

Heart of Texas Region MHMR Center Quality Assurance Plan 2007 – 2008

The Heart of Texas Region MHMR Center has long held the philosophy that quality is the responsibility of all personnel. Long before a staff position existed at the Center with the title of “Quality” in it, the Center was engaged in practices that assessed the type and adequacy of the services provided. Today, the quality of services delivered to the community is based on implementing the Center’s values and guidelines, as well as putting the mission statement into action. The mission statement was revised with the help of consumers and stakeholders in Fiscal Year ‘02 as a result of the Planning Advisory Committee’s advice. It currently reads:

The Heart of Texas Region MHMR Center strives to deliver accessible, caring, and responsive support services to individuals and families coping with mental illness, mental retardation, developmental delays and emotional conflict.

The Center’s Guiding Principles, established years before, were developed in a process that polled various direct service staff across the entire organization. Those principles state:

- The Heart of Texas Region MHMR Center is committed to providing quality services in partnership with the individual, the family and the community.
- The Heart of Texas Region MHMR Center strives to empower the individual and family by respecting their right to make choices about their lives.
- The Heart of Texas Region MHMR Center is actively involved with community initiatives that will improve quality of life.
- The Heart of Texas Region MHMR Center believes that it is through commitment to the individual’s personal and professional development that you build an organization that strives for excellence.

The Center holds the position that the mission statement is applicable to every service provided and applicable for every individual and family receiving services. The mission statement is displayed in public areas in Center facilities.

