

## **Heart of Texas Region MHMR Center Quality Assurance Plan 2010**

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 ‘00 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. New staff are introduced to the mission statement and the Guiding Principles as a part of new staff orientation. The mission statement is displayed in public areas in center facilities.

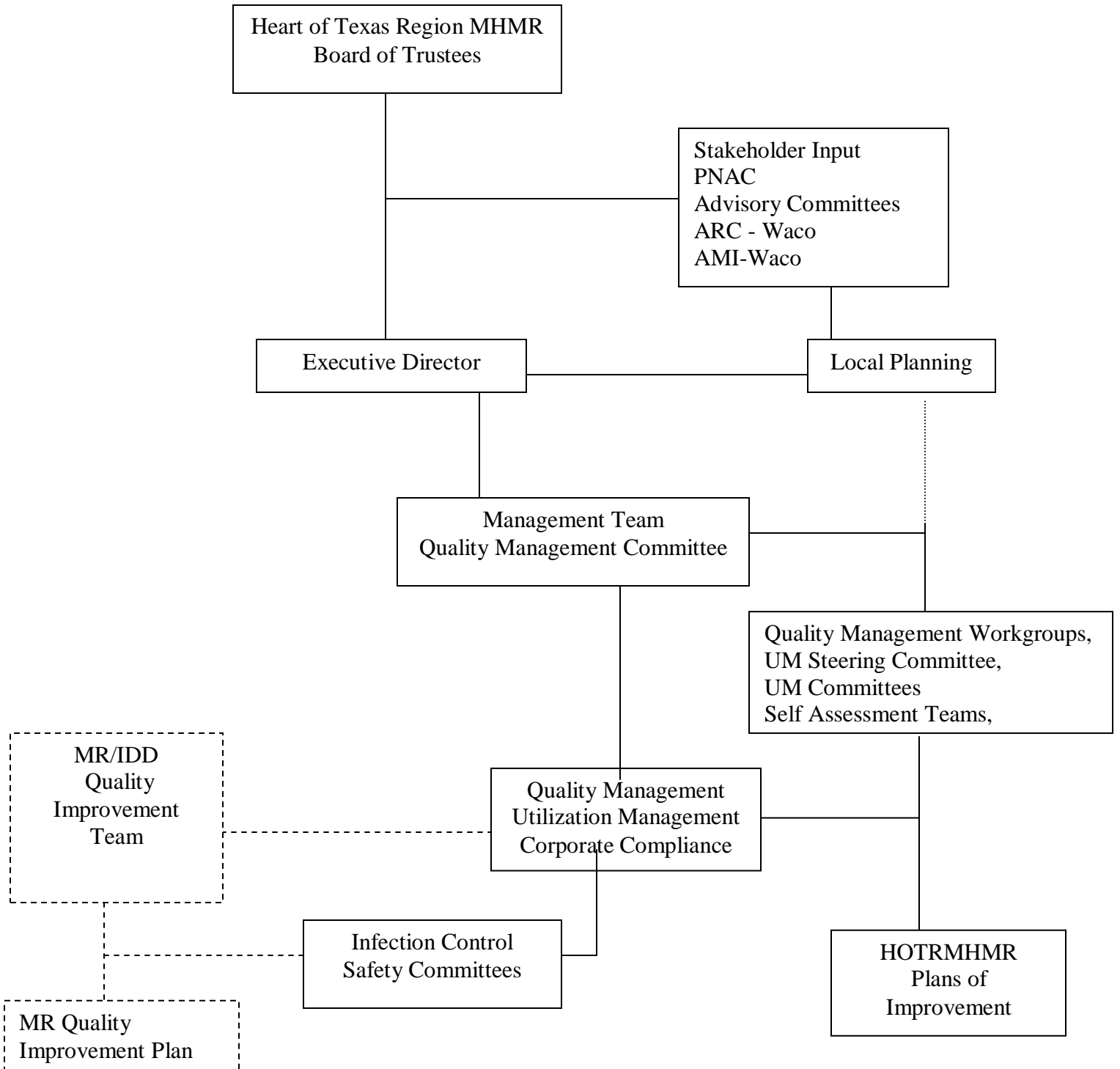
### **QUALITY MANAGEMENT FUNCTIONS**

- 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 division directors and program directors from Mental Retardation Services, Mental Health Services, Administration, Quality Management, Information Services, and Finance. The decision to appoint division directors and program 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 and 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 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 became HOTRMHMR employees with the merger in 1999. 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 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, and ad hoc members. It meets at least quarterly to review encounter data and to analyze service trends and patterns. Three UM Subcommittees meet routinely to address clinical issues, billing issues and crisis services.

The Quality Management Committee (QMC) is charged with considering data from a variety of sources including quality management activities, self assessments, and external assessments. The committee is charged with conducting an analysis, and developing strategies for improvement. The QMC has typically defined its parameters, including establishing benchmarks, and has set priorities for the Quality Improvement efforts at the center.

The Management Team will review the strategies for improvement in management meetings to gauge its effectiveness and process made against benchmarks established in the plan. The center’s format is shown below.

