

Center for Life Resources

Quality Management Plan

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## I. OVERVIEW

### A. Purpose

The QM (QM) Plan is a programmed, coordinated, comprehensive and continuous effort to measure and assess the performance of all care and services provided by or contracted by the Center for Life Resources (Center), a Mental Health and Mental Retardation Community Center. The goal is to use all available resources in striving to achieve optimal outcomes with continuous, incremental improvements in quality, which are consistently representative of a high standard of practice in the community.

The QM function must ensure that management, Board of Trustees and advisory groups have the data and information they need to make management decisions which support the provision of the highest quality of services. The QM process is a critical element in demonstrating best value, and balance between cost and quality in building the agency's network of providers. The QM process is vital to demonstrating that the Center is maintaining an objective relationship between internal providers and its contractors.

The QM Plan defines an organizational and functional structure and ensures a core set of performance indicators, identified by DSHS and DADS, the behavioral health care industry and the Center. Such indicators are monitored and reviewed for trends.

The purpose of the QM plan is:

- To provide a process for monitoring, evaluating and improving the quality and appropriateness of the service delivery system.
- To define quality for the Center and its providers from the perspective of stakeholders. This includes consumers, families and advocates in order to assure service quality, accountability, choice and best use of public resources.
- To describe the relationship between the Center's QM Plan and other management functions such as local planning, self-assessment processes, fiscal operations, human resources and information systems.
- To provide data-driven information to the Center for relevant planning and decision-making processes.
- To operationalize on-going efforts to achieve optimal outcomes related to DSHS and DADS standards and rules, managed care and behavioral healthcare principles and professional ethics and accreditation standards.

### B. Authority, Leadership, and Delegation of Responsibility

The development and implementation of a QM Program is a required element indicated in the Performance Contracts between the Texas Department of State Health Services (DSHS) and the Center and the Texas Department of Aging and Disability Services (DADS) and the Center. The QM Program derives its authority from the Executive Director who is hired and supervised by the governing body, the Board of Trustees. The Executive Director delegates the responsibility for the development, implementation, monitoring and evaluation of the QM Program to the QM Director and staff. The Center's Risk Management and UM Committees are integral components in the oversight process. The role of these two committees is to ensure implementation and integration of the various components of the QM Program. These committees are comprised of

QM staff, Licensed Professional Counselors, clinicians, program managers, Center Psychiatrist and other contributing clinicians. The weekly agendas are comprehensive, including routine, emergency, and anomalies relevant to the objectives of the QM Program. The implementation of the QM plan as Center Policy and Procedure is approved by the Executive Director.

Center operations are divided between the Mental Health Service Authority role and the Authority role for Individuals with Intellectual and Developmental Disabilities. All operations and services are under the direction of the Executive Director. The QM Department operates in the Administration branch under the supervision of the Executive Director.

### **C. Defining Quality**

The Center defines quality through an ongoing collaborative effort of internal customers, external customers and stakeholders through varied forums that afford each group an opportunity to describe and define quality. This process entails local planning initiatives and the local Planning and Network Advisory Committee. The concept of quality involves a dynamic attitude that is evident throughout all areas of the organization and has a direct impact on all consumers, parents, and stakeholders. The ultimate achievement of quality lies in meeting the highest expectations of the individuals served. QM integrates fundamental management techniques, existing improvement efforts, and technical tools in a planned disciplined approach, focused on continuous process and outcome improvement.

### **D. Mission, Vision and Value Statements**

The QM Plan is driven by, and supports, the vision and mission of the Center. These statements follow, respectively:

#### **Mission**

Provide a service delivery system that will ensure consumer outcomes based on choice and satisfaction.

#### **Vision**

Systemically create a timely, innovative, cost efficient, appropriate service delivery system, through a developed provider network, while sustaining an effective infrastructure to support the Center's role as the provider of last resort. Education, training, motivation, and constructive monitoring will be conducted to ensure consumer driven services that comply with departmental, state, and federal guidelines.

#### **Values**

The Center, philosophically, is committed to building community, the scope of which encompasses staff, private providers, consumers, family members, and all stakeholders. This commitment to infrastructure growth and community spirit requires that, administratively, the following values be embraced and practiced:

Dignity - We believe in the inherent worth of every individual.

Integrity - We believe that our personal and professional integrity is the basis of public trust.

Choice - We encourage the freedom to make choices.

Empowerment - We encourage personal decision-making.

Personal Growth - We believe in every individual's ability to continuously develop and achieve.

Relationships - We strive to build upon natural supports, developing each individual's connectedness to the community.

Innovations - We embrace an environment that encourages and rewards creativity and promotes leadership.

## II. ORGANIZATION, SERVICES AND FUNCTIONS

### A. Organization

The Center is organized as a “Mental Health Authority” with the Texas Department of State Health Services and as a “Mental Retardation Authority” with the Texas Department of Aging and Disability Services. A network of internal and external providers is available to provide services to both individuals with mental illness and Individuals with Intellectual and Developmental Disabilities. The network is developed through competitive and non-competitive procurement, open enrollment process, informal competitive solicitation, and formal competitive solicitation based on Chapter 412, Subchapter B of the Texas Administrative Code. This process enables the Center to give the consumers a choice in selecting providers.

### B. Center Services

The Center provides and manages a full array of services for every age group. Availability, accessibility, and a “user friendly” environment enhance the quality of services provided. Those services that are provided, and managed, include children’s services, adult mental health services, and services to Individuals with Intellectual and Developmental Disabilities.

#### 1. Children’s Services

- A. **Early Childhood Intervention** - ECI makes developmental screenings and assessments available to infants and young children (ages 0 through 2). Children with medical diagnoses that typically result in developmental delay qualify automatically. Qualifying children receive developmental services in their natural environment.

Services Provided:

- **Developmental Screenings**
- **Educational Services**
- **Nursing Services**
- **Occupational Therapy**
- **Parent/Infant Training**
- **Physical Therapy**
- **Service Coordination/Case Management**

Services Managed:

- **Nutrition Services** - The Center contracts with a registered dietician to provide dietetic services.
- **Speech Therapy** - The Center contracts with a licensed speech therapist to provide speech therapy.

- B. **Child and Adolescent Services** - The Center’s Child and Adolescent Services Program provides quality family-focused, community-based mental health services and supports to children ages 3 through 17 and their families. Services and supports are individualized based on family-identified strengths, needs, preferred services and supports, and outcomes.

Basic Services Provided:

- **Crisis Hotline** - A telephone hotline service, accredited by the American Association of Suicidology (AAS) is available 24 hours per day, 7 days

per week for information, support and referrals when a child is experiencing a psychiatric crisis.

- **Mobile Crisis Outreach Teams** - expedite a combination of crisis services that provide emergency care, urgent care, and crisis follow-up in the child, or adolescent's community location.
- **Screening** - A Qualified Mental Health Professional (QMHP) talks to a parent or a legally authorized representative and their child, either face-to-face or over the phone, to gather information to find out if there is a need for a detailed assessment.
- **Pre-Admission Assessment** - Diagnostic Eligibility Assessment: This face-to-face pre-admission assessment determines whether or not the child is eligible for services based on the definition of priority population and treatment needs. There is no waiting list for this service. The assessment is conducted by a QMHP and authorized by the UM Director, an LMHA. QMHP Assessment: The TRAG assessment is a face-to-face interview by a QMHP designed to obtain information from the child and family seeking services. This service must be provided to all children and their families who have been screened and who appear to have a need for services through the Center.
- **Routine Case Management** - The Center's case manager helps the child access medical, social, educational, and other appropriate services that will help the child achieve quality of life and community participation acceptable to the child and family. Routine Case Management is primarily a site-based service delivered face-to-face to the child or primary caregiver. Routine Case Management is intended for children who generally have few needs. This service is provided in Service Packages 1.1 and 1.2. The Case Manager identifies the immediate needs of the child and links the child with the appropriate community resources.
- **Intensive Case Management** - The Center's case manager helps the child access medical, social, educational, and other appropriate services that will help the child achieve quality of life and community participation acceptable to the child and family. Intensive Case Management is primarily a community-based service delivered face-to-face to the child and parent or primary caregiver. Intensive Case Management is intended for children who have multiple, complex needs. Wraparound Planning is an evidence-based model selected for RDM, is used to develop the Case Management Plan. This service is provided in Service Packages 2.1, 2.2, 2.3, 2.4 and 3.
- **Counseling** - Individual, group and/or family counseling is provided by the Center's LPHA to resolve problems that result from the consumer's mental, emotional or behavioral disorder. Cognitive-Behavioral Therapy (CBT) is included in Service Packages 1.2 and 2.3 for children with internalizing disorders (anxiety and depression); CBT uses the evidence-based models selected for RDM.
- **Respite Services** - Respite is provided as a temporary, short-term periodic relief of primary caregivers. The Center can provide either program-based or community-based respite for children. Respite services can be planned

ahead of time or provided in a crisis. Respite may be purchased with Flexible Community Support funds in Service Packages 2.1, 2.2, 2.3, and 2.4.

