COMMUNITY HealthCORE

Quality Management Plan
FY2022-2024

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3/23/2023
Date

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3/23/23
Date

Table of Contents

ACRONYMS

ANE	Abuse, Neglect, and Exploitation
BHQR	Behavior Health Quality Review
CAO	Contract Administration Office
CARE	Client Assignment Registration
CCBHC	Certified Community Behavioral Health Clinic
CFC	Community First Choice
CFTM	Child and Family Team Meeting
CLAS	Culturally and Linguistically Appropriate Services
CLASS	Community Living Assistance & Support Services
CPAC	Comprehensive Planning and Advisory Committee
CWP	Comprehensive Waiver Provider
DCO	Designated Collaborating Organizations
ECC	Enhanced Community Coordination
EMT	Executive Management Team
FY	Fiscal Year
GPRA	Government Performance and Results Act
GR	General Revenue
HCS	Home & Community-based Services
HHS	Texas Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HR	Human Resources
HRC	Human Rights Committee
HRSA	Health Resources and Services Administration
ICF	Intermediate Care Facilities
IDD	Intellectual Developmental Disabilities
IPC	Individual Plan of Care
ISS	Individualized Skills and Socialization
LAR	Legally Authorized Representatives
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer
NCQA	National Committee for Quality Assurance
NEO	New Employee Orientation
PASRR	Preadmission Screening and Resident Review
PDSA	Plan-Do-Study-Act
PNAC	Planning and Network Advisory Committee
QCC	Quality Coordination Committee
QM	Quality Management
RNAC	Regional Network Advisory Committee
SAMA	Satori Alternatives to Managing Aggression
SDOH	Social Determinant of Health
SUD	Substance Use Disorders
TAC	Texas Administrative Code
TAS	Texas Application Specialists
TDCJ	Texas Department of Criminal Justice
TDFPS	Texas Department of Family and Protective Services

ACRONYMS (Continued)

TxHml	Texas Home Living
VA	Veterans Affairs
YES	Youth Empowerment Services

GLOSSARY

Care Coordination is the organization of an individual's care across multiple health care providers. It involves deliberately organizing the individual's care activities and sharing information among all of the participants concerned with an individual's care to achieve safer and more effective care.

Critical incident is a sudden, unexpected, and overwhelming event that is out of the range of expected experiences. There may be feelings of intense fear, helplessness, horror, and completely out of control.

Health Equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. This requires ongoing societal efforts to:

- Address historical and contemporary injustices.
- Overcome economic, social, and other health and health care obstacles.
- Eliminate preventable health disparities.

High Reliability Organization is an organization that strives to achieve error-free performance and safety in every procedure, every time while operating in complex, high-risk or hazardous environments. It has predictable and repeatable systems that support consistent operations while catching and correcting potentially catastrophic errors before they happen.

Medically Underserved Areas are areas or populations designated by Health Resources and Services Administration (HRSA) as having too few primary care providers, high infant mortality, high poverty or a high elderly population.

Mental Health Professional Shortage Area are areas and population groups have a shortage of health professionals.

Person-Centered Care is health care delivered in a setting and manner that is responsive to the individual and their goals, values, and preferences in a system that empowers individuals and providers to make effective care plans together.

Quadruple Aim Framework is a model accepted by public and private health organizations as a means for optimizing health system performance. It includes:

- Enhancing the individual's experience.
- Improving population health.
- Reducing cost of care.
- Improving provider satisfaction.

Social Determinants of Health are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life.

I. OVERVIEW

The Community Healthcore (Center) Quality Management (QM) Plan adheres to the Center's mission, vision, and values. It is approved by Center leadership and communicated to staff.

Mission

Helping people achieve dignity, independence and their dreams.

Vision

- We envision a world in which all people have the opportunity to make choices for themselves that will lead to the highest quality of life possible.
- We envision a world in which all people are independent and free from poverty, pain, and despair.
- We envision a world in which there is no stigma associated with all populations seeking treatment or assistance for mental illness, intellectual disability, or substance use.
- We envision a world in which all people receive supportive, nurturing care appropriate to their needs in the least restrictive environment possible.

Values

- We value recovery and the ability of people we serve to live beyond their illness.
- We value creativity, innovation, and empowerment of individuals receiving services and employees.
- We value the success of individuals receiving services and employees.
- We value providing safe, healthy, and therapeutic environments for individuals receiving services and employees.
- We value the abilities and talents of individuals receiving services and employees.
- We value continuous quality and performance improvement.
- We value the pursuit of excellence by each employee.
- We value cooperation and teamwork within the center, and between agencies.
- We value community concerns, ideas, and opinions.
- We value respect, dignity, space, and confidentiality for individuals receiving services and employees.
- We value the judicious and effective use of, and access to, available resources.
- We value diversity of thought, opinion and approach born of different backgrounds.
- We respect the value of change.

II. QM SYSTEM STRUCTURE

The Executive Director establishes necessary procedures to achieve the Center's mission and values.

The Director, Business Operations, implements and monitors the QM System.

The Executive Management Team (EMT) oversees QM activities. They set expectations and priorities for activities to improve organizational and clinical outcomes and processes.

Center leadership provides resources and assures staff are trained about assessing and improving processes. Leadership also fosters communication among staff to improve coordination of activities.

Center leadership appoints teams to achieve identifiable goals. Internal and external providers assess their delivery of services and implement improvement changes.

III. QUALITY IMPROVEMENT PRIORITIES

The first priority is the individual's safety and standard of care. Concerns identified by the individual are paramount to their treatment success. This is the foundation of the Center's desire to become a High Reliability Organization.

