MHMR SERVICES FOR THE CONCHO VALLEY

Working together to help people help themselves.

TABLE OF CONTENTS

Table of Contents

MH QUALITY MANAGEMENT PLAN

DEFINING QUALITY

At MHMR Services for the Concho Valley (MHMRCV), quality can be described as an attitude and orientation that permeates the entire organization while conducting internal and external business. The individuals served by the Center, family members of individuals served by the Center, staff, and other stakeholders will have the opportunity for involvement in the quality management program through various public forums. This is very important as our organization and the quality of services we provide has a direct impact on all stakeholders.

The ultimate achievement of quality lies in meeting the highest expectations of the individuals served and assuring satisfaction with all services offered. Quality management integrates fundamental management techniques, existing improvement efforts, and technical tools in a planned approach focused on continuous process and outcome improvement.

VISION AND MISSION STATEMENTS

The Quality Management Program is driven by, and supports, the vision and mission of MHMR Services for the Concho Valley. These statements are provided next.

VISION:

The MHMR Services for the Concho Valley will provide, develop, and discover quality individual services in an environment sensitive and respectful to all consumers and staff. We will strive as a team to provide continuous individual choices for consumers, and develop their awareness so they may enjoy independent, unrestricted quality of life.

Our vision will be realized when our consumers and families tell us with confidence, we are doing everything possible to continually provide services of their choice, and maintain and continually practice respect, dignity, and responsive valued services.

MISSION:

The mission of MHMR Services for the Concho Valley is to offer an array of services and supports which respond to the needs of people with mental illness, intellectual and developmental disabilities, autism, and substance use disorders, enabling them to make choices that result in lives of dignity and increased independence.

DESCRIPTION OF CONCHO VALLEY MH SERVICES

Adult Mental Health Services

SERVICE NAME	DESCRIPTION
SCREENING	Activities performed by a QMHP-CS to gather triage information to determine the need for in-depth assessment. The QMHP-CS collects this information through face-to-face or telephone interviews with the individual or collateral.
PRE-ADMISSION ASSESSMENT	A face-to-face assessment of the individual conducted by a QMHP-CS for the purposes of determining eligibility for services which includes gathering and documenting required information.
CRISIS HOTLINE	A continuously available, QMHP staffed and AAS certified, telephone service providing information, support, referrals, and screening and intervention that responds to callers 24 hours per day, 7 days per week.
ENGAGEMENT	Activities with the client or collaterals in order to develop treatment alliance and rapport with the client and includes activities such as enhancing the individual's motivation, providing an explanation of services recommended, education on service value, education on adherence to the recommended level of care and its importance in recovery.
ROUTINE CASE MANAGEMENT	Primarily site-based services that assist an adult or caregiver in gaining and coordinating access to necessary care and services appropriate to the individual's needs and delivered in accordance with 25 TAC, Part 1, Chapter 412, Subchapter I.
COUNSELING	Individual, family and group therapy focused on the reduction or elimination of a client's symptoms of mental illness and increasing the individual's ability to perform activities of daily living. The CBT/CPT treatment model is provided by an LPHA.
PEER SUPPORT	Activities provided between and among clients who have common issues and needs that are client-motivated, initiated, and/or managed and promote wellness, recovery, and an independent life in the community.
CRISIS RESPITE	Respite service is provided to individuals for temporary, short-term, periodic relief for primary caregivers. Program-based respite services are provided at temporary residential placement outside the client's usual living situation. Respite can be provided up to 10 days.
PROVISION OF MEDICATION	The Center provides psychoactive medication to clients registered in CARE who have no source of funds for such, as determined to be medically necessary and as prescribed by an authorized provider.
PHARMACOLOGICAL MANAGEMENT	A service provided to a client by a physician or other prescribing professional which focuses on the use of medication and the in-depth management of psychopharmacological agents to treat a client's signs and symptoms of mental illness.
PSYCHIATRIC/ DIAGNOSTIC EVALUATION	Psychiatric diagnostic interview examination by MD, Licensed Psychologist, APN or PA.
CRISIS INTERVENTION	Interventions provided in response to a crisis in order to reduce symptoms of severe and persistent mental illness or emotional disturbance and to prevent admission of an individual or client to a more restrictive environment.

MEDICATION TRAINING AND SUPPORT	Education and guidance about medications and their possible side effects is provided to consumers and family members using HHSC promulgated patient and family education curricula.
PSYCHOSOCIAL REHABILITATIVE SERVICES	Social, educational, vocational, behavioral, & cognitive interventions provided by members of a client's therapeutic team that address deficits in ability to develop and maintain social relationships, occupational or educational achievement, independent living skills, and housing, that are a result of a severe/persistent mental illness. .
SKILLS TRAINING AND DEVELOPMENT	Training provided to a client that addresses the severe and persistent mental illness and symptom-related problems that interfere with the individual's functioning, 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.
CO-OCCURRING PSYCHIATRIC SUBSTANCE USE DISORDER (COPSD)	Intervention services offered within programs that are part of the TRR service array to meet the needs of people with co-occurring disorders. COPSD treatments integrate mental health and substance abuse interventions at the level of provider engagement. COPSD is integrated treatment provided by the same clinicians or teams of clinicians to provide appropriate mental health and substance abuse interventions in coordination to support persons in their recovery.
SUPPORTED EMPLOYMENT	Intensive services that are designed to result in employment stability and to provide individualized assistance to clients in choosing and obtaining employment in integrated work sites in regular community jobs is provided.
SUPPORTED HOUSING	Activities to assist clients in choosing, obtaining, and maintaining regular, integrated housing. Services consist of individualized assistance in finding and moving into habitable, regular, integrated (i.e., no more than 50 percent of the units may be occupied by clients with serious mental illness), and affordable housing.
RURAL ACT (RACT)	A self-contained program that provides treatment, rehabilitation and support services to clients who have a history of multiple hospitalizations or at least one hospitalization of greater than 30 days duration in the last two years. Rural ACT clients are prioritized for supported housing, supported employment, and COPSD services as needed.
INTENSIVE CRISIS RESIDENTIAL/CSU	Rapid crisis stabilization services are provided under arrangement with local participating licensed psychiatric hospitals. Should a more extended treatment be indicated, a contract with the State Hospital is in effect.
CONTINUITY OF CARE SERVICES	Services are provided primarily for individuals being transferred from one service area to another (inpatient to outpatient). A designated Qualified Mental Health Professional ensures, via concurrent planning and frequent contact, that services are consistent and follow the treatment plan from one service/program to the next.
CRISIS FOLLOW-UP AND RELAPSE PREVENTION	A service provided to or on behalf of individuals who are not in imminent danger of harm to self or others but require additional assistance to avoid recurrence of the crisis event.

SUPPLEMENTAL NURSING SERVICES	A service provided to a client by a licensed nurse or other qualified and properly trained personnel working under the supervision and delegation of a physician or RN to ensure direct application of a psychoactive medication to the client's body by any means and to assess target symptoms, side effects and adverse effects, potential toxicity and the impact of psychoactive medication for the client.
PRIMARY CARE SERVICES	Primary care service available to individuals admitted to MHMR services who have no insurance or Medicaid benefits and who currently do not have a primary care provider. This service is available as part of the 1115 Medicaid Waiver program and in partnership with a local medical clinic in Tom Green County.
MILITARY VETERAN PEER NETWORK SERVICES	The Military Veteran Peer Network is an affiliation of Service Members, Veterans and Family Members dedicated to establishing camaraderie and trust with each other, identifying and vetting community resources and, collectively, contributing to the communities where we live.
JAIL DIVERSION SERVICES	When someone is involved or at risk for involvement in the criminal justice system, or court ordered for treatment, jail diversion and competency restoration programs can help them get the services they need to stay in the community and take care of their health.
SAN ANGELO CLUBHOUSE	The San Angelo Clubhouse is a program for adults living with mental illness who have a desire to improve the quality of their lives through meaningful work and social relationships. Members of Clubhouse work along with staff to do the clubhouse work. From helping to prepare and serve lunch to social media and marketing, staff and members live, learn and grow together.
OUTPATIENT COMPETENCY RESTORATION	Outpatient competency restoration is the process by which defendants who have been found incompetent to stand trial (IST) are provided treatment and education so that they have a rational and factual understanding of the legal proceedings they will encounter. Historically, competency restoration was provided in an inpatient setting, but due to a shortage of psychiatric beds in Texas psychiatric facilities, the state began to utilize outpatient competency restoration.
M.I. PRE-ADMISSION SCREENING & RESIDENT REVIEW (PASRR)	PASRR is a federally mandated program that requires all states to prescreen all people, regardless of payer source or age, seeking admission to a Medicaid-certified nursing facility. PASRR has three goals: To identify people, including adults and children, with mental illness and/or IDD; To ensure appropriate placement, whether in the community or the nursing facility; To ensure people receive the required services for mental illness and/or IDD.
HB-13 :"CONTINUUM OF CARE: FROM CRISIS TO RECOVERY"	A program designed to provide a rapid and effective system of care that assists a person from crisis onset, reduces suicide, improves depression care and offers COPSD interventions across a spectrum of agencies and providers. The goal of this project is to expand/enhance access and availability of timely and effective crisis mental health and COPSD services delivered by a coalition of agencies serving individuals in 7 counties located in rural West Texas. The program also includes a "Zero Suicide" initiative.