Strategic Initiative			
Dept or Unit	Department/Unit Goal		Time frames and Responsibility
	Activities	Steps to accomplish department/unit goal (criteria)	
	Department/Unit goal		
	Activities	Steps to accomplish department/unit goal (criteria)	

The Heart of Texas Region MHMR Center Board of Trustees has established strategic goals for the center. These goals are reviewed at planning junctures such as development of the local plan, etc. The strategic goals have historically served as the basis for any “plan” that the center develops and for setting short term organizational objectives

## **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 strategic processes 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, any self assessment typically examined performance data, local data, Business Objects data, and CARE data, the result of external reviews, the MR assessment processes, and any other information or data recommended for study by the PNAC or stakeholder groups. Analysis conducted in ad hoc committees or in established work groups is also vital for consideration in the any self assessment.

**MR/IDD Assessments** HOTRMHMR has a lengthy history of conducting self assessments. The Developmental Services division conducts periodic internal reviews that combine chart review and personal interviews with consumers and families to assess the center’s efforts with person directed planning and quality of services. The Quality Management department assists the quality coordinator in IDD to conduct these interviews. Rights, Abuse, Safety and Health data will continue to be collected per the performance contract and this data contributes to the self-assessment and quality improvement process. Other Utilization processes for the IDD programs are described in Exhibit B-2.

### **Satisfaction Surveys**

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 division directors and program directors 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:** All new staff receive training in the center’s code of conduct and DFRA during orientation. Quality Management staff conduct investigations at the request and direction of the Executive Director as Corporate Compliance enforcement. Reports are maintained in the Quality Management office
- **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 through 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 Executive Director.

- Data Verification/Encounter Verification Reviews: The Quality Management staff is responsible for conducting the Data Verification/Encounter Reviews as outlined by the state. In a typical review, Quality Management staff notify program directors, service coordinators and/or other responsible staff of the review once the list of names and the protocols are received from the state. Clinical records are pulled or brought in from the regional counties and a date for review is established and QM staff. Once the review is completed, the results are delivered to the state, as required. Any problems noted in the review are communicated to the program director or supervisor and plans for remediation are developed. Overall results of the Data Verification 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. 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
- ➤ 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. Incidents of abuse, neglect and/or exploitation are tracked and reported according to departmental regulations. Personnel action is taken in any confirmed case. The Personnel Officer maintains documentation of personnel action taken as a result of the findings of the investigation. 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.
- 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. The center has terminated some contracts in the last year, but none for the provision of services to consumers. 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 contract monitoring department has developed a database, which tracks licensure renewals.

- 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 and Environmental Review: 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 routinely throughout the fiscal year to consider several issues. Incident Reports are reviewed by the Infection Control Committee chair and screened 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 significant incidences of consumer and staff illness/infections and makes recommendations if needed.
- Center for Developmental Services Safety Committee: The CDS Safety Committee meets regularly, with participation from the Quality Management Staff, to consider Rights, Abuse, Safety, and Health data and other issues identified in the quality management process. Additional areas covered 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.
- 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.
- Rule Review: Quality Management staff review departmental 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.

The center historically has issued routine reports from the internal computer system which are available through the computer network to division directors and program directors, unit directors, and directly to staff (depending on the report) as part of the center's 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.

Computer reports include:

- Caseload Management Report: This report lists a caseload by staff. In addition, it lists the LOCA, the date of the last Fee Assessment, the date of the last Uniform Assessment performed, date of the last diagnosis sent to CARE, and the date of the current admission or services. The report indicates if these dates exceed compliance.
- Authorization Overdue Report: This report lists overdue authorization by date, client and staff person.

- Deviation from LOC-R to LOC-A: This report is available in both a summary and a detail report. It lists deviations from the recommended Level of Care to the authorized Level of Care by client, reporting unit, admission status, Medicaid status, Uniform Assessment date, and by diagnosis.
- Contact Time and Billing Report: This report shows each staff in a designated unit and notes the amount of available hours, the number of hours spent in contact with consumers, the number of billed hours and the amount billed. In addition, the year to date amount billed is shown. This report also is disseminated monthly.
- ASH Bed Day Report: This report goes directly to the unit responsible for tracking the utilization of Austin State Hospital. Decisions are made and strategies are developed based on that data.
- Inpatient Census Report: This report tracks persons admitted to and discharged from the local psychiatric hospital.
- Crisis Care Center Census Report: This report tracks persons admitted to the Crisis Care Center respite and other residential programs.
- Benefit Eligibility Report: This report tracks persons with active benefits and those in the process of applying for benefits.
- Service Audit Report: This lengthy report tracks services provided on a client by client basis and the billing actions for each service.
- Staff Percentage Report: This report summarizes the amount of direct and indirect service delivery on a staff by staff basis by month.

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. Communication is not restricted to the lines shown in the charts, however. The Quality Management 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 and area of importance and continues to be developed at the agency. The center's PNAC meets regularly and is described 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 (GR) Service Coordination department and the HCS program hold regular meetings with consumers, families and stakeholders in Waco, Mexia, and Marlin. Information is gathered from these groups both formally and informally. Most recently, the center has focused outreach efforts in explaining programmatic changes.

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 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.

DSHS/DADS 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 is often 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 with all other departments in the agency in order improve the quality of services delivered by HOTRMHMR. The Quality Management Plan is reviewed annually as a part of the planning process.

**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.