The second is to meet and excel in areas important to state, federal, and third party regulators. This ensures the Center's continued availability to individuals. The Center also seeks feedback from stakeholders who make it possible for services to be effective to individuals.

IV. KEY PERFORMANCE INDICATORS

The Center continually seeks to assess behavioral methods and outcomes that are appropriate, timely, efficient, and reliable. Key performance indicators include:

- Timely and appropriate level of care.
- Care coordination for follow-up of referrals to external providers and for individuals waiting for services.
- Appropriate staff utilization.
- Approved and accurate documentation.
- Equitable termination, reduction, and denial of services.
- Steadfast adherence to training targets.

- Evaluation of individuals awaiting services.
- Risk assessments and safety for individuals and staff.

Quality staff in programs review records of individuals served (records) monthly to ensure Texas Health and Human Services (HHS) requirements are met. Programs use reports from data systems to monitor timely documentation and suitable investment of staff hours. Records are evaluated for compliance with Texas Administrative Code (TAC), Joint Commission, National Committee for Quality Assurance (NCQA), and contractual standards.

Staff complete required training as needed. Training includes workplace dynamics (safety, environmental management, ethics, and effective communication). Also included are elements that impact care (abuse, trauma, suicide screening, cultural diversity, rights, Health Insurance Portability and Accountability Act (HIPAA), person-centered care, and recovery). Staff must score at least 80% in all areas or be relieved from duties until they meet the score.

V. QUALITY COORDINATION COMMITTEE

The Quality Coordination Committee (QCC) meets at least quarterly. It includes the Director, Business Operations; Program Operations staff; QM staff; Clinical staff; and Business staff. The QCC:

- Identify and analyze current service provider and safety patterns.
- Develop and implement methods to educate clinical decision makers regarding service improvement.
- Assess and improve rights restrictions. Evaluate incidents. Determine appropriate and immediate responses.

The QCC reports at least quarterly to the EMT via published committee minutes.

VI. OTHER QM COMMITTEES

The Center has several committees. They assure compliance and assess opportunities for improvement in each area.

- EMT.
- Comprehensive Planning and Advisory Committee (CPAC).
- Safety and Environment of Care.
- Medical Services.
- Quality Coordination.

VII. PERFORMANCE IMPROVEMENT

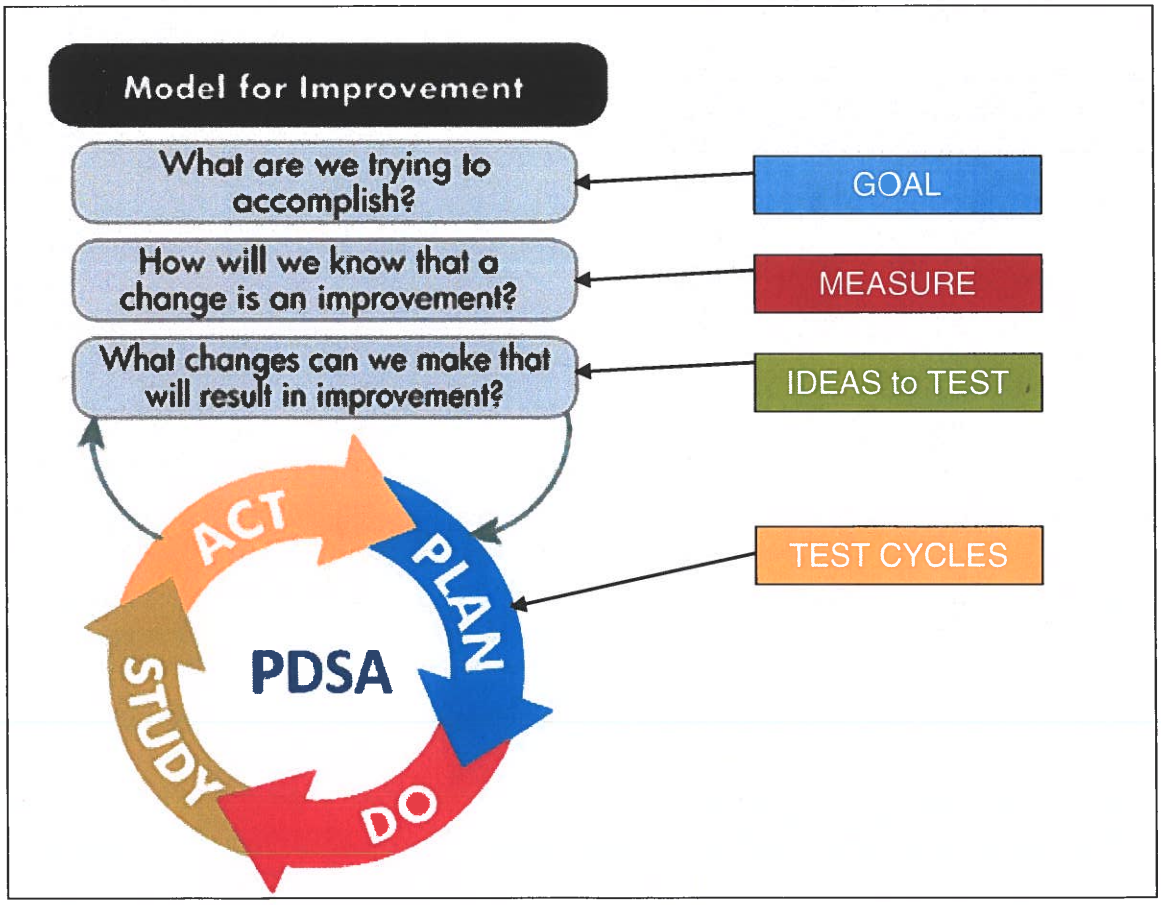
Improvement efforts use the Quadruple Aim Framework. This model is widely accepted by public and private health organizations as a means for optimizing health system performance. It includes:

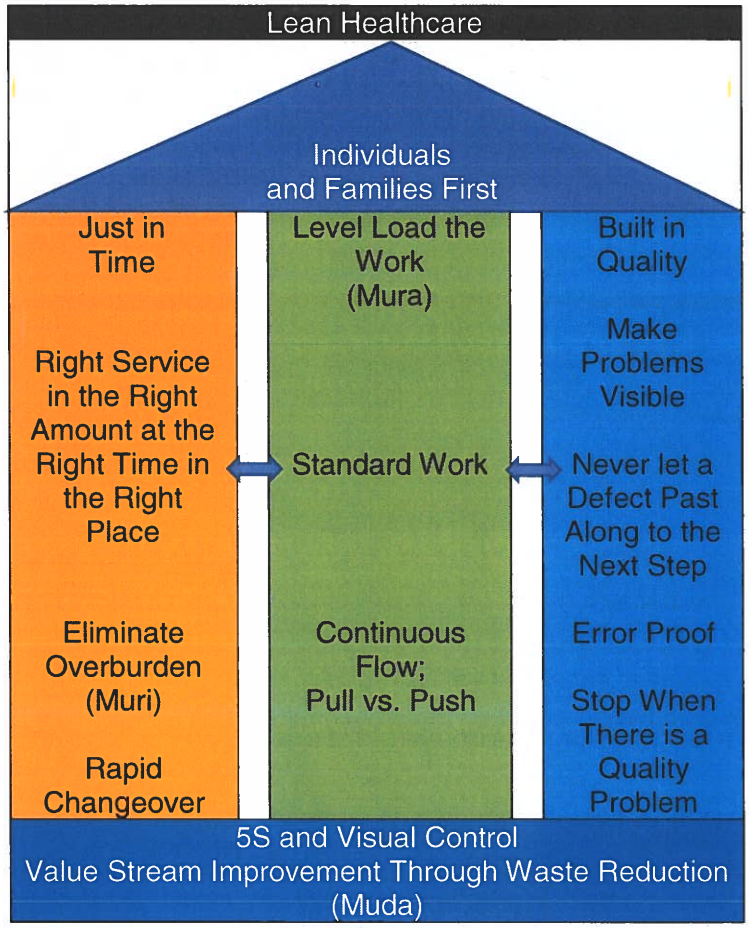
- Enhancing the individual's experience.
- Improving population health.
- Reducing cost of care.
- Improving provider satisfaction.

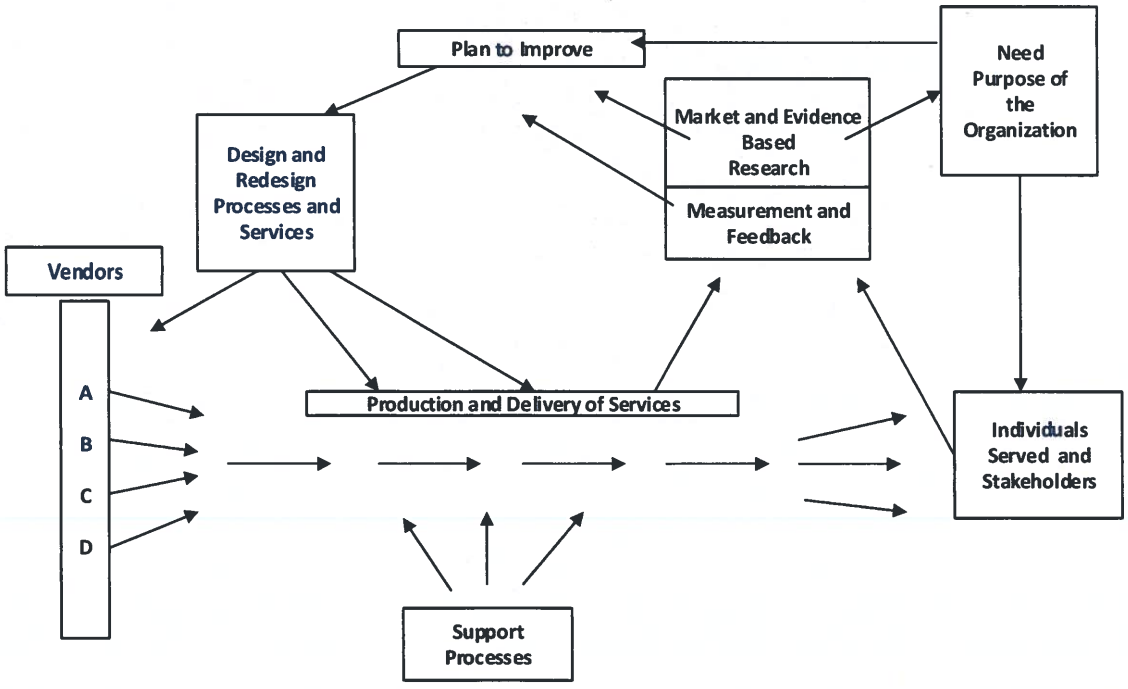
Each project shall align with and support one or more of the Center's strategic initiatives.

Improvement Teams use a blend of the following methodologies.

