Individual's Plan or other documentation issued by the UM/RA.

COVERED SERVICES MAY NOT BE REIMBURSED WITHOUT PRIOR WRITTEN AUTHORIZATION (SEE EXCEPTION FOR EMERGENCY SERVICE AUTHORIZATION BELOW). HOWEVER, AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT (see reasons for denial or adjustment of submitted Claims/Invoices in the Claim/Invoice Section of this Provider Manual).

Emergency Authorizations

Emergency authorizations may be issued retroactively by the UM/RA, at Integral Care's sole determination. An "Emergency" requires immediate intervention (see the "Definitions" section of this Provider Manual for a complete definition of "Emergency"), and must be approved verbally by the appropriate UM/RA prior to service delivery. The Provider must request a written authorization from the appropriate UM/RA no later than the following business day after the Emergency.

If Integral Care provides crisis intervention to a Covered Individual who is currently receiving or scheduled to receive authorized Covered Services from a Provider, Integral Care will notify the Provider of the intervention within twenty-four (24) hours of the intervention.

Triage of Psychiatric Patients: Guiding Principles

Patients experiencing psychiatric emergencies in Travis County are often first seen in hospital emergency departments, having either come in on their own or via law enforcement. In many cases, the individual can be stabilized in that setting with follow-up care provided in the community. In other cases, it is determined that the individual is in need of psychiatric services in an inpatient setting.

There are five inpatient psychiatric hospitals open to Travis County residents. These include Austin Lakes Hospital (ALH), Austin State Hospital (ASH), Seton Shoal Creek Hospital (SSCH), Austin Oaks Hospital and Brackenridge Hospital.

In order to ensure the most effective and efficient use of these resources and to optimize response to individual needs, the community has undertaken the creation of a triage system to guide decisions about referrals to inpatient care. The guiding principles of this triage system are:

1. The patient's best interests are served by receiving care in a facility that knows him/her as opposed to one that does not.
2. The advantages of waiting for an available bed in the optimal inpatient facility must be balanced by the need to avoid excessive waits in emergency departments. Therefore, waiting time should generally not exceed 24 hours.

3. None of the psychiatric crisis stabilization inpatient settings in Travis County is able to accept psychiatric patients with complex medical needs. Given the current lack of more appropriate resources, individuals with both psychiatric and complex medical needs are served in general medical hospitals. Triage of individuals with a criminal history that involves violence should be addressed on a case-by-case basis with designated psychiatric hospital personnel, taking into account such things as recent violent behavior within the psychiatric hospital setting and time elapsed since any criminal behavior.
4. The resources of certain inpatient facilities to address special needs populations will be considered in making triage decisions. Among these:
 - Individuals with intellectual and/or developmental disabilities are, in general, best be served at ASH, which has a unit that provides appropriate services for individuals with these types of disabilities. Individuals with mild mental disabilities, who can benefit from cognitive therapeutic interventions, may be able to benefit from the services at ALH and SSCH (but this determination is dependent upon an accurate assessment of the individual's level of functioning).
 - ALH provides specialty services to geriatric patients.
 - SSCH is the only inpatient resource for individuals in need of electroconvulsive therapy (ECT).
5. Individuals who have had repeated stays in a particular facility without apparent benefit should be considered for referral to an alternative facility and/or be discussed in Integral Care's peer review system (see "Rights of Covered Individuals" section, below).

Service Delivery Requirements

Communication and Reporting

- The Provider must have and maintain a valid email address to facilitate communication between the Provider and Integral Care.
- The Provider is responsible for notifying the UM/RA if, for any reason, Covered Services cannot be delivered as authorized or as described in the Plan.
- In addition, the Provider is responsible for notifying the UM/RA of any significant incidents *or knowledge* of anything related to the safety, health, rights, and abuse or neglect of any Covered Individual.
- In cases of Serious Incidents including, but not limited to, alleged abuse, exploitation or neglect, required reporting protocols must be followed and an Incident Report must be completed and submitted by the Provider within one business day of such incident or knowledge of an incident (see "Provider Requirements for Reporting/Documenting Serious Incidents" section, below) for detailed reporting requirements.

Supervision during Service Delivery

Each Covered Individual receiving Covered Services from a Provider must receive supervision consistent with that Covered Individual's Level of Need, and as delineated in the Plan. Supervision is a primary, necessary and reasonable component of the provision of a Covered Service to each Covered Individual. At a minimum, unless clearly specified otherwise in the definition of the Covered Service or in writing by the UM/RA, appropriate supervision requires that the Provider be aware of the Covered Individual's activities at all times, while showing appropriate respect for the privacy of the Covered Individual. Being aware of



the Covered Individual's activities requires the Provider to direct focused attention on the Covered Individual within the same physical space, which includes the Provider being within sight and/or hearing range of the Covered Individual at all times (as appropriate to the specific situation and/or Covered Individual's age).

Service Delivery and Care Philosophy / Interaction with Covered Individuals

The Covered Individual's Individualized needs, strengths and preferences must be considered and respected during the course of delivering any Covered Service to the Covered Individual. The Provider is responsible for delivering Covered Services and engaging in activities that demonstrate respect for, and are relevant to, the Covered Individual's culture, age, preferences and specialized needs, and that are provided with Cultural Competence. All Covered Individuals and their families need Providers who work collaboratively with them and are respectful of diverse cultural backgrounds and diverse family compositions. In addition:

- Providers must ensure the health, safety and welfare of all Covered Individuals during the course of service delivery.
- Covered Services will be Covered Individual-focused and, when families are involved, family-centered.
- When either parents of minor children, or LARs of minor children or adults are involved, they will be fully included in service planning and service delivery activities.
- The needs, strengths or abilities, wishes and goals of the Covered Individual must be incorporated into the Covered Services that are provided (or the wishes and goals of the Covered Individual's LAR, as applicable).
- Providers will adhere to Joint Commission Accreditation Standards that can be found at:
- Covered Services will offer smooth transitions to other service systems.

Goals and Objectives

Service delivery (for reimbursement) will be designed to meet service goals or objectives as designated by the Service Coordinator, clinician or UM entity. Integral Care will not pay for Covered Services otherwise available in the community at no cost to Integral Care or the Covered Individual.

Covered Services authorized and/or intended to be provided on a one-on-one basis may not be provided to multiple Covered Individuals at the same time.

Plans for Covered Individuals

Service provision is guided and directed by the Plan developed by the UM/RA or other designated clinician. Plans are described for different populations/divisions as follows:

Integral Care DIVISION	SPECIFIC NAME OF PLAN USED
BHS, CSD	Treatment Plan/Service Plan
CFS	Plan of Care
IDD	Person-Directed Plan
ECI	Individualized Family Service Plan

For IDD and CFS Covered Services, Providers must obtain a copy of the Plan and/or other documentation indicating:

- Needs of the Covered Individual and family, if relevant;
- Delivery schedules for authorized Covered Services (frequency and duration of service delivery);
- Specific objectives or goals toward which the Provider should direct Covered Services;
- Activities beneficial and/or not approved during the provision of the authorized Covered Services: and
- Other relevant service provision guidelines.

Documentation of Covered Services delivered by the Provider, and the needs and goals/objectives documented by the Provider must match the Plan, Provider Activity Sheet, and/or the written authorization issued by the UM/RA or the designated clinician.

Transfer to another Integral Care-Contracted Provider

Transfer of a Covered Individual to another Integral Care Provider requires authorization from the UM/RA. Requests by a Provider to transfer a Covered Individual to another Provider are authorized by the UM/RA when there is clear justification for the transfer. Failure to obtain approval will result in non-authorization/non-payment for those unapproved services.

A Covered Individual may request a change of Provider at any time. The Covered Individual's UM/RA is responsible for determining whether the transfer will be authorized, and for facilitating any authorized transfer. Providers must assist in, and cooperate with any transfer of a Covered Individual to a different Provider.

Emergency Contract

An emergency contract may be requested if Emergent care is necessary or if services cannot be provided by a current Provider due to special clinical or geographical needs. To initiate the emergency contract process, contact Integral Care's Utilization Management Department.

It is also important to have the Covered Individual remain physically with the Provider, if possible, while the transition occurs. Any Provider encountering a barrier in the emergency contract process should call Integral Care's Ombudsman.

Provider Requirements for Reporting/Documenting Serious Incidents

All Serious Incidents (as defined below) involving a Covered Individual which occur during service provision or that the Provider otherwise learns of must be documented in the required web-based Joint Commission Texas Application Specialists Incident Report Database Reports must be submitted electronically via this database to Integral Care's Quality Management Coordinator, and/or any other entities, departments required by law and/or specified in the Integral Care Incident Reports Training Guide (Attachment C) and Provider Manual, within 24 hours of Provider's first knowledge of the Serious Incident. **Incident Reports may not be faxed under any circumstances.**

Serious Incidents

Serious Incidents that must be reported include, but are not limited to:

- A serious physical attack on or by a Covered Individual.
- Physical or other restraint of a Covered Individual necessary during the course of service delivery to that Covered Individual.
- A Covered Individual's injury or death. (See "Injury To, Or Death Of, A Covered Individual" below in this section)
- Allegations of abuse, neglect or rights violations including, but not limited to:
 - Breach of confidentiality.
 - Non-consensual sexual contact involving a Covered Individual.
 - Any sexual contact involving a Covered Individual and a Provider.
 - Any sexual contact involving a Covered Individual under age 18.
 - Physical abuse involving a Covered Individual.
 - Verbal/emotional abuse involving a Covered Individual.
 - Exploitation
 - Neglect of a Covered Individual
- Unauthorized departure from Covered Services by a Covered Individual under age 18.
- Other examples as listed in the Incident Report Training Guide.

Medication Errors include, but are not limited to, the situations described in the Incident Report Training Guide, which is included in Attachment C.

Reporting of Abuse, Neglect and Exploitation (see additional detail and information in the "Rights of Covered Individuals" section, below).

If the incident involves an allegation of abuse or neglect, in addition to submitting an Incident Report to Integral Care's Quality Management Coordinator, the Provider must contact DFPS at 800-252-5400 immediately, obtain a report number, and enter that report number on the Incident Report. Integral Care's Ombudsman must also be notified via e-mail at Phyllis.wolf@integralcare.org or by phone at 512-440-4086.

Reporting Covered Individual Rights Violations

All Covered Individual rights violations including, but not limited to, breach of confidentiality, informed consent, the right to participate in Individualized services and the right to the least restrictive environment must be reported by submitting an Incident Report as described in this Provider Manual. Integral Care's Ombudsman must also be notified via e-mail at Phyllis.wolf@integralcare.org or by phone at 512-440-4086. No employee or affiliate of Integral Care shall engage in any retaliatory action against any Provider and/or Covered Individual who reports a possible rights violation.

Injury To, Or Death Of, a Covered Individual

In the event of an injury to a Covered Individual, appropriate medical intervention must be obtained immediately. Upon ensuring Covered Individual safety, initiate incident reporting protocols as described above. Integral Care's Medical Director or others may initiate a Medical Peer Review. In cases of Covered Individual death during service delivery or at the service delivery location, for any reason, a copy of the Covered Individual's record must be forwarded immediately to Integral Care's Medical Records Department at 1430 Collier Street, Austin, Texas 78704. All records or relevant documentation must be delivered in a sealed enveloped marked "CONFIDENTIAL". Death Review and subsequent Administrative Review, as appropriate, will be initiated. The Provider will continue to forward any new information and appropriate documentation to Integral Care's Death Review Coordinator. The Death Review will be completed only after the Medical Examiner's determination of all facts and of the cause of death.



Integral Care's Clinical Quality Committee (CQC) and Medical Peer Review Committee, Infection Prevention and Control Committee, and Health and Safety Committee review high severity-rated incidents. Ways to decrease actual and potential risk factors will be discussed. Unresolved issues or suggestions will be forwarded to Integral Care's Quality Leadership Team (QLT).

All data are summarized and reported to appropriate oversight entities.

Reporting Medication Errors

Any kind of medication errors should be reported in accordance with the procedures outlined for reporting Serious Incidents using Integral Care's Medication Error Report form instead of Integral Care's Incident Report form. A Medication Error Report is included in the Required Forms Section of this Provider Manual.

Media Protocols

As soon as a Provider becomes aware of any event that could cause negative media attention to the Provider or Integral Care, they are to immediately contact the Communications Manager (see the Key Contacts List section of this Provider Manual). PROVIDERS MAY NOT COMMUNICATE DIRECTLY WITH THE PUBLIC OR THE MEDIA ON INTEGRAL CARE'S BEHALF ABOUT SUCH AN EVENT. ALL COMMUNICATION TO THE PUBLIC OR THE MEDIA ON INTEGRAL CARE'S BEHALF MUST ORIGINATE FROM INTEGRAL CARE'S CHIEF STRATEGY OFFICER.

Confidentiality

1. Before any identifying information regarding any Covered Individual can be released, either verbally or in writing, the Covered Individual or legal guardian must complete and sign an Integral Care Authorization for Release of Protected Health Information which can be found at <http://integralcare.org/content/medical-records>. Verbal authorization is not sufficient.
2. Unless calling 911 for cases of medical emergency or Imminent Danger**, or when the Covered Individual is the alleged victim of a DSHS rights abuse investigation, the Covered Individual or legal guardian must complete and sign an Authorization for Release of Protected Health Information .
**Imminent Danger - The Covered Individual is in danger of hurting himself/herself or someone else within 24 hours.
3. Information that identifies a Covered Individual can be released to other Texas community mental health centers or Texas state hospitals without an authorization. **This does not include substance abuse or HIV information, which almost always requires a completed and signed authorization prior to its release to any third party.**
4. Information that identifies a Covered Individual should be shared only with Provider staff with a need to know.
5. Take the following measures to avoid violating a Covered Individual's privacy:
 - Talk to Covered Individuals about personal information in a private area away from others.
 - Make sure all identifying information regarding Covered Individuals is stored in a confidential area that is inaccessible to persons who are not authorized to have it, and not left on desktops, chairs, unlocked cabinets, etc.
 - Make sure all telephone (including cell phone) conversations involving Covered Individuals take place in a private area where conversations cannot be overheard.

6. Providers should not identify Covered Individuals as service recipients when interacting with others in the community. In order to avoid rudeness, the Provider could introduce the Covered Individual by first name without indicating that the Covered Individual is a service recipient. The Covered Individual is allowed to give any information about himself/herself that he/she chooses.
7. In order to release substance abuse or HIV/AIDS information, those specific items must be checked on Integral Care's authorization form (#400D). These can be in addition to other items checked on the form.
8. Providers who will receive access to Integral Care's Electronic Medical Records will be required to present a picture ID to a representative of Integral Care's Management Information Systems (MIS) staff and sign a confidentiality agreement prior to receiving access to the Electronic Medical Records.
9. E-mailing protected health information over the internet is prohibited unless an Integral Care-approved encryption software program is installed on Provider's computer. Integral Care uses Voltage encryption software.

Rights of Covered Individuals

Covered Individual Complaint/Appeal Process

Covered Individuals who are dissatisfied with any aspect of Covered Services may complain to Integral Care by calling Integral Care's Ombudsman. Complaints may also be made by mail through the Ombudsman at P.O. Box 3548, Austin, TX, 78764-3548 or by e-mail at Phyllis.Wolf@integralcare.org.

Providers must inform Covered Individuals of Integral Care's Complaint and appeal processes. Providers must assist a Covered Individual in complaining or appealing Adverse Determinations/appeals at no charge, if requested to do so by the Covered Individual. Providers must cooperate fully with Integral Care in the investigation of Covered Individual Complaints or appeals.

Providers must display in a prominent location at the service site (unless the service site is the Provider's home) a notice ("Resolution of Concerns") informing Covered Individuals of their right to make Complaints about Providers, and how to make a Complaint. A copy of this notice is included in the "Required Forms" section of this Provider Manual. The notice is also available from the Ombudsman.

Allegations, Investigations and Reporting of Covered Individual Abuse, Neglect or Exploitation

A Provider who knows or suspects that a Covered Individual is being or has been abused, neglected, or exploited must:

1. Report such knowledge or suspicion to DFPS immediately, if possible, but in no case more than one hour after knowledge or suspicion by calling 1-800-252-5400 or reporting via the web site <https://reportabuse.ws>
2. Preserve and protect any evidence related to the allegation in accordance with instructions from DFPS. For allegations of sexual abuse or if physical injury has occurred it is most likely DFPS will request that the Covered Individual receive a medical examination if the Covered Individual consents; and
3. Cooperate with the DFPS investigator during the investigation.



Failure to report Covered Individual abuse, neglect or exploitation could result in disciplinary action such as termination of the Provider's contract.

A Provider or Covered Individual who reports abuse, neglect or exploitation shall not be subjected to retaliatory actions by any employee or affiliate of Integral Care.

Investigations of Alleged Provider Abuse, Neglect or Exploitation

Investigations of abuse, neglect or exploitation at Integral Care and/or its affiliate and Provider sites are conducted by the DFPS personnel

When DFPS notifies Integral Care of an allegation of Provider abuse, neglect or exploitation by a Provider, the Ombudsman will notify Integral Care's Contract Manager so that appropriate action can be taken. Law prohibits an alleged perpetrator/Provider from providing services to the alleged victim during an open investigation. Other actions may include, but are not necessarily limited to, a medical exam with the Covered Individual's consent, and/or steps to protect the Covered Individual from harm. No Group Member of an accused Organization Provider, and no accused Individual Provider shall discuss the allegation with anyone other than DFPS investigatory staff during the DFPS investigation. The alleged perpetrator/Provider will be informed of the allegation and of his/her obligation to cooperate fully with the DFPS investigation.

To avoid conflict of interest, Providers must not conduct any part of the investigation, such as interviewing staff or Covered Individuals, but are expected to assist the investigator as requested, by making time and space available for interviews, locating records as requested, and/or preserving physical evidence. DFPS generally does not need the Covered Individual's consent to view records; however, federal law protects any documentation of HIV status or substance abuse as discussed in the "Confidentiality" section, above, and elsewhere in this Provider Manual.

