MHMR

Concho Valley

Continuous Quality Improvement Plan

FISICAL YEAR 2025

Revised: 05/08/25

Introduction

MHMR Concho Valley's (MHMRCV) Continuous Quality Improvement (CQI) Plan has been created to embrace transparency of measures and outcomes, accurate measurement and data reporting, and personal and collective accountability for excellent outcomes. It is driven by, and supports, the mission, vision, and values of MHMRCV and supports the 3-year strategic plan.

Mission:

"Working together to help people help themselves."

To accomplish our mission MHMRCV offers an array of services and supports which respond to the needs of people with mental illness, intellectual and development disabilities, and substance use disorders, enabling them to make choices that result in lives of dignity and increased independence.

Vision:

"Creating Better Health & Wellness in our Community."

To achieve our vision MHMRCV strives to:

- Provide quality services; customer-focused and accountable
- Promote a safe and healthy environment,
- Foster a spirit of mutual respect, dignity, and cooperation among the people served, their families, staff, Board, and all communities in our area,
- Advocate for those we serve,
- Educate the people we serve, their families and the community about mental illness and intellectual and developmental disabilities services and,
- Work with other agencies toward the provision of early intervention services to reduce the effects of mental illness and intellectual and developmental disabilities.

Values:

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

Respect – Value and celebrate the unique & diverse talents, experiences & perspectives of everyone, and treat others with sensitivity and respect.
Integrity – Accountable for performance by working towards open & honest dialogue with persons served & staff, while within & across organizations to deliver the most positive outcomes.
Support – Encourage, validate, and build up our staff, persons served, & community partners.
Excellence – commitment to continuous improvement in our systems & service delivery

MHMRCV Organizational Foundation, Planning Processes, and Committee Structure

MHMRCV is based in its mission, vision, and values. The Center's Board of Trustees, which is appointed by the organization's sponsoring agencies, selects the MHMRCV Chief Executive Officer (CEO). The CEO hires an Executive Leadership Team (ELT) that is responsible for specific organizational planning, implementation of planning activities, along with other duties. The ELT membership includes: CEO, Chief Financial Officer, Chief Operations Officer, Chief of Administrative Services, Chief of Behavioral Health (BH) Services, Chief Information Officer, Chief Human Resources Officer, and Chief of Intellectual and Developmental Disabilities (IDD) Services.

The primary organizational plans are the MHMRCV Strategic Plan and CQI Plan. The three-year Strategic Plan is followed by additional independent planning documents that further expand on how to operationalize goals from the Strategic Plan. The secondary planning document is the MHMRCV Quality Management Plan which is updated as needed, but at a minimum, biennially. The remaining MHMRCV plans, listed next, support the Strategic and Quality Management Plans: Utilization Management Plan, Corporate Compliance Plan, Americans with Disabilities Act (ADA) Self-Evaluation and Transition Plan, Infection Control Plan, Consolidated Local Service Plan (CLSP) and Local Planning and Network Development (LPND) Plan. Each of these plans are *independent* documents but work collaboratively to achieve the Center's goals and objectives.

Organizational efforts required from these planning documents are supported by a network of MHMRCV committees. Please refer to Figure 1 on page 3. The committee structure starts with the Quality Assurance Committee. This committee is the linchpin for all other MHMRCV committees which are: Utilization Management Committees (IDD and BH), Human Rights Committee, Administrative Death Review Committee, Risk Management Committee, Clinical Records Committee, Employee Engagement Committee, and Professional Review Committee. Each MHMRCV committee reports to the Quality Assurance Committee. The Quality Assurance Committee Chairperson/Chief Operations Officer then reports all committee activity to the Executive Leadership Team. From there, the CEO communicates committee work to the Board of Trustees. Work completed in committees informs the planning process which culminates in the Quality Management Plan, then the Strategic and CQI Plans.