- **Medication-related Services** - The Center provides Medication-related Services by a licensed nurse or other qualified and properly trained persons working under the supervision of a physician or registered nurse, as proved by state law, for any child prescribed psychiatric medication. These services include medication administration, medication monitoring, pharmacological management, and provision of medication.
- **Crisis Intervention Services** - Interventions provided in response to a crisis in order to reduce symptoms of sever and persistent mental illness and to prevent admission of an individual or consumer to a more restrictive environment.
- **Skills Training and Development Services** - The Center provides training to a consumer and the primary caregiver that addresses the serious emotional disturbance and symptom-related problems that interfere with the individual's functions, provides opportunities for the individual to acquire and improve skills needed to function as appropriately and independently as possible in the community, and facilitates the individual's community integration and increases his or her community tenure. This service includes treatment planning to facilitate resiliency.
- **Family Case Management** - Activities to assist the consumer's family members gain and coordinate access to necessary care and services appropriate to the family members' needs.
- **Family Training** - This service is taught face-to-face. Family Training is taught using the evidence-based Parent Skills Training models selected for RDM. This service is included in Service Packages 1.1, 2.1, 2.2 and 3 for parents or primary caregivers of children with externalizing disorders.
- **Family Partner** - Family Partners are the experienced parents of children with serious emotional disturbances who provide peer mentoring and support to the parents or primary caregivers of children in services who are receiving services in Service Packages 2.1,2.2,2.3,2.4 and 3.
- **Parent Support Group** - Routinely scheduled support and informational meetings for the consumers' primary caregivers.
- **Flexible Community Supports** - Non-clinical supports that assist in community integration, reduce symptomatology, and maintain quality of life and family integration for children.
- **Intensive Crisis Residential** - 23-hour, usually short-term residential services provided to a client demonstrating a psychiatric crisis that cannot be stabilized in a less restrictive setting.

Services Managed:

- **In-Patient Services** - The Center currently manages the contract with River Crest Hospital to provide psychiatric crisis services for children.
2. **Adult Mental Health Services** - The priority population for adult mental health services consists of adults who have severe and persistent mental illnesses such as schizophrenia, major depression, and bipolar disorder. Service determination is

based on the level of functioning of the individual, the need of the individual, and the availability of resources.

Services Provided:

- **Crisis Hotline** - A telephone hotline service, accredited by the American Association of Suicidology (AAS) is available 24 hours per day, 7 days per week for information, support and referrals when a child is experiencing a psychiatric crisis.
- **Mobile Crisis Outreach Teams** - expedite a combination of crisis services that provide emergency care, urgent care, and crisis follow-up in the adult's community location.
- **Screening** - A Qualified Mental Health Professional (QMHP) from the Center talks to an individual or a legally authorized Representative, either face-to-face or over the phone, to gather information to find out if there is a need for a detailed assessment.
- **Pre-Admission Assessment - Diagnostic Eligibility Assessment:** This face-to-face pre-admission assessment determines whether or not the individual is eligible for services based on the definition of priority population and treatment needs. There is no waiting list for this service. The assessment is conducted by a QMHP and authorized by the UM Director, an LMHA. QMHP Assessment: This assessment is a face-to-face interview by a QMHP designed to obtain information from the individual and family seeking services. This service must be provided to all children and their families who have been screened and who appear to have a need for services through the Center.
- **Routine Case Management** - The Case Manager assists the consumer in accessing medical, social, educational, and other appropriate services that will help the consumer achieve a quality of life and community participation acceptable to him or her. Routine Case Management activities must be provided to consumers regardless of age and in accordance to TAC 412 I. The Center must be the provider of this service.
- **Respite Services** - Respite is provided as a temporary, short-term periodic relief of primary caregivers. The Center provides program-based respite. Respite services can be planned ahead of time or provided in a crisis.
- **Medication-related Services** - The Center provides Medication-related Services by a licensed nurse or other qualified and properly trained persons working under the supervision of a physician or registered nurse, as proved by state law, for any consumer prescribed medication. These services include medication administration, medication monitoring, pharmacological management, and provision of medication.
- **Rehabilitation Services - Mental Health Rehabilitation Services:** These include medication training, psychosocial rehabilitation and skill training and development. Rehabilitative Counseling and Psychotherapy: Individual or group counseling is provided by the Center's LPHA to resolve problems that result from the consumer's mental, emotional or behavioral disorder. This service is provided in vivo or on-site.
- **Best Practices - Supported Employment:** The Center's Supported Employment program provides individualized services to assist consumers

in choosing, obtaining, and maintaining employment. Supported Employment includes intensive and maintenance levels of services. Supported Housing: Supported Housing provides individualized services to assist people in choosing, getting and maintaining regular, integrated housing. Required elements include housing assistance, services and supports, and regular housing. Assertive Community Treatment Alternative- The ACT Alternative program at the Center has been approved by DSHS and provides Intensive Case Management (ICM) services with a team approach. The ICM team maintains 24-hour responsibility and availability for covering and managing crisis and emergencies for ACT Alternative consumers.

- **Crisis Respite** - Crisis Respite is provided for temporary intervention and stabilization of individual's in a state of crisis. .24 hour, usually short-term respite services are provided to a client demonstrating a psychiatric crisis that cannot be stabilized in a less restrictive setting.
  - **COPSD Services** - Through funding by the Texas Commission on Alcohol and Drug Abuse (TCADA); the Center identifies, develops, and implements effective and efficient methods of engagement, assessment, and treatment models for persons with co-occurring substance use and mental illness disorders (COPSD).
  - **Prevention Services** - Through funding by the Department of State Health Services, Substance Abuse Division, the Center provides an indicative prevention program using an evidenced based curriculum called Leadership and Resiliency. The prevention program provides services in Brown, Coleman, Comanche, and Eastland Counties. These services consist of individual classroom time at local schools, alternative activities in the community after school and on weekends, and five experiential challenge trips over the course of the year.
  - **In-Patient Services** - Contract Services are provided by private hospitals giving consumers a choice when demonstrating the capacity to do so.
3. Adult Services for Individuals with Intellectual and Developmental Disabilities:  
Services Provided:
- **Screening** - This face-to-face or telephone contact service is provided by the Center to determine a need for service.
  - **Eligibility Determination** - This service determines if an individual has intellectual and developmental disabilities or meets the criteria for definition of priority population.
  - **Service Coordination** - The Center's service coordinator coordinates and monitors services to ensure the individual's needs is addressed across time and programs. In addition, the service coordinator assists with consultation and coordination when changes in services are needed. Service Coordination includes: 1) Basic Service Coordination; 2) Continuity of Services-State Facilities; 3) Continuity of Services-Medicaid Programs; 4) Service Authorization and Monitoring and 5) Service Coordination, Texas Home Living Program.