Providers must be honest and forthcoming and work cooperatively with the investigator. Refusal to cooperate is a violation of Texas law and may result in disciplinary action, such as termination of the Provider's contract.

Receipt of DFPS Findings

Once the DFPS investigation is completed, the DFPS investigation report will be reviewed by Integral Care's Chief Executive Officer, who determines whether to accept the DFPS finding(s) or to request that DFPS review its finding(s).

Once the finding(s) is final, the Ombudsman notifies the Covered Individual and Integral Care's Contract Manager, completes the A-N-I A form and enters the required information in the CANRS system. The Contract Manager provides written notification to the Provider against whom the findings were made. The Contract Manager may require the Provider to submit a plan of improvement based on the investigative findings. If the final finding is confirmed and the harm is severe enough, the Provider will be prohibited from further interaction with Covered Individuals and/or the Provider's contract with Integral Care will be terminated.

Investigation of Alleged Abuse, Neglect or Exploitation in Substance Abuse Services

Providers of substance abuse programs who know or suspect that a Covered Individual is being or has been abused, neglected, or exploited must immediately call the Ombudsman or, if the Covered Services

provided to the Covered Individual are DSHS-funded, DSHS at 512- 349-6724. The Provider must also submit a written Incident Report form within 24 hours to the Quality Management Director (see incident reporting protocols in the "Provider Requirements for Reporting/Documenting Serious Incidents" section, above).

To avoid conflict of interest, Providers must not conduct any part of the investigation, such as interviewing staff or Covered Individuals, but are expected to assist the investigator as requested, by making time and space available for interviews, locating records as requested, and/or preserving physical evidence. The investigator does not need the Covered Individual's consent to view records; however, federal law protects any documentation of HIV status or substance abuse as discussed in the "Confidentiality" section, above, or elsewhere in this Provider Manual.

Allegations of Covered Individual abuse or neglect in substance abuse services are investigated by the Ombudsman and reviewed by Integral Care's Investigation Review Committee (IRC). The IRC, based on preponderance of evidence, recommends to the Executive Director whether the allegation should be confirmed, not confirmed, or found inconclusive.

Nursing and Medical Peer Review

If an incident involves clinical practice issues, the situation is reviewed by the appropriate Integral Care peer review committee or referred directly to the appropriate licensing board. If there is an allegation of abuse, neglect or exploitation, it will be investigated and reviewed using the above procedures. If confirmed upon investigation, the allegation will be forwarded to Integral Care's Medical Peer Review Committee or the Professional Nursing Peer Review Committee if the actions involved were those of a physician, or of an RN or LVN, respectively.

Confidentiality of Covered Individual Abuse, Neglect or Exploitation Reports

Covered Individual abuse, neglect or exploitation investigation reports are confidential. Integral Care's copy of the DFPS report (or the Ombudsman's report of a substance abuse investigation) is kept on file by the Ombudsman only, and is not released to other parties either inside or outside Integral Care (other than the Covered Individual, as described in the following paragraph). Contract Managers who are responsible for addressing issues raised by the report may arrange with the Ombudsman to review the report, but may not copy it. Requests for copies of a DFPS report will be referred to the regional office of the DFPS.

Copies of an investigative report of abuse, neglect or exploitation involving substance abuse services shall be released upon request to the involved Covered Individual or his/her LAR (if applicable). The names of other Covered Individuals in the report shall be rendered unreadable.

Allegations, Investigation and Reporting of Covered Individual Rights Violations (non-clinical medical issues)

All Covered Individual rights violations including but not limited to breach of confidentiality, informed consent, the right to participate in Individualized services and the right to the least restrictive environment, must be reported by submitting an Incident Report form as described in this Provider Manual. No employee or affiliate of Integral Care shall subject any Provider and/or Covered Individual who reports a possible rights violation to any retaliatory action.



The Ombudsman conducts an investigation of alleged rights violations; Providers must assist and cooperate in the investigation. Refusal to cooperate may result in disciplinary action such as termination of the Provider's contract.

Investigation reports are reviewed by Integral Care's Investigative Review Committee (IRC) which, based on preponderance of evidence, recommends to the Chief Executive Officer whether the allegation should be confirmed, not confirmed, or found inconclusive.

If a rights violation by a physician, RN, or LVN is confirmed under the above procedures, the investigation report shall be forwarded to the Medical Peer Review Committee or the Professional Nursing Peer Review Committee, as appropriate.

Covered Individual Records and Documentation

Creating and Maintaining Records and Documentation

Each Provider must create and maintain both complete, thorough documentation of the Covered Services provided to EACH Covered Individual, and any other documentation that Provider would normally be expected to provide in accordance with any applicable professional standards.

Integral Care uses AZ Central, confidential and propriety software from Anasazi Software, for its client data and electronic health record (EHR). Use of any EHR information including, but not limited to, on-line information and any printed reports, documents, screen prints, etc., must be limited to providing Covered Services under the Provider's contract. In order to access the EHR, the Provider must execute a confidentiality and licensing agreement form(s). In addition, Citrix access is required in order to access the EHR over the Internet. Providers are responsible for any and all upgrades necessary to their hardware to use the EHR system, and for payment of any license or other fees related to use of AZ Central and/or Citrix.

Connecting to the Integral Care Client Data/Electronic Health Record System, AZ Central:

Using AZ Central via the Internet requires:

1. A computer workstation;
2. An Internet connection;
3. A local or network printer; and
4. Installation of Citrix client software compatible with the then-current designated version of Citrix Presentation Manager.

The required Citrix software self-installs the first time that a Provider computer is used to access AZ Central. Any computer-experienced Provider should be able to self-install by following the on-screen prompts. If the Provider chooses to install the Citrix client software using Provider's own technical resources, the software must be installed in accordance with instructions published at the time by Integral Care's Management Information technology staff.

Minimum specifications for Citrix software are described in Citrix Systems, Inc., documentation at <http://www.citrix.com>.

NOTES:

1. Maintenance of the computers, printers, software, and Internet connection used to access the EMR system is the responsibility of the Provider and will not be provided by Integral Care.
2. Make/brand of the computer and the computer's operating system is not relevant as long as the computer is supported by Citrix Presentation Manager.
3. Although Citrix specifies a minimum Internet connection speed of 50Kbps, a broadband connection (DSL, T1, cable service, etc.) is recommended for appropriate performance.
4. Only printers approved by Citrix will be supported. Information concerning supported printers can be found at <http://www.citrix.com>.
5. Citrix client software will be self-installed and/or updated automatically as needed when connecting to the Integral Care network, so it is possible that there will be conflicts should the Provider use Citrix for other, non-Integral Care connections. Provider's staff will have to review their use of Citrix to best determine installation and update procedures.

Service Delivery Records

Each Covered Service provided must be documented in Integral Care's EHR or the appropriate form and/or a service delivery record (Instructions: Attachment A). Service delivery records, at a minimum, must include:

1. name of the Covered Individual to whom the Covered Service was provided or authorized, including the LAR or primary caregiver, if applicable;
2. type of Covered Service provided (by service description, or CPT or procedure code);
3. date the Covered Service was provided;
4. begin and end time of the Covered Service;
5. location where the Covered Service was provided;
6. summary of the activities that occurred;
7. modality of the Covered Service provision (e.g., individual, group);
8. method of Covered Service provision (e.g., face-to-face, phone, telemedicine);
9. training methods used, if applicable (e.g., instructions, modeling, role play, feedback, repetition);
10. title of the curriculum being used, if applicable;
11. Plan objective(s) that was the focus of the Covered Service;
12. progress or lack of progress in achieving Plan goals;
13. signature of the Individual Provider or Group Member, as applicable, providing the Covered Service and a notation as to whether that person is an LPHA, a QMHP-CS, a pharmacist, a CSSP, an LVN, a peer Provider or otherwise, as required for that Covered Service;
14. any pertinent event or behavior relating to the Covered Individual's intervention which occurs during the provision of the Covered Service;
15. appointment type (face to face, telephone or collateral);
16. intensity of Covered Service; and
17. other information required by applicable law, rules, regulations or any applicable Prime Contract.

The Covered Service narrative description must match the Covered Service authorized and its definition included in the specific service training manuals that are available on Integral Care's website at:

http://www.integralcare.org/?nd=for_providers

Substance Abuse Records and Documentation (including records for youth and adults)



Records of a Covered Individual who has requested, or is receiving treatment for substance abuse must be documented on a separate service delivery record, and maintained separately from that Covered Individual's other records.

HIV/AIDS Records and Documentation

Records of a Covered Individual's diagnosis of and/or treatment for HIV and/or AIDS must be documented on a separate service delivery record, and maintained separately from that Covered Individual's other records.

Claim/Invoice Submission, Request, Processing and Payment

Fee for Service Billing Process

Provider obtains an authorization and bills in accordance with an established fee for unit of service billing. Depending upon the Covered Service, the units can be increments of minutes, hours, days, weeks or months, or can be on a per service basis.

A Provider who has provided Covered Services to a Covered Individual must obtain authorization and request payment from Integral Care as specified below.

Third Party Payer Billing Process

Third party payer billing is a situation in which a Provider bills for Covered Services funded or reimbursed by a third party benefit plan administrator other than Integral Care including, but not limited to: Medicaid, STAR Medicaid, CHIP, private insurance or other third party insurance billing.

1. Providers must obtain authorization and bill designated benefit plan administrators for third party payer Covered Services by following one of the two processes below:
 - Submit Claims/Invoices directly to the insurance payers or benefit plan administrators for Medicaid, STAR, CHIP or private insurance company; or
 - For ECI only: Invoices for Covered Services under a third party insurance plan are “authorized” by the ECI Program Director, and submitted to Integral Care for third party billing and reimbursement to the Provider (Provider submits billing and is reimbursed by Integral Care in the same manner as other Covered Services billed to the ECI program through Integral Care. Integral Care, in turn, seeks reimbursement from the appropriate third party payer or benefit plan administrator (ECI, Medicaid, etc.)
2. A Claim/Invoice submitted for third party billing is due by the 3rd business day of the month immediately following the month in which Covered Services were provided, unless Provider’s contract with Integral Care contains different requirements. (Instructions: Attachment B)
3. For inpatient Covered Services, the claim is due within 30 days of the Covered Individual’s discharge date.

Cost Reimbursement Billing Process

A billing situation in which a Provider bills for cost incurred to operate the program and/or deliver Covered Services, consistent with the budget submitted by the Provider and documented in the contract between Provider and Integral Care.

1. Providers will submit a Claim/Invoice on an Integral Care-approved Claim/Invoice form to the designated Integral Care office.
2. The deadline for submission is the 3rd business day of the month following the month in which Covered Services were provided.

Claim/Invoice Processing for Payment

Complete Claims/Invoices will be submitted either in person or by mail and must be received by Integral Care by the submittal date, as follows:

1. Claims/Invoices (CMS1500 and UB04 Claims Forms) for BHS and CSD: 1700 S. Lamar, Austin, TX, 78704, or by mail to P.O. Box 3548, Austin, TX, 78764
 - IDD Claims: 5225 North Lamar, Austin, Texas 78751
 - CFS and ECI Claims: 1717 West 10th Street, Austin, Texas 78703
2. All other Claims/Invoices are submitted to the claims adjudication office at the location specified on the appropriate Claim/Invoice form.

Please visit the following link for detailed Claim/Invoice instructions:

http://www.integralcare.org/?nd=provider_training

Integral Care will date stamp all Claims/Invoices upon receipt. Integral Care will review and adjudicate each Claim/Invoice presented for payment, and will verify the following information before a submitted Claim/Invoice is paid:

- Authorization number approval matches the Claim/Invoice in all respects (including, but not limited to, procedure or service codes, number of units charged, unit type (hourly, daily, etc.).
- Individual Provider or Group Member providing the Covered Services was approved by Integral Care's Credentialing Department at the time the Covered Services were provided.
- Current contract with Integral Care that includes the Covered Services for which payment is sought at the time the Covered Services were provided.
- Provider is in compliance with all Integral Care contract terms applicable to Provider.
- Rates of payment requested for each Covered Service match the Integral Care contract terms applicable to the Provider at the time Covered Services were provided.
- Provider service delivery records must be verified for each Covered Service submitted on the Claim/Invoice.
- Covered Individual name or identification number, when applicable.
- Dates on which Covered Services were provided.
- Indication of whether Claim/Invoice is for Provider's final Covered Services to Covered Individual.
- Total Claim/Invoice amount.
- Name of Provider and, if applicable, of Group Member providing Covered Services.
- Provider's Integral Care-assigned ID number.
- Claim/Invoice is submitted correctly and completely- all blanks filled in, and applicable written instructions are followed.
- Covered Individual's date of birth or social security number, as required by the funder.
- Goals/objectives are identified for each Covered Service provided and billed.



Claims/Invoices submitted will be processed for payment or denied. Denial of claim will be reflected on the Explanation of Benefits (EOB).

Claim/Invoice Payment Terms

All Claims/Invoices must be received by 5pm at Integral Care on the third (3rd) business day of the month immediately following the month in which Covered Services were provided. For the purpose of this requirement, a “business day” is defined as any calendar day in which Integral Care is open to the public for business. The contract between Integral Care and a Provider may specify alternate due dates for Claims/Invoices. For situations in which the Provider has chosen semi-monthly billing, the mid-month deadline specified in the Invoice Instructions (Instructions: Attachment A) must also be followed.

Failure to comply with these deadlines may result in non-payment or denial of the Claim/Invoice at Integral Care’s sole discretion.

Integral Care will date stamp all Claims/Invoices when received. Claims will be processed for payment within thirty (30) days of Integral Care’s receipt of a complete and accurate Claim/Invoice packet. Payment will be denied for any Claim/Invoice that is originally submitted to Integral Care either incomplete or past the due date, as specified above.

Corrections and Adjustments to Payments

Within 30 days of Integral Care’s receipt of a complete, timely Claim/Invoice, Provider will receive either payment, or an Adjustment Letter/EOB indicating denials, adjustments or recoupment of the Claim/Invoice, or portions of the Claim/Invoice.

All resubmissions of original Claims/Invoices, or portions of Claims/Invoices, must be submitted by the Provider within 30 days of the date on the Provider’s Adjustment Letter/EOB for the applicable Covered Services. Integral Care will not process or pay any Claims/Invoices, or parts of Claims/Invoices, resubmitted beyond this deadline.

Conditions that may result in billing denials, adjustments or recoupment include (but are not limited to):

- UM/RA did not authorize all, or part of the Covered Services invoiced.
- Covered Services billed exceeded authorizations for the month.
- Covered Services billed were submitted past the Claim/Invoice submission due date for the service billing month.
- The Covered Individual’s Monthly Ability to Pay, Co-payment was equal to or more than the invoiced amount.
- Documentation on the Provider’s service delivery record did not exist for each billable event.
- For CFS and IDD Covered Services only: there was no Provider service delivery record submitted with the Claim/Invoice.
- Service delivery records or Claims/Invoices forms had incorrect or blank start and stop times or dates.
- The Claim/Invoice submitted was not signed and/or dated.
- Billable time on Claim/Invoice did not correspond with start and stop time on the Service Delivery Record.
- Incorrect Claim/Invoice Forms and/or Provider Service Delivery Records were used.

- Two or more Covered Services were billed for the same Covered Individual during the same date/time period.
- According to the individual, family, Care Coordinator, or some other credible source, the Covered Individual/family did not receive the Covered Services billed.
- Provider was not authorized/credentialed/licensed/contracted to provide the Covered Services at the time they were provided.
- The person documenting the Covered Service is not the person who provided the Covered Service to the Covered Individual/family.
- Documentation of Covered Services did not meet required standard of accuracy and comprehensiveness.
- Covered Service delivery did not correspond with stated Outcomes, goals, and/or objectives.
- Covered Services delivered did not meet the definition of the Covered Services authorized, as per the authorization letter.
- Covered Services were not delivered as required by the contract between Integral Care and Provider.
- Covered Services were not delivered at the duration or frequency delineated in the Plan, authorization letter or other Integral Care staff documentation (i.e. Provider Activity Sheet for CP and YAFAC only).

If Integral Care overpays a Provider, Integral Care will either, in its sole discretion, require immediate repayment from the Provider or adjust future payments to the Provider accordingly, to the extent permitted by applicable law. If Integral Care underpays a Provider, Integral Care will either pay the Provider immediately, or adjust future payments to the Provider accordingly, to the extent permitted by applicable law.

Credentialing/Recredentialing

Credentialing Requirements for Continuation of Active Provider Network Status and Renewal of Contracts

Providers are required to provide time-sensitive documents to Integral Care's Credentialing Department as they are requested on an ongoing basis. At time of re-credentialing and/or renewal of contract, Providers will be contacted by the Credentialing Department regarding the required documents. The following table lists required documents and time lines for submission to the Credentialing Department. Responsibility for some items depends on whether Provider is an Individual Provider, an Organization Provider, or Group Member, as follows:

Organization Provider: The Organization Provider is responsible for submitting proof of training, risk management checks and other requirements being met for each of its Group Members prior to delivery of Covered Services by such Group Member.

Individual Provider: Integral Care will perform all required risk management checks.