Governing Body

MHMRCV's Board of Trustees has delegated to the CEO responsibility to ensure a planned, system-wide approach to designing quality goals and measures; collecting, aggregating, analyzing data; and improving quality and safety. The Board has the final authority and responsibility to allocate adequate resources for assessing and improving the organization's performance. Per MHMRCV Procedure #3.06.07.01 – "Quality Assurance and Improvement Program," the CEO designates quality assurance and quality improvement duties to the MHMRCV Quality Management Department which is led by the MHMRCV Chief Operations Officer (COO). The CEO will provide the Board with recommendations emanating from the quality improvement activities described in the CQI Plan. The Board has established a standing committee, the Program Committee of the Board of Trustees, to assess and promote patient safety and quality healthcare. The Program Committee provides input and reports to the Board on all areas of clinical risk and clinical improvement for patients, employees, and medical staff. The MHMRCV Planning and Network Advisory Committee (PNAC) is an additional advisory committee that reports to the Board of Trustees regarding services, outcomes and improvement activities.

Figure 1

Leadership

MHMRCV's CEO and COO, along with the ELT and Medical Director, will execute and manage the organization's quality improvement initiatives. Quality leadership provides the framework for planning, directing, coordinating, and delivering the improvement of healthcare services that are responsive to both community and patient needs that improve healthcare outcomes. MHMRCV leaders encourage involvement and participation from all staff in quality initiatives and provide the stimulus, vision, and resources necessary to execute quality initiatives.

MHMRCV's CQI Plan Goals

1. Continue to build upon a learning health system focused on continuous quality improvement, patient safety, and improving processes and outcomes. Partner with Human Resources to enhance educational offerings focused on quality and safety education with all new employee orientation. Hardwire a process for continuous readiness activities that comply with all legislative regulations and accrediting agencies' standards (e.g., CCBHC).

2. Use transparent and meaningful measures to champion the delivery of high-quality evidence-based care and service to patients and their families and assure that it is safe, effective, timely, efficient, equitable, and patient centered care. Refine and enhance data management to support a transparent environment to provide accessible, accurate, and credible data about the quality and equity of care delivered.

3. Develop, integrate, and align quality initiatives throughout MHMRCV. Reinforce the current committee structure to cover broad quality and safety work through the Quality Assurance Committee (QAC). Develop action items to improve initiatives at the program level. Develop and strengthen internal learning collaboratives.

To ensure alignment with survey readiness as a Certified Community Behavioral Health Clinic (CCBHC), the MHMRCV CQI Plan focuses on ***indicators related to improved behavioral and physical health outcomes*** and ***takes actions to demonstrate improved patterns of care delivery, such as reductions in emergency department use, re-hospitalization, and repeated crisis episodes***. The CQI Plan incorporates processes to review known significant events/indicators which are listed below. Also, an explanation as to why each indicator has been included in the CQI Plan is provided.

Indicators Related to Improved Mental Health, Substance Use, and Physical Health Outcomes

- Deaths by suicide or suicide attempts of people receiving services
  This indicator is included per the FY '25 – FY '27 MHMRCV Strategic Plan, Goal 3, "To Improve Quality Across All Center Functions," Objective B, "To achieve and maintain a zero suicide rate from the 2022 baseline."

- Overdoses
  This indicator is included per the FY '25 – FY '27 MHMRCV Strategic Plan, Goal 3, "To Improve Quality Across All Center Functions," Objective B, "To achieve and maintain a zero suicide rate from the 2022 baseline," Strategic Plan, Goal 5, "Pursue Efficiencies and Revenue Growth Opportunities Across the Center," Objective B, "Develop and Implement Substance Use Disorder Services," and per MHMRCV Procedure #4.15.01.00 – "Reports of Incidents, Injuries, Property Damage or Loss, Unusual Events" and Procedure #4.15.01.01 – "Death of a Person Served."

- All-cause mortality among people receiving CCBHC services
  This indicator is included per MHMRCV Procedure #4.15.01.01 – "Death of a Person Served" and the Quality Management Plan.

- 30-day hospital re-admissions for psychiatric or substance use reasons
  This indicator is included per the FY '25 – FY '27 MHMRCV Strategic Plan, Goal 3, "To Improve Quality Across All Center Functions," Objective D, "Meet and maintain 100% of Center CCBHC quality metrics."