- **Respite Services** - Respite is provided as a temporary, short-term periodic relief of primary caregivers. This support service is provided in the home or at another location.
- **Supported Employment** - The Center's Supported Employment program provides temporary employment assistance to consumers who are seeking community employment and who are not receiving Vocational Training. This program also provides support services to enable an individual to maintain employment with an employer.
- **Vocational Training** - Janie Clements Industries provides day training services to consumers in a workshop environment as well as a road crew to help them obtain and retain employment. Specific services are tailored to fit each individual's needs and abilities.
- **Day Habilitation** - The Center's Alternative Day Program (ADP) Is a companion program to the vocational program and accommodates the needs of those who are not ready to participate in vocational training. These services provide the training needed to help the individual participate in the community.
- **ICF/MR Residential Services** - An individual must be eligible for ICF/MR services. The Center for Life Resources owns and operates 3 Intermediate Care Facilities for Persons with MR (intellectual and developmental disabilities) (ICF-MR) units. These facilities provide residential and habilitative services, skills training, and adjunctive therapies with 24-hour supervision and coordination of the individual program plan. Thirty-two individuals with intellectual and developmental disabilities or a related condition currently reside in the ICF-MR units.
- **Home and Community-based Services** - The Center's HCS Program provides services to individuals with intellectual and developmental disabilities who either live with their family, in their own home, in a foster/companion care setting or in a residence with no more than four individuals who receive services. The HCS Program provides services to meet the individual's needs so that he/she can maintain him/herself in the community and have opportunities to participate as a citizen to the maximum extent possible. In the HCS Program, individuals pay for their room and board either with their SSI check or other personal resources. Thirty-five individuals currently receive HCS services through the Center for Life Resources.
- **Texas Home Living Program** - The TxHmL Program provides essential services and supports so that Texans with intellectual and developmental disabilities can continue to live with their families or in their own homes in the community. TxHmL offers a number of services to support people who live in their own homes or with their families. TxHmL services are intended to supplement instead of replace the services and supports a person may receive from other programs, such as the Texas Health Steps Program, or from natural supports such as his or her family, neighbors, or community organizations. TxHmL Program services are limited to a yearly cost of \$10,000 per participant.

- **In Home & Family Support Services** - Program funds are used to purchase items or services that would not be required if the person did not have a disability; are disbursed upon fund availability; and is not an entitlement or income supplement. There is a limit of \$2,500 per year, with the amount granted depending on the individual's needs, income, and application of a sliding fee scale. This is a resource of last resort.

Services Managed:

- **Respite Services** - The Center currently arranges for Respite Services on an on-going basis.
- **Foster Care** - The Center contracts with Foster Care Providers through the HCS Program.
- **Psychological Services** - The Center contracts with a private provider to provide psychological evaluations, assessments, endorsements, and behavioral management programs.
- **Dietetic Services** - The Center contracts with a registered dietician to provide dietetic services for the ICF-MR programs.

### **C. QM Program Structure**

The Structure of the QM Program can be described organizationally and functionally. Although the QM plan is primarily the responsibility of the QM department, the QM process does not occur solely in this department but occurs throughout all levels and departments of the agency as an ongoing and collaborative effort.

The QM Department performs those functions, which support and facilitate the development, implementation, monitoring and evaluation of the QM Plan. The Department's role is not to be the sole or primary source of performance improvement activities. Rather, its objective is to involve and provide support, expertise and guidance to administrative, management and provider staff in performance improvement activities. The Risk Management and Utilization Committees and their respective members provide assistance with plans of improvement to meet the Performance Contract with DSHS; oversight of UM reviews and activities; performing and ensuring compliance with internal audit/self assessment activities; participating in the MR outcomes self-assessment; providing corporate compliance training to new and tenured staff; and providing technical and other assistance to Center service providers as well as other programs and departments as needed.

The QM Director provides oversight for local planning and the day-to-day operations of the QM program, directs Local Planning initiatives and serves as Contract Manager. The QM Program Specialist serves in multiple roles. Support for all QM program initiatives, including Policy and Procedures, provider contracts, clinical staff monitoring, QMRP specialist to address program needs for Individuals with Intellectual and Developmental Disabilities, and works in conjunction with the CEO's office to ensure performance contract compliance. The Center's Medicaid Compliance Officer provides oversight to Medicaid Administrative Claiming process and conducts audits such as encounter/data verification criteria audits, corporate compliance audits and fidelity reviews of RDM Billing. The Data Coordinator is responsible for Medicaid and Third Party Billing and works with the Administrative Tech in data management activities including Business Objects Reports and other performance reports. The Consumer Rights/Safety

Officer is responsible for consumer rights, abuse, and neglect, appeals, safety issues, and training for internal and external providers.

The QM Department is comprised of the following positions:

- QM Director
- QM Program Specialist
- Adjunct roles to support QM objectives include Medicaid Compliance Officer, Data Coordinator, Administrative Tech, Utilization Manager, and Consumer Rights and Safety Officer.

The QM Department is directly accountable to the Executive Director.

The QM Department is responsible for oversight functions:

- Local Service Area Plan, QM Plan, Local Planning and Network Development Plan, Crisis Redesign Plan, and the UM Plan;
- PNAC meetings and functions;
- Utilization Management;
- Performance Contract Compliance;
- Texas Administrative Codes;
- Grants;
- Contracts Management for external providers of service;
- Center Policy & Procedure;
- Consumer Rights & Complaint Program;
- Data management and analysis activities;
- Center audits and reviews;
- Abuse and Neglect investigation process;
- Appeals and notification process;
- Training of internal and external providers; and
- Risk and Safety Management.

#### **D. QM Committees**

The advent of the Business Objects Report, the need to take a more global approach to risk factors, Resiliency and Disease Management (RDM) Guidelines, Crisis Redesign, Local Planning and Network Development, and the evolving Authority Role for the two populations served necessitated two distinct committees. The Total Quality Management Committee (TQMC) became the **Risk Management Committee** and the **UM Committee** component was expanded and specialized to better focus on the clinical needs of consumers.

Committee integration provides critical oversight of the:

- Processes that monitor and improve the quality of care across all network services
- Analysis of ongoing measurements of organizational processes to improve the LA's authority functions.
- Analysis of ongoing measurements of organizational outcomes
- Analysis of ongoing measurement of service processes
- Analysis of ongoing measurement of service outcomes
- Analysis of ongoing measurements to assess improvement of consumer rights, reduction of abuse, neglect, exploitation and existing protections.
- Analysis of ongoing measurements to determine service capacity and service accessibility.
- Analysis of ongoing measurements to assess and improve data accuracy and subsequent reporting processes.

- Identification of trends and patterns
- Identification and prioritization of performance improvement opportunities
- Formulation and implementation of actions plans for improvement
- Monitoring plans of improvement for effectiveness
- Oversight of the annual network wide self assessment

The **Risk Management Committee** is responsible for risk prevention and intervention, including but not limited to any risk event impacting the consumer and/or staff resulting from treatment, training, or service operations problems. Risk Management is comprised of the QM Department, Consumer Safety and Rights Officer, Human Resources Director, Information Systems Staff, Crisis Director, MH Clinical Director, Intake Director for Individuals with Intellectual and Developmental Disabilities, Medicaid Compliance Officer, Data Verification Coordinators, and any responsible staff member with pertinent knowledge of a risk event. The Committee meets weekly to review the activity for the past seven days with regards to the following areas of responsibility. Functions of the QM Committee include:

- Medicaid Inquiry
- Workers' Compensation
- Incident Reports
- Safety Issues-New Business
- Rights/Abuse
- Consumer Complaints
- Infection Control
- MR Data Elements-New Business
- Behavioral Plans
- Payee Services
- Productivity Reports
- Timeliness Reports
- Data Verification
- State Performance Contract Monitoring
- Provider Contracts Monitoring-New Business-AN/Q
- Management Risk Assessment
- Bed Days
- Policy and Procedure Action
- Credentialing
- Service Barriers

The **UM Committee** monitors the utilization of the Center's clinical resources to assist the promotion, maintenance and availability of high quality care in conjunction with effective and efficient utilization of resources. The utilization core membership consists of the Center Physician, UM staff representative, QM staff representative, Consumer and Safety Rights Officer and a fiscal/financial services representative. Participation by others may be indicated based on the nature of issues under consideration. This could include clinical/professional staff, contracts management staff, network development staff, information systems staff, medical records staff, mental health professionals and intake and eligibility staff. The UM Committee meets weekly to conduct clinical reviews, review admissions, monitor and review hospital, crisis and Respite recidivism, TRAG questions, services targets, and waiting lists. Objectives of the UM Team includes:

- Clinical Overrides
- High Risk Alerts
- Client Deaths
- Suicide Attempts
- Case Reviews
- Appeals
- Crisis Outliers
- Gate keeping
- Access/Waiting Lists
- Discharge Reports
- Productivity (Run TRAG Productivity Report by service package)
- Capacity
- Substance Abuse Programs Report
- Medication errors/Exceptions
- Medication Request for Weekly/Monthly Refills
- Hospitalizations/Bed Days/Continuity
- Behavior Plan Development
- Financial Issues

The Center selected the simplified option to have one single advisory committee. **The Planning and Network Advisory Committee** (PNAC) has twenty five members and nineteen of these members are either parents or clients. The QM Department coordinates the PNAC meetings. The committee acts as a community liaison, meets quarterly for input, and formulates recommendations to the Center's Governance Board. The Governance Board entertains the review as a routine agenda item. In addition, participation provides a mechanism for input and participation from consumers, families and other stakeholders in the planning and evaluation of services, thus involving the Center's stakeholders in the QM process. The Advisory committee is linked directly to the QM's Local Planning process.