Credentialing Requirements for Re-credentialing and/or Renewal of Contract		
SERVICES PROVIDED	DOCUMENTATION REQUIRED	REQUIRED RENEWAL SCHEDULE
Professional or licensed /certified Covered Services (regardless of location in which provided)	<ol style="list-style-type: none"> 1. Re-credentialing Application (Texas Standardized Credentialing Application) 2. License and/or Certification 3. Professional Liability Insurance in Integral Care-established amounts 	<ol style="list-style-type: none"> 1. Every 2 years 2. Prior to expiration 3. Prior to expiration
Covered Services provided in the Provider's home	<ol style="list-style-type: none"> 1. Homeowner's or Renter's Insurance in Integral Care-established amounts 2. Fire Inspection 3. Site Review 	<ol style="list-style-type: none"> 1. Prior to expiration and, when new service site, prior to delivery of Covered Services at new service site 2. Prior to expiration annually, and, when new service site, prior to service delivery of Covered Services at new service site 3. Every 2 yrs. or for each new service site-conducted by Integral Care
Covered Services provided in an office, facility or other site-based location	<ol style="list-style-type: none"> 1. General Liability Insurance in Integral Care-established amounts 2. Fire Inspection 3. Site Review 	<ol style="list-style-type: none"> 1. Prior to expiration and, when new service site, prior to delivery of Covered Services at new service site 2. Every 2 yrs and, when new service site, prior to delivery of Covered Services at new service site 3. Every 2 years or for each new service site-conducted by Integral Care's Contract Monitor
Transportation of Covered Individuals (or their family members) when provided as a reimbursable Covered Service, or incidental to another Covered Service being provided (such as mentoring, respite, etc.)	<ol style="list-style-type: none"> 1. Texas Driver's License 2. Texas DPS 3-year Drivers Record 3. Auto Insurance Policy 	<ol style="list-style-type: none"> 1. Prior to expiration 2. Every two years 3. Prior to expiration
Risk Management Checks All Covered Services	<ol style="list-style-type: none"> 1. CANRS 2. Criminal Background 3. Employee Misconduct Registry /Nurse's Aide Registry 4. USDHHS Office of Inspector General (OIG) 5. Texas Office of Inspector General 6. System for Award Management (formerly 	<ol style="list-style-type: none"> 1. Annually-conducted by Integral Care for Group Members 2. Annually-conducted by Organization Provider for Group Members, or by Integral Care for Individual Providers 3. Annually-conducted by Organization Provider for Group Members or by Integral Care for Individual Providers

Credentialing Requirements for Re-credentialing and/or Renewal of Contract		
SERVICES PROVIDED	DOCUMENTATION REQUIRED	REQUIRED RENEWAL SCHEDULE
	General Administration Services Excluded Parties List System	4. Annually-conducted by Organization Provider for Group Members or by Integral Care for Individual Providers 5. Annually-conducted by Organization Provider for Group Members or by Integral Care for Individual Providers 6. Annually-conducted by Organization Provider for Group Members or by Integral Care for Individual Providers
Risk Management All Covered Services	Changes in criminal background status, Nurse's Aide Registry or Employee Misconduct Registry	Changes in status to any of the referenced risk management checks/documents must be reported to the appropriate Contract Manager as soon as they occur or, for an Organization Provider, as soon as the annual checks for Group Members are repeated or Organization Provider discovers the change of status, whichever is sooner. Persons with criminal convictions as listed in Title 25 TAC Chapter 414, Subchapter K, Section 414.504 (d), are not eligible to provide Covered Services to Covered Individuals.

Change in Provider Status

All Providers must immediately report changes to Provider information such as name, address, email address, phone, fax, tax ID number, etc. in writing by mail, email or fax to Integral Care's Credentialing Department. Providers must immediately report any changes in licensure/certification status that affect the Provider's ability to provide Covered Services, or any investigation into licensure or arrest for or conviction of any crime, to Integral Care's Credentialing Department. All Providers must immediately report changes in Group Member information such as employment start and end dates, by mail, email or fax to Integral Care's Credentialing Department.

An approved Organization Provider adding an employee or subcontractor who will provide Covered Services must submit a Verification Checklist for Contract Organization Group Member Providers and, if the additional person is licensed, must also submit a Texas Standardized Credentialing Application (Version 01/2007) to Integral Care's Credentialing Department. **The employee or subcontractor to be added must be approved by Integral Care's Credentialing Department before that person provides any Covered Service.**



A Provider who wishes to add to or remove any Covered Service from its contract must contact the Contract Manager to request a contract amendment. Additional documentation, as appropriate to the Covered Services that might be added, may be required.

A Provider who wishes to change its status as either an Individual or Organization Provider must submit the appropriate application(s) obtained from Integral Care's Coordinator of Legal Services. Current copies of the Provider's licensure/certification and insurance must be on file in Integral Care's Credentialing Department, or included with the appropriate application for the status change to be considered.

A Provider who no longer wishes to participate in Integral Care's Provider Network must submit written notification of intent to terminate the contract, within the timeframe required in that Provider's contract with Integral Care.

When an Organization Provider learns that a Group Member will no longer provide Covered Services (i.e. leaving employment or subcontracting status) the Organization Provider must immediately report that to Integral Care's Credentialing Department in writing, by mail, email, or fax, and provide the Group Member's name, the Organization Provider's name and the effective date of the Group Member's discontinuation of provision of Covered Services.

Provider Training

All Providers must, at their own expense, complete trainings required by their contracts with Integral Care. Integral Care provides certain training for a fee. Providers may also need to ensure that persons providing Covered Services under the Provider's contract with Integral Care have completed additional specialized trainings and service modalities, as specified either in that Provider's contract with Integral Care, or by the assigned Contract Manager as special Covered Individual-specific disabilities, funder requirements, circumstances and/or needs dictate. Contact either Integral Care's Human Resource Development Training Coordinator for Integral Care-sponsored training schedules, or with questions regarding training requirements, or the Contract Manager for further assistance.

Providers with access to Integral Care's Electronic Health Records will be required to attend Integral Care's training on the use of the Electronic Health Records software. Additional clinical training will be required prior to the Provider being authorized to provide Covered Services. Trainings include but are not limited to: resiliency and disease management program, Texas Recommended Authorization Guidelines (TRAG) assessment, Texas Medication Algorithms, co-occurring Psychiatric substance use disorders competencies, cognitive behavioral therapy (as appropriate), Wraparound, Person-Directed Planning and documentation of assessments, services and treatment planning in the electronic medical record.

Training Options

Individuals may be able to complete trainings other than attending classes, as described below.

CPR

Many community programs offer CPR and Standard First Aid training, and Integral Care is happy to accept their certifications with prior written approval. Providers may attend any CPR/Standard First Aid course that is either an American Red Cross or American Heart Association approved course, taught by a certified instructor. Upon completion, mail, email (ken.kiff@integralcare.org) or fax a copy of the course



certification card(s), both front and back, to the Human Resource Development Training Coordinator, who will document and notify the Contract Manager of completion. Following is a list of several available community resources for CPR/Standard First Aid training:

C.P.R. Resources: (512) 292-3130 or www.cpr-resources.com.

Austin/Travis County EMS: (512) 972-7277

American Red Cross: (512) 928-4271

Non-violent Crisis Intervention

Integral Care will accept SATORI (SAMA) training and evaluate other comparable training in place of Integral Care's Non-violent Verbal Intervention courses. Individuals providing services to may need to attend additional training. Please contact the contract manager for assistance. Again, after Provider receives Integral Care's prior written approval for the course, provide documentation of completion of this training to Integral Care's Human Resource Development Training Coordinator.

Refresher Training

All Individual Providers and Group Members must complete Rights, Abuse, Neglect, Exploitation and Client Grievance; Confidentiality; Infection Control; and non-violent Verbal intervention training requirements on an annual basis by completing Integral Care's self-paced module(s) in paper format, web-based training, or in-class presentation. To complete web-based training, send the name and a valid e-mail address for each person for whom access is requested to Integral Care's Human Resource Development Training Coordinator. There is a fee of \$25 per year, per individual for web-based training.

Non-violent Crisis Intervention must be completed annually.

Listed below are general training requirements:

Course Title	Initial Training Time Frame/Method	Refresher – Method/Frequency/Time Frame
Rights, Abuse, Neglect, Exploitation and Client Grievance	Initial – Required completion before providing Covered Services Self-paced paper module, in class presentation or web-based training	Annual Refresher Required Web-based training self-paced module, in class refresher training or web-based training
Confidentiality	Initial – Required completion before providing Covered Services Self-paced paper module, in class presentation or web-based training	Annual Refresher Web-based training self-paced module, in class refresher training or web-based training
Corporate Compliance (Deficit Reduction Act/Fraud Prevention)	Initial – Required completion before providing Covered Services Self-paced paper module or web-based training	Annual Refresher Self-paced module or web-based training

Course Title	Initial Training Time Frame/Method	Refresher – Method/Frequency/Time Frame
Infection Control	Initial – Required completion before providing Covered Services Self-paced paper module or web-based training	Annual Refresher Self-paced module or web-based training
Non-Violent Crisis Intervention Verbal /Physical Holds	Initial - Complete within 60 days of completed and approved contract	Annually Not eligible for web-based training
Standard First Aid w/CPR	Initial - Complete within 60 days of completed and approved contract Training can be completed though any site using approved American Red Cross or American Heart Association training.	Refresher every two (2) years
Electronic Health Records software	Initial - Class Presentation	As required to maintain competency In-class refresher training

Location

Classes are taught at:

Integral Care Annex (across from Integral Care's Collier Street Administration Building)
1700 South Lamar
Building # 1, Suite 102 (must park and enter from the rear of building)
Austin, Texas 78704

Ombudsman

Provider Complaint/Appeals Process

All Provider Complaints are routed to Integral Care's Ombudsman.

- Providers with any Complaints or suggestions are encouraged to call the Ombudsman, who also handles Covered Individual Complaints. Every effort will be made to resolve all Complaints informally within a short period of time.
- If a Complaint is not resolved to the Provider's satisfaction in five (5) days after the Provider notifies the Ombudsman, Integral Care will ask the Provider to submit the Complaint to the Ombudsman in writing, and the Ombudsman will give the Provider written acknowledgement upon receipt of the Complaint.

- If a written Complaint is not resolved to the Provider's satisfaction within thirty (30) days after the Ombudsman receives it, the Provider may submit a written request for an appeal of the unsatisfactory resolution to the Ombudsman within ten (10) days after either receipt of the unsatisfactory resolution or thirty (30) days after the Ombudsman receives the written Complaint, whichever is earlier.
- An Appeal Committee will be convened to rule on any adverse determinations that were not informally resolved.
- The determination by the Appeal Committee is final.

Integral Care's procedure for Adverse Determinations other than those related to Utilization Management/Resource Allocation (service denials) is the mechanism for facilitating a review and reconsideration of the following types of decisions:

- Credentialing/ re-credentialing
- Privileging
- Provider Network enrollment/ disenrollment
- Billing and/or payment issues
- Other administrative issues

Integral Care obtains input from Providers on an annual basis regarding this procedure, its implementation and effectiveness. A written copy of the procedure is available to Providers upon request.

Contract Compliance

Contract Monitoring

Integral Care may conduct contract monitoring activities on a routine basis, in which case, a minimum of ten days prior notice will generally be given to the Provider. Unannounced monitoring reviews may occur at any time in response to a Complaint, concern, problematic service delivery, billing documentation issue, or any other reason determined necessary by Integral Care in its sole judgment.

Contracts may be monitored through one or any combination of the following:

- Site visit
- Record review
- Billing desk review
- Covered Individual/family interviews
- Provider staff interviews
- Interviews with UM/RAs

All contract monitoring must include at least one of the following methods:

- Billing audits and validation of data submitted by provider
- Clinically focused chart reviews
- Contractual compliance
- Environmental/ special reviews (if appropriate)
- Verification of training and credentials
- Performance profiling
- Covered Individual, Provider staff interviews

- Observation of service delivery

All contract monitoring must sufficiently determine:

- Provider's compliance with the contract terms for service delivery;
- whether Covered Individual health/safety is being adequately protected;
- Provider's qualifications;
- whether administrative requirements (such as billing compliance, program certifications/licensures and insurance requirements) have been met; and
- satisfaction of Covered Individuals and their family members with the Covered Services received from the Provider.

Providers will be notified in writing of the results of all formal contract monitoring activities. A Provider may be required to submit a written plan of correction to address non-compliance and/or quality improvement issues. Written plans of correction must be approved by the Contract Manager or his/her designee. The Contract Manager will provide a reasonable amount of technical assistance to bring the Provider into compliance.

The Contract Manager will review records to ensure that licensures and certifications, health and safety inspections, and Provider training and other credentialing requirements are up to date; that Covered Services are provided and billed for as specified in the Provider's contract and the then-current Provider Manual; and that the health, safety, rights and privacy needs of Covered Individuals are being met. Specifically, some of the documents and the elements the Contract Manager will review are listed below.

Termination of a Provider's contract may be initiated if the Provider does not respond to technical assistance provided or fails to implement the approved plan of correction to the satisfaction of the Contract Manager, or if Provider's performance is significantly below Integral Care's standards, as determined by Integral Care in its sole judgment.

Provider Qualifications and Training

Provider qualifications and training requirements must be renewed every two years, or as specific licensing or certification standards dictate. Relevant insurance such as professional liability insurance, or auto insurance if a Provider transports Covered Individuals, or homeowner's insurance if a Provider provides Covered Services in his/her residence, will also be reviewed.

An Organization Provider must submit the credentialing checklist verifying that each Group Member who provides Covered Services to Covered Individuals under the Provider's contract meets all relevant qualifications and training requirements.

Service Delivery

The Contract Monitor may review progress notes to ensure that the Plan objectives are written on the service delivery records, and that service documentation addresses these objectives.

Billing Practices

Covered Services must be delivered, and billed for, as authorized on the written authorization letter. The Contract Monitor will monitor Claims/Invoices for completion and correctness, and may review the Provider's billing practices by comparing a Claim/Invoice with the related service delivery note

documentation and service authorizations. The Contract Monitor may review specific billing issues and documents, as follows.

- A service delivery note must exist for each billable Covered Service delivery event.
- Claims/Invoices should include only Covered Services provided up to the amount of service units authorized by Integral Care in writing.
- Overlapping service billings (Covered Services provided to two different Covered Individuals by the same Individual Provider or Group Member at the same or overlapping times, and billed as a one-on-one service provided to each Covered Individual). This billing situation is disallowed.
- Group or multiple Covered Services: All Covered Services, unless otherwise authorized in writing or otherwise implied by the service type, are to be provided one-on-one (by either one Individual Provider or Group Member, as applicable, to one Covered Individual). An example of a Covered Service that is a group service type is Camp. A Covered Service must specifically be authorized and billed as a group service if the Coordinator intends for the Covered Service to be delivered in a group setting, or provided to more than one Covered Individual at the same time. Group Covered Services generally carry a lower rate per Covered Individual than one-on-one Covered Services.
- A typical service delivery schedules.
- Insufficient service documentation to substantiate service billing.

Sanctions

Integral Care may impose, upon the recommendation of the Director of Network Development and Management with the approval of Integral Care's General Counsel, sanctions upon a Provider as a result of activities or events, which constitute a default of the conditions of the Provider's contract.

The Director of Network Development and Management will investigate any allegation of actions which could constitute an event of default under a contract, and will discuss the activity in question with the Provider, giving the Provider an opportunity to correct the default and respond in writing within an appropriate time frame depending upon the severity of the finding. The Director of Network Development and Management will review the written response offered by the Provider. A joint decision will be made by the Director of Network Development and Management and the General Counsel about whether the imposition of sanctions is appropriate and what sanctions will be imposed.

Possible sanctions include but are not limited to:

- Sanctions included within the terms of a Provider's contract;
- Suspension of authorizations or withdrawal of previously issued authorizations for Covered Services;
- Suspension of outstanding payments, in whole or part;
- Request for the recoupment of funds paid to Provider for Covered Services;
- Suspension of contract and transfer of Covered Individuals to other Providers, pending additional review;
- Offsets against future payments;
- Additional training; and
- Other sanctions as jointly determined by the Director of Network Development and Management and the General Counsel.



The Director of Network Development and Management or, in appropriate situations, the General Counsel, will notify the Provider in writing of Integral Care's decision to impose sanctions and of the type of sanctions to be imposed, including instructions on how to appeal the decision to impose sanctions.

The Contract Monitor will consult with the Provider in the development of any required Plan of Correction to address the area of concern, subject to the terms of the Provider's contract. The Plan of Correction will include Integral Care-determined timelines for ensuring that the problem is resolved in a timely manner.

Health, Safety and Rights of Covered Individuals

The Contract Monitor will review for compliance in the following areas:

- Allegations or suspicions of abuse, neglect or exploitation of Covered Individuals are reported to DFPS, as directed by law. All Provider staff must have knowledge of what constitutes abuse, neglect or exploitation.
- Incident Reports are completed when serious or non-routine events occur. Incident Reports are not to be filed in the Covered Individual's record, but should be maintained in a separate file.
- Environmental safety and use of universal precautions at site-based programs.
- Medication administration and storage.
- Covered Individuals are informed of their rights and any rights violations are reported in a timely manner to Integral Care's Consumer Rights Officer/Ombudsman.
- Covered Individuals are properly notified of Integral Care's Complaint process.
- Providers protect Covered Individual confidentiality and privacy.

Consumer Satisfaction

Provider must participate with Integral Care in evaluating satisfaction of Covered Individuals with Covered Services from Provider at an agreed-upon frequency. Provider has three options to meet this requirement:

- Conduct satisfaction surveys and submit survey results to Integral Care.
- Provide Integral Care with current contact information upon Covered Individual discharge from Provider services to enable Integral Care to administer satisfaction surveys telephonically or by mail.
- Provide Covered Individuals with an on-line link to Integral Care's satisfaction survey.

Key Contacts

Integral Care (Main Number)	(512) 447-4141
Communications Manager	(512) 440-4034
Contract Manager	(512) 804-3175
Contract Monitor	(512) 804-3172
Claims Department	
Requests for payments submitted on UB04 or CMS 1500 forms	(512) 445-7752



Claims Adjudication Department/Accounts Payable (Invoices) Department - Requests for payments submitted on the standard Integral Care Claims/Invoice forms are submitted to the appropriate front office that processes the claims (as listed on the invoice form in the “Required Forms” section of this Provider Manual, or as specified by the Contract Manager).

