MHMR Concho Valley

My Health My Resources

LIDDA QUALITY MANAGEMENT PLAN

FY '23 – FY '24

Revised 08/26/22

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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 LIDDA SERVICES

SERVICE NAME	DESCRIPTION
SCREENING	Gathering information to determine a need for services. This service is performed face-to-face or by telephone contact with persons. Screening includes the process of documenting individuals' initial and updated preferences for services and the LIDDA's biennial contact of individuals on the HCS Interest List and TxHmL Interest List. The service does not include providing information and referrals.
ELIGIBILITY DETERMINATION	An interview and assessment or an endorsement conducted in accordance with Texas Health and Safety Code, §593.005, and 40 Texas Administrative Code Chapter 5, Subchapter D to determine if an individual has an intellectual disability or is a member of the IDD priority population.
COMMUNITY SUPPORT	Individualized activities that are consistent with the individual's plan of services and supports and provided in the individual's home and at community locations (e.g., libraries and stores). Supports include: • Habilitation and support activities that foster improvement of, or facilitate, a individual's ability to perform functional living skills and other daily living activities; • Activities for the individual's family that help preserve the family unit and prevent or limit out of-home placement of the individual; • Transportation for an individual between home and the individuals' community employment site or day habilitation site; and • Transportation to facilitate the individual's employment opportunities and participation in community activities
SERVICE COORDINATION	Assistance in accessing medical, social, educational, and other appropriate services and supports that will help an individual achieve a quality of life and community participation acceptable to the individual as described in the plan of services and supports. Service coordination functions are: • Assessment — identifying the individual's needs and the services and supports that address those needs as they relate to the nature of the individual's presenting problem and disability; • Service planning and coordination — identifying, arranging, advocating, collaborating with other agencies, and linking for the delivery of outcome-focused services and supports that address the individual's needs and desires; • Monitoring — ensuring the individual receives needed services, evaluating the effectiveness and adequacy of services, and determining if identified outcomes are meeting the individual's needs and desires; and • Crisis prevention and management — linking and assisting the individual to secure services and supports that will prevent or manage a crisis.

RESPITE	Planned or emergency short-term relief services provided to the individual's unpaid caregiver when the caregiver is temporarily unavailable to provide supports. This service provides an individual with personal assistance in daily living activities (e.g., grooming, eating, bathing, dressing and personal hygiene) and functional living tasks. The service includes assistance with: planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulating and mobility; reinforcement of behavioral support or specialized therapies activities; assistance with medications and the performance of tasks delegated by a Registered Nurse in accordance with state law; and supervision of the individual's safety and security. The service also includes habilitation activities, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities, and assistance in developing socially valued behaviors and daily living and functional living skills.
CRISIS RESPITE	• Crisis Respite – Out-of-Home: Therapeutic support provided in a safe environment with staff on-site providing 24-hour supervision to an individual who is demonstrating a crisis that cannot be stabilized in a less intensive setting. Out of home respite is provided in a setting for which the state provides oversight. • Crisis Respite – In-Home: Therapeutic support provided to an individual, who is demonstrating a crisis, in the individual's home when it is deemed clinically appropriate for the individual to remain in his/her natural environment and it is anticipated that the crisis can be alleviated in a 72-hour period.
HOME & COMMUNITY-BASED SERVICES	The HCS program is a federally funded program for Medicaid recipients who have a diagnosis of IDD and provides service coordination, day habilitation, supported employment, nursing, counseling/therapies, respite, adaptive aids, home modifications, behavioral support, residential supports (group homes, host home companion care, supported home living) and dental treatment.
EMPLOYMENT ASSISTANCE	Assistance to an individual in locating paid, individualized, competitive employment in the community, including: helping the individual identify employment preferences, job skills, work requirements and conditions; and identifying prospective employers offering employment compatible with the individual's identified preferences, skills, and work requirements and conditions.
SUPPORTED EMPLOYMENT	Supported employment is provided to an individual who has paid, individualized, competitive employment in the community (i.e., a setting that includes nondisabled workers) to help the individual sustain that employment. It includes individualized support services consistent with the individual's plan of services and supports as well as supervision and training.