Perspectives, issues, and outcomes include, but are not limited to the following:

- Observations of budget reduction implications
- Knowledge of unfulfilled needs related to client care in the communities
- Noticeable trends that may impact client care
- Identification of barriers to services or access issues
- Suggestions related to quality of care

- Knowledge of any client care deficiencies, client rights or abuse

Staff members are very involved in the community and many serve on various boards to include organizations such as ARK Domestic Violence Shelter, Brown County United Way, Brownwood Chamber of Commerce, Brown County Association for Retarded Citizens, the American Red Cross and private healthcare providers. Participation allows staff frequent opportunities to share information and solicit input regarding services. The Center's participation in the local Community Collaborative, Community Resource Coordination Group-Adult, and Community Resource Coordination Group-Children provides additional insight to assist in identifying consumers and providers.

### **III. QM METHODOLOGY**

#### **A. Design of the Quality Improvement Program**

Quality Improvement processes are designed consistent with the center's mission, vision, values, plans, and focus on stakeholders needs. The Center's QM Plan monitors key indicators in identified areas. The center will identify and develop, through collaboration with its stakeholders, specific quality indicators. These reflect the unique cultural, linguistic, demographic, and regulatory requirements of its catchment area.

#### **B. Data Collection and Measurement**

Data is gathered from databases such as the CARE (Consumer Assignment Registration) System and its many subsystems (Texas Home Living billing system, Webcare, Consumer Abuse and Neglect System, Home and Community Based Services System, Intermediate Care Facilities billing system and the In-Home and Family Support System) and the Anasazi software database used by The Center. Additionally, information is received from the Business Objects Reports facilitated by DSHS and DADS, internal and external program audits (Intermediate Care Facilities, Texas Home Living, Home and Community Based Services and Early Childhood Intervention). Data from chart audits, observations, committee meeting reports, budget reports and reports from The Center's Incident/Injury reporting system are also utilized. The annual facility site safety inspections and environmental/Americans with Disabilities Act inspections provide valuable data on the safety and accessibility of our facilities. Satisfaction data is gathered from consumer surveys, interaction with community leaders and complaints to the Consumer Rights and Safety Officer. In addition to data that is developed for internal use, The Center participated in the Texas Council's Balanced Scorecard project. Financial and service information were collected from all community centers to enable the establishment of benchmarks.

Methods for measuring and assessing service processes and outcomes will be formalized in FY08-FY09 through self-assessment activities conducted for both Mental Health and Services for Individuals with Intellectual and Developmental Disabilities. Information on compliance with the Performance Contract, service delivery, assessment completion rates, appropriateness of assessments, length of stay in the community, readmissions to state hospitals, discharge reasons, and encounter information are reviewed for adults and children receiving Mental Health Services. Information is also reviewed regarding improvement in school functioning for children receiving services. For consumers receiving services for Individuals with Intellectual and Developmental Disabilities the interviews/surveys conducted serve as measures for evaluating the processes and reaching positive outcomes.

The data collected will be utilized to develop the comprehensive center-wide risk self-assessment.

### **C. Assessment of Data**

Weekly data reviews are analyzed to effectively assess the organization's performance and to determine the following:

- Strengths and Weaknesses
- Outliers
- Effectiveness of designed process
- Level of performance and stability of important existing processes
- Opportunity for Improvement

### **D. Monitoring**

All of the services provided by the Center are monitored through the Utilization Management and Risk Management Committees.

The following services are available for children age birth to the third birthday:

- Early Childhood Intervention

The following services are available for children and adolescents:

- Crisis Hotline
- Screening
- Pre-Admission Assessment
- Routine Case Management
- Intensive Case Management
- Counseling
- Respite Services
- Pharmacological Management
- Provision of Medication
- Medication Training
- Crisis Intervention Services
- Skills Training
- Family Case Management
- Family Training
- Family Partner
- Parent Support Group
- Flexible Community Supports
- Intensive Crisis Residential

The following services are available for adults with a mental health diagnosis:

- Crisis Hotline
- Screening
- Pre-Admission Assessment
- Routine Case Management
- Respite Services
- Pharmacological Management
- Provision of Medication
- Psychiatric Evaluation
- Medication Training

- Psychosocial Rehabilitative Services
- Rehabilitative Counseling and Psychotherapy
- Skills Training
- Supported Employment
- Supported Housing
- ACT Alternative
- Intensive Crisis Residential
- Substance Abuse, Prevention Services, and COPSD Services

The following services are available for adults with a diagnosis of Intellectual and Developmental Disability:

- Screening
- Eligibility Determination
- Service Coordination
- Respite
- Supported Employment
- Vocational Training
- Day Habilitation
- ICF/MR Residential Services
- Home and Community-based Services
- Texas Home Living
- In-Home and Family Support

Other services should be monitored quarterly due to critical importance. These services include:

- Continuity and Community Aftercare
- Medicaid Review
- Utilization Review
- New Generation Medications
- TIMA

The following services are managed by the Center:

- Dietetic (Nutrition) Services (ECI and ICF-MR)
- Speech Therapy (ECI)
- In-Patient Services (C&A and MH Adults)
- Respite Services (HCS)
- Foster Care (HCS)
- Psychological Services (MR)

### **E. Findings, Reporting and Trending**

The results of the analyses are to be reported to the areas, persons, or systems from which the information was gathered. The reports, including any identified trends are sent to the supervisors, program managers, the Executive Director, Consumer Rights and Safety Officer, and other pertinent staff. Corrective measures and improvements are monitored through ongoing evaluations of the systems that the Center has in place while maintaining those that are in compliance.

Data is analyzed weekly, monthly and quarterly in differing formats to identify trends. The data guides the development of plans of improvement and over time, will reduce negative trends. Additionally, this planning process lends itself to identifying best practices. Best practices are those clinical, programmatic and/or administrative processes, protocols, or practices that have

resulted in the apparent and incremental improvement in clinical and program outcomes, consistently and predictably. These identified best practices will serve as benchmarks for leading the Center in the continual quality improvement planning process.

## **F. Outcomes**

The QM Department in conjunction with respective Program Managers, the Risk Management Committee, and Utilization Committee will monitor compliance, appropriateness of services, health and safety, incident reporting, rights, and quality of care issues.

Performance measures will encompass:

### **MRA**

- Monitoring adherence to a designated staff for roles exclusive to the MRA.
- Less restrictive setting
- Time line enrollments for HCS
- Time Line requirements for Permanency Plans
- Time line requirements for completed Permanency Plans
- Time line for placement of children/adolescents from a SMRF or ICF-MR
- Appropriate inclusion of Respite Services in Person Directed Plans.

### **MHA**

- Timeliness in response to all crisis calls
- Greater timeliness with documentation of services provided
- Clear documentation of appropriate credentialing of staff members rendering services.
- More effective process to coordinate transportation issues with law enforcement.
- Monitoring of processes to ensure service compliance with Fidelity Measures.
- Implementation of data collection processes to address discrepancies that resulted in sanctions
- Monitoring of compliance with corrective actions regarding the Center's respite program
- Development of a more effective process to monitor timeliness on Performance Contract submissions.

Outcome Targets of 95% or greater are required.

The Center will strive to achieve the identified goals by implementing outcomes predicated on management activities. Outcome management activities use information and knowledge gained from outcome monitoring to achieve optimal results for individuals through improved clinical decision-making and service delivery. Outcome management is the result of the performance (or non-performance) of a function or process (es). Qualitative outcomes include organizational outcomes (e.g., evaluation of strategic goals), system outcomes (e.g., LBB measures), clinical outcomes (e.g., level of care), functional outcomes (e.g., TRAG) and personal outcomes (e.g., Productivity and Timeliness Reports.) An outcome indicator assesses what does or does not happen as the result of a function or process.