1. Plan-Do-Study-Act (PDSA) cycles.
2. Lean.
3. Deming System of Profound Knowledge also known as Systems Thinking.




Lean Healthcare
Individuals and Families First
Just in Time
Level Load the Work (Mura)
Built in Quality
Right Service in the Right Amount at the Right Time in the Right Place
Standard Work
Make Problems Visible
Never let a Defect Past Along to the Next Step
Eliminate Overburden (Muri)
Continuous Flow; Pull vs. Push
Error Proof
Rapid Changeover
Stop When There is a Quality Problem
5S and Visual Control
Value Stream Improvement Through Waste Reduction (Muda)


Plan to Improve
Need Purpose of the Organization
Market and Evidence Based Research
Design and Redesign Processes and Services
Measurement and Feedback
Vendors
A
B
C
D
Production and Delivery of Services
Individuals Served and Stakeholders
Support Processes

An Improvement Plan is required when a problem is identified and a process(es) is chosen for improvement. The plan must:

- State the problem. How the project will improve the problem.
- Identify objectives, performance measures, and future goals.
- Identify initial change ideas (PDSA). Identify the expected return on investment in meeting Center goals, vision, and values.
- How data will be collected. Determine that the change is an improvement. Compare the results of Center standard practices with established benchmarks of performance.

The QCC considers Improvement Projects based on the plan, the need, and the intended outcome. The team shall submit a status report to the QCC quarterly and to the EMT when required.

Improvement Projects:

- Help grow the scope and quality of services.
- Enhance performance.
- Provide better experiences and health outcomes.
- Respond to changes within the communities.

VIII. HEALTH EQUITY

To improve health equity for individuals, the Center is committed to closing the health care disparity gap.

The Center serves a 6,721 square mile area of Northeast Texas. The area consists of Bowie, Cass, Gregg, Harrison, Marion, Panola, Red River, Rusk, and Upshur counties. It borders Oklahoma, Arkansas, and Louisiana. The region has been challenged by insufficient health care resources for generations. Two-thirds of this region is rural. Caucasians are the majority of residents (73.2%), followed by African Americans (13.5%) and Hispanics (13.3%). HRSA has designated seven counties as Medically Underserved Areas. Six counties are Mental Health Professional Shortage Areas. In most counties, the Center is the largest and often the only provider of behavioral health care. Ninety percent of individuals served are low-income and 60% are uninsured. African Americans and Hispanics are over represented in comparison to regional demographics. In an effort to address disparities, the Center has two populations of focus: youth (ages 13 to 18) with substance use disorders (SUD) and veterans needing specialized mental health care. There are an estimated 16,000 such individuals living in the nine counties. Lesbian, gay, bisexual, transgender, queer (LGBTQ) youth, male

veterans, persons of color, and low-income persons are over-represented.

Community Demographics								
Area	Total Pop.	Poverty Pop. %	White %	Black %	Hispanic %	<18 years %	Veterans %	Median Income
Total	454,466	73,695 (16.2%)	294,370 (64.8%)	86,667 (19.1%)	57,058 (12.6%)	109,114* (24.0%)	31,003 (6.8%)	$49,297
Bowie	93,622	16.8	63.3	24.9	7.7	23.7	7.6	$51,796
Cass	30,002	17.5	76.2	17.3	4.7	22.4	8.1	$47,539
Gregg	123,633	17.6	56.8	19.6	18.9	25.8	6.6	$52,027
Harrison	66,547	16.8	62.9	20.7	13.3	25.2	6.4	$54,234
Marion	9,987	18.5	70.8	22.6	4.3	18.2	9.5	$39,093
Panola	23,186	14.1	73.2	16.2	8.9	23.2	6.3	$51,297
Red River	12,115	20.2	73.4	16.0	7.4	19.9	6.1	$37,135
Rusk	53,988	11.2	63.2	16.4	17.1	22.3	5.9	$56,223
Upshur	41,386	14.9	80.0	8.1	8.7	23.9	6.6	$54,330
*of the 109,114 children and youth, an estimated 3,371 are between the ages of 13 and 18.								

Note: The Center's service population varies from the above. 90% are low-income (<200% of poverty), 60% are uninsured, and more than half are persons of color.

The impact of inadequate behavioral health care resources for youth with SUD and veterans with post-traumatic stress and other mental health disorders is shown below.

- In a 2020 survey, 11.7% of middle and high school youth reported binge drinking one or more times in the preceding month. Binge drinking is five or more alcoholic drinks in a two hour period. This is 10.4% higher than the Texas average. There are no youth-focused substance abuse treatment programs in any of the nine counties.

- A 2016 Needs Assessment commissioned by the Texas Veterans Commission found that the need-resource gap experienced by Texas veterans was greatest for mental health care. The region with the most limited state and local resources was East Texas, which includes the nine counties. The nearest Veterans Affairs (VA) clinic is in Shreveport, Louisiana 50-100 miles away.

- Suicide is the ultimate indicator of the insufficiency of behavioral health resources. In the nine counties the evidence is stark and painful. The counties' suicide rate (15.2/100,000) is 35.7% higher than Texas' rate and the rate among veterans (31.0) was highest of all.

There are significant behavioral health needs and co-occurring physical health conditions among the population of focus and other individuals served. The nine counties have higher rates of heart disease, diabetes, lower respiratory conditions; higher age-adjusted incidence of invasive cancers; and higher mortality rates than state or national averages. The Needs Assessments found inadequate care resources (too few physical and behavioral health care providers) and access barriers (transportation and cost for uninsured populations) to be major factors. The physical, behavioral health, and recovery

support needs of the focus population are complex. Care coordination and measurement-based care to enhance treatment outcomes and recovery are critical.

The Center is an HHS Certified Community Behavioral Health Clinic (CCBHC). It covers existing and future integrated clinics. New clinic locations will be placed based on unmet needs in the area and accessibility of surrounding communities. Future clinics are in close to roughly half the focus population and drivable under 30 minutes. Care Management Teams will be positioned at each integrated clinic to connect disparate subpopulations with vital and necessary services and activities. The collaborative team approach includes behavioral health and primary care clinicians, care coordinators, and certified peer specialists. It involves the provision of evidence-based practices to individuals and their families. The goal is to improve health outcomes and the life span of the individual. The project's quality improvement plan has identified access barriers experienced by underserved subpopulations. It has challenged Care Team Managers to redevelop methodologies in an effort to improve engagement and retention.