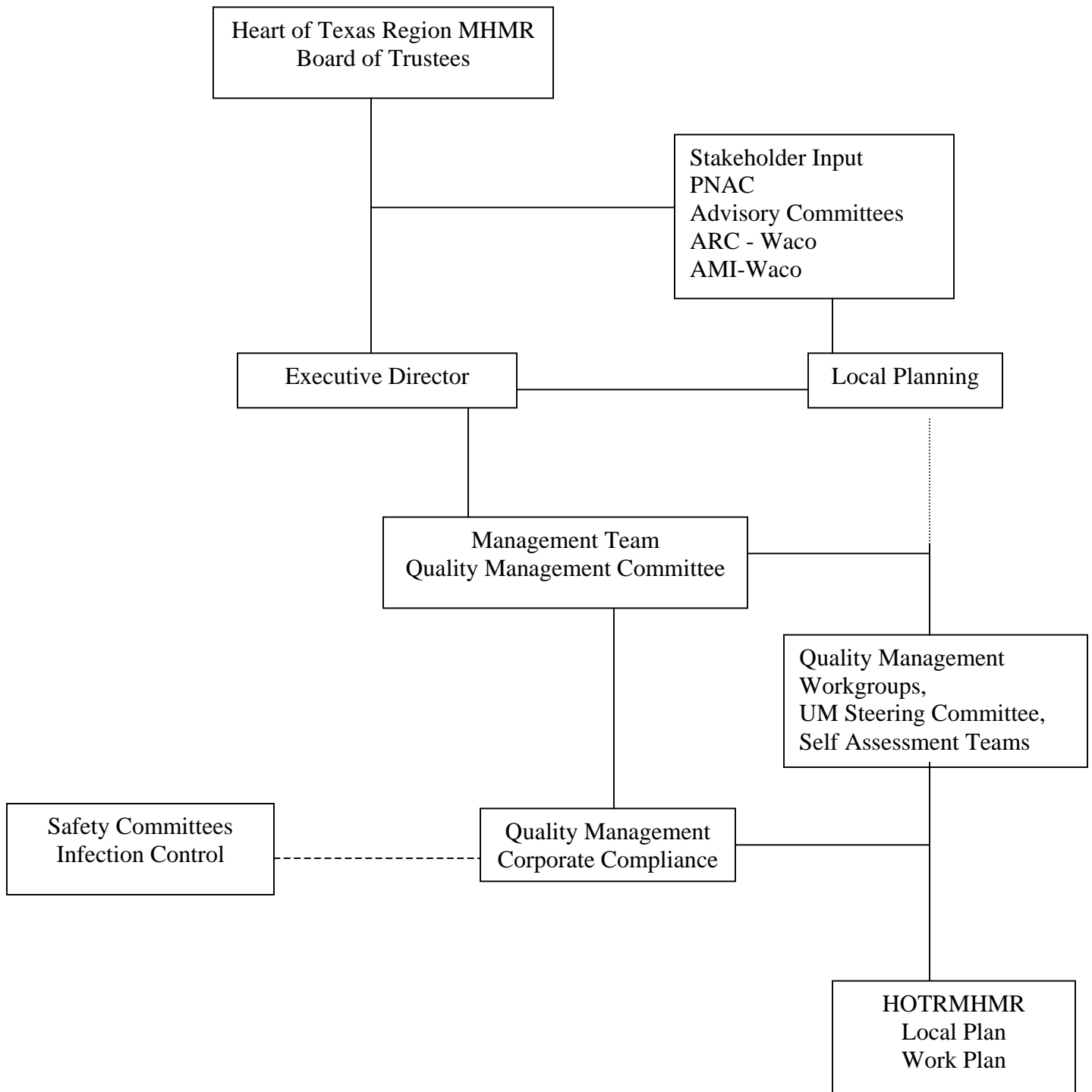
QUALITY MANAGEMENT FUNCTIONS

- Quality Management Committee
- Assessments
- Activities

QUALITY MANAGEMENT COMMITTEE

The Quality Management Committee functions within the membership of the Management Team that is selected by the Executive Director. It consists of the Division Directors from Mental Retardation Services, Mental Health Services, and Administration, and the directors from Quality Management, Information Services, and Finance. The decision to appoint these directors was made so that any plan of improvement may be implemented immediately, rather than be processed through an additional step of explanation and justification. (However, input from all sectors into a plan of improvement is important. Other personnel may be pulled in to the committee on an ad hoc basis.)

Quality Management Committee



The Management Team (Quality Management Team) has been a body in place for many years, has met regularly, and has disseminated its information on a Center wide basis. This body has historically analyzed data, reviewed audit results, examined problems and has set annual performance goals (strategic initiatives) for the Center. When quality management issues are brought before the Management Team, the Executive Director appoints a work group to address the issue. Work groups are charged to examine relevant data, create solutions to problems and to oversee the implementation of the solution.

HOTRMHMR has several standing workgroups or sub-committees:

- The Compensation Committee was initially formed to consider methods to bring parity between the positions and salaries of those staff who worked previously for the Blacklands SOC and who became HOTRMHMR employees with the merger. The Compensation Committee also formed to consider the HOTRMHMR benefit package. Since accomplishing its goals of “leveling” staff positions, the committee established procedure for creating new positions or modifying existing positions. The committee continues to meet routinely to consider issues of position changes, compensation, benefits, and related issues.
- The Utilization Management Steering Committee is composed of a psychiatrist who is the chair of the UM Committee, the UM Director, the Quality Assurance director, a representative from finance and IT, division directors, and ad hoc members. It meets routinely to review encounter data for accuracy and to analyze service trends and patterns.
- CAM Workgroup. At the beginning of FY’03, the CAM workgroup engaged in the tedious task of aligning CAM codes with service grid codes, MAC codes, CARE codes and local IS codes. The result of this work was a modification and re-mapping of local service activity codes. Since that time, the CAM Workgroup convenes annually in a series of meetings during August to realign and re-map the various coding requirements into a functional system of reporting to ensure data accuracy. Additional revisions were made as needed throughout the year.

The Quality Management Committee (QMC) is charged with considering data to measure both authority functions and provider functions, from a variety of sources including quality management activities, self assessments, and external assessments. The committee is charged with conducting an analysis, and developing a quality improvement plan known at the Center as the Work Plan which is based on current strategic initiatives. The QMC typically develops the Work Plan annually at a planning meeting, bringing information from stakeholders into consideration. The planning process typically sets priorities, defines parameters, and establishes benchmarks. Throughout the years, this planning process has been modified to accommodate various state initiatives such as the Authority Certification rule, the MRLA implementation, QAIS, Texas Home Living Waiver and enrollment procedures and the dual contract requirements of DADS and DSHS. Despite the modifications, the basic process has remained stable at HOTRMHMR, relying on traditional Quality Management activities and Quality Improvement methodologies.