Child and Adolescent Mental Health Services

SERVICE NAME	DESCRIPTION
CRISIS HOTLINE	A continuously available, QMHP staffed and AAS certified telephone service providing information, support, referrals, screening and intervention that responds to callers 24 hours per day, 7 days per week.
SCREENING	Activities performed by a QMHP-CS to gather triage information to determine the need for in-depth assessment. The QMHP-CS collects this information through face-to-face or telephone interviews with the individual, caregiver or collateral.
PRE-ADMISSION ASSESSMENT	A face-to-face assessment of the individual conducted by a QMHP-CS for the purposes of determining eligibility for services which includes gathering and documenting required information.
ENGAGEMENT	Short term planned activities with the child/youth, caregiver and/or legally authorized representative (LAR) to develop treatment alliance and rapport with the child/youth, caregiver and/or LAR. Activities include: enhancing the child/youth and/or caregiver/LAR's motivation to participate in services; explaining recommended services; and providing education regarding value of services, adherence to the recommended level of care and its importance in recovery.
ROUTINE CASE MANAGEMENT	Primarily site-based services that assist a child/youth, or caregiver/LAR in obtaining and coordinating access to necessary care and services appropriate to the individual's needs.
INTENSIVE CASE MANAGEMENT	Activities to assist a child/youth, or caregiver/LAR in obtaining and coordinating access to necessary care and services appropriate to the individual's needs. Wraparound Planning is used to develop the Case Management Plan.
COUNSELING	Individual, family and group therapy focused on the reduction or elimination of a child/youth's symptoms of emotional disturbance and increasing the individual's ability to perform activities of daily living. The CBT/CPT treatment model is provided by an LPHA.
PHARMACOLOGICAL MANAGEMENT	A service provided to a client by a physician or other prescribing professional which focuses on the use of medication and the in-depth management of psychopharmacological agents to treat a client's signs and symptoms of mental illness
MEDICATION PROVISION	Ensuring the provision of psychoactive medication benefits to clients registered in the CARE System who have no source of funds for such.
SUPPLEMENTAL NURSING SERVICES	A service provided to a client by a licensed nurse or other qualified and properly trained personnel working under the supervision and delegation of a physician or RN to ensure direct application of a psychoactive medication to the client's body by any means and to assess target symptoms, side effects and adverse effects, potential toxicity and the impact of psychoactive medication for the client.
PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATION	Psychiatric diagnostic interview examination by MD, Licensed Psychologist, APN or PA.

CRISIS INTERVENTION	Interventions provided in response to a crisis in order to reduce symptoms of severe and persistent mental illness and serious emotional disturbance and to prevent admission of an individual or client to a more restrictive environment.
MEDICATION TRAINING AND SUPPORT	Education and guidance about medications and their possible side effects is provided to children, youths and caregivers and/or LAR using HHSC promulgated patient and family education curricula.
SKILLS TRAINING AND DEVELOPMENT	Training provided to an individual and/or the primary caregiver or LAR that addresses the serious emotional disturbance and symptom-related problems that interfere with the individual's functioning, 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.
FAMILY CASE MANAGEMENT	Activities to assist the individual's family members in accessing and coordinating necessary care and services appropriate to the family members' needs.
FAMILY TRAINING	Training provided to the individual's primary caregivers to assist the caregivers in coping and managing with the client's emotional disturbance.
FAMILY PARTNER	Peer mentoring and support provided by Certified Family Partners to the primary caregivers of a child who is receiving mental health community services. This may include introducing the family to the treatment process; modeling self-advocacy skills; providing information, making referrals; providing non-clinical skills training; assisting in the identification of natural/non-traditional and community supports.
PARENT SUPPORT GROUP	Routinely scheduled support and informational meetings for the client's primary caregivers.
FLEXIBLE FUNDS	Funds utilized for non-clinical supports that augment the service plan to reduce symptomatology and maintain quality of life and family integration.
INTENSIVE CRISIS RESIDENTIAL/CSU	Under arrangement with local participating licensed psychiatric hospitals, rapid crisis stabilization services are provided. Should a more extended treatment be indicated, a contract with the State Hospital is in effect.
CRISIS FOLLOW-UP AND RELAPSE PREVENTION	A service provided to or on behalf of individuals who are not in imminent danger of harm to self or others but require additional assistance to avoid recurrence of the crisis event.
YES WAIVER SERVICES	The Youth Empowerment Services waiver is a 1915(c) Medicaid program that helps children and youth with serious mental, emotional and behavioral difficulties. The YES waiver provides intensive services delivered within a strengths-based team planning process called wraparound. Wraparound builds on family and community support and utilizes YES services to help build your family's natural support network and connection with your community. YES services are family-centered, coordinated and effective at preventing out-of-home placement and promoting lifelong independence and self-defined success.

REPORTING RELATIONSHIPS

LEADERSHIP & DELEGATION OF RESPONSIBILITY:

Quality management systems exist to plan for, measure, and improve the quality of care provided to individuals served and improve the supporting administrative systems. Every person in the organization shares responsibility for quality management. As a Community Center, MHMRCV will be accountable for the quality of services provided directly by our staff as well as those services that are subcontracted to other providers. As a result, it is important that there be a clear delineation of responsibilities, and a clear designation of authority. At MHMRCV, the following reporting relationships exist.

- *Relationship Between Concho Valley and the Health and Human Services Commission (HHSC):*
  Concho Valley is obligated to HHSC through a contract agreement to do the following:

  - Comply with all HHSC standards
  - Comply with the performance contract targets for individuals served and the outcome measures required

- *The Board of Trustees:*
  The Board of Trustees mandates the implementation of an effective Quality Management Program through Center Policy # 3.06.07.00 and actions taken by the Executive Director. The Board of Trustees is responsible for requiring ongoing reporting from the Executive Director, or designee, regarding the quality management activities and strategies for improvement.

- *The Executive Director:*
  The Executive Director will achieve the goals required by HHSC through the performance contract and regulations. The Executive Director has the authority and responsibility to establish an integrated Quality Management Program within the Community Center. The Executive Director is also responsible for ensuring and supporting an ongoing process for monitoring, evaluating, and reporting performance outcomes.

- *Director of Operations:*
  The Executive Director of MHMRCV has designated the responsibility for coordinating all quality management activities within the Center to the Director of Operations, who reports directly to the Executive Director. The Director of Operations has also been designated as the Corporate Compliance Officer, with the responsibility of developing, monitoring, and coordinating all aspects of Corporate Compliance.

  The current Director of Operations has twenty years of experience in this type of work and has been determined by the Executive Director to be an individual with adequate and appropriate experience in quality management. Additionally, as the quality management responsibilities grew over time, the Executive Director allocated adequate resources to add additional staff to the Quality Management Department. As a result, a Quality Management Coordinator was added to the department to assist with the completion of necessary mental health related quality management

functions. The Quality Management Coordinator has seven years of experience in this type of work.

There is a standing agenda item on the Board of Trustees Program Committee Agenda entitled "Quality Management Reports." During this portion of the Program Committee Meeting the Executive Director designates the Director of Operations the authority to provide appropriate quality management updates to the Board of Trustees Program Committee members. The entire Program Committee Report is taken to the full board and a report is delivered. These activities are reflected in the Board of Trustees meeting minutes and/or records.

- *Texas Department of Family and Protective Services (TDFPS):*
  TDFPS is the contact agency for all allegations of abuse/neglect or exploitation reported that involves individuals receiving services from MHMCV. The Center does not investigate allegations. Concho Valley is obligated to:

  - Comply and cooperate with all TDFPS investigations; and
  - Supply information needed to complete TDFPS investigations.

THE QUALITY MANAGEMENT PROGRAM

The implementation of the Quality Management Program allows for a coordinated approach to planning and improving performance. The goal is to use available resources in striving to achieve optimal outcomes with continuous, incremental improvements in quality. An effective Quality Management Program should:

- Identify desired outcomes;
- Measure performance;
- Promote changes to improve performance; and
- Measure the effect of those changes in relation to the desired outcomes.

The over-all objectives of Concho Valley's Quality Management Program are to:

- Facilitate and advance the delivery of quality care to the people we serve;
- Evaluate and take opportunities to improve quality of care and service;
- Enhance the health status of the communities we serve;
- Provide an interactive needs assessment process, encouraging community involvement with meaningful participation by people served, families, advocates, and other stakeholders;
- Allow for an avenue of feedback regarding satisfaction with the quality, quantity, and types of services desired by the persons served;
- Ensure the communication of information to service areas when opportunities to improve services are provided;
- Ensure compliance with contracting agencies, federal, state, and licensing requirements; and
- Ensure the ongoing evaluation of the effectiveness of processes identified and implemented through the plan for quality improvement.

