MHMR Concho Valley
My Health My Resources

# LMHA QUALITY MANAGEMENT PLAN

## FY '23 – FY '24

**Revised 09/12/22**

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## DEFINING QUALITY

At MHMR 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 especially 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.

## MISSION, VISION AND VALUES

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

*MISSION:*
"Working together to help people help themselves."

*VISION:*
"Creating Better Health & Wellness in our Community"

*VALUES:*
*R.I.S.E – "Respect, Integrity, Support and Excellence"*

## DESCRIPTION OF CONCHO VALLEY LMHA SERVICES

*Adult Mental Health Services*

| SERVICE NAME | DESCRIPTION |
|---|---|
| OUTREACH | Activities provided to reach and link to services individuals who often have difficulty obtaining appropriate behavioral health services due to factors such as acute behavioral symptomatology, economic hardship, homelessness, unfamiliarity with or difficulty in accessing community behavioral health care services and other support services, fear of mental illness, and related factors. |
| SCREENING | Activities performed by a Qualified Mental Health Professional – Community Services (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 | Pre-Admission QMHP-CS 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 information. |
| CRISIS HOTLINE | A continuously available telephone service that provides information, support, referrals, and screening and intervention that responds to callers 24 hours per day, 7 days per week. |
| CRISIS TRANSPORTATION | Transporting individuals receiving crisis services or Crisis Follow-up and Relapse Prevention services from one location to another. Transportation is provided in accordance with state laws and regulations by law enforcement personnel, or, when appropriate, by ambulance or qualified staff. |
| 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 (LOC) and its importance in recovery, and short term planned activities designed to develop a therapeutic alliance and strengthen rapport. |
| ROUTINE CASE MANAGEMENT | Primarily site-based services that assist an adult, child or youth, or caregiver in gaining and coordinating access to necessary care and services appropriate to the individual's needs. |
| 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. Cognitive-behavioral therapy is the selected treatment model for adult counseling services. |
| 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 | Services provided 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 includes both planned respite and crisis respite to assist in resolving a crisis. Respite can be provided up to 10 days. |

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| PROVISION OF MEDICATION | Ensuring the provision of psychoactive medication benefits to clients registered in the Client Admission and Registration system (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 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 SERVICES | Interventions 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 provided to consumers and family members. |
| PSYCHOSOCIAL REHABILITATIVE SERVICES | Social, educational, vocational, behavioral, and cognitive interventions provided by members of a client's therapeutic team that address deficits in the individual's ability to develop and maintain social relationships, occupational or educational achievement, independent living skills, and housing, that are a result of a severe and persistent mental illness. This service includes treatment planning to facilitate recovery. |
| 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. This service may address skill deficits in vocational and housing. |
| 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 use 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 | Services designed to help individuals who are seeking mental health recovery supports with employment stability and individualized assistance in choosing and obtaining competitive employment in regular community jobs. This includes activities such as matching an individual to a job that aligns with their preferences and strengths, symptom-management and coping skills, assisting with job applications and interview preparations, building employer relationships through job development, rapid job search, benefits counseling, and time-unlimited support. |
| SUPPORTIVE 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. Includes: Housing Assistance - Funds for rental assistance. Services and Supports - Assistance |