The Care Coordination team will review the Social Determinant of Health (SDOH) screening tool and Government Performance and Results Act (GPRA) data. The goal is to identify opportunities to improve services for disparate groups. Care Coordinators will provide outreach services such as phone calls, home visits, contacts in the community, and coordination with other community health related partners and social service agencies. GPRA data is reviewed monthly by the Quality Improvement team and quarterly by the Center's Community Advisory Committee (CPAC). PDSA and quality improvement plans will be utilized to improve access to care and reduce the negative impact of social determinants of health issues.

SDOH areas that will be targeted will be health care access, transportation, housing, education opportunities, and safety.

The Center is committed to improving health care equity by delivering services that are culturally and linguistically appropriate. To ensure compliance with the National Culturally and Linguistically Appropriate Services (CLAS) standards, the Center:

- Offers new hire and annual courses for providers who serve diverse populations to increase cultural understanding. The Center continually seeks to provide the most up to date and relevant course material.
- Works to recruit, promote, and support a culturally and linguistically diverse workforce that is responsive to the populations served.
- Has an individuals' rights and grievance process that is culturally informed and in full compliance with regulations.
- Conducts regular assessments of community health assets and needs.

Uses the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

- Collects and maintains accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity.
- Conducts ongoing assessments of CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
- Conducts ongoing training of leadership and workforce in culturally and linguistically appropriate policies and practices.
- Offers language assistance to individuals who have limited English proficiency and/or other communication needs at no cost. A telephonic interpreter service/language line is available 24/7.

IX. FUTURE PLANNING

STRATEGIC GOALS 2022-2023

	ACCOUNTABILITY		WORKFORCE
GOAL 1	Review and revise the comprehensive plans for security as identified within the organization by the QCC.	**GOAL 1**	Develop a plan for stabilizing the Center's workforce via competitiveness, recruitment, training, orientation, and formalized mentoring all with a mission-driven framework.
GOAL 2	Create a continuous Quality Improvement project that implements HMA and Genua recommendations and the next steps for CORE Health to include FQHC development.		
GOAL 3	Develop and review sustainability plans for selected projects including grant-funded programs including the Intern Academy, Care Coordination, and Primary Care.		
GOAL 4	Plan Peer growth and development.		
GOAL 5	Evaluate targeted all owned and leased facilities /properties for future utilization or disposition i.e. Texarkana, HG Mosley, Community Connections, 4th & 6th Street & empty building locations.		
GOAL 6	Evaluate security at targeted owned and leased facilities/ properties for future utilization or disposition i.e. Texarkana, HG Mosley, 4th & 6th Street building locations.		
	TECHNOLOGY		**INNOVATION**
GOAL 1	Create a plan to fully utilize data from the next-generation electronic health records.	**GOAL 1**	Developing KPIs and management standards.
GOAL 2	Electronic Health Record implementation Plan B.	**GOAL 2**	Develop a collaborative model for criminal justice.
		GOAL 3	Develop a Harrison County community collaborative effort that builds an intact value system for middle school children focusing on a strong sense of self and understanding of their role in becoming leaders in the community.

ATTACHMENTS

A. Behavioral Health Plan
B. Intellectual Developmental Disabilities (IDD) Plan
C. Substance Use Disorders (SUD) Plan
D. Youth Empowerment Services (YES) Waiver Plan

ATTACHMENT A - Behavioral Health Plan

BEHAVIORAL HEALTH PLAN
QUALITY ASSURANCE

PURPOSE

To ensure the provision of high quality targeted case management services that will assist individuals in sustaining recovery and gaining access to needed medical, social, legal, educational, and other services and supports.

PROCEDURE

1. The Center completes random internal audits to ensure services follow appropriate TAC guidelines to operate behavioral health services in the State of Texas.

2. The Center audits the following services through behavioral health clinics:

    a. Psychiatric services.
    b. Counseling.
    c. Psychosocial rehabilitation.
    d. Skills training.
    e. Crisis services.
    f. Case management.
    g. Nursing.
    h. Peer provider services.
    i. Substance use screening and assessment.
    j. Substance use counseling (individual and group).

3. Center audits ensure that behavioral health services for all populations of individuals served (adults, child and adolescent, and substance use disorders populations) are utilizing evidenced based curriculum and services.

4. The Center uses satisfaction surveys to ensure the highest quality of services are provided by the Center, and that these high quality services meet the individual needs of each individual. Random satisfaction surveys are completed during each internal Center audit.

5. Center audits ensure that needs of individuals served are appropriately identified and treated by the services provided.

6. Center audits target case management services offered by a designated collaborating organizations (DCO), and the Center has a formal agreement with the DCO(s) to ensure audit compliance.

ATTACHMENT B - Intellectual Developmental Disabilities (IDD) Plan

INTELLECTUAL DEVELOPMENTAL DISABILITIES (IDD) SERVICES
QM PLAN FISCAL YEAR (FY) - 2022-2023

Effective: November 1, 2005
Revised: FY 2006, FY 2007, FY 2008, FY 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2021, 2022, 2023

I. QM ACTIVITIES

A. Electronic Health Record indicators: Data retrieved to:

1. Ensure timely data entry.
2. Ensure status of services.
3. Ensure staff productivity.
4. Achieve target of serving an average of 45 individuals receiving monthly services per Service Coordinator.