THE QUALITY MANAGEMENT PLAN:

The Quality Management Plan is a functional tool to assist the Center in accomplishing its mission and directing the staff in achieving identified performance outcomes. The plan will assist the Center with moving in a positive direction for change. This will be possible by implementing, and monitoring the following quality management activities:

- Local Strategic Planning
- Policy and Procedure Development and Revision
- Competency Reviews of Staff
- Rights Protection and Advocacy
- Risk Management/Safety/Infection Control
- Utilization Management
- Record Reviews
- Client Satisfaction
- Corporate Compliance Reviews
- HIPAA Compliance

PROGRAM STRUCTURE AND DESIGN:
The Quality Assurance Committee (QAC) is responsible for overseeing the Quality Management Plan. The members of this committee play a role in setting standards, deciding whether the organization is headed in the direction intended, determining whether the services being provided are leading to the desired results, and determining whether the contract rules and requirements are being met.

Quality related issues or concerns regarding services may be identified at various levels throughout the Center and by external bodies or parties including committees, management staff, volunteers, advisory committees, external consultants, etc. In order for the Center to identify opportunities for improving services, all identified problems or deficiencies which impact care and clinical performance shall be reported through minutes, reports, etc. to the QAC and the administrative staff.

STRATEGIC PLANNING:
The responsibilities and key participants for each step are described next.

Step 1 - The foundation of the planning process is our organizational vision. We envision our community to be a place free of stigma that includes everyone, regardless of ability or disability, and this vision guides us through each step of the strategic planning process.

Step 2 - The Executive Director defines the Center's ***goals*** and presents them to the Board of Trustees (BOT) for approval. The Board of Trustees approves the goals and evaluates the performance of the Executive Director against the set goals on an annual basis. Key factors in developing goals include patient and community feedback, employee feedback, socioeconomic and demographic analysis, forecasts of the number of people that need services, legislative requirements, and resource allocation. The data is reviewed to assure that the strategic direction is balanced with our responsibility to individuals served, community, employees and HHSC. (*Goal* - **A goal is defined as a generally desirable outcome. A goal implies a direction for change but does not in itself include criteria for success or measurable objectives.)**

Step 3 - The organization's Executive Leadership Team develops the ***outcomes*** and action plans in support of the organizational goals. The PNAC plays a role in fine-tuning this information. The alignment of these initiatives with the goals is discussed by the Executive Leadership Team.

Step 4 - MHMRCV deploys the direction and goals through careful alignment of action plans and subsequent identification of work tasks for all personnel. Each action plan has a leader responsible for the execution. The role of the leader is to communicate to the employees the outcomes of the plan and how their work will contribute to goal achievement.

Step 5 - At MHMRCV we believe that a comprehensive review of our activities and results against the set outcomes culminates in planned improvement actions. Self-assessment helps identify gaps between where the Center is, and where it needs to be in order to provide relevant services. In the absence of goals and outcomes an organization cannot tell whether or not it has effectively achieved its goals. It is essential to establish meaningful outcomes to honestly appraise the progress the organization is making. Please refer to page 35 to review the goals, objectives and performance indicators that will be monitored.

COORDINATION, INTEGRATION AND PLANNING

MECHANISMS FOR GATHERING INTERNAL DATA:

The Center has established a variety of committees to carry out quality management activities and other vital functions. Each of these committees plays a role in gathering and reviewing data. Feedback is solicited from Center committees on a quarterly basis through use of "Committee Feedback Reports." These reports are reviewed by the Quality Assurance Committee which then develops a plan to improve the system. After the plan is implemented, it is monitored to ensure it continues to be effective.

The internal committees that are an integral part of the Quality Management Program include:

- Executive Leadership Team
- Quality Assurance Committee/Corporate Compliance Committee
- MH Utilization Management Committee
- Clinical Records Committee
- Risk Management/Safety Committee
- Clinical Peer Review Committee
- Human Rights Committee
- Administrative Death Review Committee
- Jail Diversion Committee
- Benefits Committee

Each of these committees is described next.

Executive Leadership Team (ELT)
Purpose: To provide leadership for MHMR Services for the Concho Valley **Membership:** Executive Director, Chief Financial Officer, Director of Operations, Director of Mental Health, Director of IDD, Director of Human Resources, and Director of Administrative Services/Contract Manager. **Frequency:** Monthly and PRN
Quality Assurance Committee/Corporate Compliance Committee (QAC)
Purpose: To provide a forum for review and action related to committee reports, record reviews, surveys, plans of improvement, Corporate Compliance issues, the Quality Management Plan, and all quality assessment activities. On a quarterly basis, all committees turn in a report to the QAC. The information is reviewed, and trends are identified. Plans of improvement are developed and results are monitored. **Membership:** Director of Operations, Quality Management Coordinators – MH and IDD, Director of IDD, Director of Mental Health, Human Resource Specialist, Supportive Housing Specialist, MH Program Manager, Executive Director, Director of Administrative Services/Contract Manager, Director of Reimbursement, Clubhouse Director, C&A Counselor, ABC Center Program Manager, IDD Provider Program Manager **Frequency:** Quarterly and PRN

MH Utilization Management Committee (UM)

Purpose: To provide an ongoing and continuous mechanism for review and improvement of AMH and C&A MH clinical care including review activities that address eligibility determination, level of care assignment, authorization, reauthorization, outlier review, exception/clinical overrides, appeals and inpatient admissions. This committee is also responsible for reviewing hospital bed-day utilization, deaths of persons served, the timeliness, and clinical necessity of admissions, continuity of treatment and discharges.

Membership:
Medical Director/UM Physician, Utilization Manager, Executive Director, Director of Operations, Quality Management Coordinator/UM Reviewer, Director of Mental Health, Chief Financial Officer, MH Program Manager, HB-13 Manager, Director of Reimbursement

Frequency: Quarterly

Clinical Records Committee

Purpose: To review and monitor the Center's records system to assure it is effective and efficient for clinical use and quality management reviews. The members are responsible for ongoing review of records policies/procedures and communication of procedural changes to staff. The committee reviews and approves new forms or changes to documents in the record.

Membership:
AMH/C&A/IDD/Records Supervisors, ABC Records/Reception Staff, Director of Operations, Quality Management Coordinator-MH, Director of Reimbursement

Frequency: Quarterly and PRN

Risk Management/Safety Committee

Purpose: This committee will assure a safe, healthy and risk-free environment for the people served at MHMR Services for the Concho Valley. The committee is charged with conducting routine, timely reviews of trends regarding infection control, safety management, incident/accident reporting, and legal issues impacting patient care.

Membership:
Risk Management/Safety Officer, Director of Operations, Infection Control RN, Staff representation from each MH and IDD program, Quality Management Coordinators – MH and IDD, Director of Mental Health, Director of IDD, Center Maintenance Personnel

Frequency: Quarterly and PRN

Clinical Peer Review Committee

Purpose: To provide a forum for clinical disciplines to assess the quality of care provided to people served. Peer review committees are established for nurses, licensed professional counselors and licensed social work staff. Requests for review are submitted by other committees, through review of incident reports, or by documented special request of a discipline member or other provider of patient services.

Membership: Persons from the same discipline as the peer being reviewed

Frequency: PRN

Human Rights Committee (HRC)

Purpose: This committee protects, preserves, promotes, and advocates for the health, safety, welfare, and legal and human rights of individuals in our services. The committee reviews rights restrictions, and ensures due process when rights are restricted.

Membership:
Director of Operations, Quality Management Coordinator - IDD, IDD Day Activity Supervisor, Center Employed Certified Licensed Psychological Associate, Representative of the Public-Volunteer

Frequency: Quarterly and PRN

Administrative Death Review Committee

Purpose: The purpose of the Administrative Death Review Committee is to review the information and recommendations provided by the clinical death review committee and/or from the preliminary investigation; review operational policies and procedures and continuity of care issues which may have affected the care of the individual and formulate written recommendations for changes in policies and procedures, if appropriate; and act upon any recommendations.

Membership:
Director of Operations, Quality Management Coordinator, three senior administrative and medical personnel, one representative of the public, other individuals appropriate to the death being reviewed.

Frequency: PRN

Jail Diversion Committee

Purpose: This committee ensures quality crisis services are provided in our community.

Membership:
Director of Mental Health, Medical Director, TCOOMMI Program Director, Executive Director, Tom Green County MH Deputy Representatives, Tom Green County Sheriff's Department Representatives, Tom Green County Jail Representative, San Angelo Police Department Representative, Local Hospitals and ED Representatives, Surrounding Counties Representatives, TCOOMMI Jail Diversion Coordinator

Frequency: Quarterly and PRN

Benefits Committee

Purpose: This committee is responsible for evaluation and assessment of employee fringe benefits (sick, vacation, health insurance, dental), FMLA issues and specific employee situations related to benefits.

Membership:
Executive Director, CFO, Human Resources Specialist, Director of Reimbursement, YES Waiver Supervisor, IDD Provider Program Manager, MHFA Specialist

Frequency: PRN

MECHANISMS FOR STAKEHOLDER INVOLVEMENT

MECHANISMS FOR GATHERING DATA:

The continuous quality improvement process involves a combination of internal and external stakeholders. These combined stakeholder groups include people served, family members, advocates, providers, volunteers, contractors, the community at large and staff. The stakeholders will be offered an opportunity to identify desired outcomes and provide input that will guide our service delivery system. This is a way to ensure that the needs of the community are being met.