Credentialing Coordinator	(512) 445-7787
Confidential Credentialing Fax Number	(512) 440-4059
Death Review Coordinator	(512) 440-4062
Department of Family and Protective Services (Reports of abuse, neglect and exploitation)	1-800-647-7418
Director of Communications	(512) 440-4083
Hotline	(512) 472-4357 or (472-HELP)
Human Resources Development Training Coordinator	(512) 440-4025
Coordinator of Legal Services	(512) 440-4062
Ombudsman	(512) 440-4086
Quality Management	(512) 440-4049
Utilization Management for BHS and Crisis Services	(512) 440-4044 Resource Allocators
Utilization Management Director	(512) 703-1332

**TTY users (requesting ASL interpreting) may access the above listed phone numbers by dialing:
1-800-RELAY TX (1-800-735-2989).

Definitions

Adverse Determination:

Determination made by a health care plan or by a utilization review program, that a health care service is not a Medical Necessity. It also refers to the decision taken by the Office of Personnel Management barring health care service providers or suppliers from participating in the health care program. Any health care services provider or supplier subject to an adverse determination by the Office under 5 USCS § 8902a (h)(1) shall be entitled to reasonable notice, an opportunity to request a hearing of record, and to judicial review after the Office renders a final decision.

At-Risk:



Children and adolescents who are at higher risk for developing mental health problems because certain factors have occurred in their lives or environments. Some of these factors are physical abuse, emotional abuse or neglect, harmful stress, discrimination, poverty, loss of loved one, frequent moving, alcohol and other drug use, trauma and exposure to violence.

CANRS (Client Abuse and Neglect Reporting System):

The governmental database used in Texas to track abuse, neglect and exploitation allegations and Outcomes.

Care Coordination:

An intensive form of Service Coordination used in a Wraparound approach to service delivery.

Care Coordinator:

An individual who organizes and coordinates services and supports for children and adolescents with mental health and/or psychosocial needs, and their families using the Wraparound approach to service delivery (Alternate terms: Service Coordinator, advocate, and facilitator.)

Clinical Quality Committee (CQC):

A group of Provider and Integral Care representatives who review actual and potential risk factors and make recommendations for decreasing those risks.

Complaint:

A complaint by either a provider or a Covered Individual, as applicable.

Contract Manager:

Various Integral Care staff responsible for developing, managing and monitoring Provider contracts.

Co-payment:

A payment made to a Provider by a Covered Individual for Covered Services, in accordance with the terms of a health plan agreement, Medicaid regulations or Integral Care's financial assessment.

Cost Reimbursement:

A contractual arrangement in which the Provider bills for the cost of providing a service or program on a monthly basis, based on the actual allowable cost incurred during the billing period.

Covered Services:

Behavioral health, psychosocial support, intellectual/developmental disabilities, and/or substance abuse services which are purchased from Providers for provision to Covered Individuals.

Cultural Competence:

Sensitivity and responsiveness to cultural differences. Providers must be aware of the impact of their own cultures and possess skills that help them provide services that are culturally appropriate in responding to a Covered Individual's and his/her family's unique cultural differences, such as race and ethnicity, national origin, religion, age, gender, sexual orientation, physical disability, values and customs.

DSM (Diagnostic and Statistical Manual of Mental Disorders, the most current edition):

The then-current version of the official manual of mental health problems developed by the American Psychiatric Association. Psychiatrists, psychologists, social workers, and other health and mental health care providers use this reference book to understand and diagnose a mental health problem. Insurance companies and health care providers also use the terms and explanations in this book when they discuss mental health problems.

Emergency:

A situation in which a Covered Individual is:

- At risk of harm to self or others; and/or
- Exhibits acute onset of psychosis or severe thought disorganization; and/or
- Rendered unmanageable, or where a child's mental, emotional or physical safety is At-Risk, as a result of significant emotional, behavioral, mental and/or social conditions.

Emergent:

A situation in which a Covered Individual is at risk of immediate harm to self or others (within 23 hours or less) and requires intervention within one hour.

Fee for Service:

A contractual arrangement in which a Provider bills for services according to an established rate structure based on a measured unit of either time or service provision.

Group Member:

Individual Provider performing Covered Services under a contract between an Organization Provider and Integral Care.

Individual Provider:

An individual person who may perform Covered Services (non-traditional or traditional) under a direct contract between that person and Integral Care.

Individualized:

Covered Services designed to meet the unique needs of each Covered Individual and his/her family. Covered Services are Individualized when, in delivering them, the Provider considers the needs, strengths, ages, stages of development, cultures, capacities and/or motivations of the Covered Individual and his/her family.

Internal Contract Provider:

Network Providers who provide a contracted service at an Integral Care facility or office.

Level of Care (or Level of Need) Guidelines:

Criteria that may include diagnosis, symptomology, level of functioning, behaviors, situations and/or life domain circumstances that define the Level of Need and/or intensity of service required to effectively meet the needs of the Covered Individual. Level of Care or Level of Need may define the service type, mix and quantity of services warranted according to designated criteria.

Medical Necessity:

Those mental health and or substance abuse services that:

- Are essential for the treatment of a disease, condition or illness, as defined by standard diagnostic nomenclatures (ICD9-CM, DSM);
- Can reasonably be expected to improve a Covered Individual's condition or level of functioning to a usual and customary level of functioning for that individual;
- Are in keeping with national standards of mental health professional practice;
- Are rendered at the most cost effective and safe Level of Care and are necessary to help the Covered Individual to return to his or her usual and customary level of functioning; and
- Could not have been omitted without adversely affecting the Covered Individual's mental and/or physical health or the quality of care rendered.

Ombudsman: Integral Care's staff person who mediates Complaints.

Organization Provider:

A party to a contract with Integral Care to provide Covered Services where that party is either not an Individual Provider, or is an Individual Provider with at least one other person performing Covered Services under that contract. A federal **Employer Identifier Number** (EIN) is required.

Outcome:

A measurement of the impact of services provided. Examples include: Covered Individual satisfaction with Covered Services; changes in scores of standardized instruments which show change in functioning or symptoms (i.e. Ohio Scales); and Covered Individual's employment status.

Person-Directed Planning:

Approaches to life planning which promote self-determination and require commitment and partnership by participants to coordinate services around the requests, desires, and needs of the Covered Individual rather than around programs and professionals. This term is used to describe the service planning and service delivery approach used within Integral Care's Intellectual and Developmental Disabilities Division.

Plan (or Plan of Care):

A generic term, which refers to the written service or care Plan designed to address a Covered Individual's Individualized needs and abilities. The Plan identifies the needs, strengths, goals and interventions. The Plan is developed by the coordinator, clinician, Provider and/or "care team", which includes, but is not limited to, the Covered Individual, guardian and/or family, if family is involved.

Prime Contract:

Any contract between Integral Care and any third party including, without limitation, the City of Austin, Travis County Health and Human Services, the Texas Department of Assistive and Rehabilitative Services, and the Texas Department of State Health Services, under which Integral Care provides or otherwise arranges for any or all of the Covered Services.

Provider:

Any Individual Provider or Organization Provider.

Quality Leadership Team (QLT):

Comprised of Integral Care's executive management and other key individuals, this group reviews recommendations of the CQC and provides additional direction to ensure continuous quality improvement.

Resource Allocation:

The process of allocating resources (by the Resource Allocator) to implement a Wraparound Plan or Person-Directed Planning that matches a Covered Individual's identified choices, resources, and needs with available resources. This function encompasses authorization of services and management of budgets. Resource Allocation determinations are based upon the Covered Individual's Level of Need, intensity of support needed/requested, psychosocial or Medical Necessity, relationship to the Covered Individual's disability, and other relevant assessment information. The person providing Resource Allocation services ("Resource Allocator") or single identified Care Coordinator assesses the Level of Need and/or intensity of service required, develops the Plan of Care, monitors the effectiveness of the Plan of Care, and quality of service provision, and modifies the Plan of Care as needed to meet the identified goals and objectives. This term is used in Person-Directed Planning and Wraparound models of service delivery, and is synonymous with the term Utilization Management (used in traditional managed care service authorization models).

Service Coordination:

Involves identifying individual desires, capacities, and needs and assisting Covered Individuals in locating, obtaining, and negotiating supports and services identified as wanted and needed by Covered Individuals and by other involved persons as deemed appropriate and necessary. Service Coordination includes monitoring, consulting, and coordinating services with other agencies, service providers, and persons involved with the Covered Individual in a Wraparound service delivery model (Care Coordination refers to a more intensive form of Service Coordination).

Service Coordinator:

A person designated by Integral Care to organize services and supports for Covered Individuals with multiple needs.

START Services:

START (Systemic, Therapeutic, Assessment, Resources & Treatment) is a person-centered approach that strengthens efficiencies and service outcomes for individuals with intellectual/developmental disabilities and behavioral health needs using an evidence-informed best practice system of care approach. START engages with individuals through specialized case consultation, assessment, education and outreach.

Wraparound:

This is a "full-service" approach to developing a Plan with services and supports that meets the holistic needs in ten life domains of individual children and their families. Children and families may need a range of professional and community support services to help them fully benefit from traditional behavioral health services or other professional services such as individual, group and family therapy, psychiatric evaluation and medication management. Non-traditional services used frequently in this service delivery model include mentoring, respite, and intensive home and community-based services. Wraparound refers to "wrapping services around a family like a warm blanket".

Acronyms

BHS: Behavioral Health Services: Adult Mental Health, Substance Abuse and Specialized Services, a division of Integral Care

CANRS: Client Abuse and Neglect Reporting System

CFS: Child and Family Services, a division of Integral Care

CP: The Children's Partnership, an interagency Wraparound program

CSD: Crisis Services Division, a division of Integral Care

DADS: The Texas Department of Aging and Disability Services

DARS: The Texas Department of Assistive and Rehabilitative Services

IDD: Intellectual and Developmental Disabilities Services, a division of Integral Care

DFPS: The Texas Department of Family and Protective Services (formerly, the Texas Department of Protective and Regulatory Services)

DSHS: The Texas Department of State Health Services

DSM: Diagnostic and Statistical Manual of Mental Disorders, the most current edition

ECI: Early Childhood Intervention Program, a state funded program operated under the Child and Family Services Division of Integral Care, utilizing internal staff and Providers and a single identified coordinator of services.

EOB: Explanation of Benefits

ICD9-CM: International Classification of Diseases—Ninth revision, Clinical Modification

SED: Severe Emotional Disturbance

UM/RA: Integral Care's Utilization Manager/Resource Allocator

YAFAC: Youth and Family Assessment Center, a single point of entry for assessments and service delivery using the Wraparound process for At-Risk youth and their families.

Required Forms*

- Resolutions of Concerns (English and Spanish)
- Integral Care Provider Manual Acknowledgement
- Eligibility and Consent Form
- Clinical Screening Information

*This list is not exhaustive

Resolution of Concerns

If you have a **suggestion or concern** about Integral Care services, or believe **your rights have been violated**, please contact any of the following:

Phyllis Wolf, Integral Care Ombudsman
P.O. Box 3548, Austin, TX 78764-3564
512-440-4086

DADS Consumer Rights
1-800-458-9858
P.O. Box 149030 Austin, TX 78714-9030

Department of State Health Services
Office of Consumer Services & Rights Protection
1-800-252-8154
P.O. Box 12688, Austin, Texas 78711-2668

To report abuse, neglect or exploitation, please call 1-800-252-5400.

Disability Rights Texas, Inc.
512-454-4816 or 1-800-223-4206

The Joint Commission
1-800-994-6610
complaint@jointcommission.org

Resolucion de Dudas

Si usted tiene una sugerencia o inquietud sobre los servicios de Integral Care o considera que sus derechos han sido violados, por favor comuníquese con cualquiera de los siguientes recursos:

Por favor, comuníquese con cualquiera de los siguientes contactos:
Informacion de Contacto:

Phyllis Wolf, Defensora de Integral Care
512-440-4086
Apdo. Postal 3548 Austin, TX 78764-3564

DADS Consumer Rights
1-800-458-9858
P.O. Box 149030 Austin, TX 78714-9030

Department of State Health Services
Oficina de Servicios a Consumidores & Protección de Derechos
1-800-252-8154
Apdo. Postal 12688, Austin, TX 78711-2668



Para reporter abuso, negligencia o explotación por favor llame 1-800-252-5400.

Disability Rights Texas, Inc.
512-454-4816 or 1-800-223-4206

The Joint Commission
1-800-994-6610
complaint@jointcommission.org



Eligibility and Consent Form – Central Health

☐ Inpatient Treatment
 ☐ Partial Hospitalization Program Treatment
 ☐ Intensive Outpatient Treatment
 ☐ Inpatient Detox Treatment
 ☐ ECT Treatment (Exceptional Referral required)

Today's Date:

Consumer's Name:

Consumer or legal guardian to fill out with staff assistance:

I attest that the following is true and accurate:

I am currently a Travis County resident. My <u>permanent</u> address is: or I am <input type="checkbox"/> literally homeless <input type="checkbox"/> marginally homeless.	True or False Initials: _____
I also plan to continue living in Travis County after I receive these services. I understand that this information may be verified, and I will be liable to pay the Hospital for all services received if I have provided false information.	True or False Initials: _____
a. My family's monthly income is: \$ My family's annual income is: \$ b. Number of persons in my household, including myself: c. Did the consumer provide a check stub or other documentation to verify their income? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what documentation was used? (Staff note: Document income verification source in the clinical record, as well). d. The staff person (who will sign as the witness below) has determined as of today that my household income is less than 200% of the latest federal poverty income guidelines.	True or False Initials: _____
Please check one and initial to the right: <input type="checkbox"/> I do <u>not</u> have insurance or <u>other options</u> that could pay for the services that I need. In other words, I do <u>not</u> have Medicaid, Medicare, Veteran's Benefits, or any other benefits or private insurance that will pay for the services I need. <input type="checkbox"/> I have insurance or other options that could pay for the services that I need.	Initials: _____

Understanding that my confidentiality will be protected, I hereby give my written permission to this agency () to disclose my name and other identifying information, as well as substance abuse information collected by this agency, to Integral Care, or other authorizing entity, and to representatives from Central Health (funding source) for data collection, tracking purposes, and activities related to improving health care, program evaluation, and developing procedures. Only anonymous results



compiled from all consumer data will be published. I understand that this consent to disclose information may be revoked at any time, in writing, to this agency, but the revocation will not affect any disclosures already made prior to the cancellation notice. This agency cannot control how the protected health information will be used by the agency/person who receives it under this authorization. The consent, unless revoked sooner, will expire one (1) year from the date of my signature.

Signature of Consumer

Month/Day/Year (form is completed)

Before me on this day personally appeared _____ (the consumer) who attested that everything recorded on this Eligibility and Consent Form is true and accurate.

Staff/Witness Signature

Month/Day/Year



Clinical Screening Information

Consumer's Name:
SSN:

Gender: ☐ Male

☐ Female

DOB:

Ethnicity:

☐ White
☐ Black

☐ Asian
☐ Other

☐ Native American
☐ Hispanic-Mexican

☐ Hispanic-Puerto Rican
☐ Hispanic-Cuban

Referral Source:

☐ Medical Hospital

☐ Austin Lakes
☐ The Inn

☐ Austin Police Department
☐ Austin State Hospital

☐ Crisis Intervention Team
☐ Seton Shoal Creek Hospital

☐ Travis County Jail
Clinic

☐ Self/Walk-In

☐ Next Step Program

☐ Mental Health Outpatient

☐ Family/Friend
Emergency Dept.

☐ Other

☐ Psychiatric Emergency Svcs

☐ Hospital

Date of admission:

Time of Adm.:

MD:

Adm. Status:

Utilization Management staff who approved admission:

☐ Brandon Cutro

☐ Jennifer Coulthurst

☐ Laura Alley

☐ John Kauffroth

☐ Lacy

Scarborough

Presenting clinical information meeting current medical necessity, previous hospitalizations, and any history of suicide attempts:

CD issues/drug screen results (if applicable):

Motivation for CD treatment (if applicable):

Axis I :

Axis II:

Axis III :

Axis IV:

Axis V:

Psychiatric medications prescribed prior to admission:

Psychiatric medications ordered upon admission:

Estimated length of stay:

Assigned UR Hospital Staff:

FOR UM USE ONLY: Criteria 1-4 below must all be "Yes" for client to meet eligibility for CH funding	
1. Client meets medical necessity for requested level of care If no, doc to doc was offered with (Integral Care doctor name)	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Client is homeless in Travis Co. or Travis Co. residence address verified via Travis Co. CAD website/Bing Map	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Client meets financial eligibility according to the latest poverty guidelines	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Client has a lack of insurance or other benefit coverage verified via TMHP/Navinet	<input type="checkbox"/> Yes <input type="checkbox"/> No
UM Name:	Date:
Current address or homeless in Travis Co. status entered in clinical documentation in AZ and MCO	<input type="checkbox"/> Yes <input type="checkbox"/> No
New demographic completed in AZ to reflect current address for date of admission	<input type="checkbox"/> Yes <input type="checkbox"/> No

Sources of Verification through Documents and Other Sources

Proof of Address for Travis County Residency; Proof of Identity: (Must include the client date of birth)

- Any state-issued driver's license/identification card
- Passport
- Mexican Consulate identification card
- Mexican identification
- INS document with picture (e.g. Forms 1-86,1-94,1-551, etc.)
- School or employment identification with a picture
- Foreign national document with a picture
- Any picture identification issued by a business or agency except identification issued through a flea market (e.g. Money Box Store 10, etc.)
- Receipt of Eligibility and Consent form signed by client, when no other verification is available
- Address verified via Travis Co. CAD website/Bing Map

Proof of Family Size:

- Adult living alone
- Emancipated minor
- Minor child living alone or with other not supporting child
- Pregnant minor child living alone or with others (excluded from minor's parent's family size)
- Persons legally married
- Persons common-law married
- One or both legal parents and minors and legal minor children
- Legal guardian, minor child and legal guardian's spouse and other legal minor children
- One or both adult caretakers of minors and caretaker's legal minor children
- Unborn child if proof of pregnancy provided and not seeking pregnancy termination

Proof of other current health coverage, if any:

- Private health insurance card with proof of non-covered benefit.
- Verification checks through Navinet and TMHP

Proof of earned and unearned income, if any: (Include all earned and unearned income received.)