## **G. Improvement**

Based on the indicators, targets, and standards outlined in the QM plan, performance that does not meet target criteria must be addressed via a plan of improvement that is submitted to the respective QM committees. Subsequent performance relating to the deficient indicator will then be evaluated to determine the effectiveness of each plan of improvement. A standardized format for the development and reporting of any required written plan of improvement will individually include the following areas:

- Date (issue) Initiated
- Problem identification/improvement opportunity/description
- Corrective action/method of resolution
- Responsible staff
- Status/Measure
- Completion Date

Deficiencies identified through other assessment processes, by the QM Department will be prioritized for resolution. Each program is responsible for identifying and prioritizing deficiencies as they apply to their respective entity. These deficiencies will also be prioritized and become part of our local plan of improvement.

The Center's approach to improving its performance involves six essential steps:

- Designing processes
- Monitoring performance through data collection
- Analyzing current performance
- Improving and sustaining improved performance
- Monitoring the improved performance
- Trending and reporting

The Center's system for design and performance measurement, analysis, trending, reporting, and improvement is based on a continuous quality improvement model.

## **IV. QM PROCESS**

### **1. Consumer Satisfaction**

Activity - The QM Department facilitates the surveys for the Center and monitors the annual satisfaction surveys by all providers.

- The annual departmental survey provides objective information in a non-threatening convenient format that prevents repetitious internal surveys.
- External Provider Survey-The Contracts Management Department surveys requests staff feedback on each of the external providers. The survey results are used as one component in the annual evaluation process of all external providers to determine best value and contract renewal.
- Organizational Self-Assessment-A self-assessment is conducted at three-year intervals by the QM department to evaluate organizational strength, based on local planning initiatives, management functions, fiscal operations, and information services.
- Community Collaborative Comprehensive Survey-The Center partners with various local agencies to conduct regional surveys to address issues relating to basic needs.

Measures/Tools - QM provides support services to the Department to facilitate satisfaction surveys.

Documentation/Routing - On as-needed basis assistance is available to locate addresses and contact information on individuals that are selected for survey.

Results - Upon receipt of the survey responses, QM distributes survey data and establishes guidelines for provider feedback. Corrective action based on the development of a written plan of improvement to address the identified needs is required in the process.

## 2. Risk Management

Activity - Risk management is undertaken to minimize risk events occurring with consumer and/or staff resulting from treatment, training, or service operations problems. Risk Management addresses all concerns related to:

- Medicaid Inquiry
- Workers' Compensation
- Incident Reports
- Safety Issues
- Rights/Abuse
- Consumer Complaints
- Infection Control
- System Alert
- MR Data Elements
- Behavioral Plans
- Payee Services
- Productivity Reports
- Timeliness Reports
- Business Objects Reports
- Data Verification
- State Performance Contract Monitoring
- Billing
- CARE
- Encounter Data
- Provider Contracts Monitoring
- Management Risk Assessment
- Bed Days
- Policy and Procedure Action
- Credentialing
- Service Barriers

Measures/Tools - Risk issues are addressed immediately. A system of reporting incidents and accidents is implemented throughout the Center for staff and contract providers.

Documentation/Routing - Trends identified through reports are discussed and appropriate action taken. The Safety Officer catalogs incident reports and discusses problem areas in the Risk Management Committee meeting on an ongoing basis.

Results - The Risk Management Committee, through program managers, will track correction of identified problems. Follow-up reports will be provided to the CEO as requested.

## 3. Internal Provider and Services Reviews

Activity - A self-assessment review of each internal provider will be conducted annually. QM staff, in cooperation with the respective Program Manager, will facilitate the procedures.

Measures/Tools - Elements of the internal review include an audit of safety and therapeutic environment, current standards, applicable Center policies and procedures, the most recent program review, satisfaction survey results, current mission and vision statements, and the presence of desired outcomes. An on-site inspection is conducted.

Documentation/Routing - A summary evaluation report will be submitted to the Program Manager and the CEO. The report includes identified trends and problem areas. When a corrective action plan is required, it is submitted to QM and should outline the Program Manager's plan to correct identified deficiencies within a specified time.

Results - The QM Department monitors follow-up of any needed corrective action plan, within specified time frames, with the assistance of the Program Manager. The review will solicit outcome data to facilitate pro-active improvements in the quality of care provided consumers. Consumer satisfaction and outcome data will dictate future program development. The QM Director will inform the Program Manager and the CEO concerning the progress and/or completion of the corrections. Files of internal program reviews and corrections are maintained in the QM department. The QM Director will provide the CEO with an annual report in August reflecting report results and corrective measures. This information will comprise the annual report the CEO submits to the Board of Directors each fiscal year. The QM Director communicates identified training needs to Staff Development. Staff Development addresses the need and reports the action taken to QM.

#### 4. External Provider Reviews/Contracts Monitoring

Activity - External provider reviews of the Center's contract services are completed on an annual basis.

Measures/Tools - The QM Contracts Manager has developed a quarterly contractor report card for appropriate staff to review. Expenditures, insurance, training, credentialing, timeliness of service entry, and productivity are the areas that are used to identify contract compliance or non-compliance. Annually, the QM Contracts Manager circulates evaluation forms to the appropriate Center staff requesting opinions concerning the quality of services of the external providers that they have utilized during the year. After review, the QM Contracts Manager summarizes and distributes the evaluations to the staff and the external contract provider. The quarterly and annual information are used to determine best value and contract renewal.

Documentation/Routing - Results of contract monitoring activities are documented and summarized with recommendations for correcting deficiencies and expected completion dates.

Results - QM monitors any required follow-up with the assistance of the external provider, Center's Program Managers, and/or CEO, as needed. Contract revision needs are identified in the review document. Contract revisions are made prior to the renewal of contracts for the next fiscal year. Each contract specifies the terms whereby the contract can be terminated at the discretion of either the external provider or the Center.

#### 5. Utilization Management

Activity - The UM Manager monitors compliance with the Center's UM Plan (See complete Local Plan for details).

Measures/Tools - To facilitate management of timely and appropriate service utilization, the Center coordinates the flow of information between the crisis response system, single point of entry and the UM program:

- Access to UM staff is consistent throughout each business day. The UM Manager meets with Crisis staff daily to review and authorize crisis services from the night before.
- UM staff are available throughout the business day to review clinical information needed to make authorization decisions.
- For potential adverse determination decisions, psychiatric consultation is available twenty-four hours a day through the crisis response system.
- The Center will provide a twenty-four hours a day seven days a week telephone answering system and FAX machine through which authorization request messages may be received. If the provider has any concerns about the case (i.e., that any of the admission criteria are not

met, the assigned LOC is incorrect, or the consumer refuses some or all the services) the provider must contact UM to document and discuss the case.

Documentation/Routing - Upon receipt of all required information, requests for authorization of services are reviewed by the Center's UM staff in accordance with the following standards:

#### Initial Determination

- Determination made within two business days.
- Notification to provider of determination by Anasazi computer system or via fax or telephone within two business days of making the determination.

#### Concurrent Review

- Determination made within one business day.
- Notification to provider of determination by Anasazi computer system, telephone or facsimile within two business days of making the determination.

#### Retrospective Review

- Determination made within 30 business days.
- Written notification to provider of denial determinations within five business days of making the determination.

Results - Information about the right of persons requesting or receiving services to express concerns or dissatisfaction or appeal an adverse determination decision will be posted at all service sites and included in the Consumer Rights Handbook. The information will include an easily understood explanation of the appeal process:

- How the consumer may receive assistance in requesting an appeal;
- The consumer's right to meet with the person(s) who will be deciding the appeal;
- Time frames for the appeal review; and
- Method used to inform the consumer of the outcome of the appeal review.

## 6. Staff Competency and Credentialing

Activity - Required competencies are required for all staff positions. QM establishes the required credentials for all licensed, QMHP staff and licensed external providers. The Medicaid Compliance Officer trains and credentials staff for billing privileges through Medicaid Measures/Tools - Educational coursework, background history checks, licensure, training, and excluded provider listings are tools used to evaluate licensed staff and licensed external providers' credentialing.

Documentation/Routing - The Training Specialist coordinates all staff and external provider training. Information regarding training is entered into the Anasazi Human Resources computer system. The Billing Department enters credentialing information about staff into the system. Credentialing information is kept in personnel files.

Results - Staff with areas of inconsistencies in program reviews or competency are required to submit a plan of action to their Departmental Supervisor with timelines and outcomes. The supervisor provides documentation of action to the QM Department.