An assessment of needs will be conducted in our catchment area via the Local Planning process and other initiatives. The Quality Assurance Committee will review the feedback that is received, and efforts will be made to meet the needs of the people we serve. Further, input will be gathered through satisfaction surveys and information gathered from the following committees:

MH & IDD PLANNING & NETWORK ADVISORY COMMITTEE (PNAC):

The PNAC is established by the Board of Trustees and its membership is composed of fifty percent participation by individuals with IDD or family members of individuals with IDD and fifty percent participation by MH patients or family members of patients with mental illness. Prior to assuming their membership duties, the PNAC members are trained regarding the following topics:

- Organization of MHMRCV Services
- Responsibilities and Guidelines of Advisory Committees
- HHSC Performance Contracts
- Center Vision, Mission and Values
- Local Plan and Objectives
- Operating Budget
- Confidentiality
- Abuse/Neglect/Exploitation of People Served.
- Community Advocate Advisory Committee

The PNAC is responsible for the following activities:

- Advising the Board and Center staff on issues relating to: delivery of service, operations, evaluation of services, provider network expansion, provider selection criteria, impartial evaluation of network providers, and mechanisms for determining which services shall be put up for bid
- Reviewing information provided by Center staff regarding the implementation of the Quality Management Plan
- Making recommendations to the Board regarding Local Planning
- Responding to special charges assigned by the Board
- Meeting on a quarterly basis

MEASURING – EVALUATING – IMPROVING ESSENTIAL FUNCTIONS

MHMRCV will use a variety of methods to measure, assess and improve essential functions. Essential functions are identified by stakeholders, advisory committees, as well as internal committees. Contractual requirements, departmental rules, and federal and state laws will also be adhered to when determining what data should be measured. (See page 27 for a description of quality monitoring elements.)

MEASURING-EVALUATING-IMPROVING MH AUTHORITY FUNCTIONS:

Authority Function	Measurement/Evaluation	Improvement
Local Planning	The Executive Leadership Team conducts reviews of the achievement of goals and outcomes defined in the Local Plan.	Based on Executive Leadership Team (ELT) review and consideration, local planning improvement of goals and outcomes is achieved by instituting additional staff training where necessary and charging local Center committees with special tasks for completion and presentation to the QAC for implementation. The PNAC plays a role in developing the direction of this plan.
Policy Development and Management	As new TAC rules, contract mandates and other governing guidelines are released, the Quality Management Department reviews/revises/consults w/other program directors and/or develops appropriate policies for BOT approval.	The Executive Director presents policies for approval to the Board of Trustees as needed. The Board of Trustees will approve the policies as presented or with their revisions. The Executive Director, along with the ELT, will then develop local procedures to operationalize the policies.
Coordination of Service System with Community and HHSC	Concho Valley coordinates with the Social Health Resource Coalition, CSCD, Jail Diversion Task Force, Homeless Coalition, CRCG, sponsoring agencies, the Chamber of Commerce, ELT membership on the boards or governing committees of various agencies and councils, and M.O.U.s with various affiliates. The Center measures and assesses its coordination efforts by maintaining current relationships with community agencies.	Concho Valley seeks to improve coordination of service systems with community agencies by consistently maintaining communication and involvement with relevant agencies. Staff commitments to work toward solutions that enhance our community ensure forward progress. Open communication and education are vital to improvement. Concho Valley hosts meetings, trainings, etc. with agencies to promote stronger relationships with community agencies.
Resource Development & Management	Establish target cost per unit for services to meet targets.	Redeploy staff not meeting target cost.
Resource Allocation & Mgt.	Percent of face-to-face patient encounters per employee.	Utilization of Performance Improvement Procedure.
Disaster Services	The Risk/Safety Officer will participate in disaster exercise drills and also review disaster status reports, aggregate DBH services delivered with the Risk Management Committee in order evaluate whether the interventions promoted the desired outcomes for the community.	Improvement will be achieved via lessons learned, PDSA cycles occurring during a disaster response as a result of review of status reports.

MEASURING-EVALUATING-IMPROVING MH SERVICE ACCESS AND CAPACITY:

Prospects for enhancement of access and capacity will be identified using several methods. The Center's committee structure plays a primary role in this process along with the use of the Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW) and the Center's Electronic Health Record (EHR) service reports.

Access to mental health services will be monitored by examining trends identified in the patient feedback process, appeals process, mystery caller process and by reviewing EHR reports. By scrutinizing the rate of admitted clients versus those screened for intake and other comparable data reports we can monitor access issues and make improvements when needed. Additionally, anonymous local Quality Management "mystery caller" oversight related to the Center's intake system will be utilized to ensure that patients have access to mental health care within defined HHSC standards. MH issues related to access that appear to be problematic and deserve enhancement will be evaluated and monitored by the Utilization Management Committee and Quality Assurance Committee.

MH capacity will be evaluated by monitoring AMH Outpatient Clinic and Family and Youth Guidance Center operating efficiencies and management reporting compared with benchmark and contract indicators. Specifically, MH Directors will monitor staff ability to comply with standards of care within defined limits. If staff cannot perform essential functions based on caseload size, then the Utilization Management Committee will be called upon to review elements such as waiting list necessity, state-wide caseload management limits, cost per unit of service and TRR fidelity with current client population. Recommendations for capacity adjustments will be made by the Utilization Management Committee.

MEASURING-EVALUATING-IMPROVING LMHA SERVICE DELIVERY:

Several steps are taken to monitor and evaluate opportunities to improve care and service operations, and to solve identified problems. Patient feedback, provider performance reviews, and other committee activities are reviewed to identify issues. Further, contracts with all service providers are reviewed by the Center's PNAC to ensure they comply with Community Standards and patient satisfaction standards. The Quality Management Department offers feedback on all contracts in compliance with Center procedure # 6.01.02.00 – "Contract Selection, Monitoring and Evaluation."

Problem areas identified by the methods previously described are assessed by outlining their priority, impact on care provided to individuals, implementation costs, and accessibility to services. Upon completion of any Quality Management review, the Quality Management staff present review findings to program directors, make recommendations for improvement and offer one-on-one or group technical assistance when needed. The Quality Assurance Committee manages any subsequent improvement strategies. Table #1, found on page 25, indicates the Quality Management review schedule and the frequency of the reviews for improvement of provider services.

MEASURING-EVALUATING-IMPROVING TX RESILIENCE/RECOVERY (TRR) PRACTICES:

Quality of Implementation of TRR Practices:

The Center's Utilization Management Committee plays a key role in determining the quality of implementation of TRR practices. This committee reviews HHSC MBOW UM reports related to appropriateness of eligibility determinations, use of exceptions and overrides, over and under

utilization, appeals and denials, fairness and equity, and cost-effectiveness of all services delivered. In conducting research required to accomplish these tasks, particular focus is on ensuring that each function is being conducted in accordance with TRR UM Guidelines. When TRR deployment inaccuracies are pinpointed, the committee defines the expectations for TRR implementation and in-services staff as necessary. Any identified inaccuracies will be continuously monitored by the Center's Quality Assurance Committee for evidence of correction.

Oversight of Fidelity to the Service Models:
The Quality Management Department conducts fidelity reviews of TRR service models. The HHSC authorized fidelity instruments are used for oversight. During a fidelity chart review the service model fidelity is reconciled against evidence in the clinical record and EHR service reports to ensure that services are being provided in accordance with guidelines described in the Fidelity Toolkit. The results of reviews are shared with the appropriate program directors, the Utilization Management Committee and the Quality Assurance Committee. Necessary internal plans of improvement are developed and monitored by the Quality Assurance Committee and training sessions are conducted as needed.

Patient/Family Education Implementation:
The system-wide implementation of TRR includes enhanced patient and family education protocols. Patient records that include nursing and case management notes refer to HHSC promulgated patient/family education principles.

The AMH nurses are distributing and explaining literature approved by HHSC during patient appointments. The nursing progress notes clearly indicate that nurses are teaching patients regarding aspects of mental illness. The nursing notes available in the clinical record address the following principles:

- Appetite
- Sleep patterns
- Medication side effects
- Medication compliance
- Medication response
- Relapse prevention
- Justification for notifying non-Center doctors of any/all Center prescribed medications
- Hospitalization prevention

Additionally, QMHP-CS staff conduct the Schizophrenia Positive Symptom Rating Scale & Brief Negative Symptom Assessment, the Brief Bipolar Disorder Symptom Scale and the Quick Inventory of Depressive Symptomatology-Self Report. All of the diagnosis specific algorithm results of these assessments are filed in the clinical record. Education materials are available in nurses' offices and are used to reinforce the education process.

Peer Support:
An MHMR staff is available to encourage and assist support group facilitators during meetings and provide educational materials as needed. The meetings occur as needed, are scheduled for one-hour

duration and are evidenced by way of a sign in sheet. Most recently, the Center's peer provider has become involved in reinvigorating the peer support groups to promote recovery for those involved.

MEASURING- EVALUATING -IMPROVING YES WAIVER ACTIVITIES:

YES Waiver Quality Management Objectives:

The following objectives apply to and guide the YES Waiver Quality Management activities performed at this Center:

1. To assure quality YES Waiver services are provided to individuals served.
2. To utilize and supply data-driven YES Waiver information that is the catalyst for improvement.
3. To be a good steward of the YES Waiver resources.