TEXAS HOME LIVING (TxHmL)	The TxHmL program is a federally funded program for qualified Medicaid recipients who have a diagnosis of IDD and provides service coordination, day habilitation, supported employment, nursing, counseling/therapies, respite, adaptive aids, home modifications, community support, and dental treatment.
DAY HABILITATION	Assistance with acquiring, retaining, or improving self-help, socialization, and adaptive skills necessary to live successfully in the community and to participate in home and community life. Individualized activities are consistent with achieving the outcomes identified in the individual's plan of services and supports and activities are designed to reinforce therapeutic outcomes targeted by other service components, school or other support providers. Day habilitation is normally furnished in a group setting other than the individual's residence for up to six (6) hours a day, five (5) days per week on a regularly scheduled basis. The service includes personal assistance for individuals who cannot manage their personal care needs during the day habilitation activity as well as assistance with medications and the performance of tasks delegated by a RN in accordance with state law.
NURSING	Treatment and monitoring of health care procedures prescribed by physician or medical practitioner or required by standards of professional practice or state law to be performed by licensed nursing personnel.
SPECIALIZED THERAPIES	Specialized therapies are: • Assessment and treatment by licensed or certified professionals for: o Social work services; o Counseling services; o Occupational therapy; o Physical therapy; o Speech and language therapy; o Audiology services; o Dietary services; and o Behavioral health services, other than those provided by a local mental health authority pursuant to its contract with the Health and Human Services Commission (HHSC); and • Training and consulting with family members or other providers.
CONTINUITY OF SERVICES	This is a service coordination activity that is provided for a individual residing in a state supported living center whose movement to the community is being planned or for a individual who formerly resided in a state facility and is on community-placement status. This service can also be provided for a individual enrolled in the ICF/MR program to maintain the individual's placement or to develop another placement for the individual.

BEHAVIORAL SUPPORT	Specialized interventions by professionals with required credentials to assist an individual to increase adaptive behaviors and to replace or modify maladaptive behavior that prevent or interfere with the individual's inclusion in home and family life or community life. Support includes: • Assessing and analyzing assessment findings so that an appropriate behavior support plan may be designed; • Developing an individualized behavior support plan consistent with the outcomes identified in the individual's plan of services and supports; • Training and consulting with family members or other providers and, as appropriate, the individual; and • Monitoring and evaluating the success of the behavioral support plan and modifying the plan as necessary
COMMUNITY LIVING OPTIONS INFORMATION PROCESS (CLOIP)	Concho Valley provides community living options information to adults residing in a state supported living center (SSLC) and/or their LAR a minimum of one time per year. The Center also completes the community living options process instrument and provides a written report of the CLOIP process to the state supported living center and designated MRA no later than 14 calendar days prior to the individual's SSLC annual planning meeting. Concho Valley attends the SSLC annual planning meeting in-person or by teleconference 100% of the time unless the resident and/or their LAR has specifically requested the MRA not participate.
PERMANENCY PLANNING	A planning process that focuses on achieving family support for individuals under 22 years of age by facilitating permanent living arrangements that include an enduring and nurturing parental relationship. Permanency Planning is for all individuals under 22 years of age and reside in an institutional setting.
INTEREST LIST	Maintenance/monitoring of IDD services that are not currently available. Monitored services include General Revenue services and Medicaid funded services. Services are offered on a first come, first served basis.
RESIDENTIAL SERVICES	Twenty-four-hour services provided to an individual who does not live independently or with his or her natural family. These services are provided by employees or contractors of the LIDDA who regularly stay overnight in the individual's home. This service category includes: • Family Living: Residential Services provided to no more than three individuals living in a single residence that is not a Contracted Specialized Residence. • Residential Living: Residential Services provided to more than three individuals living in a single residence that is not a Contracted Specialized Residence.