## 7. Policy And Procedures

Activity - The QM P&P Manager coordinates the Center's Policy and Procedure Process. The goal of the Center is to demonstrate effective, objective, and fair policy development.

Measures/Tools - Policies are to be updated on an as needed basis when program changes are identified.

Documentation/Routing - Each Program Manager is responsible for writing and updating their policy. Upon completion, the policy is subjected to the policy review process. All staff are

notified of the review and written recommendations to the policy are accepted by the QM P&P Staff. Typically, policies are posted for one week. At the end of the review week, a meeting is held (if needed) to address staff input. If major revisions are necessary, the policy is returned to the Program Manager for correction and resubmitted through the policy review process. If minor revisions are necessary, the revisions are presented at the Risk Management weekly meeting. If revisions are not necessary, the policy is sent to the CEO for signature. In the event that the CEO does not approve the policy, the policy is returned to the Program Manager for correction and resubmitted through the policy review process.

Results - Once the CEO approves and signs the policy, it is returned to the QM P&P Staff for distribution to the programs. Program Managers are responsible for dissemination in their program's manuals and implementation of policy compliance.

## 8. Contracts

Activity - It is the policy of the Center to develop, manage, and evaluate a network of external providers, through contractual agreements, to provide community mental health and services for individuals with Intellectual and Developmental Disabilities in its service delivery area. The QM Contracts Manager monitors this activity.

Measures/Tools - The Center secures contracts through competitive, non-competitive procurement, open enrollment process, informal competitive solicitation, and formal competitive solicitation based on Chapter 412, Subchapter B of the Texas Administrative Code. The Center will renew contracts if the contract meets best value as determined by considering all relevant factors.

Documentation/Routing - A written request must be submitted on a Contract Request for External Providers form to the Contracts Department. The projected contract amount and type of services requested will determine the Center's procurement method. After the contract process has been completed, contracts are kept on file in the Contracts Manager's office.

Results - The Contracts process is designed to ensure consumer's choice and clinical outcomes that are compatible to the assessed needs of all consumers. A Directory of Network Providers has been disseminated to consumers listing current information about each contractor in the Center's provider network. The consumers are allowed to freely choose any contractor participating in the provider network that provides the type of service that the Center has authorized for the consumer. A Network Provider Panel has also been developed to assist in the procurement process.

## 9. Grants

Activity - The Center pursues grants on an as needed basis to provide direct services or to develop programs in the community that will provide additional resources to consumers and has obtained a 501(c)3 status from the state of Texas. The QM Director and the QM Specialist are the initial contacts for the Center's grants.

Measures/Tools - Internet research, survey results, the Texas Register, newsletters, and networking are some of the tools used in the grant process.

Documentation/Routing - Program Managers and staff are encouraged to notify the Grants Department when a need is identified in their program. Based on the information received, the Grants Department searches for opportunities to match the program need with a grant. A grant writing team is organized on an as needed basis. The Grants Department provides oversight to the grant writing team. The Grants Department is continuously searching for funding prospects.

Results - The Center routinely pursues and receives grant funding. The impact of additional funding to develop meaningful infrastructure will be evaluated.

## **V. SCOPE OF QM FUNCTIONS**

The ultimate goals of the Center's QM Program are to:

- Design and describe the system of QM activities;
- Monitor and evaluate the quality and appropriateness of consumer care;
- Report service and system needs to appropriate administrators for resolution;
- Integrate findings of QM activities into assessment processes;
- Recommend service, process, outcome improvement;
- Integrate risk management and quality enhancement activities;
- Ensure that managed care and utilization activities are evident in the delivery of services; and
- Ensure that the collection and analysis of outcome data is evidenced in the delivery of services.

### **A. Organizational Self-Assessment**

The Center's Organizational Assessment is based on four domains, Financial Perspective, Internal Business Perspective, Customer Perspective, and Innovation and Learning Perspective and is conducted on an as-needed basis.

Purpose: To identify and to increase the Center's ability to meet Consumer needs. The ability to do this depends on continuously improving all of the processes that contribute to providing services and producing results that satisfy Consumers, their families, the community, staff, funding sources and other stakeholders.

Planning: Center wide program managers, internal providers, and network staff participate in the Organizational Staff Assessment. The information is assessed to determine trends, identify strengths and weaknesses and compliment planning strategies.

Process: Each Program Manager is given an Organizational Assessment package to distribute to internal providers and network staff. Upon receipt, each program is required to have an in-service to review key definitions and to hand out materials. Information and/or consultation is provided upon request by QM staff.

Scoring: Scoring is based on a scale from 0-5 (0=don't know, 1=none/never, 2=proposed barely, 3=just starting/partly, 4=sometimes, mostly, 5=always, totally.) After tallying the results for each category, an overall score is obtained. Scores create baseline measurements, provide important information about particular areas that could benefit the most from improvement activities, help to establish priorities, and provide a mechanism for comparison with other organizations throughout business, industry, and government.

Timeline: The assessment will be conducted once in every three years.

## **B. Ongoing QM Activities**

- Review of performance data to facilitate management decisions;
- Review of performance contract measures, including targets;
- Review of complaints, appeals for services and consumer surveys to obtain information about satisfaction and other outcomes (e.g. consumer waiting time, phone answering waiting time);
- Review of data pertaining to abuse and neglect issues;
- Review of unusual incidents including medication error data;
- Review of utilization data;
- Review of clinical records for clinical outcome data and to evaluate compliance with standards, rules, laws, and other contract requirements;
- Review of any other data determined to be important to the center, internal and external providers of services and stakeholders;
- Review of clinical services and program management;
- Review of service outcomes through Benefit Design;
- Review and maintenance of the Center's Disaster Plan;
- Review and update Crisis Redesign Plan; and
- Review and update the Local Plan and Network Development document.

## **C. Contract Monitoring**

Contract monitoring is a function of gathering and evaluating fiscal and qualitative indicators specific to a particular contracted service to determine whether the service provider is in compliance with the contract. Fiscal and qualitative data are evaluated to make informed decisions regarding re-contracting with service providers. The qualitative indicators should be tailored to the service provided and ensure achievement of desired outcomes, compliance with applicable rules, laws, and standards which relate to the contracted service.

Contract development and monitoring is centralized in the QM Office. The QM Contracts Manager has developed an annual contractor report card for appropriate staff to review. Expenditures, insurance, training, credentialing, timeliness of service entry, and productivity are the areas that are used to identify contract compliance or non-compliance. Annually, the QM

Contracts Manager circulates evaluation forms to the appropriate Center staff requesting opinions concerning the quality of services of the external providers that they have utilized during the year. After review, the QM Contracts Manager summarizes and distributes the evaluations to the staff and the external contract provider. The annual information is used to determine best value and contract renewal. Results of contract monitoring activities are documented and summarized with recommendations for correcting deficiencies and expected completion dates.

QM monitors any required follow-up with the assistance of the external provider, Center's Program Managers, and/or CEO, as needed. Contract revision needs are identified in the review document. Contract revisions are made prior to the renewal of contracts for the next fiscal year. Each contract specifies the terms whereby the contract can be terminated at the discretion of either the external provider or the Center.

## **D. Provider Profiling**

Provider profiling is the development of mechanisms to document and report the performance of individual internal and external contracted providers to assist management in answering questions for decision-making. Examples of indicators include achievement of positive clinical outcomes, number and nature of complaints, percent of direct service time, no show rates, provider cancellations, recidivism rate, timeliness of provider documentation and billing, appointments kept and follow-up to missed appointments, and timely closure of cases. Profiling providers can also be accomplished via productivity expectations and identifying critical performance indicators. Profiles will be used to make determinations of risk, such as, “good or acceptable,” or “problem” performance. Profiling will be used to assist the Center decision process to improve services.

- Consumer /family/staff Satisfaction-Data collected and analyzed to provide information about satisfaction with services
- Rights/Abuse & Neglect-data from investigation information regarding confirmed cases,
- Complaints & Appeals
- Regulatory Compliance
- Clinical Record Review

External provider profiling is completed using data collected by the Center. Elements of the profile include training compliance, consumer satisfaction, billing and documentation requirements, timeliness and access to services and quality of service. The QM Department is responsible for tracking quality improvement efforts, bringing attention to areas needing improvement and monitoring to see that intervention has occurred. This information is communicated to the Executive Director through written or verbal reports and Risk Management minutes. Administrative recommendations are given a priority status.