Traditionally, the Work Plan is developed annually with the final document specifically stating what is to be accomplished, how it will be accomplished, when and by whom. The Management Team will review the plan quarterly to gauge its effectiveness and process made against benchmarks established in the plan. The Center’s format is shown below.

| Strategic Initiative | Objective | Strategy Action Steps | Responsibility | Resources | Time lines | Outcomes |
|------------------------|-----------|-----------------------|----------------|-----------|------------|----------|
| Strategic Initiative 1 | | | | | | |
| 1.1 Objective: | | 1.1.a. | | | | |
| | | 1.1.b. | | | | |

ASSESSMENTS

Various methods have been employed in years past in order for the Center to assess its services. Several years ago, the Center hired a consultant who interviewed over 100 mental health consumers and front line staff to assess the Center from the “consumer’s point of view.” The same consultant did similar work with the Center’s mental retardation services as an adjunct to a QAIS review. Most of the Self Assessments and Quality Management process in the past few years have focused on this relationship in an attempt to balance good service with good management. In past self assessments, the Center used methods from the text, *How to Respond to Managed Behavioral Healthcare*. In addition, the Self Assessment typically examined performance data, local data, CARE data, Business Objects data and now MBOW data, the results of external reviews, and any other information or data recommended for study by the PNAC or stakeholder groups. (For example, this year, the PNAC recommended that the Center examine underserved populations and this recommendation became part of the Work Plan.) The Center discovered from past assessments the difficulty of taking a “snapshot” or one-day approach to assessments, so any additional analysis of its operations and data on an ongoing basis, outside of the time frame of a self assessment, is considered as well. Analysis conducted in ad hoc committees or in established work groups is also vital for consideration in the assessments. In the past year, the Center consulted with a DARS expert to improve consumer vocational and employment services.

MR Assessments and Interviews:

Currently, the Quality Assurance coordinator for Developmental Services (MR) routinely conducts record reviews of consumer charts assigned to each service coordinator. These charts are selected at random. Following the chart review, the QA coordinator may interview the consumer using a standard set of questions to determine the consumer’s satisfaction with services and the Center’s effectiveness of programming. The QA coordinator may conduct up to five interviews per month. Information from the chart review is returned directly to the service coordinator and supervisor. Problems or concerns from the review process are usually resolved by the Service Coordinator, the supervisor for Service Coordination, and the consumer and/or family. Any critical issues that emerge from the interviews are immediately addressed. Developmental Services conducts quarterly consumer/family meetings and administers consumer satisfaction surveys in all program areas several times each year. As with the chart reviews and consumer interviews, the outcomes are discussed with the relevant service coordinator, the supervisor and any problematic issues are resolved as soon as possible. Review of the survey process this year determined that the survey tool does not adequately address the outcomes from the provision of services. The survey tool is currently being revised.

Satisfaction Surveys

The annual DSHS Adult MH Satisfaction Survey and the Child and Adolescent Satisfaction Survey are coordinated through the Quality Management office at HOTRMHMR. Each year, the results of the survey are copied and distributed to management staff. The results are discussed and analyzed by the

Management Team (QMC) and recommendations for any areas specific to this Center falling below 85% are made and become part of the Work Plan. Ad hoc workgroups are formed to address specific problems and to implement the Center's Work Plan. Results from other external surveys are managed in like manner. Internally, various program directors conduct informal satisfaction surveys by randomly selecting consumers to call and question. Participation in these informal surveys is voluntary and the responses remain "anonymous."