B. Business Objects database is utilized in assessing:

1. Encounter Exceptions.
2. IDD Financial.
3. IDD Performance.
4. IDD Contract Administration Office (CAO) Audit.

C. The Center monitors:

1. **Outcomes** - Overall score on outcomes and supports for people who have IDD.

    a. 95% of enrollments into Home & Community-based Services (HCS) meet timelines.
    b. 95% of Permanency Plans are completed within timeline requirements.
    c. 95% of enrollment into Texas Home Living (TxHml) meet timeline requirement.
    d. 100% Interest List monitoring- Biannually.

2. **Specific targets** monitored monthly/quarterly during FY-2023 are:

    a. **Documentation Timelines.** Goal is 95% of services delivered will have documentation submitted for filing in the chart prior to submission of the service log.
    b. **Interest List Maintenance.** The computerized interest list for IDD services will be collected and managed using the Client Assignment Registration (CARE) system.
    c. **Community Awareness.** The Center will increase community

awareness of its services by participating in community events, health fairs, and presentations to community.

d. **Individual Participation.** Signature of the individual indicating participation in person-directed planning and care will be tracked through clinical records reviews.

D. Additional QM Activities

1. **Clinical Record Reviews** are conducted for reconciliation of billed services to documented services. Results of reviews are presented to the EMT and relevant service providers for correction. Training needs are identified and provided.

2. **Satisfaction Surveys** are conducted for the following programs:

   a. HCS.
   b. TxHml.
   c. Intermediate Care Facilities (ICF)-IDD.
   d. Community Living Assistance & Support Services (CLASS).
   e. General Revenue (GR).
   f. Preadmission Screening and Resident Review (PASRR).
   g. Enhanced Community Coordination (ECC).
   h. Community First Choice (CFC).

   Results from the surveys are shared with management. Concerns, questions, and recommendations from individuals/Legally Authorized Representatives (LAR) are reviewed.

3. **Participate in Encounter Data Verification Activities** as defined in the performance contract. This includes:

   a. Performing self-audits.
   b. Submitting self-audit results and supporting documentation as required for HHS desk reviews.
   c. Participating in HHS on-site reviews.

4. **Monitor Monthly Critical Incident Data into CARE System** for ICF-IDD, HCS, TxHml, CFC, ECC, and GR services. Measure, assess, and reduce critical incidents and incidents of abuse, neglect, and exploitation (ANE). The Safety/Environment of Care Committee analyzes data quarterly from the Texas Application Specialists (TAS) Risk Management Database regarding incidents of death, injury, restraints, and ANE. Refer to Administrative Procedure 2.01.04 for the Behavior Intervention Plan. Findings, recommendations, actions taken, and results of performance improvement activities are made to the QCC and appropriate management staff.

5. **The Rights Protection Process** includes all newly admitted individuals to Center services receive the appropriate rights handbook and privacy notice. Each newly admitted individual or LAR shall be informed orally of all rights and responsibilities in their primary language using plain and simple terms within 24 hours of admission into services. This includes an explanation of the circumstances under which those rights may be limited and how a complaint may be filed. This must occur at least annually and upon any updates/changes to this information. Delivery of information is designed for effective communication, tailored to each person's ability to comprehend, and responsive to any visual or hearing impairment. Individuals are informed about:

   a. Their rights and responsibilities.
   b. Their rights to appeal.
   c. The appeals process.

   New Employee Orientation (NEO) introduces staff to the principles of individuals' rights in accessing and receiving Center services. This includes the definition of rights, due process, complaint process, confidentiality, Corporate Compliance, and reporting procedures for ANE. Staff must pass a written competency assessment at the conclusion of training. Refresher training is done annually. Training is provided in appropriate cultural and linguistic formats. Any rights restrictions are discussed by the planning team and recommendations are presented to the Human Rights Committee (HRC) for review.

6. **Monitoring of IDD Services** include:

   a. Provider QM staff routinely monitor for compliance to TAC.
   b. Authority QM staff routinely monitor records for compliance.
   c. QCC monitors statistical reports monthly.

II. AUTHORITY FUNCTIONS

The HHS Performance Contract defines the following Center Authority Functions.

A. **Local Planning** is conducted by the Director of Contracts Management through the Planning and Network Advisory Committee (PNAC). The purpose of the committee is to advise the Center in the development of local and network plans. The PNAC reports on issues of individual's needs, priorities, and the implementation of plans to the Board of Trustees.

The Center is a member of the Regional Network Advisory Committee (RNAC) with other local Community IDD Centers. The RNAC contributes to the development and content of the Network Plan. The Network Plan assures appropriate procurement of goods and services and reviews and makes recommendations that consider public input, best value, and care issues to ensure choice and best use of public money in assembling a network of providers. The RNAC evaluates Center programs and services and compares services to other network Centers. Outcomes of these activities form the basis for improvement activities. The RNAC meets quarterly. The Director of Contracts Management reports to the EMT and the Board of Trustees to take action as necessary regarding recommendations from the RNAC.

B. **Policy Development** is through the governing body of the Center and ensures the needs of the local service area is in accordance with state and federal laws.

III. ACCOUNTABILITY AND RESOURCES

A. **Oversight of IDD Services**: The Center provides the following services:

- Screening.
- Eligibility Determination.
- Service Coordination.
- Basic Service Coordination Continuity of Services.
- Service Authorization and Monitoring.
- Service Coordination - TxHml Program Community Services.
- Community Support.
- Respite Services.
- Employment Assistance.
- Supported Employment.
- Nursing.
- Behavioral Support.
- Specialized Therapies.
- Individualized Skills and Socialization/Day Habilitation.
- Vocational Training.
- Day Habilitation.
- Residential Services.
- In Home and Family Support.
- ICF for IDD.
- HCS.
- TxHml Provider Services.
- Permanency Planning.
- Consumer Benefits Assistance.
- CLASS.