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| | in locating, moving into and maintaining regular integrated housing that is habitable. This service includes treatment planning to facilitate recovery. |
| RURAL ACT (RACT) | ACT is a team-based 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. Clients identified as needing ACT services are prioritized for supportive housing, supported employment, and co-occurring psychiatric and substance use disorder (COPSD) services as needed. ACT uses an integrated services approach merging clinical and rehabilitation staff expertise within one mobile service delivery system. |
| INTENSIVE CRISIS RESIDENTIAL/CSU | Short-term residential treatment designed to reduce acute symptoms of mental illness provided in a secure and protected clinically staffed, psychiatrically supervised, treatment environment that is licensed under and complies with a CSU. |
| CONTINUITY OF CARE SERVICES | Activities designed to ensure an individual is provided uninterrupted services during a transition between inpatient and outpatient services and that provide assistance to the individual and the individual's LAR in identifying, accessing, and coordinating LMHA or LBHA services and other appropriate services and supports in the community needed by the individual, including: assisting with admissions and discharges; facilitating access to appropriate services and supports in the community, including identifying and connecting the individual with community resources, and coordinating the provision of services; participating in developing and reviewing the individual's recovery or treatment plan; promoting implementation of the individual's recovery or treatment plan; and coordinating between the individual and the individual's family, as requested by the individual, as well as the available community resources. |
| 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. The service is provided to ameliorate the situation that gave rise to the crisis event, ensure stability, and prevent future crisis events. |
| 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 Registered Nurse (RN), as provided by state law, to ensure the direct application of a psychoactive medication to the client's body by any means (including handing the client a single dose of medication to be taken orally), and to assess target symptoms, side effects and adverse effects, potential toxicity, and the impact of psychoactive medication for the client and family. This service includes such activities as checking a client's vital signs, refilling pill packs, monitoring self-administration of medications, pill pack counts, conducting lab draws, and evaluating the severity of side effects during a home visit. |
| PRIMARY CARE SERVICES | Primary care service available to individuals admitted to MHMRCV services who have no insurance or Medicaid benefits and who currently do not have a primary care provider. This service is available in partnership with Shannon Medical Center. |

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| 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 (OCR) | OCR 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. |
| 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 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. |
| SUBSTANCE USE DISORDER SERVICES | Treatment for individuals who have experienced recurrent use of alcohol and/or drugs which has caused clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. Services include ambulatory detox and outpatient services. |
| CARE COORDINATION | Care Coordination facilitates the appropriate and efficient delivery of health care services both within and across systems for individuals. It is the deliberate organization of care that requires sharing of information among all of the participants concerned with an individual's care to achieve a safer and more effective treatment |
| OUTPATIENT CLINIC PRIMARY CARE SCREENING & MONITORING | Adult BMI, blood pressure, tobacco use, and unhealthy alcohol use screening and follow up services. |

*Child and Adolescent Mental Health Services*

| SERVICE NAME | DESCRIPTION |
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| OUTREACH | Activities provided to reach and to link services to individuals who often have difficulty obtaining appropriate behavioral health services due to factors such as acute behavioral symptomatology, economic hardship, homelessness, unfamiliarity with or difficulty in accessing community behavioral health care services and other support services, fear of mental illness, and related factors. |
| CRISIS HOTLINE | A continuously available telephone service that provides information, support, referrals, screening and intervention that responds to callers 24 hours per day, 7 days per week. |
| SCREENING | Activities performed by a Qualified Mental Health Professional – Community Services (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 | Pre-Admission QMHP-CS 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 information. |
| ENGAGEMENT ACTIVITY | 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 but are not limited to: 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 and caregiver/LAR in obtaining and coordinating access to necessary care and services appropriate to the individual's needs. |
| COUNSELING | Individual, family, and group therapy focused on the reduction or elimination of a child/youth's symptoms of serious emotional disturbance and increasing the individual's ability to perform activities of daily living. Counseling services include treatment planning to enhance recovery and resiliency. Cognitive Behavioral Therapy (CBT) is the selected treatment model for Children's Mental Health (CMH) counseling services. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is the approved counseling treatment model for children/youth with trauma disorders or children/youth whose functioning or behavior is affected by their history of traumatic events. |
| PHARMACOLOGICAL MANAGEMENT | A service provided 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 individuals registered in the Client Assignment and Registration System (CARE), who have no source of funds for such, as determined to be medically necessary and as prescribed by an authorized representative. |