	• Contracted Specialized Residences: Residential Services provided to an individual in a general hospital, a substance abuse program, an autism program, or an AIDS hospice.
HABILITATION COORDINATION	Assistance for a designated resident residing in a nursing facility to access appropriate specialized services necessary to achieve a quality of life and level of community participation acceptable to the designated resident and legally authorized representative.
CRISIS INTERVENTION SERVICES	Lead Crisis Intervention Specialist provides information about IDD programs and services; collaborates with LIDDA staff and Transition Support Team members to identify individuals with IDD in the LIDDA's local service are who are at risk of requiring crisis services.
Pre-Admission Screening and Resident Review (PASRR)	PASRR is a federally mandated program that requires that we prescreen all people, regardless of payer source or age, seeking admission to a Medicaid-certified nursing facility. PASRR has three goals: 1. To identify people, including adults and children, with mental illness and/or IDD. 2. To ensure appropriate placement, whether in the community or the nursing facility. 3. To ensure people receive the required services for mental illness and/or IDD.
Community First Choice (CFC)	Services include help with activities of daily living and health-related tasks through hands-on assistance, supervision or cueing, services to help the individual learn how to care for themselves, backup systems or ways to ensure continuity of services and supports and training on how to select, manage and dismiss attendants.

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 IDD 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." During 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.

PERFORMANCE INDICATORS:

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 "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
- IDD 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 Mental 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 Mental 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

IDD Utilization Management (UM) Committee

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

Membership:
Director of Operations, Quality Management Coordinator - IDD, Director of IDD, Chief Executive Officer, Director of Reimbursement, IDD Authority Program Manager, IDD Provider Program Manager

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 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: As needed

Human Rights Committee (HRC)

Purpose:
This committee protects, preserves, promotes, and advocates for the health, safety, welfare, and legal and human rights of individuals. The committee reviews rights restrictions, and 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, 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, 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:
Chief Executive Officer, CFO, Director of Reimbursement, , IDD Provider Program Manager, Mental Health First Aid Specialist, Director of CMH 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 process. 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 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
- 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 LIDDA 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 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 IDD 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-ANALYZING-IMPROVING LIDDA 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.

IDD services access will be monitored by examining trends identified in the individual feedback process, appeals process, electronic health record reports, data revealed in the IDD Utilization Management Committee and mystery caller survey results. By scrutinizing the rate of admitted clients versus those screened for intake and other comparable data reports the Center can monitor access issues and make improvements when needed. IDD issues related to access that need enhancement will be evaluated by the IDD UM Committee and subsequently monitored by the Quality Assurance Committee.

Capacity will be evaluated by monitoring IDD operating efficiencies, management reporting compared with benchmark indicators, and IDD UM trends. IDD services capacity is primarily measured and assessed in relation to the following service components: Service Coordination, Day Habilitation, Respite and Community Support. The Director of IDD Services is designated as the responsible staff for capacity review. The IDD Director has predetermined capacity markers for each Service Coordinator depending on their specific job duties and case load type. When a Service Coordinator is approaching or has reached this predetermined limit, the director will instruct Service Coordinators to scrutinize their current caseloads to determine need for Service Coordination for each individual. If it is determined that discharge is appropriate for an individual, that action will be taken. If discharge is not appropriate, caseloads will be rearranged amongst the current Service Coordinators or determination of the need to hire additional Service Coordinators to meet demand will occur.

Further, the Director of IDD monitors and assess capacity for Day Habilitation. The primary capacity determinant is staff to client ratio. When the individual attendance rate meets the staff to client ratio and the IDD budget will not allow for hiring additional staff, then this service component has reached capacity. A secondary capacity item is the physical plant. If the staff to client ratio is not a factor, then the only other boundary is the Center's ability to properly and safely serve the individuals within a comfortable format within the confines of the building. Limited capacity has not been an issue in Day Habilitation. In the event that this does become an issue, it would be reported to the IDD UM Committee and Quality Assurance Committee for consideration, review, and action.