- Check stubs (most recent)
- Day laborer income affidavit
- Child support receipts or printout from Domestic Relations
- Proof of TANF grant amount
- Workers' Compensation check stubs or benefit letter
- Current year's Social Security benefit letter
- Current year's Veterans' Administration benefit letter
- Unemployment benefits letter/check stubs
- Letter indicating cash contributions
- Current year's retirement benefits letter
- Bank statement showing interest payments
- Receipt of Eligibility and Consent Form signed by client when no other verification is available



Self-Employment Income: Self-employment income is calculated on a monthly basis; receipts for allowable expenses must be for the 4 weeks prior to the data of interview.



ATTACHMENT A
INSTRUCTIONS ON USE OF PROVIDER SERVICE DELIVERY RECORD

All invoices must be received by the 3rd working day of the month immediately following the month in which covered services were provided in order to be processed for payment. Semi-monthly invoices are due on the 20th of each month for services rendered from the 1st – 15th and on the 3rd working day of the following month for services rendered from the 16th – the end of the month. Provider Service Delivery Records (PSDR) must accompany the invoice.

DO NOT COMBINE DIFFERENT MONTHS OF SERVICES ON A PSDR OR INVOICE.

Section 1 of the PSDR (see example)

Check the applicable program box from the choices listed under the form title.

Consumer Name: Enter the name of the consumer (and/or family member, if applicable, in parenthesis) who received services.

DOB: Enter the consumer's date of birth.

Consumer ID#: For Integral Care consumer only. List the Integral Care Case number.

Organization Name / ID #: Enter the name of the provider organization (if applicable) and ID number assigned by the Credentialing Coordinator (as indicated on the cover letter included with your executed contract package).

Provider Name /ID #: Enter the name of the individual provider who provided services and their individual provider ID number.

Coordinator: Enter the name of the Coordinator assigned to the consumer.

Record one code only for each of the code boxes on the billing strip of the Provider Service Delivery Record. If two or more codes apply, record the code that applies to the majority of time for that service event.

Section 2 of the PSDR (see example)

Ref: Numbers 1 through 7 are used for corresponding progress notes on the bottom portion of the form.

DO NOT RECORD ANY ENTRIES PAST LINE 7.

Service Date: Enter the date of service.

Service Code: Enter the service code of the service provided. This number can be found on the authorization letter.

Start Time: Enter the time the service began (include am/pm) rounded to the nearest quarter hour.

Stop Time: Enter the time the service ended (include am/pm) rounded to the nearest quarter hour.

Total Time: Enter the total amount of time in hours/minutes or days for each service line, this is the number of units recorded on the Claim/Invoice form. Minutes should be entered in quarter hour increments. For example: one hour and fifteen minutes equals a total time of 1.25 hours.

Person Contacted: Enter the letter code that describes the person with whom service contact was made. As only one letter code may be entered per box, use the code that reflects who the provider was with the majority of time services were being provided.

Place of Service: Enter the letter code that describes where the service was provided. As only one letter code may be entered per box, use the code that reflects where the majority of the service was being provided.

Contact Type: Enter the letter code that describes the type of contact made (face-to-face or telephone).

Billable services require face-to-face contact with the consumer or family, unless otherwise specified in the Service Definition and Billing Guidelines.

Intensity: Enter the letter code that describes the intensity of need of the consumer at the time services were provided. Mark **routine** for services provided under usual circumstances (not a consumer emergency). Mark **urgent** if services were provided in response to an urgent consumer need within 48 hours of the coordinator's request for services. Mark **emergent** if services were provided services in response to a consumer emergency within 4 hours or 1 business day of the coordinator's request for services.

Appointment Code: Enter the letter code that indicates if the service occurred as scheduled or why it did not occur.

Progress: Enter the letter code that describes the consumer's movement toward their goals/objectives.

Section 3 of the PSDR (see example)

Plan of Care Goal or Person Directed Plan Objective: List the goal(s)/objective(s) as shown on the Provider Intervention Sheet, Person Directed Plan or IPC. Refer to the appropriate goal/objective, by its letter, in the written notes. If all goals and objectives do not fit in the space provided, please continue them on an attached page.

Section 4 of the PSDR (see example)

Ref: Corresponds to numbers 1 through 7 of Section 2.

Date: Date service was provided (corresponds to the date in Section 2).

Service Delivery Notes: Notes are a written record of each contact with the consumer. Notes are a summary of what occurred and must state the progress or lack of progress toward the stated goal or objective of the consumer's plan. Notes should be specific, giving sufficient detail to show progress toward goals and objectives.

Signature: The individual provider's signature and credentials, if licensed, must follow each note.

*For additional information on billing see the Service Definitions and Billing Guidelines Training Manual
http://www.integralcare.org/?nd=for_providers*

If all elements of the Provider Service Delivery Record are not completed the Claim/Invoice will be denied.

INSTRUCTIONS FOR PROVIDER INVOICE FORM

All invoices must be received by the 3rd working day of the month immediately following the month in which covered services were provided in order to be processed for payment.

DO NOT COMBINE DIFFERENT MONTHS OF SERVICES ON AN INVOICE

Section 1 of the invoice (see invoice example)

Check the applicable program box from the choices listed under the form title. Use a separate invoice form for each program area checked.

Type of Provider: Check the box that applies: Organization – payment is made to network contracted company. Individual – payment is made to network contracted individual.

ID Number/Name: Enter the provider number assigned by the Credentialing Coordinator (as indicated on the cover letter included with your executed contract package) **and** the name of the organization or individual network contract provider.

Email Address: Enter the organization's or individual's current email address.

Address: Enter complete mailing address; including apartment/building numbers, zip codes, etc.



Telephone Number: Enter the organization's or individual's current telephone number.

Tax ID# or Social Security #: Enter either the federal tax identification or social security number.

Sort all services billed by consumer and then by service date (list all of one consumer – in date order, then all of the next consumer – in date order, etc.) Consumers receiving services from the same program area should be listed on the same invoice.

Section 2 of the invoice (see invoice example)

Auth #: Authorization number listed on the authorization letter that covers the date the services were authorized to be provided.

Service Date: Enter the date of service. This should match the dates on the Provider Service Delivery Record (PSDR).

Consumer Name: Enter the full name of the consumer which is to include first name, last name and must include hyphenated last name if available (and/or family member, if applicable, in parenthesis) who received services.

Integral Care Case#: For Integral Care consumers only. List the Integral Care Case number.

Service Code: Enter the service code of the service provided. This number can be found on the authorization letter and should match the PSDR.

Coordinator: Enter the name of the Coordinator assigned to the consumer.

Person Providing Service: Enter the name of the individual delivering direct services to the consumer.

Units: Enter the number of units that correspond to the "Total Time" entry on the PSDR. Only include billable units (do not include no-shows or cancellations).

Type: Circle "H" for hourly service or "D" for daily service as indicated on the authorization letter.

Unit Rate: Enter the rate of pay per unit, as identified in the authorization letter and provider agreement.

Co-pay: Enter the co-pay as indicated on the authorization letter. Enter "0" if there is no co-payment.

Line Total: This total should be the unit rate multiplied by the number of units.

Authorized Provider Signature: The individual provider or organizational provider designee must sign the invoice.

Date: Enter the date the invoice was signed by the authorized provider. This date must be on or after the last date of service provided during the billing period.

*For additional information on billing see the Service Definitions and Billing Guidelines Training Manual
http://www.integralcare.org/?nd=for_providers*

Within thirty (30) days of Integral Care's receipt of a complete, timely, and accurate Claim/Invoice, Provider will receive payment, or the Provider will receive an Adjustment Letter/Explanation of Benefits indicating denials, adjustments or recoupments of the Claim/Invoice, or portions of the Claim/Invoice.

If all elements of sections 1 and 3 on the invoice are not completed the Claim/Invoice will be denied.

If elements of section 2 on the invoice are not completed, specific line items will be denied.

To avoid denials please use the available Excel Invoice Template and turn in with information typed.

Please contact the designated person listed below if you have any questions regarding this information.

Dianne Burditt, IDD Services
5225 N. Lamar
Austin, TX 78751

Julia Langston, Child & Family Services
1700 S. Lamar
Austin, TX 78704



(512) 483-5800

(512) 804-3174

Ana Garza, Behavioral Health Services
1717 W. 10th Street
Austin, TX 78704
(512) 445-7752

**ATTACHMENT B
HCFA 1500 INSTRUCTIONS**

All claims must be received by the 5th working day of the month immediately following the month in which covered services were provided. Late claims are at risk of denial. If the claim form is not typed, please make sure each box is legible.

Please complete each box as follows:

- 1A** Insured Identification Number
 - Enter the Consumer's Social Security number
- 2** Patient's Name
 - Enter the Consumer's last name, first name and middle initial
- 3** Patient's Birth Date
 - Enter the Consumer's date of birth and sex
- 5** Patient's Address
 - Enter the Consumer's permanent mailing address (telephone number, optional)
 - If the person is in a residential facility use that address
- 6** Patient's Relationship to Insured
 - Check the appropriate box to reflect Consumer relationship to insured
- 8** Patient's Status
 - Enter the status of the Consumer at the time of service
- 11C** Insurance Plan Name or Program Name
 - Enter Contract (CICO, CHIP, Central Health)
- 12** Consumer's Authorized Signature
 - The Consumer or authorized representative may sign this block. If a signed Consumer authorization form is kept on file in the provider's office, "Signature on File" may be entered.
- 17** Name of Referring Source
- 21** Diagnosis (must be completed)
 - List the primary diagnosis on line 1 and secondary diagnosis on line 2, additional diagnoses are optional and may be listed on lines 3 and 4.
- 23** Prior Authorization Number
 - Enter Authorization number given by utilization manager for services provided (reference authorization letter)

24A Dates of Services

- Enter each separate date of services as six (6) digit numeric date (e.g. 09/01/11) under the “From” heading.
 - a. For inpatient services it can be for the total stay if consecutive: From: 09/01/11 To: 09/12/11.
 - b. For outpatient services the “To” date will be the same as the “From” date and it should be listed on a separate line.

24B Place of Service

- 11: Office
- 12: Home - Location other than a hospital or other facility, where the patient received care in a private residence (Transitional Housing)
- 55: Residential Substance Abuse Treatment Facility

24D Procedures

- Enter the appropriate procedure code. Please reference your authorization letter.

24F Charges

- Enter the charge for each service
- If there is more than one unit of service on a line, the charge for that line should be the total for all units.

24G Units or days**24J** Rendering Provider

- Provider rendering the service (number provided by Credentialing).

25 Federal Tax ID Number

- Enter the Federal tax ID number of the individual, group or facility to who payment is to be made

28 Total Charge

- Enter the sum of the charges shown on all lines of Block 24F

31 Signature of Physician or Supplier

- Enter the signature of the provider

32 Address/Facility where service was rendered

- List the name of the facility or location where the services were rendered

33 Billing Provider Info & Phone

- Enter the name, address and telephone number of the group or facility to who payment is to be made.
- Name should correspond to the name associated with the Federal Tax ID number entered in Block 25



ATTACHMENT C
Provider Service Delivery Record Form

PROVIDER SERVICE DELIVERY RECORD

<input type="checkbox"/> IDD SERVICES	<input type="checkbox"/> ECI	<input type="checkbox"/> THE CHILDREN'S PARTNERSHIP	<input type="checkbox"/> Integral Care-CFS	<input type="checkbox"/> YAFAC	<input type="checkbox"/> YES
---------------------------------------	------------------------------	---	--	--------------------------------	------------------------------

CONSUMER NAME: _____ DOB: _____ CONSUMER ID #:

ORGANIZATION NAME: _____ ID # _____

PROVIDER NAME: _____ ID# _____

COORDINATOR: _____

R E F	Service Date MM/DD/YY	Service Code	Start Time	Stop Time	Total Time	Person Contacted C=Consumer F=Family w/consumer G=Parent/ Guardian O=Collateral X=Family w/o consumer	Place of Service H=Consumer Home M=Community S=School D=Detention P=Provider Home C=Office/facility	Contact F=Fac e T=Phone	Intensity R=Routine U=Urgent E=Emergency	Appt. Code 1=seen as scheduled 3=cancelled (by consumer) 4=no show (consumer) 7=cancelled (by provider)	Progress P= Progress NP= No Progress M= Maintenance R= Regression
1.											
2.											
3.											
4.											
5.											
6.											
7.											

Plan of Care Goal or Person Directed Plan Objective (you must indicate the goal(s) for each service provided):

Goal/objective **A**:

Goal/objective **B**:

Goal/objective **C**:

[illegible]

ATTACHMENT D
Provider Invoice Form

To access the most current version of each of the Provider Invoice Forms, please visit the following web links:

- IDD Provider Invoice Form
https://www.integralcare.org/sites/default/files/provider_invoice_form_idd_updated_20140415.xlsx
- YES Waiver Provider Invoice Form
https://www.integralcare.org/sites/default/files/provider_invoice_form_yes_updated_20140415.xlsx
- Other (Children's Partnership, Children's Continuum, YAFAC) Provider Invoice Form
https://www.integralcare.org/sites/default/files/provider_invoice_form_tcp_yafac_updated_20140415.xlsx



Incident Report Manual

An Explanation of How to Use the System

Quality Management/ CQC Committee

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Introduction

Incident Reports are an essential part of the daily operations at Integral Care. All Staff, Interns, Volunteers and Network Providers are required to submit Incident Reports about events or actions that occur that could adversely impact the agency, you, a client, contractor, external provider or visitor. Each Incident type is also a key indicator of how well we respond and prevent future occurrences of similar events.

The submission of the Incident Report creates a stream of activities by other staff members to take action. Ultimately each Incident Report becomes an important start point for the continuous review of our daily work life at Integral Care. Incident Reports are studied within the agency to verify our processes are robust or require improvements, to note trends and to provide opportunities for continuous improvement.

Well-written Incident Reports and Follow up are records we present to our agency accreditor Joint Commission and other auditors or investigators. These records are proof of our due diligence and commitment to document events which occur in the agency and actions taken.

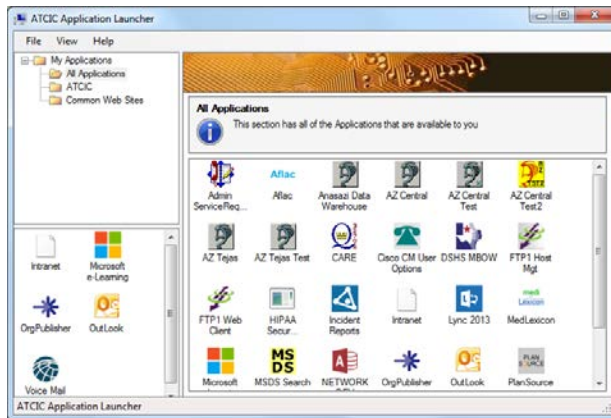
The following Incident Reporting system was designed by your fellow Integral Care members to provide clear and meaningful required information. This system is also a work in progress and will continue to evolve as the agency evolves as part of Integral Care's Continuous Quality Improvement Commitment. Suggestions for improvements are always encouraged and welcome.

Incident Report Access

Integral Care STAFF INSTRUCTIONS

For Integral Care staff two options exist for signing in to the Incident Reporting System:

Via the Integral Care Application Launcher:

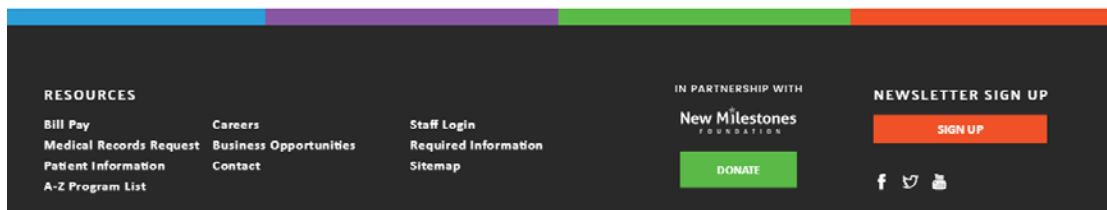


**Incident
Reports**

Select this Icon:

OR:

If you are accessing the system from home or outside of an Integral Care facility, you must go to the integralcare.org website, choose STAFF LOGIN.