QUALITY MANAGEMENT ACTIVITIES

Data and findings from quality management activities are reported to the program directors and the supervisors of the programs reviewed, and to the Executive Director and Management Team. All programs that serve consumers with mental retardation and consumers with a mental health diagnosis, including the COPSD Program are included in regular quality management activities. Beyond the regular quality management activities, the Executive Director may request certain reviews or assessments be conducted as a result of quality management issues that arise during the course of the year. Quality Management activities include (but are not limited to):

- **Corporate Compliance:** Currently, all new staff receive training on the center's Code of Conduct during new staff orientation. Quality Management staff are available for consultation regarding the Code of Conduct as it applies to center operations. The center's Corporate Compliance Plan states that Quality Management staff will conduct investigations of code violations when warranted. Investigative Reports are maintained in the Quality Management office.
- **Rights, Abuse, Neglect and Exploitation:** Each new employee receives extensive training on the rights of individuals served and in the prevention of abuse, neglect and exploitation. Annual refresher courses are also required. The Center's Code of Conduct incorporates consumer rights into the expectation for staff performance.
- **Quarterly reports to the Board of Trustees:** The QM Director reports delivers a report to the HOTRMHMR Board of Trustees on the Center's compliance with contract targets. The QM Director also uses a "report card" format to summarize the Center's compliance with contract targets with the Management Team.
- **The Utilization Management Steering Committee:** Quality Management staff routinely meets with the UM Steering Committee to review the encounter data processed by MBOW and to review center produced data. The committee observes the data for trends, patterns, benchmarks and outliers that impact Center performance. The committee tracks compliance with contract targets and outcomes and performs additional studies when compliance is identified as an issue. Information about the committee work is communicated to division directors who in turn distribute the information to the appropriate program director for action or correction. The committee compares local data to MBOW data to assess for accuracy and to make needed corrections.
- **Medicaid Monitoring and Billing Review:** The center conducts self-auditing of its service billing practices to ensure compliance with applicable regulations. Retro-active audits performed on a monthly basis examine billed services, selected on a random basis. Services include those billed to Medicaid and any other payer. This internal audit reviews both the clinical record and the service data entered into the center's computer system. Errors are reported to the Executive Director and to the appropriate division director. Additional feedback

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informs staff about the quality of service data and written notes in the clinical record. When warranted, the billing department corrects billing errors according to departmental regulations.

- **Clinical Record/Continuity Review:** Historically, a record review at HOTRMHMR was a clinical review of the quality, outcomes and continuity of services from the initial assessment and authorization, through provider services such as treatment planning, progress notes and routine treatment review/assessment. In addition, the records review assessed the presence or absence of required documentation at this Center. Quality Management conducts “spot reviews” in conjunction with the Data Verification reviews. In these spot reviews, a single data requirement (such as a financial assessment) is reviewed in addition to the information required for DVC review. Billing reviews compare progress notes with billed services to ensure documentation compliance. At other times, there is a need to conduct specialty reviews that focus on a single issue or service. Specialty reviews are conducted in the same manner as those mentioned above. The results of all of these reviews are communicated with the Division Director and the Executive Director.
- **Data Verification and Encounter Reviews:** The Quality Management staff is responsible for conducting the Data Verification Reviews as outlined by DSHS and DADS. In a typical review, Quality Management staff notifies program directors, service coordinators and/or other responsible staff of the review once the list of names and the protocols are posted on MBOW. Clinical records are pulled or brought in from the regional counties and a date for review is established by QM staff. Once the review is completed, the results are posted according to departmental instruction (currently, the ftp site). Any problems with data accuracy or with the clinical record noted in the review are communicated to the program director or supervisor and plans for remediation are developed and incorporated into the Work Plan when needed. In the past fiscal year, Quality Management personnel have conducted staff training around documentation issues as a result of the DVC/Encounter reviews. Documentation templates for specific services were developed jointly by program staff and Quality Management. These templates have been modified to “fit” additional programs at the request of other program directors. Overall results of the Data Verification/Encounter reviews are communicated to the Quality Management Committee.
- **TIMA Reviews:** The Quality Management staff will conduct a review of persons served under the TIMA regulations each year as required by the performance contract. In the past, the focus of the reviews shifted from year to year in order to meet the survey needs of the Psychiatric Services Department. Current reviews will be conducted according to instruction from DSHS.
- **Fidelity Reviews:** The Center conducts Fidelity Reviews of the Resiliency and Disease Management programming according to the guidelines set forth by DSHS.
- **Risk Management Reviews:** Risk Management activities, including review of consumer deaths, are conducted according to Administrative Procedure 1.3, Investigation of Adverse Incidents. Copies of Incident Reports are forwarded to the QM Coordinator for review and a file is maintained in the QM Coordinator’s office. The QM Coordinator reviews each Incident Report and conducts follow up as needed. Incident Reports are also copied for the Personnel Officer, the Infection Control Officer and the Safety Officer. These staff coordinate in any action that may result from an Incident Report. The written reports, findings and recommendations resulting from DPRS investigations of abuse, neglect and/or exploitation are forwarded to the QM Coordinator and maintained in a file. Any documentation of personnel