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| SUPPLEMENTAL NURSING SERVICES | A service provided to an individual by a licensed nurse or other qualified and properly trained personnel working under the supervision and delegation of a physician or registered nurse (RN), as provided by state law, to ensure the direct application of a psychoactive medication to the individual's body by any means (including handing the individual a single dose of medication to be taken orally), and to assess target symptoms, side effects and adverse effects, potential toxicity, and the impact of psychoactive medication for the client and family. This service includes such activities as checking an individual's vital signs, refilling pill packs, monitoring self-administration of medications, pill pack counts, conducting lab draws, and evaluating the severity of side effects during a home visit. |
| PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATION | Psychiatric diagnostic interview examination by MD, Licensed Psychologist, APN or PA. |
| CRISIS INTERVENTION | Interventions in response to a crisis in order to reduce symptoms of serious emotional disturbance and to prevent admission of an individual to a more restrictive environment. |
| MEDICATION TRAINING AND SUPPORT | Education and guidance about medications and their possible side effects provided to children, youths, and caregivers and/or LAR. |
| SKILLS TRAINING AND DEVELOPMENT | Training provided to an individual and/or the primary caregiver or legally authorized representative (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 individual's emotional disturbance. This includes instruction on basic parenting skills. |
| FAMILY PARTNER SUPPORTS | 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/informal and formal community supports. Family Partners/Certified Family Partners are the parent or LAR of a child or youth with a serious emotional disturbance and have at least one year of experience navigating a child-serving system as the LAR to that child or youth. |
| PARENT SUPPORT GROUP | Routinely scheduled support and informational meetings for the individual's primary caregivers. |

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| INTENSIVE CRISIS RESIDENTIAL/CSU | Hospital services staffed with medical and nursing professionals who provide 24-hour professional monitoring, supervision, and assistance in an environment designed to provide safety and security during acute psychiatric crisis. Staff provides intensive interventions designed to relieve acute psychiatric symptomatology and restore the individual's ability to function in a less restrictive setting. |
| CONTINUITY OF SERVICES | Activities that are designed to ensure uninterrupted services are provided to an individual during a transition between inpatient and outpatient services, and other transition points in mental healthcare, that provide assistance to the individual and the individual's LAR in identifying, accessing, and coordinating LMHA or LBHA services and other appropriate services and supports in the community that are needed by the individual |
| 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. The service is provided to ameliorate the situation that gave rise to the crisis event, ensure stability, and prevent future crisis events. |
| 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. |
| OUTPATIENT CLINIC PRIMARY CARE SCREENING & MONITORING | follow-up, weight assessment and counseling for nutrition and physical activity for children/adolescents, |

## REPORTING RELATIONSHIPS

*LEADERSHIP & DELEGATION OF RESPONSIBILITY:*
Quality Management systems exist to plan for, measure, and improve the quality of care provided to individuals and improve the supporting administrative systems. Every staff in the organization shares responsibility for quality management. As a Community Center, MHMR Concho Valley will be accountable for the quality of services provided directly by our staff as well as those services that are contracted to other providers. In order for processes to be put in place, 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 MHMRCV and Health and Human Services Commission (HHSC):*
  MHMRCV 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 Chief Executive Officer. The Board of Trustees is responsible for requiring ongoing reporting from the Chief Executive Officer, or designee, regarding the quality management activities and strategies for improvement.

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

- *Director of Operations / Corporate Compliance Officer:*
  The Chief Executive Officer of MHMRCV has designated the responsibility for coordinating all quality assurance activities within the Center to the Director of Operations, who reports directly to the Chief Executive Officer. 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-one years of experience in this type of work and has been determined by the Chief Executive Officer to be an individual with adequate and appropriate experience in quality management. Additionally, as the quality management responsibilities grew over time, the Chief Executive Officer allocated adequate resources to add additional staff to the Quality Management (QM) Department. As a result, a Quality Management Coordinator was added to the department to assist with the completion of necessary LMHA quality management functions. The Quality Management Coordinator has over ten years of experience in this type of work.

There is a standing agenda item on the Board of Trustees Planning and Network Advisory Committee (PNAC) agenda entitled "QM Reports." The Director of Operations delivers the QM Report to the PNAC membership. The Board of Trustees liaison to the PNAC attends the PNAC meeting. During the Board of Trustees meeting, the PNAC Board of Trustees liaison provides the QM Report to the full board. 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 MHMRCV. MHMRCV does not investigate allegations. MHMRCV 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 MHMRCV'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
- Patient 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:*

Step 1 - The foundation of the planning process is our organizational vision. We envision "creating better health & wellness in our community" and this vision guides us through each step of the strategic planning process.

Step 2 - The Chief Executive Officer 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 Chief Executive Officer 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, community, employees and HHSC.

Step 3 - The organization's Executive Leadership Team develops the objectives and strategies in support of the organizational goals.

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 implementation of performance goals. The role of the leader is to communicate to the employees the goals and strategies 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 regarding the set goals and strategies 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 and improved services.