- Crisis Intervention Services, in home and out of home respite services.
- CFC.
- ECC.
- ISS.

B. The following services are managed through contract.

- Inpatient Psychiatric Treatment and Crisis Stabilization.
- Psycho-pharmacological Services.
- Lab Services.
- Dental Services.
- Physical Therapy.
- Psychological Testing.
- Occupational Therapy.
- Speech Therapy.

IV. QUALITY IMPROVEMENT PRIORITIES

A. Training Activities

Employee training begins with the NEO program under the direction of Human Resources (HR). HHS regulations, program standards, and Center policy are followed. If required, annual refresher training occurs. Specialized training occurs for direct care employees in NEO and on-site. Ongoing training occurs on-site.

B. QM Activities

1. Monitor Home Community Based Program services.
2. Monitor ICF/IDD individuals.
3. Monitor compliance with Medicaid Estate Recovery Program guidelines.
4. Monitor compliance with Interest List Maintenance.
5. Monitor compliance with CLASS program services.
6. Monitor compliance with TxHml guidelines.
7. Monitor compliance with ISS settings rules.
8. Identify Training needs and develop curriculums (all levels of staff).
9. Permanency Planning.

V. PLAN TO REDUCE THE NUMBER OF CONFIRMED CASES OF ANE

A. Center procedures relating to ANE identify and prohibit ANE and prescribe principles for its report, investigation, and prevention.

B. The Center provides training to staff, individuals, parents, guardians, collaterals, and volunteers in recognizing, preventing, and reporting of

ANE of children, the elderly, and the disabled.

C. The Center is committed to providing services that treat people with dignity and respect, taking particular care to see that their rights are fully protected.

D. The Center uses web-based training. This system is designed to meet the needs of organizations that provide behavioral health, developmental disability, substance use, and child welfare services. Staff access training via their computer. Training includes:

- Corporate compliance.
- Confidentiality.
- HIPAA.
- Cultural diversity.
- ANE.

E. The Center provides training for all new employees. Training is necessary prior to having contact with individuals. Clinicians are familiar with applicable HHS Rights Handbooks. Reference is made to TAC Title 26, Part 1, Chapter 711, Subchapter A (Investigations of Individuals Receiving Services From Certain Providers). A test is administered at the end of the training session. All staff must achieve 80% or better on the testing. Employees who do not achieve 80% need to retake the test. Refresher training is conducted annually and as required by re-training needs. Face-to-face re-retraining will be conducted as required.

F. The Program Director ensures that staff receive Center training in Identification, Prevention and Reporting of ANE. The Program Director ensures that staff maintain competency in Satori Alternatives to Managing Aggression (SAMA) techniques. The Rights Protection Officer reviews the investigative report and makes recommendations to the Executive Director and Program Director. Recommendations could include additional computer based training, one-on-one training with the Rights Protection Officer, or review employee's job description and Center's internal procedures. Disciplinary actions are at the discretion of the Executive Director or designee.

G. All individuals receive rights handbook(s) upon entering the program, annually thereafter, and when a revision is made to the handbook. Individuals receive a new handbook as soon as possible after revisions are made. The rights handbooks will be reviewed with every individual. In the handbook, there is a list of agencies with telephone numbers and addresses. If an individual feels that their rights were violated, the individual is encouraged to contact the Center's Rights Protection Officer and/or the HHS Ombudsman. If there is a complaint of ANE, the individual

can contact the Texas Department of Family and Protective Services (TDFPS).

H. When an allegation of ANE occurs, the individual is given immediate and appropriate medical/psychological care and protection. Mechanisms are developed and implemented to handle related allegations. The staff is instructed to cooperate with the investigation and disciplinary action is taken, if applicable. Retaliation is not tolerated.

I. It is the responsibility of staff to report any concern, suspicion, or incident of ANE immediately, but not later than one hour after notification of the incident. There is no chain of command in reporting abuse or neglect. Failure to report abuse and neglect may result in disciplinary action and/or criminal charges. State laws protect individuals reporting abuse and neglect. Any employee or individual who in good faith reports abuse or neglect will not be subject to retaliation by any Center employee. Any person who believes they are being subject to retaliation due to reporting abuse or who believes a report has been ignored without cause, should immediately contact HR, Corporate Compliance, or the Executive Director. The Executive Director shall ensure that disciplinary action is taken against employees found to have retaliated against a reporter.

J. Any suspicion of ANE should be reported. Refer to the telephone numbers below to report an allegation. The numbers are posted on bulletin boards throughout program sites.

IDD Ombudsman	1-800-252-8154
Rights Protection Officer	903-831-7585 903-234-4220 903-831-3646
Office of Consumer Affairs	1-800-458-9858

K. Staff are encouraged to use the TDFPS web site at www.txabusehotline.org to report non-emergency situations (abuse/neglect) of children, the elderly, and adults with disabilities.

L. Staff will receive information identifying and preventing ANE of children, the elderly, and the disabled.

M. The Center will use the TDFPS Adult Abuse Prevention Kit to educate staff, individuals, advocates, guardians, and the general public in the prevention of ANE of children, the elderly and the disabled.

N. All staff are trained to identify signs of stress and burnout.

ATTACHMENT C - Substance Use Disorders (SUD) Plan

I. QM PLAN

The goal of the Center Substance Use Disorder (SUD) Services QM Plan is to improve behavioral health outcomes by improving performance of clinical, governance, and support processes. Performance of important functions significantly affects outcomes, the costs to achieve these outcomes, and the perspectives of individuals served about the quality and value of its services. Through the utilization of data to monitor and evaluate program implementation and performance, the improvement of outcomes of care and services provided to individuals is facilitated. Continually measuring, assessing, and improving performance of clinical processes and other processes involved in providing quality care and services is the heart of this function.