Staff Login

Select this Icon:



Browse until you locate these selections:

INCIDENT REPORTING
File an Incident Report
For Integral Care staff, you'll need your Integral Care login information.
[FILE INCIDENT REPORT](#)

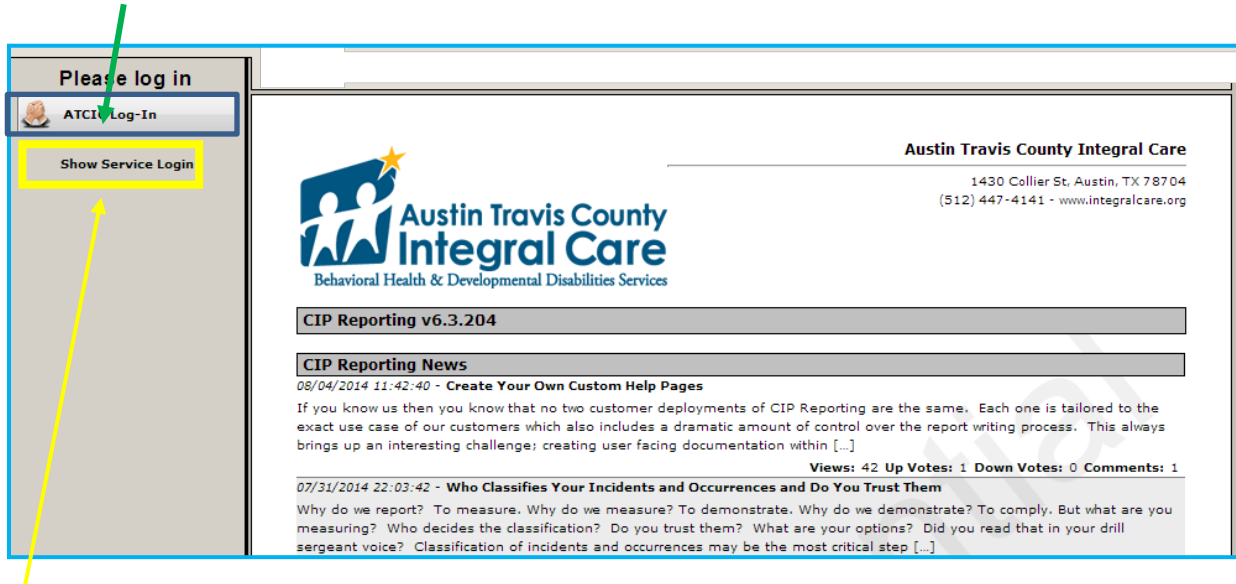
OTHER IMPORTANT NOTES

- Please note that the Incident Report program requires Internet Explorer to ensure smooth operation of the program. Firefox and Chrome do not work correctly, and your best choice is Internet Explorer which is the official web browser for Integral Care.
- If you change your password and your password is saved on the Incident Report program you must retype in your new password or you may receive a credentialing error and must start over and input our Integral Care identification information and your current system password.

Integral Care STAFF SIGN-IN PROCESS

As Integral Care Staff no matter if you are inputting an Incident Report, or simply accessing the system for follow-up or to review your reports, your user information is the same for logging into the Integral Care system. **ALL** Integral Care staff including volunteers must sign-in to the Incident Software system to ensure all the work groups are complete for follow-up and notification.

STAFF [CLICK](#) Integral Care Log- In



Please log in

ATCIC Log-In

Show Service Login

Austin Travis County Integral Care
Behavioral Health & Developmental Disabilities Services
1430 Collier St. Austin, TX 78704
(512) 447-4141 - www.integralcare.org

CIP Reporting v6.3.204

CIP Reporting News

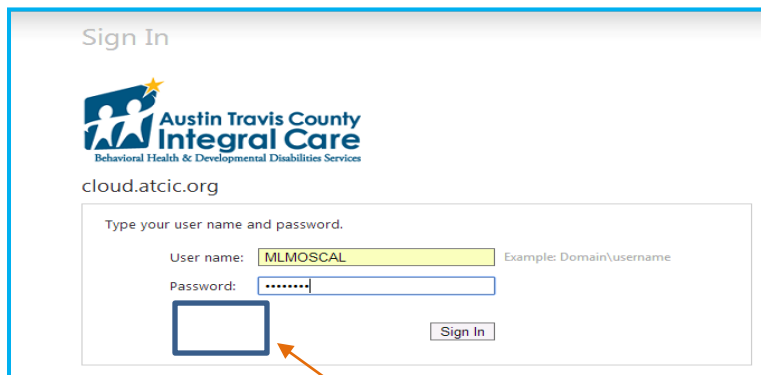
08/04/2014 11:42:40 - **Create Your Own Custom Help Pages**
If you know us then you know that no two customer deployments of CIP Reporting are the same. Each one is tailored to the exact use case of our customers which also includes a dramatic amount of control over the report writing process. This always brings up an interesting challenge; creating user facing documentation within [...]

Views: 42 Up Votes: 1 Down Votes: 0 Comments: 1

07/31/2014 22:03:42 - **Who Classifies Your Incidents and Occurrences and Do You Trust Them**
Why do we report? To measure. Why do we measure? To demonstrate. Why do we demonstrate? To comply. But what are you measuring? Who decides the classification? Do you trust them? What are your options? Did you read that in your drill sergeant voice? Classification of incidents and occurrences may be the most critical step [...]

Note: Do not click Show Provider Log In. This login is for Network Providers.

Your Sign In form appears:



Sign In

Austin Travis County Integral Care
Behavioral Health & Developmental Disabilities Services
cloud.atcic.org

Type your user name and password.

User name: Example: Domain\username

Password:

Fill-in Information (*Same as your Integral Care log-in*) and [CLICK](#) Sign In

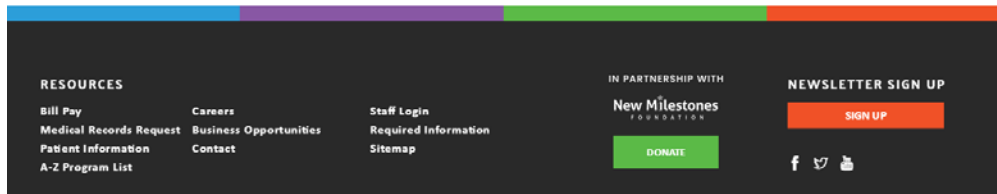
NETWORK PROVIDER SIGN IN PROCESS

ALL Network Providers are required to submit Incident Reports for all events with Integral Care clients that occur at your residence or facility or the facility that you are working within. In order to submit Incident Reports you must have a user sign-in and password. This information is available from the Managed Care Database Administrator at (512) 440-4085 or the Quality Manager at (512) 440-4049.

Once you have the required sign-in information, you will take the following steps:

On your computer screen browser type: <http://www.integralcare.org/>

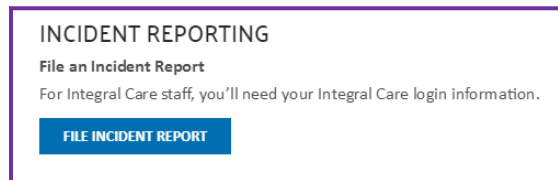
When you click Enter you will have the Integral Care website. Locate the Staff Login Icon at the bottom of the page.



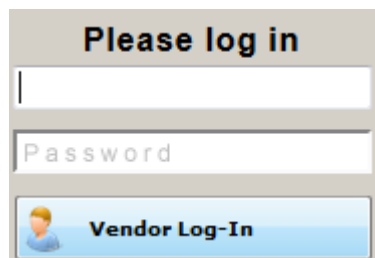
CLICK STAFF LOGIN

Locate the Section for *Individual Logins for Web-Based Software Using an Internet Brower* section and scroll down until you locate the *Incident Reporting* Section.

Locate:



CLICK Show Service Log-In



Fill in your User Name and Password and **Click Vendor Log-in**. The rest of the following information is applicable on filling out this Incident Report.

POSSIBLE SIGN IN ISSUES

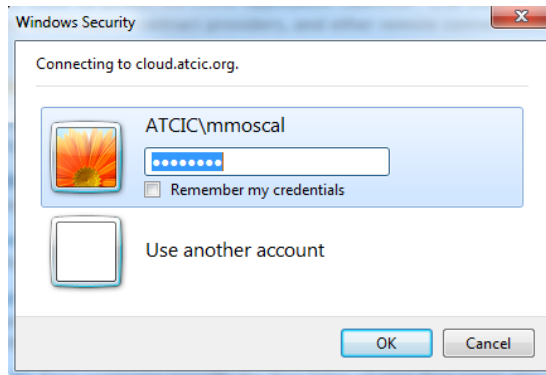
401 Unauthorized: Access is denied Error

Server Error

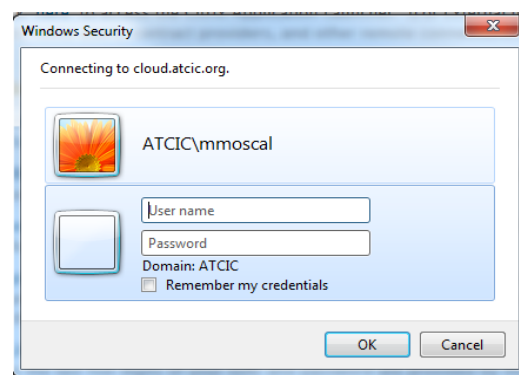
401 - Unauthorized: Access is denied due to invalid credentials.

You do not have permission to view this directory or page using the credentials that you supplied.

This Error Message will occur when a staff member's Integral Care network password has expired. Staff must reset their network (computer) password and use the new password to log into CIP system. Often a computer has to be rebooted (please save all your work before you reboot your computer) before the Incident Report program will allow access.



Screen #1



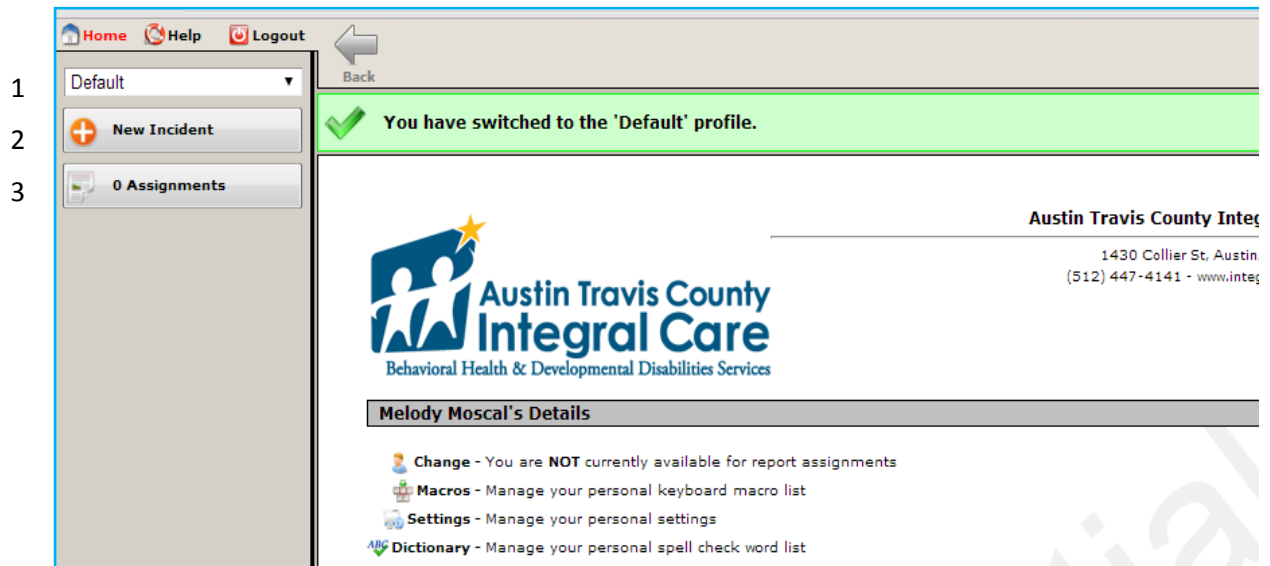
Screen #2

When this screen appears you must click [Use another account](#) and type in your sign-in information used for accessing your email and Integral Care system or for Network Providers the user ID and password assigned.

Please make sure you are using Microsoft Explorer as your web browser because the Incident Report Software is not completely compatible with Firefox or Chrome and may give you error messages and deny access to the Incident Report Program.

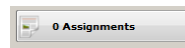
FILING AN INCIDENT REPORT

After Sign-In the following screen appears:



VARIOUS EXPLANATIONS

- 1: **Default:** The profile you are currently accessing in the Incident Software. All Integral Care staff and Network Providers have access and will be placed automatically in the Default mode. If your position is supervisory you may have assignments because of incident reports filed by staff members.
- 2: **New Incident:** The option pressed to input a New Incident into the system.
- 3: **Assignments:** The number of Incident Reports assigned to you for action (Default users have normally do not have assignments, but if further information on your incident report is required, you could have an assignment).



Please Be Advised:

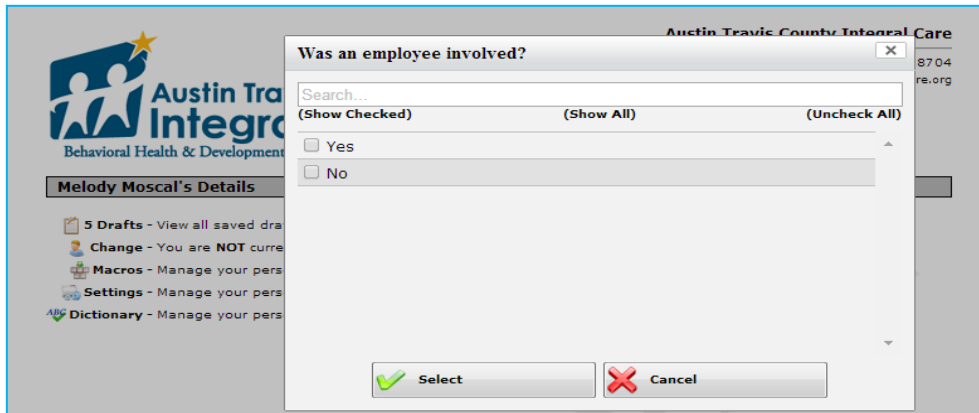
All Incident Report information is confidential and privileged and must meet the requirements of HIPAA. Printing is not allowed due to the nature of these documents. Violations in confidentiality from the misuse of this confidential information will be reported to the Integral Care HIPAA Representative for review and action.

OPENING A NEW INCIDENT REPORT

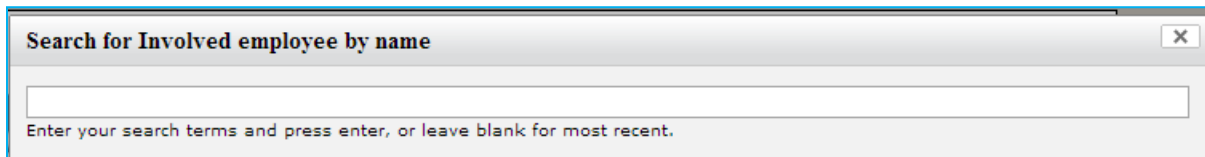
To start a new Incident the System will ask you about two groups of people: Employee or Non-Employee, in order to add identifying information about the people involved in the incident. Response to the questions **yes** or **no** will determine which screens appear for Employees or Non-Employees. When more than one person is involved staff or non-employee, you have the ability to add more people later in the process.

FOR INCIDENTS INVOLVING EMPLOYEES

This is the first screen that appears requiring a **yes** or **no** answer.

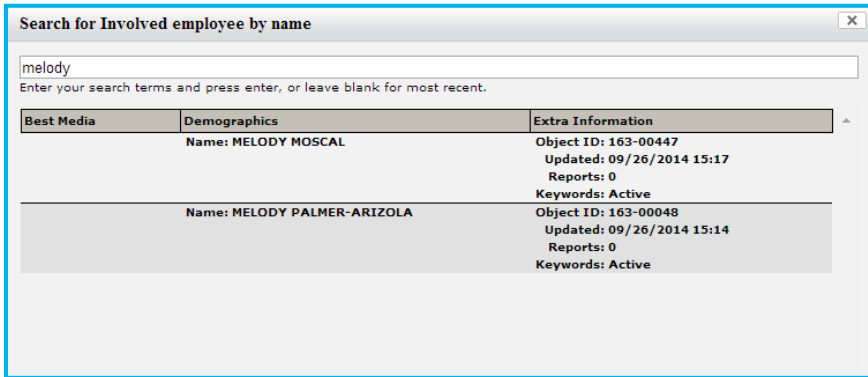


CLICK YES if an Integral Care Employee is involved (including yourself if you are writing an incident report about yourself). The Integral Care Employee or you **MUST** be the reason for the Incident such as “You had a vehicle accident”, or “Integral Care Employee fell”, you would click yes. If you simply witnessed or assisted in an Incident the answer would be **NO**.



If you **Click YES** this screen appears.

Type in the whole name, first name or last name to search for the staff member. You must type the name correctly or the system will not recognize the name. If you are unsure on spelling Outlook has a directory of names when you hit new email.



Search for Involved employee by name


melody
Enter your search terms and press enter, or leave blank for most recent.

Best Media	Demographics	Extra Information
	Name: MELODY MOSCAL	Object ID: 163-00447 Updated: 09/26/2014 15:17 Reports: 0 Keywords: Active
	Name: MELODY PALMER-ARIZOLA	Object ID: 163-00048 Updated: 09/26/2014 15:14 Reports: 0 Keywords: Active

When a name is highlighted and clicked, the Incident form is automatically filled in with the name. If more than one staff member is directly involved you can add additional names later in the body of the incident report.

FOR INCIDENTS INVOLVING CONSUMERS/OTHERS

When you Click **NO** to the question of was an Employee involved or if you click **yes** and select an employee name, the following screen appears:



Was another person (non-employee) involved?

Search...

(Show Checked) (Show All) (Uncheck All)

☐ Yes

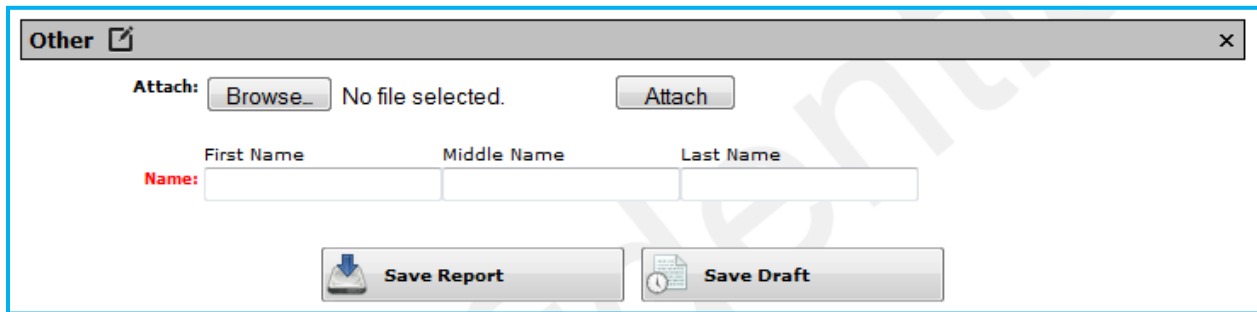
☐ No

☒ Select ☐ Cancel

Click **NO** The program will go into the main incident form for you to input all necessary information.