## COORDINATION, INTEGRATION AND PLANNING

*MECHANISMS FOR GATHERING INTERNAL DATA:*

The Center has established a variety of committees to conduct 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 Concho Valley

**Membership:**
Chief Executive Officer, Chief Financial Officer, Director of Operations, Director of Behavioral Health, Director of IDD, Director of Human Resources, Director of Reimbursement, and Director of Administrative Services.

**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 Behavioral Health, Director of Human Resources, Director of CMH Services, Chief Executive Officer, Director of Administrative Services, Director of Reimbursement, Clubhouse Director, C&A Counselor, IDD Provider Program Manager, Supported Housing Specialist

**Frequency:** Quarterly and PRN

**MH Utilization Management (UM) Committee**

**Purpose:**
To provide an ongoing and continuous mechanism for review and improvement of BH clinical care including review activities to ensure that patients receive quality, cost effective services in the most appropriate treatment settings.

**Membership:**
Medical Director/UM Physician, UM Manager, Director of Operations, Quality Management Coordinator – MH Specialist, Director of Behavioral Health Services, Chief Executive Officer, Chief Financial Officer, Director of Reimbursement, Director of Children's Mental Health Services, Mobile Crisis Outreach Team Supervisor

**Frequency:** Quarterly

**Clinical Records Committee**

**Purpose:**
To review and monitor the Center's records system to assure the records are effective and efficient for clinical use and quantitative record 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/CMH/IDD Records Supervisors, 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 MHMRCV. 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 Behavioral 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:** As needed

**Human Rights Committee (HRC)**

**Purpose:**
To protect, preserve, promote, and advocate for the health, safety, welfare, and legal and human rights of individuals. The committee reviews rights restrictions, & ensures due process when rights are restricted.

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

**Frequency:** Quarterly and PRN

**Administrative Death Review Committee (ADR)**

**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 – MH/IDD, 3, 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, Chief Executive Officer, 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:**
CEO, CFO, Director of Reimbursement, , IDD Provider Program Manager, Mental Health First Aid Specialist, Director of Children's MH Services, Human Resources Specialist

**Frequency:** PRN

## MECHANISMS FOR STAKEHOLDER PARTICIPATION

*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 and CCBHC Planning processes. The Quality Assurance Committee will review the feedback that is received, and efforts will be made to meet the needs of the people served by the Center. Further, input will be gathered through satisfaction surveys and information gathered from the following committee:

*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 and fifty percent participation by MH patients or family members of patients. 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
- Aging and Disability Services
- Mental Health Services
- Substance Use Disorder Services
- Center Mission, Vision 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 – ASSESSING – IMPROVING ESSENTIAL FUNCTIONS

MHMR Concho Valley will use a variety of methods to measure, assess and improve essential functions. These indicators are identified through 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.

*MEASURING-ASSESSING-IMPROVING LMHA AUTHORITY FUNCTIONS:*

| Authority Function | Measurement/Assessment | Improvement |
|---|---|---|
| Local Planning | The Executive Leadership Team conducts reviews of the achievement of goals defined in the Local Strategic Plan. | Based on Executive Leadership Team (ELT) review and consideration, local strategic planning improvement of goals and strategies 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 Chief Executive Officer 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 Chief Executive Officer, 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 and monitor goals for resource development in the local strategic plan. | Continue to set improvement standards over baseline and current year performance. |
| Resource Allocation & Mgt. | Percent of face-to-face patient encounters per employee. | Utilization of Performance Improvement Procedure. |
| Oversight of LMHA services | Qualitative chart reviews and individual feedback. These items are assessed by the Quality Assurance Committee. | Results of examinations are presented to the QAC for review. Strategies for improvement are developed in this forum and implemented by the appropriate directors. Follow-up on implementation is also reviewed by the QAC |

| | | |
|---|---|---|
| | | and reported to the Executive Leadership Team. |
| 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) reports and electronic health record 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 (FYGC) 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 indicates the Quality Management review schedule and the frequency of the reviews for improvement of provider services.