YES Waiver Policies and Procedures Compliance Plan

Concho Valley's YES Waiver compliance will be monitored by the Center's Quality Management Department. Periodic chart reviews will be performed by the Quality Management Department to assess the program's fulfillment of the requirements outlined in the most current version of the HHSC YES Waiver Policy and Procedure Manual posted on the HHSC website. More specifically, YES Waiver data and information will be gathered, measured and assessed in an effort to work toward improvements in dimensions of performance. Elements to be included in the chart review tool used by the Quality Management Department are briefly described in the below.

Quality Management Review Tool Elements

1	*Inquiry List Requirements*
2	*Clinical Eligibility Requirements*
3	*Enrollment Requirements*
4	*Service Authorization Requirements*
5	*Waiver Service Provision*
6	*Wraparound Plan Requirements*
7	*Crisis/Safety Plan Requirements*
8	*Engagement*
9	*Critical Incident Reporting Requirements*
10	*Reasons for Termination*
11	*Provider Credentialing Requirements*
12	*Provider Training Requirements*
13	*Utilization Patterns*
14	*Treatment Outcomes*
15	*Service Claims*
16	*Safe/therapeutic Environment*
17	*IPC Requirements*

Upon completion of a YES Waiver chart review, Quality Management staff will prepare a written review summary of the findings and any corrective actions needed and provide this information to the proper program managers for examination and further action. A copy of this report will also be sent to the Executive Director. Quality Management Department staff will offer opportunities to YES staff to meet face-to-face to review the findings summary and provide technical support to promote YES

fidelity. The YES Waiver chart review results report will be added to the Quality Assurance Committee agenda for review, discussion and monitoring of corrective actions if any were determined necessary.

Furthermore, service utilization will be monitored for compliance with the HHSC approved IPC for each waiver participant through intermittent concurrent and retrospective reviews by the Center's Utilization Management Department. This information, along with YES Waiver enrollment target information, will be further monitored at the quarterly Utilization Management Committee. The Utilization Management Committee's efforts are captured in meeting minutes and committee members sign an attendance sheet.

MEASURING- EVALUATING -IMPROVING MH DATA ACCURACY:

MHMRCV data accuracy will be measured, evaluated and improved based on active use of HHSC MBOW reports, implementation of tentative data processes and on-going staff training related to data accuracy obligations. The Center's Executive Leadership Team, Utilization Management Committee and mental health program managers will routinely review those HHSC MBOW reports that are relevant and associated with respective job duties. The Quality Management Department plays a role in each committee review. Further, accountability will be ensured regarding supervisory staff's obligations to review and act on correcting data found to be inaccurate. Job descriptions will include reference to requirements associated with data management and accuracy.

The use of tentative data processes will allow appropriate time for data submission, correction and re-submission in a timely fashion to ensure accuracy. Part of this process will be the incorporation of training for those staffs whose data submissions are determined to be problematic. Results of the training intervention will be addressed in face-to-face meetings with staff during regularly scheduled program meetings.

MEASURING- EVALUATING -IMPROVING MH OTHER OPERATIONAL METHODS:

Health Inspections:

The Center will ensure that an annual health inspection occurs for all provider programs in which patients prepare food. In the event the health department cannot provide such inspection, the agency will ensure the registered dietician completes a comparable inspection. If violations are cited, a plan of improvement will be completed along with deadlines for completion of tasks. The staff in the program in which the deficits are cited will complete this. The program manager will be responsible for following up to ensure the corrections were implemented. This process will be monitored by the Quality Assurance Committee and the Risk Management Committee.

Infection Control Program:

The Infection Control Program will be monitored and evaluated by having all incidents involving infection control and patients reported to the Infection Control Officer/Nurse who will review the incidents and report any findings to the Administrative Staff and the Quality Assurance Committee. The Risk Management/Safety Officer will work with the Center's nursing staff to follow the Infection Control Plan. The responsibilities include providing ongoing staff in-service training, conducting inquiries into reported health related incidents. The Infection Control Program will follow Community Standards, Center Policy and Procedure, federal, state and local requirements.

Trauma Informed Care Initiative (TIC):
It is the policy of the Center to create and maintain a safe, calm, and secure environment with supportive care, a system-wide understanding of trauma prevalence and impact, recovery and trauma specific services, and recovery-focused, consumer-driven services that applies to all staff, volunteers, contracted providers, and community partners. The success of this initiative will be measured through system-wide self-assessment activities and patient and staff feedback. Responses from patients or opportunities for improvement identified through self-assessment will be evaluated by the TIC Core Implementation Team and Quality Assurance Committee so that continuous improvements can be made towards trauma informed care.

MONITORING, ANALYZING & IMPROVING MH QUALITY MANAGEMENT ACTIVITIES:

Concept Fans:
Quality management activities will be improved via idea generation with concept fans. This means of creative thinking allows for each and every idea to be deemed valuable and the more ideas generated, the higher the likelihood of getting a breakthrough idea. The concept fan is a way to open up alternate ideas and concepts to achieve a defined purpose. The benefits of concept fans are as follows:

- Easy to use;
- Allows for everyone's input;
- Does not allow for judging ideas as good or bad at the start;
- Captures the high-level objectives and concepts as well as specific ideas for change; and
- It is a graphical way to display and work with ideas to drive the development of more ideas.

Concept fans allow for the generation of ideas that you may want to test, and if the results are good, implement (Edward de Bono, Lateral thinking). The promotion of improved quality management activities will be achieved by using this method.

Cause and Effect (Fishbone) Diagrams
Another tool used in Quality Management to promote improvements within the Center is the "Ishikawa Diagram" and "Why Analysis." A fishbone diagram, also known as Ishikawa diagram or cause and effect diagram, is a tool used to visualize all the potential causes of a problem in order to discover the root causes. The fishbone diagram helps one group these causes and provides a structure in which to display them. A cause and effect diagram has a variety of benefits: It helps teams understand that there are many causes that contribute to an effect. It graphically displays the relationship of the causes to the effect and to each other. It helps to identify areas for improvement.

Table #1 - "Quality Management MH Review Schedule"

TITLE OF REVIEW	FREQUENCY	FY '19 REVIEW COMPLETION	FY '20 REVIEW COMPLETION
Comprehensive MH Chart Review **(completed by QM Coordinator)** • *Demographic Assessment* • *Initial Contact Assessment* • *Psychiatric Evaluation Elements* • *Uniform Assessment* • *Diagnosis Assessment* • *Financial Assessment* • *Client Rights Review* • *HIPAA Privacy Acknowledgement* • *Consent to Tx w/ Psychoactive Meds.* • *Progress Notes* • *Recovery Plans* • *Non-final approved progress notes* • *Discharge Summary*	SEMIANNUAL		
PESC: (completed by QM Coordinator) • *Crisis Respite Facility Site Assessment* • *Crisis Respite SAM Training* • *Tier 1 CSU Utilization (UMC)* • *Crisis Hotline* • *MCOT*	SEMIANNUAL		
Fidelity: (completed by QM Coordinator) • Rural ACT • *CMH TRR - CBT, ART, Seeking Safety, Nurturing Parenting, Wraparound Planning* • *YES Waiver* • *YES Waiver Inquiry Line*	ANNUAL		
Mental Health Deputy Program **(completed by Dir. of Operations)**	ANNUAL		
Mental Health First Aid Program: **(completed by Dir. of Operations)**	ANNUAL		
Mental Health Veterans Services: **(completed by Dir. of Operations)**	ANNUAL		
Access to Routine MH Services: **(completed by QM Coordinator)**	SEMIANNUAL		
ADA Self-eval./Transition Plan: **(completed by Dir. of Operations)**	ANNUAL		
TCOOMMI: **(completed by QM Coordinator)**	SEMIANNUAL		
Rural ACT: **(completed by QM Coordinator)** • TAC/ANSA/Recovery Plan	QUARTERLY		
Delegating MD Oversight of NP Charts: **(oversight by Dir. of Operations)**	MONTHLY		
Policy/Procedure:**(completed by Dir. Operations)**	PRN		
HB 13 Initiatives: • Expand/Enhance MH Deputy Program **(completed by Dir. of Operations)** • Zero Suicide Initiative **(completed by Dir. of Operations)** • COPSD **(completed by QM Coordinator)**	QUARTERLY		

San Angelo Clubhouse **(completed by Dir. of Operations/QM Coordinator)**	ANNUAL		
Personnel Record/Job Description Review: **(completed by Dir. of Operations)** • E.D. Compensation Notification Sponsoring Agencies **(completed by Dir. of Operations)** • Certified Family Partner **(completed by QM Coordinator)**	ANNUAL		
Subcontractors **(completed by Dir. Operations)**	ANNUAL		
Outpatient Competency Restoration **(completed by QM Coordinator)**	ANNUAL		
Supported Housing **(completed by QM Coordinator)**	SEMIANNUAL		
PASRR MI **(completed by QM Coordinator)**	SEMIANNUAL		