- Reduction in safety events
  This indicator is included per the FY '25 – FY '27 MHMRCV Strategic Plan, Goal 4, "Promote Growth and Access to BH and IDD Services," Objective B, "Ensure that Concho Valley offers inviting, clean and well-maintained physical locations to facilitate a comfortable and appealing environment for both patients/clients and staff" and per MHMRCV Procedure #4.15.01.01 – "Death of a Person Served," Procedure #3.09.04.00 – "Risk Management – Safety Accident Prevention Program," Procedure #3.09.03.01 – "Risk Management Committee and Designation of a Risk Manager/Safety Officer," and the Quality Management Plan

- Staff and provider engagement
  This indicator is included per the FY '25 – FY '27 MHMRCV Strategic Plan, Goal 1, "To Be the Employer of Choice for Prospective and Current Employees," Objective A, "Reduce voluntary staff turnover by 2% from the FY '24 baseline each fiscal year," and Objective B, "Improve employee satisfaction by 1% from the FY '22 baseline each fiscal year."

- Improve patient satisfaction
  This indicator is included per the FY '25 – FY '27 MHMRCV Strategic Plan, Goal 3, "To Improve Quality Across All Center Functions," Objective A, "To improve overall client satisfaction by 1% from the FY '22 baseline each fiscal year."

- Increased access (numbers served)
  This indicator is included per the FY '25 – FY '27 MHMRCV Strategic Plan, Goal 4, "To Promote Growth and Access to BH and IDD Services," Objective C, "Increase access to Center services."

- Improved outcomes
  This indicator is included per the FY '25 – FY '27 MHMRCV Strategic Plan, Goal 3, "To Improve Quality Across All Center Functions," Objective D, "Meet and maintain 100% of Center CCBHC quality metrics."

- Equitable care delivery
  This indicator is included per the FY '25 – FY '27 MHMRCV Strategic Plan, Goal 3, "To Improve Quality Across All Center Functions," Objective D, "Meet and maintain 100% of Center CCBHC quality metrics," and Objective E, "Strengthen the Organization in Areas of Diversity and Cultural Humility."

  - *By reviewing and monitoring patient information related to CCBHC quality metrics that have been broken down into smaller, more specific subgroups, MHMRCV can achieve a more detailed analysis of trends and differences within specific patient population groups.*

MHMRCV's electronic health record has the reporting capability to provide disaggregated data so that patterns, disparities, and challenges faced by different subgroups can be identified within the entire patient population data set. More targeted interventions and solutions can be implemented to address inequalities and focus on specific needs of different population groups. The MHMRCV electronic health record reporting feature will allow the Center to review disparities based on the following factors: race, ethnicity, primary language, income, gender, diagnosis, geographic location, and social determinants of health. Disaggregated CCBHC quality metrics, and other data, will be reviewed at regularly scheduled Behavioral Health Utilization Management Committee meetings and documented in meeting minutes. Trends identified that point toward health disparities will be addressed by employing quality management/improvement tools and activities that are described in the LMHA Quality Management Plan. Strategies implemented to promote the reduction of health disparities will be monitored and reported to the Quality Assurance Committee and finally, to the Board of Trustees.

Quality Assurance Committee

The CEO has established the Quality Assurance Committee (QAC) to evaluate, prioritize, provide general oversight and alignment, and remove any significant barriers to implementation of quality, safety, and experience initiatives across MHMRCV programs. The QAC is composed of MHMRCV leadership from all programs. The QAC will approve system-wide quality and safety goals and review progress. Outcomes dashboards and all serious patient safety events are reviewed. Root Cause Analysis, Ishikawa (cause/effect) diagrams, concept fans and brainstorming are examples of formal processes used by the QAC to evaluate improvement projects. The QAC also seeks to ensure that all MHMRCV programs achieve standards set forth by the Certified Community Behavioral Health Clinic (CCBHC).