*MEASURING–EVALUATING - IMPROVING TEXAS 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 underutilization, 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 MHMRCV 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 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 director for examination and further action. A copy of this report will also be sent to the Chief Executive Officer. 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 directors/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:*

MHMRCV will ensure that an annual health inspection occurs for all provider programs in which individuals 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 individual's served 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, individual-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 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.

*Brainstorming*

Quality Management also includes the process of brainstorming. Brainstorming is a method of generating ideas and sharing knowledge to solve a particular problem, in which participants are encouraged to think without interruption. Brainstorming is a group activity where each participant shares their ideas as soon as they come to mind. The rules for brainstorming include deferring judgment, encouraging wild ideas, building on the ideas of others, staying focused on the topic, being visual, and going for quantity of ideas.

*Table #1 - "Quality Management MH Review Schedule"*

| TITLE OF REVIEW | FREQUENCY | FY '23 REVIEW COMPLETION | FY '24 REVIEW COMPLETION |
|---|---|---|---|
| **Comprehensive MH Chart Review** (**completed by QM Coordinator**)<br>• *Demographic Assessment*<br>• *Initial Contact Assessment*<br>• *Psychiatric Evaluation Elements*<br>• *Medical Services*<br>• *Uniform Assessment*<br>• *Diagnosis Assessment*<br>• *Financial Assessment*<br>• *Client Rights Review*<br>• *HIPAA Privacy Acknowledgement*<br>• *Consent to Tx w/ Psychoactive Meds.*<br>• *Progress Notes*<br>• *Recovery Plans*<br>• *Non-final approved progress notes*<br>• *Discharge Summary* | SEMIANNUAL | | |
| **PESC:** (**completed by QM Coordinator**)<br>• *Crisis Respite Facility Site Assessment*<br>• *Crisis Respite SAM Training*<br>• *Tier 1 CSU Utilization (UMC)*<br>• *Crisis Hotline*<br>• *MCOT* | SEMIANNUAL | | |
| **Fidelity:** (**completed by QM Coordinator**)<br>• Rural ACT<br>• *CMH TRR - CBT, Trauma-Focused CBT, Seeking Safety, ST-ART, Wraparound Implementation*<br>• *YES Waiver*<br>• *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**)<br>• TAC/ANSA/Recovery Plan | QUARTERLY | | |
| Delegating MD Oversight of NP Charts: (**oversight by Dir. of Operations**) | MONTHLY | | |

| | | | |
|---|---|---|---|
| Policy/Procedure:<br>**(completed by Dir. Operations)** | PRN | | |
| **HB 13 Initiatives**:<br>• Expand/Enhance MH Deputy Program<br>**(completed by Dir. of Operations)**<br>• Zero Suicide Initiative<br>**(completed by Dir. of Operations)**<br>• COPSD (**completed by QM Coordinator**) | QUARTERLY | | |
| San Angelo Clubhouse<br>**(completed by Dir. of Operations/QM Coordinator)** | ANNUAL | | |
| **Personnel Record/Job Description Review:**<br>**(completed by Dir. of Operations)**<br>• E.D. Compensation Notification Sponsoring Agencies **(completed by Dir. of Operations)**<br>• Certified Family Partner<br>**(completed by QM Coordinator)** | ANNUAL | | |
| Subcontractors<br>**(completed by Dir. Operations)** | ANNUAL | | |
| Outpatient Competency Restoration<br>**(completed by QM Coordinator)** | ANNUAL | | |
| Supported Housing<br>**(completed by QM Coordinator)** | SEMIANNUAL | | |
| PASRR MI **(completed by QM Coordinator)** | SEMIANNUAL | | |
| SUD **(completed by Dir. Operations)**<br>• AWM<br>• Outpatient Services | SEMIANNUAL | | |
| Jail Diversion | SEMIANNUAL | | |

## ANALYSIS OF QUALITY MONITORING ELEMENTS

| DATA REQUIREMENTS/ ELEMENTS REVIEWED | DATA SOURCES | RESPONSIBLE PARTY | REPORTING FREQUENCY |
|---|---|---|---|
| State hospital bed day utilization | 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/Exped. 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/ Quarterly |
| 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 Mgt./ Risk Mgt./ QAC | Quarterly/ Annually |
| Number of individuals served per program and service | Information will be collected by MBOW and EHR data. | Quality Management | Monthly/ Quarterly |
| Number of abuse, neglect and rights violations, allegations and confirmations. | This information will be collected via CANRS and internal reporting systems | Quality Mgt. Office/ Risk Mgt. Committee/ Utilization Mgt. Committee | Quarterly/ Annually |
| 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 individuals receiving LMHA services. 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:*