Capacity measurement for Respite services is driven primarily by financial allocations granted by HHSC. The Respite Supervisor monitors and manages the funding allocation for this service and recognizes that capacity is reached when funding is depleted. Along the same logic, capacity for community support services is driven by funding and staffing limitations. When there are no longer dollars or staff available to perform the service then capacity has been reached. As needed, a waiting list is implemented to manage the individual need for community support services.

MEASURING-ASSESSING-IMPROVING LIDDA SERVICE DELIVERY:

Several steps are taken to monitor and evaluate opportunities to improve care to individuals, service operations, and to solve identified problems. Results of individual feedback, performance reviews, and other committee activities are reviewed to identify issues. Further, contracts with all service providers are studied to ensure they meet compliance with Community Standards. Problem areas are assessed by outlining the priority, impact of care provided to individuals, implementation costs, and accessibility to services. Reviews occur on a scheduled basis. The Quality Assurance Committee manages improvement strategies. Table #1indicates the Quality Management review schedule and the frequency of the reviews.

MEASURING- ASSESSING -IMPROVING ACCURACY of DATA REPORTED BY LIDDA::

Concho Valley data accuracy will be measured, evaluated and improved based on active use of HHSC MBOW reports, local electronic health record reports and on-going staff training related to data accuracy obligations. The Center's Executive Leadership Team, IDD Utilization Management Committee and IDD Program Managers will routinely review those HHSC MBOW and electronic health record 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.

Additionally, 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- ASSESSING -IMPROVING OTHER LIDDA 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.

IMPROVING LIDDA 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 IDD Review Schedule"

TITLE OF REVIEW	FREQUENCY	FY '23 REVIEW COMPLETION	FY '24 REVIEW COMPLETION
Comprehensive IDD Chart Review Conducted in Conjunction w/ Program Reviews: • *Demographic Assessment* • *Initial Contact Assessment* • *Priority Population Criteria* • *Diagnosis Assessment* • *Financial Assessment* • *Client Rights Review* • *HIPAA Privacy Acknowledgement* • *Consent to Tx w/ Psychoactive Medication Consent* • *Progress Notes* • *PDP* • *Non-final approved progress notes* • *Voter Registration*	SEMIANNUAL/ ANNUAL (Depending on prog. being reviewed)		
HCS Program Review (to include): • Enrollments • Interest List	SEMIANNUAL		
TxHmL Program Review (to include): • Enrollments • Interest List	SEMIANNUAL		
PASRR Program Review	SEMIANNUAL		
General Revenue Program Review	SEMIANNUAL		
Community First Choice Program Review	ANNUAL		
CLOIP Review	ANNUAL		
CLASS Program Review	ANNUAL		
HHSC (HHSC) Annual On-site Program Review CAP – LIDDA Oversight	QUARTERLY		
Policy & Procedure Review	PRN		

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.	Quality Assurance Committee/IDD UM Committee	Quarterly
Current performance on all target driven services	Collect information from MBOW and CARE workload measures reports.	Quality Assurance Committee/IDD UM Committee	Quarterly
Number of deaths	Information will be collected through Quality Management Data and CARE data.	Quality Assurance Committee/IDD UM Committee/ Risk Management Committee	Quarterly
Number of individuals served per service	Information will be collected by MBOW/electronic health record data/CARE.	Quality Assurance Committee/IDD UM Committee	Quarterly
Number of abuse, neglect and rights violations, allegations and confirmations.	This information will be collected via internal reporting systems.	Quality Assurance Committee/IDD UM Committee/ Risk Management Committee	Quarterly
Caseload management ratio	This will be collected through MBOW and electronic health record data systems	Quality Assurance Committee/IDD UM Committee	Quarterly
Access (Intakes vs. admissions)	This information will be collected via electronic health record and internal reporting systems.	Quality Assurance Committee/IDD UM Committee	Quarterly
CLOIP	This information will be collected via electronic health record and internal reporting systems.	Quality Assurance Committee/IDD UM Committee	Quarterly
Timeliness of Data Entry	This information will be collected via electronic health record and internal reporting systems.	Quality Assurance Committee/IDD UM Committee	Quarterly
PASRR	This information will be collected via electronic health record and internal reporting systems.	Quality Assurance Committee/IDD UM Committee	Quarterly