- Quality Assurance Committee Membership:
  - Chief Executive Officer
  - Chief Operating Officer
  - Chief Human Resources Officer
  - Chief Administrative Officer
  - Chief Information Officer
  - Chief of BH Services
  - Chief of IDD Services
  - Quality Management Coordinator
  - Director of CMH Services
  - Licensed Professional Counselor – Intake/Counseling
  - Supported Housing Specialist
  - San Angelo Clubhouse Director
  - IDD Quality Compliance Coordinator
  - Director of IDD Provider Services

The QAC has oversight of the following committees, subcommittees, and/or processes:

- Clinical Records Committee
- Infection Prevention/Control
- IDD & BH/SUD Utilization Management Committees
- Risk Management/Safety Committee

- Human Rights Committee
- Administrative Death Review Committee
- Employee Engagement Committee
- Peer Review Committee
- All internal learning collaboratives (e.g., Zero Suicide, Substance Use Disorders)
- Patient Experience / Satisfaction

To ensure CQI goals are met, the Quality Assurance Committee will:

- Establish a Review Process: Implement a systematic review of CQI outcomes to monitor and/or identify areas for improvement and make necessary adjustments to staffing, services, and availability.

- Focus on Key Performance Indicators: Prioritize indicators related to behavioral and physical health outcomes, emergency department use, re-hospitalization rates, and crisis episode frequency via the Behavioral Health Utilization Management Committee activities.

  Quarterly Behavioral Health Utilization Management Committee meetings will occur to not only *monitor* patterns of care delivery (i.e., the indicators listed that begin on page 4 of the CQI Plan), but to *create and implement improvement efforts and monitor the successfully improved patterns over time as well*. Specifically, the Behavioral Health Utilization Management Committee documentation (consent agenda, minutes, etc.) will record graphs that illustrate trends over time regarding Behavioral Health and physical outcomes. Successfully improved patterns of care will be documented with measurable data points. When problematic trends are identified, the full Utilization Management Committee, or a subcommittee of the Utilization Management Committee, will complete Ishikawa (cause/effect) diagrams and conduct a "why" analysis to pinpoint root cause(s) of outcomes requiring improvement attention. Next, "brainstorming" and "plan-do-study-act" (PDSA) quality improvement cycles will be piloted to reach the best process changes that result in performance improvement. These quality improvement activities, and envisioned improved patterns of care as a result, are intended to result in at a minimum, *reductions in emergency department use, rehospitalization, and repeated crisis episodes*. Actions taken and resulting outcomes will be documented by the Behavioral Health Utilization Management Committee, reported to and monitored by the Quality Assurance Committee and communicated to the Board of Trustees by way of the Board Program Committee and Planning and Network Advisory Committee.

- Involve Medical Director: Engage the MHMRCV Medical Director in overseeing the quality of medical care and ensuring effective coordination and integration with primary care services. Medical Director involvement will be achieved via several methods.

  First, the Medical Director will serve as the MHMRCV Utilization Management Physician and Co-chair of the Behavioral Health Utilization Management Committee. In these roles, the Medical Director monitors utilization of clinical and fiscal resources with a goal of promoting and maintaining high quality care and efficient use of resources. This activity is conducted during Utilization Management Committee meetings where specific

indicators are monitored and resulting improvement strategies are developed, implemented, and communicated to the Quality Assurance Committee (*Please refer to the MHMRCV Utilization Management Plan, pages 9-10 for a list of Utilization Management activities/indicators are available for review)*.

The secondary method for Medical Director involvement is via the Peer Review Committee activities. The Medical Director is assigned the responsibility of oversight to evaluate the quality of medical care and is accountable to the QAC and also the CEO for the ongoing evaluation and improvement of the quality of patient care at MHMRCV and of the professional practice of licensed providers. The PRC will act as the authorizing committee for professional peer review and system quality committees (Procedure #3.06.07.02). The PRC will also ensure that licensing boards of professional health care staff are properly notified of any reportable conduct or finding when indicated. The PRC has oversight of the following peer-protected processes and committees:

- Medical Peer Review
- Nursing Peer Review
- Licensed Professional Review
- Closed Record Review
- Internal Review Board

Finally, the Medical Director will be involved in coordination and integration of primary care via regular consultation with the Adult Behavioral Health Outpatient Clinic lead Registered Nurse who has responsibility for coordinating primary care services available at the clinic. This effort is further supported by regular review of a primary care dashboard of indicators and CCBHC metric dashboard at the quarterly Behavioral Health Utilization Management Committee meetings.

- Address Significant Events: Develop protocols to review and respond to critical incidents, including suicides, overdoses, all-cause mortality, and 30-day hospital re-admissions through the Quality Assurance, Utilization Management and Risk Management/Safety Committees.