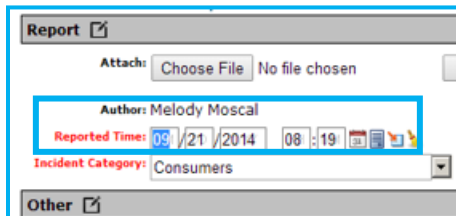
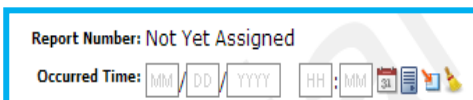
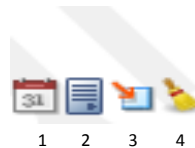
CLICK YES:

You will have a blank area to input the name of the person involved. When a consumer is involved additional information will be required and will be explained in detail on page 26 of this manual. You cannot use the search function because the function was disabled to remain HIPAA compliant.



TIME AND DATE INFORMATION

All Incident Reports have two times listed. The first time that is automatically filled in is the time you started your incident report. The second time is the time that the incident actually took place. The information in those boxes is blank and requires your input. Although the system may not flag that you have not put in the time the incident occurs you are required to provide this information.

1. Calendar sets date and time
2. Not Used Sets Future Date
3. Sets the Current Time to the Second
4. Clears Date and Time

SELECTION OF TYPES OF INCIDENTS

The selection of Type of Incident is critical to the accuracy of the Incident Report. Integral Care utilizes six distinct Incident Categories with a second drop down menu associated for Type of Incident for each Category.



The Clinical Quality Committee has endeavored to put as many incident types as possible into this system. If you believe you have a unique incident that does not “fit” any of the types listed, please contact the Quality Manager or Managed Care Database Administrator for assistance.

Most Types of Incidents are self-explanatory, but some incident types require more explanation, or have additional paperwork/actions that must be completed when filing a report. This section is under development and will be updated to include more information or criteria. Please contact Quality Management if you have questions or suggestions.

CONSUMERS

Incident Category: Consumers	Type of Incident:
	<input type="checkbox"/> Assault <input type="checkbox"/> Behavioral Emergencies <input type="checkbox"/> Behavioral Incidents <input type="checkbox"/> Injuries <input type="checkbox"/> Left AMA <input type="checkbox"/> Missing from Location <input type="checkbox"/> Near Miss <input type="checkbox"/> Police Issue

ASSAULT:

- Client is physically assaulted by a client, staff, or other person

BEHAVIORAL EMERGENCIES:

- Client’s behavior causes injury to self, other Clients, and/or staff.
- Client physically assaults another client, staff, or other individual.
- Client’s behavior causes damage to property.
- Any behavior requiring the use of a Prevention and Management of Aggressive Behavior (PMAB) physical hold.
- Law enforcement personnel are called because of behaviors.
- Suicide attempts or gestures.

BEHAVIORAL INCIDENTS:

- Behaviors that do not cause injury, but could have potentially caused injury.
- Behaviors that are resolved by redirection.
- Behaviors that require staff intervention but are resolved without injury, damage or the presence of outside authorities.

POLICE ISSUE:

- Any illegal drug use by a client on Center property, receiving a service, or taking part in a Center sponsored activity.
- Any serious incident that is unusual, lengthy, serious, or involves illegal activity.


EMPLOYEES

Incident Category:	Employees	Type of Incident:	<input type="checkbox"/> Assault <input type="checkbox"/> Injuries <input type="checkbox"/> Near Miss <input type="checkbox"/> Password Violation <input type="checkbox"/> Policy or Procedure Breach <input type="checkbox"/> Vehicle Accident <input type="checkbox"/> Vehicle Damage
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EMPLOYEE INJURIES: Employee Injuries require an incident report and include:

- Fractures
- Dislocation of joints
- Internal injuries
- Contusions (bruises)
- Concussions
- Burns
- Lacerations (cuts, severe scratches)

The First Report of Injury, Worker's Compensation documentation is to be initiated immediately for employee accidents, injuries, and infection exposures by contacting the Risk and Manager, Rod Gibbs, at 512 447-4141

- The First Report of Injury is located on the Integral Care Application Launcher clicking  and selecting once in Sharepoint System



PASSWORD VIOLATIONS:

- Never leave your written password in a public place where anyone can view it, and never share or give your password to another person for usage. If you see this situation this occurring, you must file an Incident Report.

VEHICLE ACCIDENTS:

- Vehicle accidents must be reported on Incident reports. Other required actions when vehicle accidents must be documented on the Incident Report including the notification of the accident to the Risk and Safety Manager Rod Gibbs, any direction given such as if a medical examination is required or drug testing.

LEGAL

Incident Category: Legal	Type of Incident:
	<input type="checkbox"/> Allegations Contracted Staff <input type="checkbox"/> Allegations Other <input type="checkbox"/> Allegations Self Abuse <input type="checkbox"/> Allegations Staff <input type="checkbox"/> Breach of Confidentiality / Security <input type="checkbox"/> Breach of Policies / Procedures <input type="checkbox"/> Corporate Contractual Compliance <input type="checkbox"/> Death <input type="checkbox"/> Moving Violation <input type="checkbox"/> Rights Violation / Contract Staff <input type="checkbox"/> Rights Violation / Other <input type="checkbox"/> Rights Violation / Staff

Breach and Compliance Issues must be reported so that Integral Care can investigate to understand the validity, the risk and provide direction for corrective actions that must take place. All Legal Incidents must be reported to also ensure that the Executive Management Team is aware of these incidents and provide guidance wherever needed on the incidents resolutions.

ALLEGATIONS AND RIGHTS VIOLATIONS

- Physical, sexual, or verbal abuse, neglect or exploitation (by provider or others) as defined by Integral Care Client Abuse, Neglect, Exploitation Procedure (10.03 Title: Prohibition of Client Abuse, Neglect and Exploitation)
- Rights violation as defined by Integral Care Client Rights Procedure (10.07 Title: Prohibition of Client Rights and Violations)

Additional information for Rights related issues:

- An immediate verbal report regarding allegation of abuse, neglect, and rights violations must be made to the Ombudsman. Providers also are to notify the Program Manager, Associate Director, or supervisor.
- A report to external agencies (DFPS) is to be made immediately as specified in the Integral Care Client Rights procedures, or as instructed by the Ombudsman. **You must record the DFPS/Other Agency report number on your report.** The field to enter this number is at the bottom of the Follow-

Up Tab. If you do not have access to this tab, simply record the report number in the Comments field on the Incident tab.

BREACH OF CONFIDENTIALITY/SECURITY

1. When a Client's Protected Health Information is released without a completed Consent to Release information as defined in the [Integral Care Confidentiality of Clinical Records and other Identifying Information Procedure. \(10.05 Title: Confidentiality of Clinical Records and Other Client Identifying Information\)](#)
2. **Additional information for unauthorized release of PHI:**
 - Reports of disclosures without authorization are to be recorded in an Electronic Medical Record progress note. This documentation should include date, time, circumstances surrounding the need for disclosure, names and relationship of persons to whom information was disclosed and the specific information disclosed.

CORPORATE CONTRACTUAL COMPLIANCE:

- Lack of data integrity in data collection procedures.
- Data does not meet contractual definitions of data to be provided.
- Information submitted outside of specified means or time line.
- Billing strips do not have clinical documentation for verification.
- Clinical record documentation does not support service code billed.
- Treatment plan does not cover service done.

Additional information for Data Collection and Submission Regulations Incidents:

- If supervisor suspects intentional misreporting or the error could result in fines or penalties, they assign the report to the Corporate Compliance Officer or their Associate Director or Director for follow-up.

DEATH:

- All deaths that occurred on the premises of an INTEGRAL CARE funded or contracted program.
- All deaths that occurred while or within 30 days of the individual receiving services or participating in INTEGRAL CARE funded or contracted program activities.
- Other conditions that suggest the death may reasonably have been related to the individual's care or activities as part of INTEGRAL CARE services or programs.

- Although the death may not reasonably related to the individual's care or activities as part of INTEGRAL CARE services or programs, a review of the death may be warranted.
- The cause of the death is uncertain.

SENTINEL EVENTS

Death can be a major source of Sentinel Events. Our Accrediting Agency, Joint Commission requires Sentinel Events to be reported that are generated from Incident Reports. Sentinel events are defined by the Joint Commission as:

"A Sentinel Event is defined by The Joint Commission as any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness. Sentinel events specifically include loss of a limb or gross motor function, and any event for which a recurrence would carry a risk of a serious adverse outcome. Sentinel events are identified under TJC accreditation policies to help aid in root cause analysis and to assist in development of preventative measures. The Joint Commission tracks events in a database to ensure events are adequately analyzed and undesirable trends or decreases in performance are caught early and mitigated."

ENVIRONMENT OF CARE

Incident Category: Environment of Care	Type of Incident:
	<input type="checkbox"/> Fire <input type="checkbox"/> Hazardous Materials <input type="checkbox"/> Infestations <input type="checkbox"/> Mold <input type="checkbox"/> Property Damage <input type="checkbox"/> Property Missing/Theft <input type="checkbox"/> Security <input type="checkbox"/> Water <input type="checkbox"/> Wind

HAZARDOUS MATERIALS

- Unsafe storage or treatment of hazardous materials.

INFESTATIONS

- Infestations include, bedbugs, rats, mice, and lice.

PROPERTY DAMAGE

- Most categories are self-explanatory.
- Damage caused by Consumers such as smoke detector tampering, furniture broken or ripped, sinks or other fixtures (requiring ASRs for Facilities Department notification/action).

SECURITY

- Doors are left unlocked.
- Employees sharing keys or fobs.

- Reporting loss of keys or fobs.

HEALTH AND WELLNESS

Incident Category:
Health and Wellness

Type of Incident:

☐ Allergic Reaction
☐ Client Illness
☐ Employee Illness
☐ Infectious Exposure
☐ Medication Loss
☐ Near Miss
☐ Nurse Administered Error
☐ Prescribing Conflict/Confusion/Chan
☐ Process Issue
☐ Procurement Loss
☐ Refusal
☐ Self-Medication Error
☐ Staff Illness
☐ Used Needle Stick
☐ Wrong Medicine

CLIENT ILLNESS: Client illnesses must have Incident Reports written. Types of Illnesses to be reported are:

ANTHRAX	HEPATITIS A,B or C
ARBOVIRUS	HERPES SIMPLEX (COLD SORES)
BOTULISM	HIV/AIDS
BRUCELLOSIS	IMPETIGO
CAMPYLOBACTERIOSIS	LICE (HEAD / BODY)
CHICKENPOX	MEASLES
CHLAMYDIA TACHOMITIS	MENINGITIS
COCCIDIOIDOMYCOSIS	MRSA
CONJUNCTIVITIS – PINK EYE (BACTERIAL / VIRAL)	MUMPS
CRYPTOSPORIDIOSIS	PIN WORMS
CYCLOSPORIASIS	RINGWORM
DENGUE	RUBELLA
DIPHTHERIA	SCABIES

EHRlichiosis	Scarlet Fever
Flu	Seizure
Gastroenteritis, Viral	Strep Throat
H1N1 Virus	Tuberculosis

INFECTIOUS EXPOSURE

- Any exposure, which is defined as a parenteral, mucous membrane (splatter/aerosols into the eyes, nose or mouth), or significant contamination of an open wound or non-intact skin with a body substance. Circumstances of the exposure and relevant information are to be recorded on the Incident Report form, including activity in which the individual was engaged at the time of the exposure, the extent to which appropriate work practices and protective equipment were used, and a description of the source of the exposure.
- Human or animal bites are to be reported as potential infections.
- Vomit or other body fluids requiring clean up with spill kits and other protective materials.
- Any exposure to a person with active Tuberculosis or other communicable diseases.

There are additional protocols to be followed depending on what occurred, for more information, please refer to the **Infection Prevention and Control Plan** located on the Integral Care intranet.

MEDICATION

- Errors involving wrong medication, time, dosage, route or missed medication
- Transcription errors regarding medication, time, dosage or route.
- Pharmacy dispensing errors.
- If error is caught prior to administering medicine to Client, a Near Miss Incident Report is filed.

NEAR MISS INCIDENTS

A near miss often called a close call or good catch are Client safety events that did not reach the Client. Examples would be wrong medicine that was caught prior to dispensing to Client, used needles found in public bathrooms safely disposed of by staff in sharps containers.

CONTRACTORS AND VENDORS

Report Group:	Contractors and Vendors	Report Type:	<input type="checkbox"/> Injury - Contractor <input type="checkbox"/> Injury - Vendor <input type="checkbox"/> Property Damage - Contractor <input type="checkbox"/> Property Damage - Vendor <input type="checkbox"/> Vehicle - Contractor <input type="checkbox"/> Vehicle - Vendor
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YOUR INFORMATION

Your information contains two different Author Types, Integral Care Employee and Network Provider. You will select the appropriate Author Type.

Your Information	
Author Type:	Employee
Telephone Number:	000-0000
Supervisor Tel #:	000-0000
Supervisor Name:	Louise Lynch
FOR EMPLOYEES	

Your Information	
Author Type:	Network Provider
Organization Name:	
Telephone Number:	
Supervisor Tel #:	512-804-3172
Individual Name:	
Supervisor Name:	Contract Monitor-Ellyn Eisenberg
FOR NETWORK	

If you are a Network Provider you are required to provide Your Organization Name, Name and Telephone Number. The Supervisor Name and Telephone Number will default to the Contract Monitor Name and Telephone Number. This information allows Integral Care to review Incident Reports specific to your organization or residence and allows the Contract Monitor to ensure information is complete and request/follow up on any corrections that may be required.

INCIDENT INFORMATION

The information about the incident is crucial to determining the follow up activities required. Incomplete or inaccurate information will not allow for the correct assessment and disposition of the Incident Report.

PROGRAM IMPACTED

You need to select the program impacted by the Incident. You are **NOT** selecting your assigned program unless the incident occurred does affect

your program. From the drop down list choose where the Incident occurred.

Incident Information

Program Impacted:

- ☐ Other / Not in List
- ☐ 101 - Executive Office
- ☐ 102 - Administrative Services
- ☐ 103 - Adult MH Services
- ☐ 104 - Developmental Disabilities
- ☐ 105 - Medical Services
- ☐ 107 - Human Resources
- ☐ 108 - Business Office
- ☐ 109 - Medical Records
- ☐ 112 - MGMT INFO SERVICES MIS
- ☐ 116 - Maintenance
- ☐ 117 - CONSTITUENT SERVICES
- ☐ 131 - Utilization Management

You can type a number or a word from the unit name and a partial list will appear in which you can select the correct information without having to scroll through the entire list.

UNIT SELECTION FOR NETWORK PROVIDERS

Incident Information

Program Impacted:

INCIDENT ADDRESS

You must give the specific details of where, street, city as accurate as possible. For mobile teams, provide whatever information is available.

Incident Address:

LOCATION DETAILS

You must describe the exact location of where the incident occurred (ie/ the parking lot, inside a staff office, the reception area).

Location Details:

Incident Specifics:

Format | Font family | Font size | **B** | *I* | U | ABC | [List Icons] | [Link Icon] | ABC

[Cut Icon] [Copy Icon] [Paste Icon] [Undo Icon] [Redo Icon] [Text Color Icon] [Background Color Icon] [Link Icon] [Unlink Icon] [Image Icon] [Table Icon]

This is a three part section: 1. Description/explanation of what occurred.

2. Actions Taken.

3. Follow up|

Path: Words: 12

If you click these three lines, the text box will expand using your mouse to control size.

INCIDENT SPECIFICS

You must describe what occurred. There is no limit to the amount of information you can input in this area. Under the Words: 48 are three angled lines. If you click on those three lines the area will increase in size or decrease in size depending on whether you need more room or need to shrink the amount of space. You have formatting tools you can use.

SPECIAL NOTE

*While this text box is similar to Microsoft Word, the text coding is different. You can copy and paste text from Microsoft Word into the box, **BUT** please make sure you check the text because a few characters will change and affect the readability of the text. Also available is a dictionary to ensure your incident has correct spelling. You may also use special characters such as quotation marks.*

DO NOT copy tables or anything with special formats. The coding will cause the text to spread across the screen and not be contained in the box. Please do the following if you need to provide information that is in an excel file or any other program or if you have additional documents, email copies, reports, photos ***(No client photos please)*** or other materials



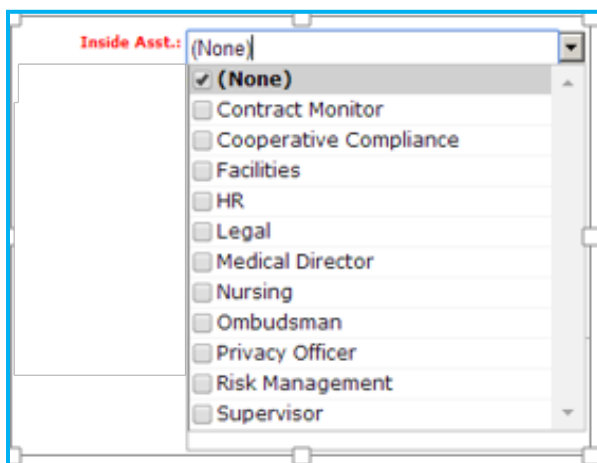
Report ☒

1 Attach: Choose File No file chosen 2 Attach

Step 1: Click Choose File and your computer file directory opens up and locate the file(s) you wish to attach.