An internal monitoring tool has been implemented to facilitate compliance and service quality issues. Data is organized using MBOW and Excel software. Case managers, service coordinators, rehab staff and program managers have access to a single sheet reporting system that includes:

- Consumer name and case number
- Consumer address and phone number
- Diagnosis
- Payor source (i.e. Medicaid, Insurance, or None)
- Service package
- TRAG, diagnosis and fee assessment due dates
- Date and time of doctor’s appointment
- Minimum number of hours needed
- Number of hours to-date

Managers have at their disposal:

- Number of consumers in each package
- Minimum hours required to achieve target per staff
- Number of hours or units provided per month for each staff
- Performance Report Card
- Single sheet with timelines of data entry information

The CEO and Administrative staff have access to:

- TRAG Tracker
- Productivity
- Timeliness

- Staff training
- Manager assignment monitoring tool
- HCS Tracker
- ICF-MR Tracker
- TCOOMMI Trackers

The process provides a self-monitoring tool that creates ownership by responsible staff members and ensures the quality and accuracy of desired outcomes.

### **E. Regulatory Compliance**

The Center will identify standards, rules and laws, which apply to the organization and its internal and external providers. The Center will regularly review a sample of clinical records using instruments that address selected performance and compliance measures, which include standards and other local center requirements. Results of reviews will be aggregated, analyzed, trended and summarized for review by QM Committee. Corrective actions will be expected including system changes when trends indicate. Records reviewed will be evaluated to verify compliance with the following service standards:

- MH Community Service Standards Adult and Children
- Medicaid Mental Health Rehabilitative Services
- ICF-MR Community Standards
- HCS Evidentiary Principles
- Data Verification Criteria Manual
- TCADA Substance Programs
- Medicaid Standards-Corporate Compliance Issues

### **F. Utilization Management**

The Center employs a UM system to ensure customers receive the right services, in the right amount, at the right time, the process will consist of timely and meaningful assessments; accurate assignments of level of need; determination of medical necessity, focused treatment plan development and active monitoring of progress towards objectives. The UM structures and processes include the creation of a UM Committee that includes:

- Include multidisciplinary membership
- Meets weekly
- Record committee minutes
- Review, identify and analyze current services, providers, and Consumer outlier utilization patterns;
- Recommend methods for minimizing inappropriate or outlier practices among providers;
- Develop and distribute basic provider profiles to individual providers and managers; and
- Develop and deploy a method to educate clinical decision makers regarding service over/under utilization and practice improvement.
- Monitor clinical and administrative appeals.
- Review and monitor over and under utilization of resources

### **G. Infection Control**

The Center has developed a provider-wide infection control plan that includes prevention, education, management and monitoring of significant infections.

- Evaluate the compliance with infection control plan

- Review compliance with Health/Food Inspections if required

#### **H. Dashboard Indicators**

The Center employs the use of numerous indicators to assist in the tracking and monitoring of several key performance elements. The Risk Management and UM Committees review the information. Indicators demonstrating poor performance or outliers will be cited for further analysis, and a plan of improvement may be developed for implementation. To initiate the use of on-going process the following performance measures will be monitored.

- Consumer Satisfaction
- Direct care staff productivity
- Twenty four hour (1 day) rule compliance - submitting progress notes into billing
- Med Clinic No Shows
- Billing/Accuracy compliance (TRAG, Treatment Plan, Medical necessity)
- GAF- Improvement by 10 points within 6 months
- MH - Treatment Plan 90-Day Compliance
- Minimum and Average Hours
- Appropriateness of Service Delivery
- TRAG Completion Rate
- MR-PDP Compliance

#### **I. Co-occurring Psychiatric and Substance Use Disorders (COPSD)**

A minimum of one annual review of processes for delivering services will be measured and assessed. The review will also focus on evaluating outcomes for individuals receiving services. This review will include a section to evaluate COPSD competency as part of monitoring provider credentialing.

#### **J. Texas Implementation of Medication Algorithms (TIMA)**

A minimum of one TIMA study will be conducted annually. The study will ensure that the process has been implemented appropriately and to verify that improvements to the process occur as needed. The TIMA review will verify the existence and consistent use of the TIMA protocol's highlighted in each of the three procedure manuals (Schizophrenia, Major Depression and Bi-Polar Disorder).

The specific elements of TIMA to be reviewed will be:

1. Medication Algorithms
2. Patient Education
3. Documentation and TIMA Forms
4. Adherence to TIMA rating scales
5. Patient Participation
6. Staging
7. Contact Intensity
8. Timing of Changes
9. Dosing
10. Assessment of Previous Treatment

The random sample is determined by the UM Director. A determination that the TIMA process is not being followed in 100% of charts reviewed will require the implementation of a plan of

improvement for identified problems. This TIMA study will be available upon request by DSHS and the Center will submit the results in accordance with the Performance Contract.

The Center's Medical staff are successfully using protocols and TIMA required forms. In addition successful distribution of family and educational materials is present at the facility. However, resistance to adherence to TIMA rating scales by the medical staff was identified. The QM Department will continue to monitor adherence to TIMA Guidelines and protocols throughout the new fiscal year and encourage implementation.

#### **K. CA-TIMA Algorithms**

Psychoactive Medication Treatment for children and adolescents having either an ADHA or major depression diagnosis are predicated on TIMA guidelines effective June 1, 2005. Staff training and procedural considerations are being developed for full implementation.

#### **L. Consumers Referred by TYC**

The Center provides services to consumers referred by the Texas Youth Commission, pursuant to Title 37, TAC, Chapter 87, Subchapter B, Special Needs Offender Programs, §87.79, Discharge of Mentally Ill and Mentally Retarded Youth.

#### **M. Determining Designated MRA & Less Restrictive Setting**

Information is provided, with adequate explanation, to all potential and incoming consumers regarding their requests for services and support.

#### **N. Permanency Planning-Children Requesting ICF-MR or HCS**

The Center's MR Intake and Continuity Director oversees the Permanency Planning process for children requesting ICF-MR or HCS services using the appropriate instrument based on age.

Permanency Plans must contain:

- Intervention specifics
- Person Responsible
- Date of Initiation
- Date of Completion
- Support Planning Information
- Action Plans
- Participant Information

#### **O. Critical Incident Data Reporting**

The Center has a designated staff that is responsible for the submission of the following critical incident data per the performance contract:

- Medication Errors
- Serious Physical Injuries
- Deaths
- Behavior Intervention Plans Authorizing Restraints
- Emergency Personal Restraints
- Emergency Mechanical Restraints
- Emergency Chemical Restraints
- Individuals Requiring Emergency Restraints

A verbal report is given in the Risk Management Committee meeting with one hard copy filed with the minutes and one filed in the QM Department.

## **P. Disaster Plan**

In the event of a disaster that incapacitates the infrastructure of Center operations; basic procedures constitute a policy to ensure the continuity of services. The design will facilitate uninterrupted services to consumers while stabilizing organizational damage to prevent further systems erosion.

The functions of three vital components are crucial to achieve these objectives.

### **I. Alternative Designees For Key Administrative Personnel Roles:**

Chief Executive Officer

First level – Internal - Don Ramsey

Second level – External - Texas Council of MHMR Centers 1-512-794-9268, Texas Council Risk Management Fund 1-512-346-6921

Third level – External - Health and Human Services – Albert Hawkins 1-512-424-6500

Chief Financial Officer

First level – Internal – Ron Dodd

Second level – External - Texas Council of MHMR Centers 1-512-794-9268, Texas Council Risk Management Fund 1-512-346-6921

Third level – External - Health and Human Services – Albert Hawkins 1-512-424-6500

Information Systems Director

First level – Internal - Mike Scheriger

Second level – Anasazi Systems 1-800-651-4411

Clinical Operations

First level – Internal - Tony Cruz

Second level – External – Natalie Cloudy, Contract Manager 1-512-206-4767

Third level – External - Mental Health/COPSD Services – Texas Department of State Health Services – Dr. David Lakey 1-512-458-7111; External – Services to Individuals with Intellectual and Developmental Disabilities – Texas Department of Aging and Disability Services – Adeline Horn 1-512-438-3011; External–Early Childhood Development–Texas Department of Assistive and Rehabilitative Services – Terrell I. Murphy 1-512-377-0500

### **II. Precautionary Measures To Implement Continued Financial Operations:**

A. All electronic files are located on the Business Share Drive of the business office computers. A separate plan by the MIS department is operational to provide availability to these files in the event the originals were lost.