ANALYSIS OF QUALITY MONITORING ELEMENTS

DATA REQUIREMENTS/ ELEMENTS REVIEWED	METHODOLOGY/DATA SOURCES	RESPONSIBLE PARTY	REPORTING FREQUENCY
State hospital bed day utilization	Information is collected for state hospital admissions. The following info will be collected: Total Days in Hospital, Number of Prior Admissions, and Length of Stay.	Utilization Management Committee	Quarterly
Continuity of Care	Appointment data; HHSC MBOW reports	Utilization Management Committee	Quarterly
Grievances/Appeals/Fair Hearings/Expedited Hearings	Utilization Management Administrator Records	Utilization Mgt. Committee/UM Admin./QM	Quarterly
Current performance on all target driven services	Collect information from HHSC MBOW reports and EHR reports	Utilization Management Committee/QM	Monthly
No-show rates	This will be collected through the EHR Appointment Scheduler software.	Utilization Management Committee	Quarterly
Waiting list	This data will be collected through internal reporting and HHSC MBOW data.	Utilization Management Committee	Quarterly
Mortality Review	Information will be collected through Quality Management data.	Utilization Management Committee/Risk Management Committee/QAC	Quarterly
Number of individuals served per program and service	Information will be collected by MBOW and EHR data.	Quality Management	Quarterly
Number of abuse, neglect and rights violations, allegations and confirmations.	This information will be collected via CANRS and internal reporting systems	Quality Management Office/ Risk Management Committee/Utilization Management Committee	Quarterly
Caseload management ratio based on assessed severity of people served	This will be collected through MBOW Utilization Management data and internal reporting systems	Utilization Management Committee	Quarterly
Cost of services	This will be collected through Utilization Management data and internal reporting systems	Utilization Management Committee/ Executive Leadership Team	Quarterly

ABUSE/NEGLECT/EXPLOITATION REDUCTION PLAN & RIGHTS PROTECTION

MHMRCV strives to deliver quality services to patients living with mental illness. In order to do this, the Center understands the importance of hiring and training qualified staff. It is our responsibility to ensure that the individuals we serve are in a safe environment and that their rights are protected. This is accomplished in a variety of ways that will be explained in detail next.

POLICIES AND PROCEDURES:

Consumer Rights

Concho Valley has policies and procedures in place that specify the rights of individuals receiving Center services, require that these rights be made known to individuals receiving Center services, assist individuals in exercising their rights in a manner which does not conflict with the rights of other persons and describe the process by which individuals may exercise their right to appeal treatment modalities and staff behavior. These policies/procedures ensure the following:

- Upon admission, each new patient and the parent(s), guardian or advocate of a minor is given a Patient Rights Handbook with an oral explanation and confirmation of understanding. Extra copies of handbooks are accessible to all individuals who request them via MH Case Management staff and the Client Rights Protection Officer. In addition, copies of handbooks are available in clinic lobbies and on the Center's website.

- Current Rights Protection information forms are posted in English and Spanish at all program sites in locations readily accessible to the individuals served.

- The HHSC Office of Ombudsman phone number is prominently posted and included in the Rights Handbooks.

- Procedures for contacting Disability Rights Texas are posted.

The Center has a staff person designated as the Rights Protection Officer who is responsible for implementation of the Center's Rights Program. This person is identified, and ways of accessing this person are reviewed with each patient upon intake. The Director of Operations functions as the Rights Protection Officer. The responsibilities of this officer include the following:

- Directing a program of self-advocacy & to protect/advocate for the legal/basic human rights;

- Investigating and resolving all individual patient complaints regarding rights issues;

- Reporting to appropriate administrative personnel any program, practices that interfere with the responsiveness of programs and services to patient needs;

- Reviewing all policies, procedures, behavior therapy programs, and rules that affect patient rights.

Abuse, Neglect, and Exploitation

Consumer abuse, neglect, or exploitation by Center employees, affiliates, and agents are prohibited and shall be grounds for disciplinary action. Any occurrence is to be promptly reported to Texas Department of Family and Protective Services and within the guidelines of TAC Title 25, Part I, Chapter 414, Subchapter L. Consumer to consumer abuse resulting in injury or allegation of sexual assault should also be reported and investigated as potential staff neglect. Employees failing to make such reports in the specified time frame may be subject to disciplinary action and possible criminal actions. Staff will be protected from retaliation for making a report.

The Center's policies and procedures regarding Abuse and Neglect and Patient Rights are reviewed and revised as needed. These policies and procedures follow the Texas Administrative Code and are posted electronically on the Center's SharePoint site to ensure immediate availability to staff and stakeholders.

PRE-EMPLOYMENT SCREENING:

The pre-employment screening process is an important step in the course for safeguarding patients from instances of abuse and neglect. Potential employees, volunteers and licensed professionals are subject to this screening practice. All potential employees are subject to hire dependent on professional reference verification, Texas Department of Public Safety, Office of the Inspector General and Department of Motor Vehicles background checks prior to employment. In addition, all volunteers are subject to a criminal history review prior to volunteering. Finally, a credentialing process for all licensed professionals has been implemented by Center staff.

NEW EMPLOYEE ORIENTATION AND EDUCATION:

The Human Resources Staff Development Program requires that all new staff participate in an extensive training and orientation series upon employment with the Center. The Staff Development training curriculum includes the following courses: Prevention and Management of Aggressive Behavior training and computer-based training modules for Prevention of Abuse, Neglect and Exploitation and Client Rights. The Center utilizes a web-based training curriculum provided through a subscription to Relias Learning. The training modules are self-paced, have audio as well as on-screen representations and Relias deploys an automated notification system for upcoming training due dates. Employees are required to be retrained in these areas on an annual basis. The Center further ensures that all programs have appropriate staff ratios, which is essential to provide for the safety and well being of all individuals.

HUMAN RIGHTS COMMITTEE:

Concho Valley maintains an active Human Rights Committee (HRC) that reviews new rights restrictions for patients to ensure appropriateness and also reviews each patient's current restriction(s). The HRC is a mechanism for ensuring due process for patients when a limitation of a patient's rights is being considered. The purpose of the Human Rights Committee is to: 1) approve proposed patient behavior intervention programs which have received the approval of the Interdisciplinary Team (IDT) and include a rights restriction and 2) review and approve rights restrictions or other special limitations

for patients as proposed by the patient's IDT. This committee meets at least once per quarter or as frequently as issues arise.

INFORMATIONAL MATERIALS:

Printed business cards with the following information: TDFPS Abuse and Neglect Hotline Number, procedure for reporting abuse and neglect, Office of the Ombudsman hotline in Austin, local Client Rights Officer phone number, and Disability Rights Texas address and phone number are available to staff and individuals served. In addition, the Center ensures that this information is posted at all service sites. Bilingual posters created by HHSC that describe how to report abuse/neglect are also prominently displayed at service sites in locations that are frequented by the individuals we serve. Contractors are subject to all of the same requirements as Center employees as outlined in the contract agreement signed by the Center authorized representative.

QUARTERLY REVIEWS:

The Risk Management Committee reviews aggregate data regarding incidents of Abuse, Neglect and Exploitation, rights violations, medication errors, deaths, serious physical injuries and PMAB usage on a regular basis. This helps identify patterns and trends that require attention. Any issues of concern are not only addressed by the Risk Management Committee, but also referred to the Quality Assurance Committee for further review and action.

CENTER RESPONSIVENESS TO ALLEGATIONS:

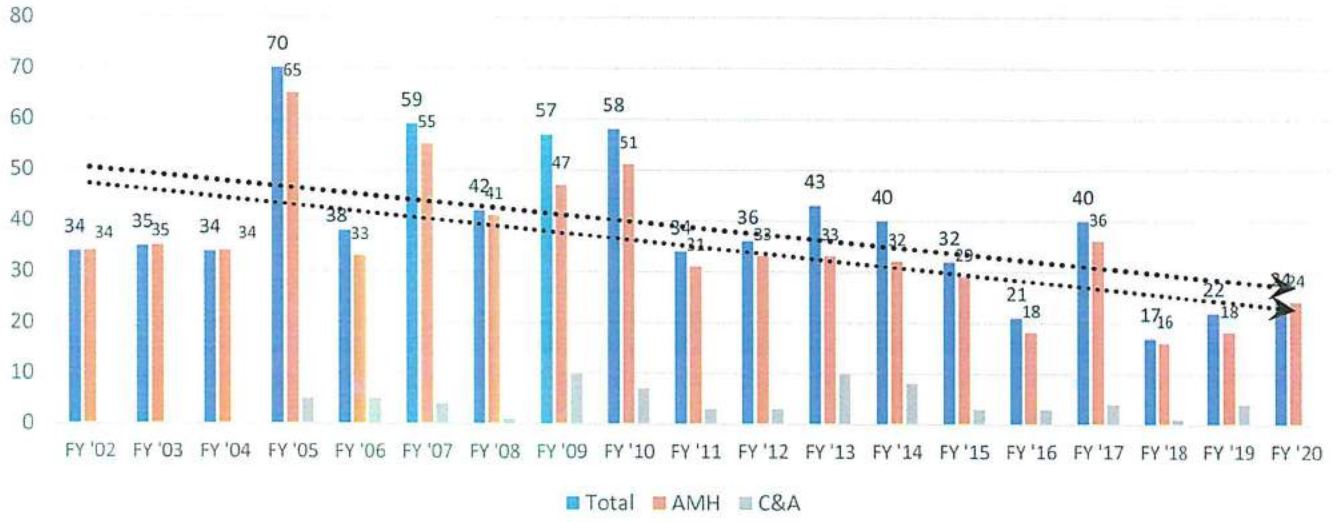
The Center ensures that all TDFPS confirmed allegations of Abuse, Neglect and/or Exploitation receive immediate disciplinary action following a review and affirmation by the Executive Director and/or designee. The Rights Officer monitors all issues of Abuse, Neglect and Exploitation and patient Rights issues, and provides follow-up to ensure appropriate action has occurred. All confirmed allegations of abuse and neglect are entered into the CANRS system in a timely manner to ensure documentation is available regarding the incident. Further, all rights violations are tracked and documented in a Quality Management database. The Center continues to be committed to the prevention of Abuse, Neglect and/or Exploitation and the protection of rights for individuals with mental illness.