Step 2: Click Attach and attach the files you wish to add to this Incident Report

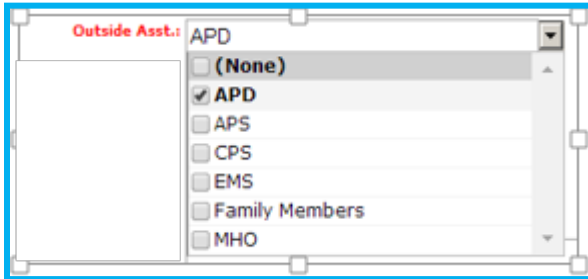
INSIDE ASSISTANCE You must select anyone assisted in this Incident. You may check more than one box in this drop-down.



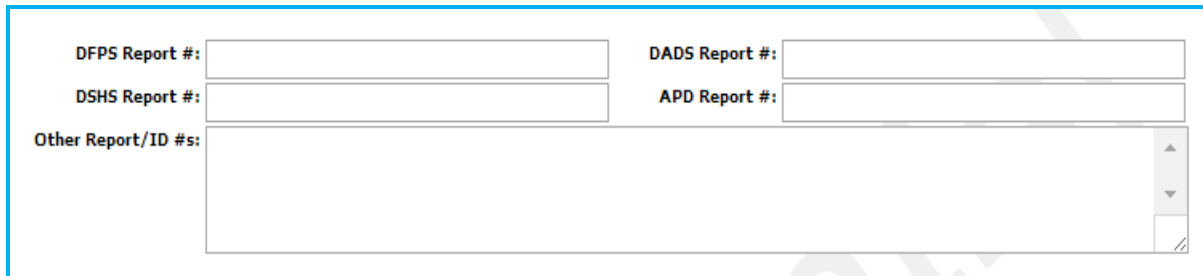
Inside Asst.: (None)

- ☒ (None)
- ☐ Contract Monitor
- ☐ Cooperative Compliance
- ☐ Facilities
- ☐ HR
- ☐ Legal
- ☐ Medical Director
- ☐ Nursing
- ☐ Ombudsman
- ☐ Privacy Officer
- ☐ Risk Management
- ☐ Supervisor

OUTSIDE ASSISTANCE You must select from the drop-down menu when outside assistance was required.



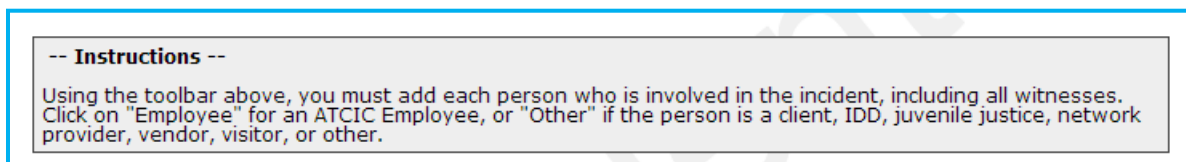
REPORT INFORMATION The Report Numbers given when filing reports with agencies are put here. This information is required for the Incident Report to be complete. If the information is missing you must contact the agency and request the information. Only the originator will be given this information.



***Note:** If the agency or person is not listed, please provide the information in the Other/Report/ID s*

INFORMATION FOR “OTHER”

This section contains additional information required for the Incident Report that you must provide when applicable.

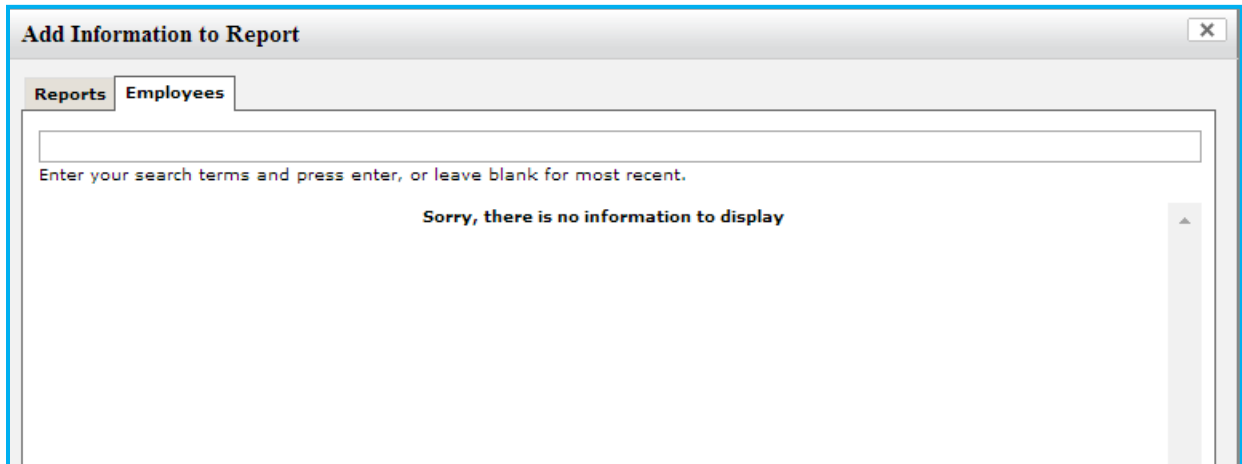



This bar is located at the top of the screen and allows you to click on Employee or Other.

“OTHER” INFORMATION When you click on CLIENT, you are required to click “OTHER” to input information about the Client when a client is involved.

EMPLOYEE You can click Employee when you have more than one Employee directly involved in the Incident to capture their information.

NARRATIVE You can use Narrative for witness statements to capture additional information about the Incident.



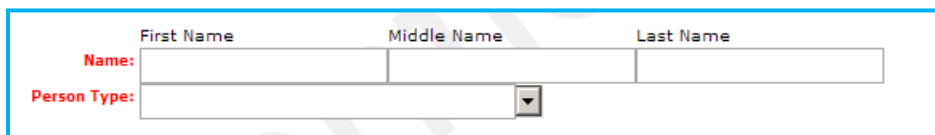
LINK Link allows you to link Employee Names or Reports to the Incident.

ATTACHMENTS

Attachments such as photos of accidents, conditions contributing to injuries such as spills or broken tile, property damage, emails with additional information. **DO NOT** attach photographs of clients to avoid any privacy issues that may result.



ADDITIONAL IMPORTANT CLIENT INFORMATION



Remember back when you selected **YES** for **Client**. This box appeared. Once you selected the Type of Incident involving a Client this additional information appears asking for the Person Type.

Person Type:

- ☐ ECI-Consumer
- ☒ **MH-Consumer**
- ☐ SA-Consumer
- ☐ IDD
- ☐ Intern
- ☐ Network Provider
- ☐ Vendor
- ☐ Visitor
- ☐ Other Person

When the Client is a client, this additional information is required for the ECI-Client, MH-Client, SA-Client and IDD.

Client #:

Organization Name:

Contact Phone:

Was 911 called ? ☐ No ☐ Yes

Did the person go to the E.R. ? ☐ No ☐ Yes

Please make sure to click the 911 and ER questions to complete the information about the client.

AUTOMATIC INFORMATION

You will notice at the end of the report information has been automatically filled out. When a person files an incident report, the information about the Employee automatically appears.

First Name	Middle Name	Last Name
Name: MELODY		MOSCAL
Employee #: 35642	Unit: 146 - Managed Care Operations	

DRAFT AND SAVE INCIDENT REPORTS

 **Save Report**
 **Save Draft**

DRAFTS The draft function of this program continuously saves your Incident report in the event you are called away and cannot complete the report in one sitting. Remember we do have a requirement that Incident Reports be filed within **24 hours of the occurrence**. The draft function also keeps track of incomplete incident reports. Please note that you do not have to open a new Incident Report if you are unable to complete the report in one sitting. Check your drafts

and locate the one that requires completion. **DO NOT** input a duplicate report, simply continue with the one you started.

7 Saved Drafts	
✖	2014-09-28 08:45:58
✖	2014-09-28 18:22:09
✖	2014-09-30 10:39:08
✖	2014-09-30 15:07:10
✖	2014-10-05 19:18:07
✖	2014-10-20 15:15:58
More...	

<The More Clicked>

Draft Reports		
Created	Size	
✖	2014-09-28 08:45:58	63839
✖	2014-09-28 18:22:09	79385
✖	2014-09-30 10:39:08	52904
✖	2014-09-30 15:07:10	76657
✖	2014-10-05 19:18:07	75551
✖	2014-10-20 15:15:58	75022
✖	2014-10-20 15:16:58	119550

You can also remove Drafts by clicking the red X, however, if you were required to fill out an Incident Report, only partially completed it and then delete it, you are in violation of Integral Care's requirement for filing Incident Reports and may be held accountable for any repercussions that occur as the result of your failure to file those Incident Reports.

SAVING YOUR REPORT

Your Incident Report is now complete.

When you Save Report a Spell Check automatically appears and questions words and spellings.

Spell Check - The following spelling errors have been found

Incorrect Word:

Suggestions:

Change To:

Occurrences:

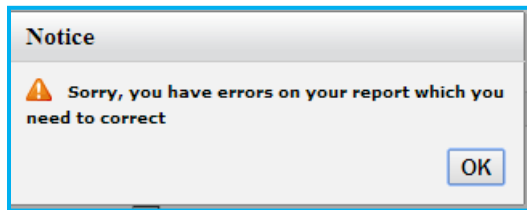
☒ Change
☒ Change All
☒ Add to Dictionary

☒ Ignore
☒ Ignore All
☒ Cancel

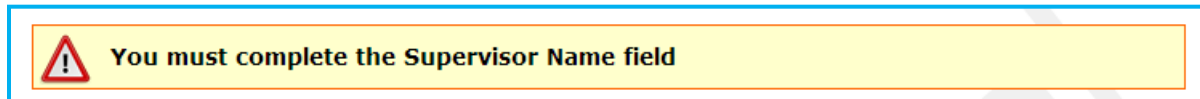
The Incident Report automatically performs a spell check when saving the Incident Report and allows you to ensure you have a correctly spelled document. You may also add words, but please verify the spelling before adding them to avoid misspells.

MISSING REQUIRED INFORMATION

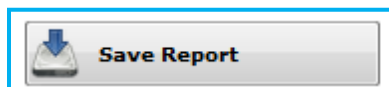
The following message will appear and you will need to click ok and review your report. When everything is complete clicking Save, the report will disappear.



An Example of an incomplete area of the incident report.



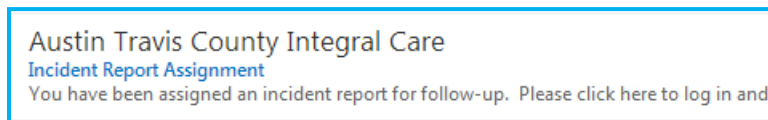
You must return to the Incident Report and enter the missing information. Once you click Save Report your report will disappear and you are finished.



INCIDENT REPORT FOLLOW UP

EMAIL NOTIFICATIONS

Once you file an Incident Report, depending on who has responsibility, an email will be sent to the staff member for follow up.



When you file an Incident Report, the report is assigned to your supervisor or an Integral Care staff member with specialized knowledge such as Medical Records, Ombudsman or Facilities. Depending on the severity of the Incident, the report may be addressed at an Executive level. The Quality Manager reviews Incident Reports as they are filed to ensure correct categorization, notifications and to take any additional actions with these reports.

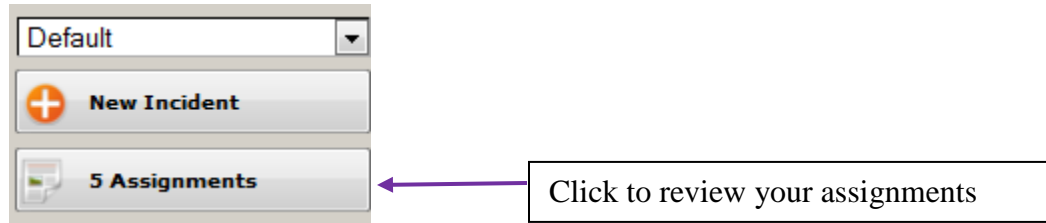
NOTE: The only exception where your Supervisor will not be notified is in the event you are reporting an alleged violation of corporate policy or HIPAA. To protect your identity, these Incident reports are forwarded to the Ombudsman for review, assignment and follow-up.

Follow-up actions occur and every month the Clinical Quality Committee meets to review each Incident Report, make recommendations to reassign, remain open or close. Incident Report Graphs are reviewed. Committee members review trends and information collected at the CQC is reported to the Quality Leadership Committee. Should any Quality Improvement Plans be recommended, the Quality Leadership Committee will request the Quality Improvement Plan to be assigned.

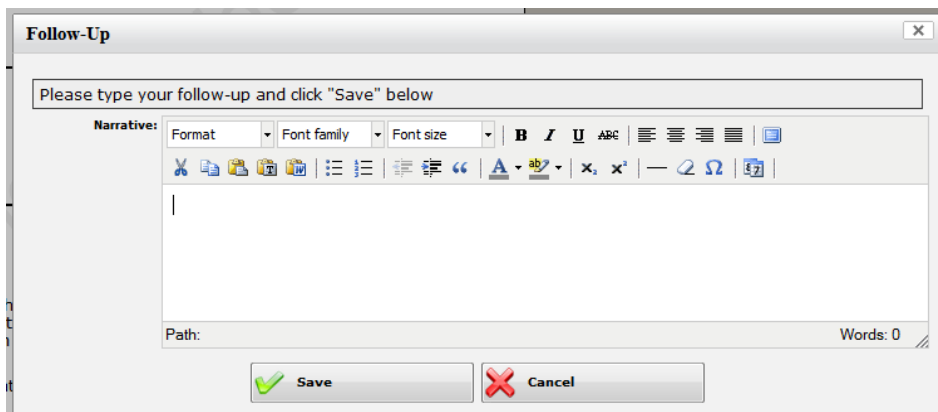
Incident Report Summary information is provided to various agencies funding Integral Care as a metric of performance. Investigators from the State of Texas request copies of Incident Reports to follow up on investigations generated by Incident Reports.

INCIDENT REPORT ASSIGNMENTS

When you are assigned follow up for Incident Reports, you must complete the following sequence of activities:

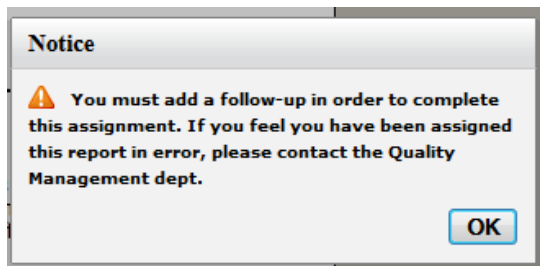


After you click the Assignments button, a very short summary will appear for each incident to be reviewed. You must double click on an assignment for the complete form to open.



A screenshot of a 'Follow-Up' form window. The title bar says 'Follow-Up'. Inside, there's a text area with the instruction 'Please type your follow-up and click "Save" below'. Below the text area is a rich text editor toolbar with options for Format, Font family, Font size, Bold, Italic, Underline, ABC, Bulleted list, Numbered list, Indent, Outdent, Link, and Unlink. The text area is empty. At the bottom, there's a 'Path:' label and a 'Words: 0' counter. At the very bottom are 'Save' and 'Cancel' buttons.

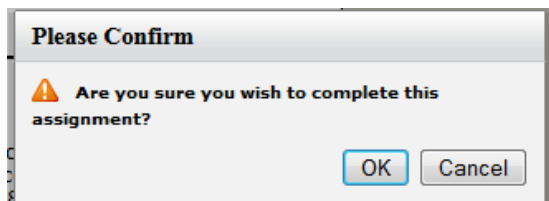
Add pertinent information or if none is needed simply write "reviewed".



If you try to Use Complete Assignment and not put any follow up this message appears.



You must click this Button to remove yourself from the QM Assigned List Report.



Once you click OK your report will disappear and your assignment number will decrease by one.

FREQUENTLY ASKED QUESTIONS

1. *Why am I required to fill out an Incident Report?* Incident reports allow Integral Care to analyze the risk to the agency, you, the client and any person impacted by the event or occurrence. Incident Reports provide evidence of our due diligence and protection.
2. *What is my log in and password?* There is no separate unique log in or password. Use your Integral Care login and password.
3. *I am a Network Provider how do I access the system?* You must contact Managed Care Database Administrator for the necessary password information.
4. *I am a Network Provider not staff but my program or unit does not appear on the Program Impacted list, what do I click?* The **Other/Not Listed** is to be checked.
5. *Why can't I see my Incident Report after I hit the submit button?* Once your report is submitted, access to the report ends. The report goes to the next level of responsibility depending on the incident type.
6. *Why can't I see other incident reports?* Incident reports are privileged and confidential and adhere to the HIPAA requirements for access.
7. *As a supervisor or manager how can I review trends occurring in my unit?* You can request a report from the Quality Management department.
8. *Should I identify my client or the client by name and case number?* Yes, this program is confidential and follows the HIPAA rules for access.
9. *I am unsure if a situation requires an incident report, should I file one?* Yes, the Quality Manager reviews all Incident Reports and if one is not considered a valid incident, will notify you and provide a reason for the invalidity.
10. *My incident doesn't appear to fit any of the categories or types of incidents, what do I do?* Please contact the Quality Database Administrator or Quality Manager for a response. While the list is comprehensive, other incidents can be added when required.
11. *What if my Incident Report is about my Supervisor or Manager, how can I be sure what I write is confidential and not seen by that staff person?* All allegations go directly to the Ombudsman for review and response. Your Supervisor nor Manager will not be emailed when your Incident Report is filed.
12. *How can I view overall trends for Incident Reports at Integral Care?* A monthly report is available on the Intranet on the QLT homepage.

This manual contains the basic information for the Incident Reporting System. Another handout titled "Let's File an Incident Report - Providers" gives an overview of how to file an incident report. This document is available through the Quality Management office.

QUESTIONS?

Please contact Melody Moscal at 512 440-4049 or Patrick Zavala at 512 440-4085.