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action taken as a result of the findings of the investigation is maintained by the Personnel Officer. All staff receive training in the prevention of abuse, neglect and/or exploitation at hiring and annually.

Other risk management activities or reviews will be conducted at the direction of the Executive Director.

- **Center for Developmental Services Safety Committee:** The CDS Safety Committee meets at least quarterly, with leadership from the MR Quality Assurance Specialist, to consider Rights, Abuse, Safety, and Health data and other critical issues identified in the quality management process. Additional areas of oversight include any infection control trends, medication errors, a review of physical injuries reported on the Center's Incident Reports, fire drill reports, and any other safety issues that arise. Based on these reviews, recommendations for improvement are made directly to program supervisors from this committee and items may be added to the Center's Work Plan. Last fiscal year, the Incident Report for the Center was improved as a result of recommendations from the Safety Committee.
- **Contract Accountability and Oversight/Texas Home Living Authority Reviews:** The Department of Aging and Disabilities Services conducts an annual Authority review. The FY2006 review occurred June 13-15, 2006. Significant findings in both reviews were discussed by Developmental Services staff. Discussions with MR-specific quality assurance personnel led to staff retraining in writing and monitoring action plans, with emphasis on matching objectives with needs stated in the Person-Directed Plan and a comprehensive quarterly review of services. All other issues in the report of findings from these reviews did not directly affect Quality Assurance activities.
- **Contract Monitoring:** The HOTRMHMR Contract Monitor is responsible for all contracted services including contracted services for consumers. Each contract specifies the monitoring duties and procedure. Contracts are officially monitored two to three times per year if contract criteria is met and maintained, more often if not. Part of the contract monitoring process includes consumer input if the consumer has made complaints. The contract monitor may ask the staff closest to the actual service delivery to complete the monitoring protocol. The monitor reviews the contract monitoring protocols for compliance as well as interviews the staff involved. The FY '06 – '07 process includes unannounced personal inspections or interviews as well. The contract monitor also oversees compliance with the departmental contracts, monitoring authority functions.
- **Internal Program Review:** Internal Program Reviews will be conducted at the request of the Executive Director or the Program Director. Elements of review included in this process consist of Rights Review, Procedure Review, Medication Procedure and Practices Review, Facility Review and any other review element mentioned above.
- **Infection Control:** The Infection Control Committee has been a cooperative effort between the medical units, the human resources/training unit, and the quality management staff at HOTRMHMR. The Infection Control Committee meets at least annually as a function of the Developmental Services Safety Committee and/or as a function of the Psychiatric Services department to consider several issues. Incident Reports are reviewed by the Infection Control Officers as well as the quality management staff to detect any trends or patterns in consumer care, in observance of universal precautions, etc. Should any negative trends be discovered, the committee assigns staff to address and correct the problems. The committee reviews

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significant incidences of consumer and staff illness/infections and makes recommendations if needed.