IMPROVING THE PATIENT RIGHTS PROCESS:

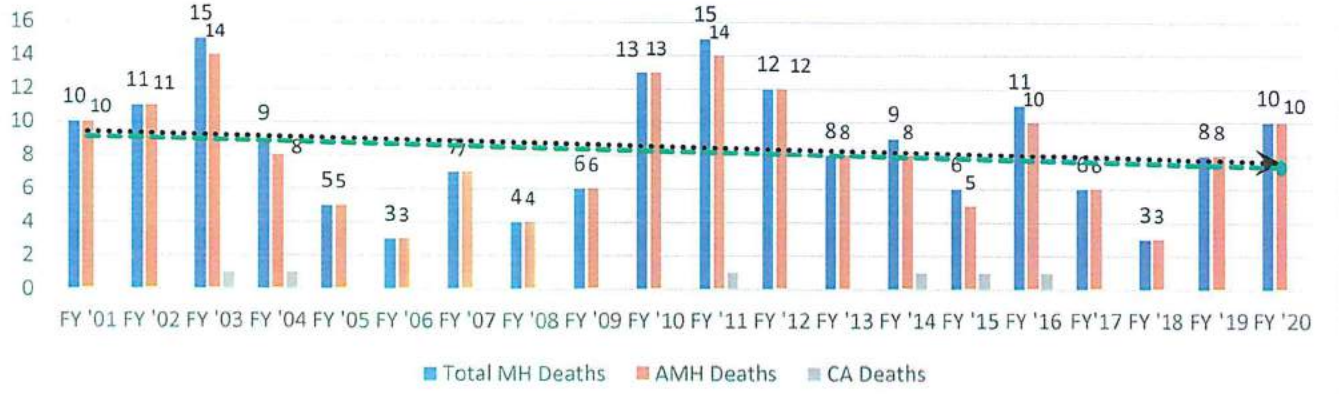
Quarterly and annual reports on patient rights statistics and trends are reported to the Center's Risk Management Committee. At this committee meeting, discussion is held regarding trends identified and a referral for improvement strategy development is submitted to the Quality Assurance Committee when necessary. The Quality Assurance Committee will handle each referral by reviewing the specific issue, revising Center policy/procedure if necessary and deploy and monitor a revised process for ensuring patient rights when appropriate.

MH Confirmed Abuse/Neglect Allegations

AMH & CMH Complaints



MH Mortality Rate



PLANS FOR TECHNICAL ASSISTANCE/REMEDIES AND TIMELINES

Program specific remedies are developed for the purpose of improving and monitoring services. This improvement activity is usually a requirement as a result of an internal Quality Management review. All remedies are reviewed and monitored by the Quality Assurance Committee.

Any review accuracy score that falls below the predetermined level of acceptability results in the need for technical assistance provided by the Quality Management Department. The acceptable review threshold is generally 80% and above. The plan for improvement requires:

- Name of program director/supervisor;
- An indication of the timeline during which specific deficiencies will be corrected; typically 5-10 business days post internal quality management review;
- A description of the type of education that will be provided to staff regarding the review and findings and if/when QM technical assistance will be provided;
- What action will be taken as a result.

In addition, improvement is made possible by Quality Management staff conducting in-service trainings for staff as needed when deficiencies are noted in reviews and problematic trends are recognized by the Quality Assurance Committee.

REVIEW/REVISION OF THE QUALITY MANAGEMENT PLAN

MHMR Services for the ConchoValley views the Quality Management Plan as an ever-changing document that continues to be updated and reassessed on an ongoing basis. The Quality Management Plan is reviewed and evaluated for its effectiveness. The intent of the review is to:

- Ensure the system-wide assessment of performance;
- Determine whether the processes in place are valid;
- Provide a forum to the stakeholders to express their needs for services and views on areas of improvement;
- Determine if the resources allotted and the cost of the tasks was in line with what was intended and what was accomplished;
- Determine if the outcomes were maintained over time;
- Review and monitor anticipated changes in standards, contracts, and funding sources;
- Define new goals and objectives for the plan based on the data elements reviewed.

PARTICIPANTS IN THE REVIEW:

The individuals selected to participate in the review of the MHMR Services for the Concho Valley Quality Management Plan include:

- Quality Assurance Committee
- PNAC
- Other interested Stakeholders

REPORTING INFORMATION REGARDING THE QUALITY MANAGEMENT PLAN:

The information gathered through the review of the plan will be shared with the following:

- Board of Trustees
- Executive Leadership Team
- Other interested Stakeholders
- HHSC (as required)

GOALS, OBJECTIVES & PERFORMANCE INDICATORS

GOALS, OBJECTIVES AND PERFORMANCE INDICATORS

Goal (Aim)	Objective(s)	Indicator(s)	Data Source/Measurement Frequency/Performance Indicator	Responsible Staff(s)
I. To be consumer driven and coordinate effective systems of care.	(A) Develop a network of providers to increase patient/consumer choice.	(1) Fulfill the role of authority with integrity. (2) When chosen as a provider, the Center meets/exceeds requirements/expectations. (3) Fulfill safety net obligation. (4) Strengthen linkages and opportunities for discreet services.	• CARE Exporter Reports • EHR Reports • MBOW Reports • Chart Review Results • Community partnership meetings with West Texas Counseling & other providers. • LPND • Community Based Agreements • Semi-Annual	Director of IDD Director of MH **Executive Director** Director of Reimbursement Director of Operations
	(B) Prepare for 92% of adult population with Medicaid benefits.	(1) Participation in the Texas Council Initiatives.	• Learning opportunities.	**Executive Director** Director of MH CFO
	(C) Promote and ensure a safe environment.	(1) Reduce preventable incidents. (2) Continue award winning safety practices. (3) Update/ improve the physical plant and general maintenance.	• Risk Management Committee reports and trend analysis • Completion of Site Assessment Surveys • Monthly/Quarterly	**Risk/Safety Officer** Director of Operations
	(D) Promote recovery and/or independence.	(1) Presence of positive outcomes and/or progression. (2) Improve the assessment process in order to identify consumers' needs.	• Consumer surveys • MH Recovery Planning • IDD Person Directed Planning • Family Involvement • Patient & Family Education • MBOW • Quarterly/Annually	Director of Operations **Director of Mental Health** **Director of IDD**

	(E) Develop strategies consistent with Health Care Reform designed to integrate primary care.	(1) Work to reduce death rate for adults with severe mental illness. (2) Pursue 1115 Waiver opportunities to bring a primary care provider into the MH OPC.	• 1115 Waiver DSRIP milestones and metrics.	Executive Director **Director of Operations**
	(F) Utilize advanced technologies such as telemedicine, video conferencing, EMRs, e-Rx, etc.	(1) Explore grant opportunities to enhance advanced technologies as appropriate.	• Grants awarded	**Chief Financial Officer**
	(G) Have a high level of consumer satisfaction.	(1) Feedback on services. (2) Exceed minimum expectations on audits/oversight activities.	• CRPO Complaint Db • Outcomes of surveys • Complaints will be addressed promptly • Documentation of positive responses to services by stakeholders • Quarterly/Annually	**Director of Operations** Director of IDD Director of Mental Health
	(H) Provide Autism services.	(1) Develop grant opportunities for implementation.	• Grants awarded	**Autism Clinic Dir.** Executive Director
	(I) IDD Crisis Response System	(1) IDD BH Cr. Respite (2) IDD BH OPC	• 1115 Waiver milestones and metrics	**Director of IDD**
Goal (Aim)	**Objective(s)**	Indicator(s)	**Data Source/Measurement Frequency/Performance Indicator**	**Responsible Staff(s)**
II. To coordinate efficient systems of care.	(A) Determine and establish cost per unit of service.	(1) Continuous improvement of cost per unit of service when compared to a baseline. (2) Cost per unit of service will be below the determined baseline. (3) Minimize overhead and administrative costs.	• CAM • Review of CARE productivity reports • G&A < 12% of direct service cost • 5% per year improvement • Monthly/Quarterly • Contracts reviewed annually	**Chief Financial Officer** Director of IDD Director of MH