*Individual 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 individual served, and the parent(s), guardian or advocate of a minor is given a Rights Handbook with an oral explanation and confirmation of understanding. Extra copies of handbooks are accessible to all individuals who request them via 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 Client Services and Rights Protection Hotline 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 individual served upon intake. The Director of Operations serves 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*

Individual abuse, neglect, or exploitation by Center employees, employees of 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 1, Chapter 414, Subchapter L. Individual to individual 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 a crucial 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 (PMAB) training and computer-based training modules for Prevention of Abuse, Neglect and Exploitation and Client Rights. The Center began utilizing web-based training offered through a company called Portico Learning Solutions in 2006. In 2012, the Center changed its web-based training curriculum by subscribing to Relias Learning instead of Portico Learning Solutions. This newer version of training is self-paced, deploys an automated notification system for training due

and has audio as well as on-screen representation. 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 individual's current restriction(s). The HRC is a mechanism for ensuring due process for individuals when a limitation of rights is being considered. The purpose of the Human Rights Committee is to: 1) approve proposed 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 individual's as proposed by the IDT. This committee meets at least once per quarter or as frequently as issues arise.

*INFORMATIONAL MATERIALS:*

Staff and individuals receiving services are given a business card with the following printed information: TDFPS Abuse and Neglect Hotline Number, procedure for reporting abuse and neglect, Individual Rights Hotline in Austin, local Client Rights Officer phone number, and Disability Rights Texas address and phone number. 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 critical incidents, 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:*

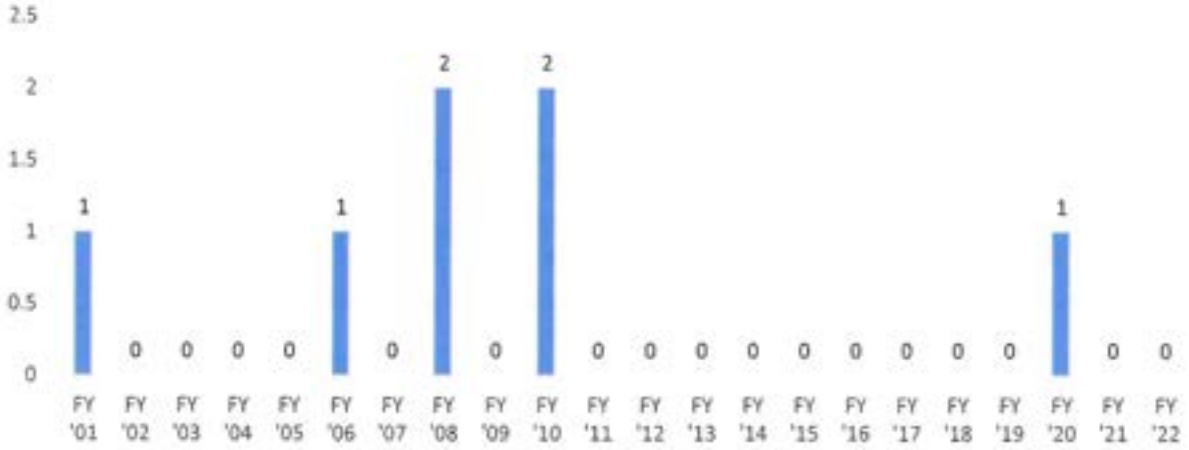
The Center ensures that all TDFPS confirmed allegations of Abuse, Neglect and/or Exploitation receive immediate disciplinary action following a review and affirmation by the Chief Executive Officer and/or designee. The Rights Officer monitors all issues of Abuse, Neglect and Exploitation and patient 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.