- **Human Rights Committee:** Quality Management staff participate on the Human Rights Committee to assist in the review of requests for restrictions and the review of any other issues brought before the Human Rights Committee. Rights training is given to each new employee at orientation and a refresher course is given annually to each staff with consumer contact. Internal training in Developmental Services on the philosophy of self-determination is part of the Work Plan and has been implemented. Volunteers also receive training prior to consumer contact. The Developmental Services Safety Committee regularly reviews data and information regarding rights, abuse, neglect and exploitation to determine trends or patterns and to determine the need for staff education or training. Beyond committee work, CDS service coordinators incorporate rights education into the Person Directed Planning process with consumers.
- **Rule Review:** Quality Management staff review DADS and DSHS Rules and related rules as they are proposed and adopted. Copies of the rules are disseminated to appropriate staff. Copies of the rules are maintained in the Quality Management office.
- **Technical Assistance:** Quality Management staff provide technical assistance on an ad hoc basis. Such assistance may include development of procedure, staff training, local planning, development of protocol, and development of plans of correction.
- **Audit Liaison:** Quality Management staff often serve as the liaison between the Center and DADS or DSHS to organize data for audits and reviews.
- Although an IHFS approval committee was in place in the past when IHFS was granted to individuals who met priority population guidelines for both Mental Health and Mental Retardation consumers, this task was delegated to the Division Director of Developmental Services, who served as the sole reviewer when funding was cut (and MH IHFS was cut) several years ago. Beginning with the review of IHFS applications for FY2007, a standing review committee consisting of the MR Quality Assurance Specialist, a Registered Nurse, a Supervisor from a Medicaid Waiver Program and the Division Director of DD Services was formed to review, critique and approve all IHFS applications. In addition to this being a tremendous teaching tool for the members and the IHFS Coordinator, the review process identified deficiencies in information and application requests. The majority of the deficits had to do with limited and inadequate justification for the requested services and/or the absence of any attempt to find alternative funding sources. The review team will remain in tact for FY 2008.

INTERNAL REPORTS

The Center historically has issued routine reports from its information system, now the Clinical and Billing System (CABS), which are available through the CABS computer network to program directors, unit directors and directly to staff (depending on the report) as part of its Utilization Management program. These reports are considered on both a formal and informal basis for trends, patterns and practices which benefit the consumer and the Center or which are ultimately detrimental to the consumer or Center. Some of the routine reports include:

CABS Reports

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- Caseload Management Report: This report lists a caseload by staff. In addition, it lists Medicaid eligibility, date of the last Uniform Assessment performed, date of the last diagnosis sent to CARE, date of the last fee assessment and case management screening and the date of the last Plan of Care for each consumer on that caseload.
- Staff Percentage Report: This report is a spread sheet listing each staff that delivers face-to-face service and data regarding those services. It is prepared and distributed to directors on a at least a bi-weekly basis as a method of measuring services and service capacity provided by the Center and any contract providers. The Staff Percentage Report also tracks the number of direct service hours delivered by each staff and the billing potential for each staff.
- Each staff person that delivers services sets a monthly goal for direct service. Achievement of this goal is tracked in CABS for each individual staff and is visible as a bar graph on the screen when a staff person is entering encounter data. By this method, each staff person is able to track personal productivity. Supervisors are also able to track productivity from an aggregated report through CABS to monitor the Center's performance. .
- Minimum Hours Report: This locally produced report details the data that impacts the state's minimum hour contract targets. The report is produced bi-weekly and distributed to division directors.
- Over/Under Report: This report tracks use of the state hospitals.
- Budget Report: CABS produces a monthly report of actual verses budget data.
- Amount Earned Report: CABS produces a report that details the amount of revenue earned by staff, by unit, or by service activity.
- Failed Billing Report: There are some instances in which the billing for an encounter "fails." This report delivers data to supervisors that details what billing failed and the cause of the failure, allowing supervisors to address repeating problems or unique events. When possible, remediation is put into place. This is one methodology for measuring authority functions.
- Local MBOW Reports: Division Directors, UM Staff, or QM staff are able to download MBOW reports and break them down to the unit level for analysis.