- Utilize Data-Driven Strategies: Leverage both quantitative and qualitative data to inform CQI activities. The MHMRCV Chief Information Officer will play a key role in this process.

- Implement Continuous Monitoring and Reporting: Establish mechanisms for ongoing monitoring, evaluation, and reporting of CQI activities and outcomes to relevant stakeholders and accreditation bodies.

- Adapt and Improve: Use feedback and data analysis to continuously refine and enhance the CQI plan, ensuring it remains responsive to emerging issues and effective in improving overall performance.

Framework for Identifying Improvements

The criteria listed below provide a framework for the identification of improvements that affect health outcomes, patient safety, and quality of care. The criteria drive strategic planning and the establishment

of short and long-term goals for quality initiatives and are utilized to prioritize quality improvement and safety initiatives.

- High-risk, high-volume, or problem-prone practices, processes, or procedures
- Identified risk to patient safety and medical/healthcare errors
- Criteria identified in the MHMRCV Strategic Plan
- Evidenced Based or "Best Practice(s)"
- Required by regulatory agency or contract requirements methodologies
- Quality frameworks are used to guide quality improvement efforts and projects
- A Root Cause Analysis (RCA) is conducted in response to serious events
- Data Management Approach and Analysis

Data is used to guide quality improvement initiatives throughout the organization to improve safety, treatment, and services for persons served. The initial phase of an improvement project focuses on obtaining baseline data to develop the aim and scope of the project. Evidence-based measures are developed as a part of the quality improvement initiative when the evidence exists. Data is collected as frequently as necessary for various reasons, such as monitoring the process, tracking measures, observing interventions, and evaluating the project. Data sources vary according to the aim of the quality improvement project. Examples include the medical record, patient satisfaction surveys, patient safety data, financial data.

Benchmarking data supports the internal review and analysis to identify variation and improve performance. Reports are generated and reviewed with the Quality Assurance Committee. Ongoing reviews of organization-wide performance measures are reported to committees.

FY '25 CCBHC Quality Metrics Targeted for CQI:

The following CCBHC Quality Metrics will be reviewed once per quarter (or more frequently if needed) by the Behavioral Health Utilization Management Committee. Improvement initiatives will be implemented as appropriate per metric data presented via dashboards. Data driven CCBHC Quality Metrics dashboards will be maintained and updated by the MHMRCV Chief Information Officer.

- Time to Services (I-Serv)
- Depression Remission at six months (DEP-REM-6)
- Preventative Care Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)
- Screening for Social Drivers of Health (SDOH)
- Controlling High Blood Pressure (CBP-AD)
- Follow-up After Hospitalization for Mental Illness (FUH)
- Follow-up After Emergency Department Visit for Alcohol or other Drug Dependence (ED-FUA)
- Follow-up After Emergency Department Visit for Mental Illness (ED-FUM)

Ongoing CQI Projects:

- SUD Program

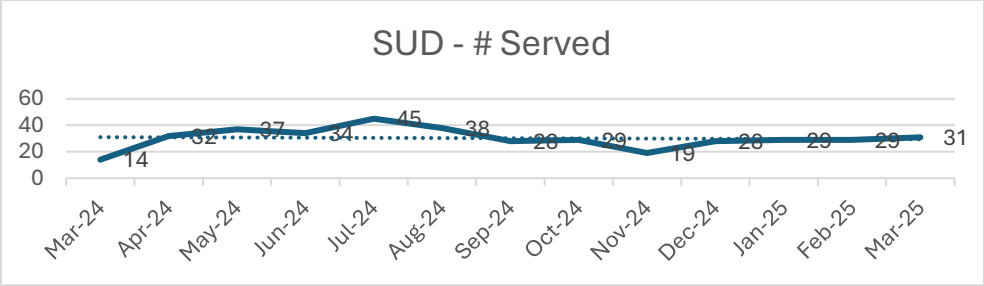
Project Initiation – FY '24

Rationale for Project – Lack of growth in the MHMRCV SUD program.