B. The Anasazi software systems for financial and human resources are used by other Community MHMR Centers within the state and knowledgeable persons could be accessed through arrangements with these centers or secured through contractual agreements to operationalize business office functions.

C. The Texas Council provides a membership benefit that provides administrative, legal and financial services to member centers on an as needed basis.

### **III. Precautionary Measures To Preserve And Implement The Continuance Of Center Information Systems.**

A. A fully developed backup schedule for client information data.

1. Backups are daily scheduled Tuesday through Saturday at 2:00 AM.

2. Backups take approximately 3 hours to complete.

B. Stored data consist of the following:

1. All Anasazi programs and data files
  2. Shared network folders for the Business Office
  3. Data Management
  4. Grants information
  5. MIS-RISK information
  6. TAS information
  7. Selected user folders
- C. Rotation pattern for process:
1. Daily: One tape for each day of the month, 1-31
  2. Monthly: Two monthly tapes. Used on the 5<sup>th</sup> day (or workday following) of the month.
  3. Quarterly: Four quarterly tapes are created to replace the monthly tapes.
  4. The pattern provides the Center with daily backups for the last 31 days, two previous monthly backups, and four quarterly backups.
- D. Tape verification is performed with each backup.
- E. Restoration of data from tapes is tested each month.
- F. Tapes are replaced annually.
- G. Most recent tapes (24-hour) are secured off premise.

### **Q. Training**

Online training for new staff and providers is utilized on a limited basis. Most training requires classroom instruction. The training is competency based and covers all required training. Some modules are accessed to give staff flexibility, and private providers an accommodation to meet their time restraints.

### **R. Provider of Last Resort**

The Center for Life Resources is responsible for developing, updating, and maintaining a Local Service Area Plan in compliance with The Department of State Health Services (DSHS) Performance Contract. The Plan is written to reflect the Center's compliance with the following newly adopted rules; §§412.751-412.754, §412.756, §412.758, §412.760, §412.762, §412.764, and §412.766, concerning local mental health authorities (LMHAs) and the development of a network of service providers within each LMHA's local service area. March 16, 2007 edition of the *Texas Register* (32 Texas Register 1458) These new rules establish the requirements of an LMHA in assembling and maintaining a network of service providers and set forth the conditions under which an LMHA may serve as a provider of services. Therefore, the Plan is designed to develop a Network of Providers that will meet local needs and priorities, allow for more consumer choice, improve access to services, make best use of available funds, and promote consumer, provider, and caregiver partnerships. The Plan, once approved, will be fully implemented within three years.

As in the past, the Center will continue to respond to the requests of DSHS and DADS and will comply with all legislative, regulatory and contractual requirements. Plans and timelines for procurement of Consumer services are no exception.

### **S. Resiliency and Disease Management**

During fiscal year 2005, all community mental health centers in the state of Texas were required to revise their service provision through by converting to the Resiliency and Disease

Management (RDM) model. This is a form of managed care, which provides benefit packages and UM guidelines for the centers to utilize. This model of services is based upon “service packages” designed to offer services to eligible individuals based upon their needs. Each individual’s needs are assessed through a tool called the Texas Recommended Authorized Guidelines (TRAG). This assessment reviews various areas of a person’s life to include support needs, risk of harm, functional impairment, employment, housing, substance abuse issues and criminal justice involvement. The TRAG also reviews a person’s current symptoms, as related to their diagnosis.

Based upon the assessment, the individual will be designated to a service package. This package will be explained to the individual and he/she has the choice to accept that package or chose a lesser service package, based on perceived needs.

The Center is currently implementing the RDM model by developing a service delivery system in accordance with the most current version of DSHS’s UM Guidelines and fidelity instruments. This includes but is not limited to monitor fidelity to service models.

#### **T. Consumer Rights**

The Consumer Services and Rights Protection Department at the Center establishes procedures regarding consumer education, the protection and advocacy of rights of consumers, as well as methods of reporting and investigating suspected violations to those rights in accordance with the applicable laws and regulations. The Consumer Rights and Safety Officer serves as a standing member of the Risk Management and UM Committees to expedite a process designed to:

- review all policies, procedures, behavior management or therapy programs, and rules which affect the rights of the consumers;
- ensure that Consumer rights have been thoroughly explained to Center staff through periodic trainings.
- Measure, assess, and reduce the number of incidents of consumer abuse, neglect, and exploitation

In addition, the Center staff receives initial training on the content of the Consumer Rights policy upon entering employment and annually thereafter; new staff may not assume job responsibilities prior to Consumer Rights Training.

All suspected violations of Consumer Rights are reported to the Consumer Rights Officer immediately. Any allegations or suspicion of Abuse, Neglect, or Exploitation involving a consumer of the Center is reported to the Department of Family and Protective Services by contacting the hotline number within one hour to initiate an investigation.

#### **U. Organizational Best Practices**

The Center has adopted the definition of Best Practices from the Texas Health Quality Alliance as our definition. “Best Practices are specific risk adjusted approaches to identify the processes, procedures, and services that have known costs and outcomes”.

Best practices are defined through comparisons of data, cost and risk related to the provision of services. Through analysis of this information the organization is able to implement change and take action.

Best Practices identified by the organization have resulted in changes in the way medications are provided to the Center. Use of the Patient Assistance Program for some consumers has allowed funds to be freed for improved services for others. Applications are submitted through our pharmacy contract, allowing customers the convenience of having their local pharmacy dispense the medications.

Case Management has been restructured with the development of clinical treatment teams consisting of a Case Manager (QMHP) and a rehab staff to implement service delivery. Each case manager is assigned a Licensed Professional Counselor for clinical supervision. The organizational structure streamlines services, improves quality of services, and provides clinical support for the case manager.

The intake process for the Center has been modified to create a user-friendly environment for individuals seeking services.

The integration of community resources has enhanced the Center's effectiveness to respond to crisis intervention while reducing costs related to care. The Center and the city and county have had for the last five years an effective process to identify and provide intensive services to those who are at risk for hospitalization and/ or incarceration. Funding supplements are received from two sources.

1. Partial funding by the City of Brownwood and Brown County provides critical interim care.
2. TCOOMI funding enables CLR to provide "crisis respite" and medications for some of the individuals served.

The Texas Commission on Drug and Alcohol Abuse has awarded The Center for Life Resources \$330,640.80 to provide treatment services to Adults, Youth, Co-Occurring Psychiatric and Substance Abuse Disorders.(COPSD) These services have been provided, and expanded since September 1<sup>st</sup>, 2006. The Center began receiving new funding in the amount of \$58,195.00 for Youth Prevention Services in 2008.

#### Program Goals:

- The COPSD program will ensure that both psychiatric and substance use disorders are addressed with intensive services designed to stabilize and engage the Consumer in active treatment.
- Outpatient treatment services will be offered to youths and adults in the respective counties. Consumers will be provided weekly individual counseling and group therapy over a three to four month period to support them in breaking the bonds of alcoholism and drug addiction.
- Prevention programs have been added in FY08 through Grant funding.

Best Practices identified for service delivery have resulted in standardization and streamlining of service processes and documentation. The processes for determining best practice for other services will mirror the processes we developed in determining the above best practices.

## **V. ADA Compliance**

The Center's Consumer Rights and Safety Officer along with the Center's Human Resources Director review the American Disabilities Act (ADA) Self Evaluation Plan Annually. The plan is updated as needed and each service location has the ADA information prominently posted.

## **VI. PLAN REVIEW/REVISION**

The Center's QM plan is intended to be a functional and dynamic document that evolves over time. Its effectiveness will be demonstrated by documented improvement in consumer outcomes and by documented improvement in the care and services provided by the Center. Thus, the QM plan will be reviewed, at least on an annual basis during the first quarter of the new fiscal year, to determine which area(s) will be revised as dictated by identified needs. At a minimum, it is expected that the plan will be revised to reflect changes in quality indicators, changes that may have occurred in the QM Department during the past year, to evaluate whether the QM process and structure has been effective and whether improvement in quality has been demonstrated within the Center. The revision of the QM Plan will result from and reflect this evaluation process and be submitted to the Executive Director for approval.