MEASURING ASSESSING AND REDUCING CRITICAL INCIDENTS, ABUSE/NEGLECT/EXPLOITATION AND RIGHTS PROTECTION IMPROVEMENT PLAN

MHMRCV strives to deliver quality services to individuals with IDD. 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 IDD Service Coordination 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 40, Part I, Chapter 4, 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 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:

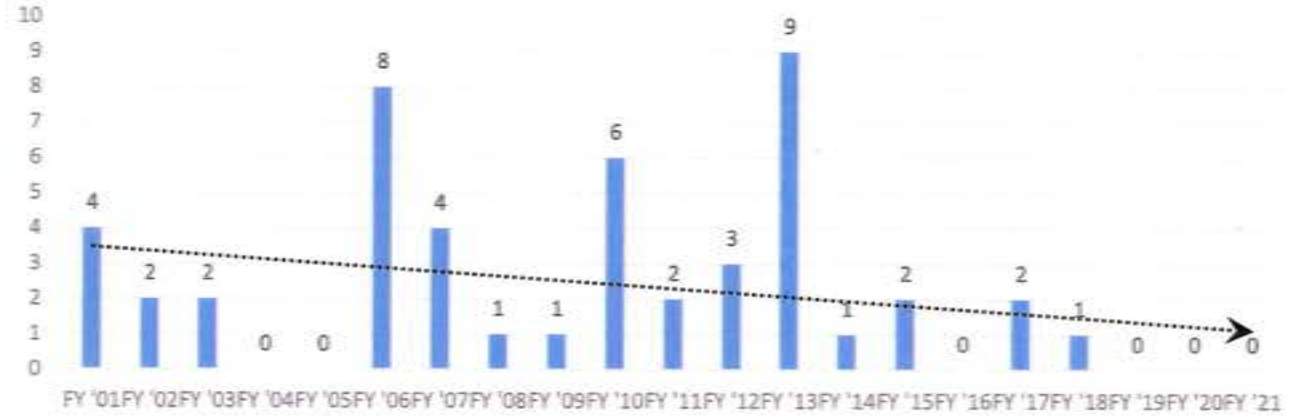
The Center ensures that all TDFPS confirmed allegations of Abuse, Neglect and/or Exploitation receive immediate disciplinary action following a review and affirmation by

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.

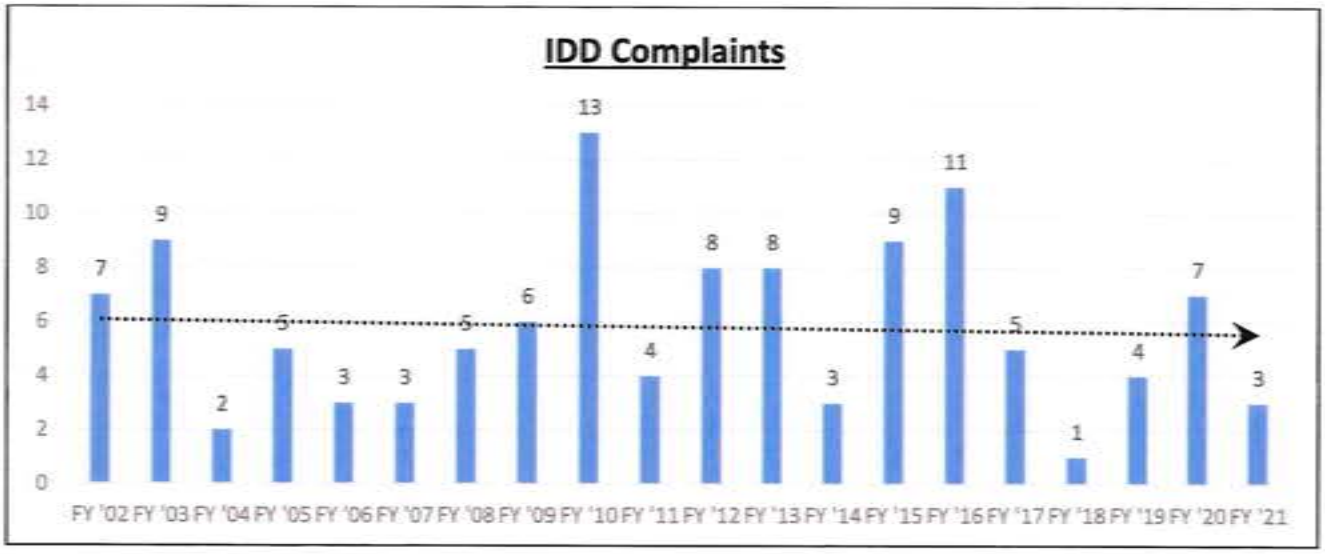
IMPROVING THE RIGHTS PROCESS:

Quarterly and annual 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.

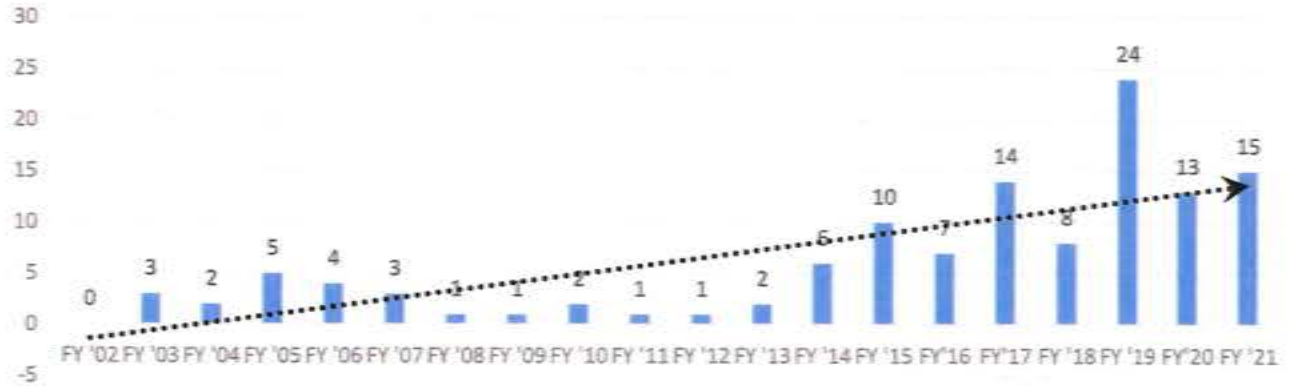
IDD Confirmed Abuse/Neglect Allegations



IDD Complaints



IDD 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 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 SERVICES FOR THE CONCHO VALLEY

FY 2023 – FY 2024 LIDDA QUALITY MANAGEMENT PLAN

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

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GREGORY J. ROWE, CHIEF EXECUTIVE OFFICER

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

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JOHN STOKES, BOARD OF TRUSTEES CHAIRPERSON

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
CFO	Chief Financial Officer
CLO	Community Living Options
CLOIP	Community Living Options Information Process
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
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
DSHS	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
HCS	Home and Community Based Services
HHSC	Health and Human Services Commission
HIPPA	Health Information Portability and Accountability Act
HR	Human Resources
HRC	Human Rights Committee
ICF/MR	Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities
IDD	Intellectual and Developmental Disabilities
IDT	Interdisciplinary Team
ISP	Individual Service Plan
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
PDP	Person Directed Plan
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
SSLC	State Supported Living Center
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
TXHML	Texas Home Living
UM	Utilization Management