Reporting: Communication of the results of any quality management activity is critical if organizational improvements will occur. Communication is planned to flow along the lines shown in the chart submitted in this plan, although it is not restricted to those lines. The Quality Management Committee develops a feedback loop as part of its function in order to communicate a unit or department's performance. Specific information is communicated to units or departments, while aggregated information is reported to the Quality Management Committee. Quality Management will also develop the format and parameters of feedback to the various stakeholder and consumer groups. The Center's PNAC is described in the local plan and receives reports throughout the year. (At times, the potentially sensitive nature of the information could possible preclude releasing unnecessary or confidential details.)

Stakeholder/Consumer Input: This in an area that continues to be an area of importance and continues to be developed at the agency. The Center's PNAC meets regularly and is described in detail in the local plan. The PNAC will continue to impact Center services through the input of the members when they consider Center data and reports submitted to them for consideration. The QM Committee chart demonstrates the relation between the PNAC and quality management efforts; as the flow of information and recommendations are exchanged. The PNAC reviewed the Center's Work Plan in April of 2006.

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In services for people with Developmental Disabilities, there is a renewed emphasis on effective and meaningful service provision, and improving consumer's social capital and community life. Since February of 2007, Developmental Services staff have been moving forward with a process of identifying core values of managers, direct service employees, and consumers in order to find a true focus, build strong mission statement for Developmental Services, and produce a new work plan. The (GR and TxHmL) Service Coordination department and the HCS program hold regular Consumer – Family Support meetings with consumers, families and stakeholders in Waco, Mexia, and Marlin. Feedback and evaluation of current services, brainstorming about future needs and discussion of service trends provides the center with valuable information that is shared with the PNAC as appropriate or is used to make changes in the way services are provided.. The Center has focused outreach efforts in explaining programmatic changes due to contract requirements and defunding, new resources for Day Habilitation services and the down-sizing of the Center's day habilitation program. .

Consumer Interview: As explained previously, quality assurance staff in Developmental Services will interview consumers (and family members when appropriate) each month to determine consumer satisfaction and program effectiveness.

Additional input from stakeholders comes from the ARC of McLennan County. Staff from this Center have served on ARC committees and on the ARC Board of Trustees. Likewise, ARC staff sit on HOTRMHMR committees and actively participate in stakeholder processes

The Division Director for Developmental Services has ongoing contact and discussion with the parent group for children with autism to exchange information about consumer needs and available programming. One particular result from this relationship is the implementation of a respite program, using a pool of autism-trained undergraduate students from Baylor University. This program, funded primarily through the United Way, allows parents to interview and hire the respite providers from this pool of students. CDS staff routinely participate in transition planning for consumers exiting the school systems with an emphasis on growing natural and community supports for the students after school rather than growing dependence on center services.

The agency has developed a close relationship with AMI-Waco and the Executive Director meets regularly with the person who is in the president's chair of AMI-Waco. Both organizations have cooperated to bring in speakers and educators to present to consumers and to staff on several occasions. The Center also receives feedback from AMI-Waco representatives through various committee functions and arrangements.

The Local Plan contains many more examples of community input an planning.

Central Office reports, surveys and feedback are considered most seriously. Often the reports and feedback are shared with the entire staff, the PNAC, and with consumer and stakeholder representatives. In every case, all of the information gathered from consumers and stakeholders is reviewed by the Executive Director and often is incorporated into quality improvement process.

Coordination with Other Administrative Functions: The Quality Management Committee consists of staff from Mental Health Services, Administration, Quality Management, Information Services, Mental Retardation Services, and Finance ensuring not only a balanced representation, but also investment by all factors. Additional members are added to the committee as needed. Developing any the plan for improvement cannot take place unilaterally. Decisions to implement changes will not happen without support from the clinical arena, the computer interaction unique to this Center, the finance department and the support of administration. Quality Management staff habitually interact

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with all other departments in the agency in order improve the quality of services delivered by HOTRMHMR.

Description of Services Provided by and Managed by HOTRMHMR: The document above describes the Quality Management Department functions. A description of specific services is found in the Local Plan.