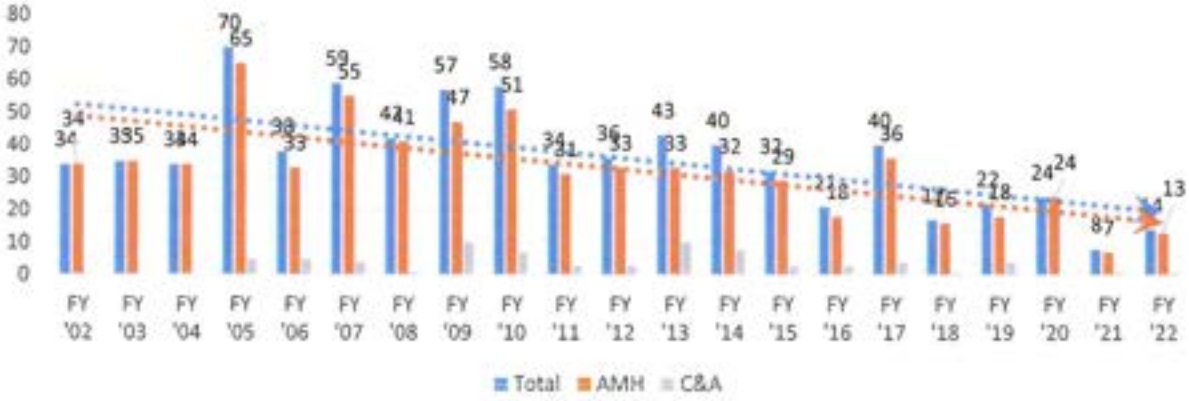
*IMPROVING THE RIGHTS PROCESS:*

Reports on individual's 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 manage 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 Data

## PLANS FOR TECHNICAL ASSISTANCE/REMEDIES AND TIMELINES

Program specific remedies are developed for the purpose of improving services. Remedies may be required 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 Quality Management Coordinator – MH Specialist will provide the technical assistance training to staff in-person. The acceptable review threshold is generally 80% and above. If a plan of improvement is also required from the program being reviewed, the plan will include:

- 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 Concho Valley 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 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)

## BOARD OF TRUSTEES APPROVAL OF QUALITY MANAGEMENT PLAN

**MHMR CONCHO VALLEY**

**FY 2023 – FY 2024 LMHA QUALITY MANAGEMENT PLAN**

**THE LMHA QUALITY MANAGEMENT PLAN HAS BEEN REVIEWED AND APPROVED BY GREGORY J. ROWE, CHIEF EXECUTIVE OFFICER.**

Gregory J. Rowe — 9/22/2022

***GREGORY J. ROWE, CHIEF EXECUTIVE OFFICER*** ***DATE***

**THE LMHA QUALITY MANAGEMENT PLAN HAS BEEN REVIEWED AND APPROVED BY JOHN STOKES, BOARD OF TRUSTEES CHAIRPERSON.**

John R Stokes — 9/22/2022

***JOHN STOKES, BOARD OF TRUSTEES CHAIRPERSON*** ***DATE***

# APPENDIX A

**ACRONYM DEFINITIONS**

| | |
|---|---|
| ADR | Administrative Death Review |
| AIDS | Acquired Immune Deficiency Syndrome |
| AMH | Adult Mental Health |
| BOT | Board of Trustees |
| 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 |
| CCBHC | Certified Community Behavioral Health Clinic |
| CFO | Chief Financial Officer |
| CMH | Children's Mental Health |
| COC | Continuity of Care |
| CRCG | Community Resource Coordination Group |
| CRPO | Client Rights Protection Officer |
| CSCD | Community Supervision and Corrections Department |
| DBH | Disaster Behavioral Health |
| DFPS | Department of Family and Protective 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 Rights Committee |
| IDD | Intellectual and Developmental Disabilities |
| IDT | Interdisciplinary Team |
| LAR | Legally Authorized Representative |
| LIDDA | Local Intellectual and Developmental Disabilities Authority |
| 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 |
| OPC | Outpatient Clinic |
| 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 |
| RFP | Request for Proposal |
| RN | Registered Nurse |
| SHRC | Social Health and Resource Coalition |
| SPMI | Serious Persistent Mental Illness |
| TAC | Texas Administrative Code |
| TDFPS | Texas Department of Family and Protective Services |
| TCOOMMI | Texas Correctional Office on Offenders with Medical and Mental Impairments |
| TIC | Trauma Informed Care |
| UM | Utilization Management |