Potential Solutions Attempted

- Continue Supported Housing referrals.
- Create SUD specific, non-judgmental, trauma informed marketing materials that address services available and build trust in the Center's SUD program. Direct mail to individuals with SUD dx.
- Plan for MHMRCV SUD staff to attend community drug abuse service organization meetings.
- Present and promote MHMRCV SUD services available at sober living facilities.
- Encourage and support current LBHA qualified staff to pursue LCDC.
- Patient engagement with a variety of service providers.
- Continuing staff TIC training.
- Advocate for principles of CCBHC integrated care approach.

Progress Achieved



- Adult Mental Health/Children's Mental Health Clinic No-Show Rates

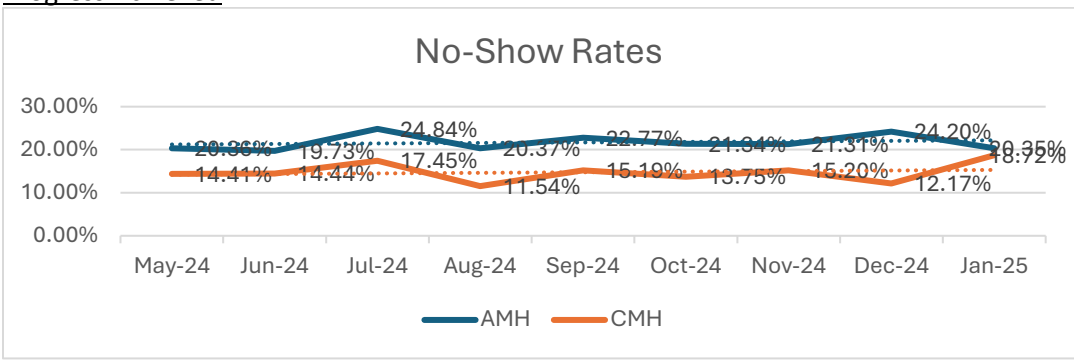
Project Initiation – FY '24

Rationale for Project – High no-show rates for AMH and CMH prescribing provider clinic appointments.

Potential Solutions Attempted

- CMH catchment area ISD Calendars are available as a ready reference
- Additional confirmation calls
- Doxy.me
- Automated text appt. reminders
- Transition provider high no show time slots to administrative time slots
- Arrival time 15 minutes prior to psychiatric evaluation appointment time
- AMH 30/60 minute appt. slots for prescribers so they are interchangeable
- Appointment backfill standby list

Progress Achieved



Reporting

CQI Plan metrics are routinely reported to the QAC. The QAC is notified if a new issue is identified. Roll up reporting to the Board of Trustees occurs on a quarterly basis and more frequently as indicated.

Evaluation and Review

At least annually, the ELT will evaluate the overall effectiveness of the CQI Plan and program including assuring components of the plan are met.

Root Cause Analysis (RCA):

The key to solving a problem is to first understand it. Often, focus shifts too quickly from the problem to the solution, and attempts are made to solve a problem before comprehending its root cause. What we think is the cause, however, is sometimes just another symptom. One way to identify the root cause of a problem is to ask "Why?". When a problem presents itself, ask "Why did this happen?" Then, don't stop at the answer to this first question. Ask "Why?" repeatedly until you reach the root cause.

Setting Aims

Improvement requires setting aims. The aim should be time-specific and measurable; it should also define the specific population of patients that will be affected.

Establishing Measures:

Teams use quantitative measures to determine if a specific change actually leads to an improvement.

Selecting Changes

All improvements require making changes, but not all changes result in improvement. MHMRCV will identify the changes that are most likely to result in improvements.

Testing Changes

The Plan-do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting – by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method used for action-oriented learning.

Implementing Changes:

After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, MHMRCV can implement the change on a broader scale — for example, for an entire population or on an entire unit.

Spreading Changes:

After successful implementation of a change or package of changes for a pilot population or an entire unit, the changes can then be spread to other parts of the organization.

Sources:

Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance.

The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-Do-Check-Act (PDCA) cycle. W. Edwards Deming modified Shewhart's cycle to PDSA, replacing "Check" with "Study." [See Deming WE. The New Economics for Industry, Government, and Education. Cambridge, MA: The MIT Press; 2000.]