	(B) Maximize revenue diversity.	(1) Increase net number of payer sources. (2) Adjust to fluxing funding levels. (3) Secure grants as deemed value added.	• Financial Statements • # of new payer sources • OSCAR data network • Claim MD Reports • Quarterly	**Executive Director** Chief Financial Officer Director of Reimbursement Director of IDD Director of MH
	(C) Utilization Management	(1) Increase number of claims that are accurate and paid on the first submission. (2) Optimize workflow. (3) Assure policies and procedures are current, strategic and relevant. (4) Maximize office space and locations. (5) Streamline admin. processes. (6) Establish a standard for billable hours for each service position. (7) Continue no-show mgt. techniques for IDD and MH.	• Accounts Receivable • Claims paid vs. claims submitted measure • Institutional knowledge • Establishment of baselines • Workflow map • Elimination of barriers • Claim MD Reports • EHR Scheduler No-Show reports • Monthly/PRN	**Chief Financial Officer** **Director of MH** Director of Reimbursement Director of IDD Executive Leadership Team
	(D) Maximize pharmacy purchasing efficiencies.	(1) Maximize PAP. (2) Maximize medication samples. (3) Utilize Medicare Part-D.	• Paid medications versus history • PAP and sample dollars • RFP outcomes	**Chief Financial Officer** Director of Operations
	(E) Effective and timely Quality Management activities.	(1) Audit compliance (2) Audit improvement (3) Audit education for staff	• Audit findings summaries • Quarterly/Semi-annually/Annually	**Director of Operations**

Goal (Aim)	Objective(s)	Indicator(s)	Data Source/Measurement Frequency/Performance Indicator	Responsible Staff(s)
III. To develop and maintain a competent and respected staff.	(A) Affording opportunities for professional development training.	(1) Tabulation of the documentation evidencing opportunities for training taken.	• HR Staff Dev. Report • Increase training development by seeking training opportunities for staff. • Relias Learning Reports • Quarterly	**Director of Human Resources** Director of Staff Development
	(B) Measure competency.	(1) Scores on competency-based testing.	• HR Staff Development Reports • Relias Learning Reports • Annually	**Director of Human Resources** Director of Staff Development
	(C) Manage FTE benefitted turnover.	(1) Analysis of turnover rates as compared to baselines. (2) Continually engage staff in decision making via Q.A.C. surveys. (3) Foster a climate which encourages staff innovation and diligence.	• HR Reports • Increases/decreases will be analyzed in relation to current business environment, but fluctuations will not exceed +/- 5%. • Input from surveys. • Annually	**Director of Human Resources** Director of Staff Development
	(D) Assess, maximize, and communicate the total compensation package available to employees.	(1) Complete individual compensation analysis. (2) Provide the best benefit package for the least cost. (3) Educate employees about benefits package, options and choices.	• Center Business Reports • Annually • PRN	**Chief Financial Officer** **Benefits Committee** Payroll and Human Resource staff
	(E) Conduct performance evaluations.	(1) All annual performance evaluations for staff are current on a quarterly basis. (2) Develop a new and more meaningful review tool.	• HR Reports • 100% current • Quarterly	**Director of Human Resources** Executive Leadership Team

	(F) Eliminate all confirmed claims of abuse and neglect.	(1) Strengthen HR function. (2) Pursue legal charges against employees when warranted.	• Supervisors' training	**Executive Director** Executive Leadership Team
	(G) Collaborate and continue to strengthen ASU intern program.	(1) Contract renewal with university. (2) Communication regarding expectations of the program	• Feedback from student participants. • Feedback from Center supervisors/employees	**Director of Human Resources** Director of Staff Development
Goal (Aim)	**Objective(s)**	Indicator(s)	**Data Source/Measurement Frequency/Performance Indicator**	**Responsible Staff(s)**
IV. To be a collaborative leader in the community and influential in state-wide solutions.	(A) Marketing and community education.	(1) Offer education in the community re: MH/IDD. (2) Develop articles and submit positive press stories. (3) Educate community about enhanced services available via new programs. (4) Strengthen/ promote the Center's website /social media. (5) Community partners are better equipped to serve and interact with people who have disabilities. (6) When community partners seek and acknowledge our expertise. (7) Work with local partners to reduce the suicide rate, provide meaningful Veteran's services and JJC services.	• Community Partnership meetings • Non-profit network • Concho Valley Health & Social Resources Coalition • CARES Coalition • Local service agencies • Public Information Feedback Report • Staff Public Information Report • Executive Leadership Team meeting minutes • Satisfaction Surveys • Increase training by proactively seeking opportunities to educate the community • Increased number of speaking engagements/ presentations • Monthly/Quarterly	Executive Leadership Team Director of Development and Community Relations
	(B) Promote a Mental Health First Aid	(1) Continue to offer MH 1st Aid training in the community	• Evaluation of training/ trainer. • Mental Health America	Director of Staff Development
	(C) Engage BOT in generative thinking.	(1) Encourage robust interaction.	• Trustee feedback.	**Executive Director**

	(D) Participate or lead in inter-agency initiatives.	(1) Staff appointments to partnership roles. (2) Reduce overlap. (3) Assure proper Center presence at initiatives so the community is aware of the mission. (4) Collaborate with agencies that deliver similar services. (5) Build relationships.	• ELT meeting minutes • Public information reports • Annually	**Executive Director** Director of Development and Community Relations Executive Leadership Team Director of Human Resources
	(E) HHSC Crisis Response	(1) Continued support of the MH Deputy Program in the Concho Valley.	• Jail diversion statistics from the county as compared to CARE. • Monthly/Quarterly	**Dir. of Mental Health** HB-13 Project Coordinator

BOARD OF TRUSTEES APPROVAL OF QUALITY MANAGEMENT PLAN

MHMR SERVICES FOR THE CONCHO VALLEY
FY 2021 – FY 2022 MH QUALITY MANAGEMENT PLAN

The MH Quality Management Plan has been reviewed and approved by Gregory J. Rowe, Executive Director.

Gregory J. Rowe

Gregory J. Rowe, Executive Director

The MH Quality Management Plan has been reviewed and approved by John Stokes, Board of Trustees Chairperson.

John Stokes

John Stokes, Board of Trustees Chairperson

APPENDIX A

ACRONYM DEFINITIONS

AAS	American Association of Suicidology
ACT	Assertive Community Treatment
ADR	Administrative Death Review
AIDS	Acquired Immune Deficiency Syndrome
AMH	Adult Mental Health
A/N	Abuse/Neglect
APN	Advanced Practice Nurse
ART	Aggression Replacement Training
BOT	Board of Trustees
C&A	Child and Adolescent
CAM	Cost Accounting Methodology
CANRS	Client Abuse and Neglect Reporting System
CARE	Client Assignment and Registration System
CARES	Concho Valley Community Action and Resources for Empowerment and Success Coalition
CBT	Cognitive Behavioral Therapy
CCBHC	Certified Community Behavioral Health Clinic
CFO	Chief Financial Officer
COC	Continuity of Care
COPSD	Co-occurring Psychiatric and Substance Use Disorder
CPT	Cognitive Processing Therapy
CRCG	Community Resource Coordination Group
CRPO	Client Rights Protection Officer
CSCD	Community Supervision and Corrections Department
CSU	Crisis Stabilization Unit
DADS	Department of Aging and Disability Services
DARS	Department of Assistive and Rehabilitative Services
DBH	Disaster Behavioral Health
DFPS	Department of Family and Protective Services
HHSC	Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment Program
ED	Emergency Department
EHR	Electronic Health Record
ELT	Executive Leadership Team
EMR	Electronic Medical Record
FMLA	Family Medical Leave Act
FTE	Full Time Employee
FY	Fiscal Year
HHSC	Health and Human Services Commission
HIPPA	Health Information Portability and Accountability Act
HR	Human Resources
HRC	Human Resources Committee
IDD	Intellectual and Developmental Disabilities

IDT	Interdisciplinary Team
ISP	Individual Service Plan
LAR	Legally Authorized Representative
LIDDA	Local Intellectual and Developmental Disabilities Authority
LPHA	Licensed Practitioner of the Healing Arts
LPND	Local Planning Network Development
MBOW	Mental Retardation and Behavioral Health Outpatient Warehouse
MCOT	Mobile Crisis Outreach Team
MD	Medical Doctor
MH	Mental Health
MOU	Memorandum of Understanding
MRA	Mental Retardation Authority
OCR	Outpatient Competency Restoration
OPC	Outpatient Clinic
PA	Physicians Assistant
PAP	Prescription Assistance Program
PASRR	Preadmission and Screening and Resident Review
PMAB	Prevention and Management of Aggressive Behavior
PNAC	Planning and Network Advisory Committee
PRN	Latin – "when necessary"
QAC	Quality Assurance Committee
QM	Quality Management
QMHP-CS	Qualified Mental Health Professional – Community Services
RACT	Rural Assertive Community Treatment
RFP	Request for Proposal
RN	Registered Nurse
SHRC	Social Health and Resource Coalition
TAC	Texas Administrative Code
TCOOMMI	Texas Correctional Office on Offenders with Medical and Mental Impairments
TDFPS	Texas Department of Family and Protective Services
TIC	Trauma Informed Care
TRR	Texas Resilience and Recovery
UM	Utilization Management
YES	Youth Empowerment Services