The QM Plan is coordinated by the SUD Program Director and covers both internal and external reviews. It has the following goals:

1. Provide a comprehensive framework for monitoring and evaluating the quality, efficiency and effectiveness of care and clinical performance (services) in the areas of:

    a. Internal Program Reviews.
    b. Licensure/Contract Monitoring.
    c. Facility Monitoring.
    d. External Program Reviews.

2. Establish a proactive approach to the maintenance and improvement of quality services:

    a. Report service and system needs to appropriate resources for resolution.
    b. Integrate findings of quality assessment and improvement activities into annual evaluation of component performance.
    c. Anticipate changes in individual needs and Center resources.
    d. Provide a mechanism for comprehensive evaluation of the total program.

3. Provide for the review of SUD service trends and patterns related to program effectiveness through the functions of the Quality Improvement Team that is comprised of the SUD Program Managers, Behavior Health Quality Review (BHQR) Manager, and BHQR team. The QCC meets monthly to:

a. Make recommendations.
b. Look for trends and review program findings for assurance of corrective action.
c. Follow-up on all findings.
d. Annually select critical objectives including core set of performance measures.
e. Maintain documentation of QCC meetings.

4. Internal Program Reviews of all units and services occur at least quarterly. Audits exist apart from external or continuing audits conducted by other agencies. Audits to determine that services are in compliance with:

   a. HHS.
   b. Texas Department of Criminal Justice (TDCJ).
   c. Center guidelines.
   d. Applicable departmental rules and directives.
   e. Applicable accreditation (i.e. Joint Commission), certification, licensure, and registration standards.

II. **QM PLAN** must identify quality indicators that are able to effectively measure performance in the following areas:

- Identification of staff training needs.
- Clinical records review.
- Satisfaction of provided services.
- Safety/risk management.
- Infection control.
- Utilization management.

Each identified indicator of care is monitored through the collection, analysis, and trending of data. If an indicator is monitored monthly and has been found to be in compliance for three consecutive months, new indicators may be selected for monitoring. Documentation of the reviews is sent to the SUD Program Manager and Director of SUD Services and includes: findings, review of rules, recommendations, and corrective actions.

SUD Services Management Objectives are to ensure that the delivery of quality substance use disorder treatment services for all adults are provided in a manner that aligns with the Center's mission and goals. These objectives are accomplished by:

- Ensuring staff follow policies and procedures to improve care through quarterly record monitoring by Behavioral Health Quality Review Team and SUD Program Managers; and ensure staff training are in compliance with program services.
- SUD Program Manager shall ensure all incident reporting is entered into

the Risk Management System within 24 hours of the incident.

- SUD Program Manager shall review Satisfaction Surveys to review areas for improvement and implement changes as needed.
- Director of SUD Services will meet with SUD Program Managers when quality of services are not optimal and implement corrective action plans when needed. Staffing minutes of meetings with the BHQR Manager and SUD Program Manager of services shall be documented on the Center's approved Staffing Form.
- SUD Program Manager will ensure all services are monitored and billed appropriately in the CMBHS system.

ATTACHMENT D - Youth Empowerment Services (YES) Waiver Plan

YOUTH EMPOWERMENT SERVICES (YES) WAIVER
QM PLAN

POLICY

The QM Unit, the Director of Program Operations, and/or designee shall be responsible for the monitoring of services provided through the YES Waiver by the Center.

PURPOSE

To monitor compliance with all YES Waiver policies and procedures.

To address any necessary corrective actions identified during QM Reviews.

PROCEDURE

A. Data is collected, measured, and analyzed to improve dimensions of performance through periodic reviews by the QM Unit and/or designee. Results of the reviews will be reported to the Executive Director through the QCC.

B. Service utilization is monitored for compliance with HHS approved Individual Plan of Care (IPC) for each waiver participant through periodic reviews by the QM Unit. Results of the reviews will be reported to the Executive Director and QCC.

C. Critical incidents will be reviewed to assure compliance with reporting requirements and to identify follow up activity or need to update the IPC.

D. Documentation is monitored through periodic reviews by the QM unit and/or designee to ensure compliance with Waiver requirements. Results of the reviews will be reported to the Executive Director through the QCC.

E. YES Waiver quality monitoring tools will be used and are stored electronically at J:\Shared\YES Waiver\Quality Management\QM Tools.

   1. YES Individual Chart Review.
   2. Child and Family Team Meeting (CFTM) Observation.
   3. Checklist for Care Coordinator Responsibilities.
   4. YES Provider Qualifications Audit Tool.

F. Monitoring of contracted YES Service Providers to ensure compliance with all YES Waiver policies and procedures as outlined in the YES Waiver Policy Manual is conducted through periodic reviews by the QM Unit and/or designee. Any necessary corrective action identified is addressed

in writing to the Comprehensive Waiver Provider (CWP) or individual service provider.

PERFORMANCE DIMENSIONS

1. Providing timely access to Waiver services.
2. Providing timely enrollment of participants.
3. Providing at least one billable service per month (or monthly monitoring if the need for service(s) is less than monthly).
4. Basing plans of care and services on underlying needs and outcome statements.
5. Providing services according to the participant's service authorization.
6. Participating in Child and Family Team meetings.
7. Assuring development and revision of the service authorization.
8. Identifying and updating health and safety risk factors.
9. Collecting, reporting, and responding to critical incident data.
10. Credentialing and training providers.
11. Adhering to policies and procedures.
12. Maintaining continuity of care.