Tri-County Behavioral Healthcare

Healthy Minds. Meaningful Lives.

Tri-County Behavioral Healthcare

Intellectual and Developmental Disabilities Quality Management Plan For Fiscal Years 2024-2025

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Chapter 1: Introduction to the Quality Management Program

Introduction

The Intellectual and Developmental Disabilities (IDD) Quality Management (QM) Plan is a document written to provide a qualitative framework of activities that are designed to ensure that individuals who are receiving services through Tri-County Behavioral Healthcare (Tri-County), are receiving quality services provided by culturally competent and adequately trained staff in a manner that is financially viable.

The IDD QM Plan is guided by Tri-County's stakeholders, the performance contract between Tri-County and the Texas Health and Human Services Commission (HHSC), the Board of Trustees, the Center's Local Provider Network Development Plan (Local Plan), East Texas Behavioral Healthcare Network (ETBHN), the Management Team, the Intellectual and Developmental Disabilities Planning Network Advisory Committee (IDD PNAC), and the Regional Planning Network Advisory Committee (RPNAC).

The QM Department continues to work closely with program managers and direct service staff to ensure that they are compliant with contract requirements and Texas Administrative Code (TAC). We are constantly measuring, assessing, analyzing, and striving to improve our local authority services, functions, access, capacity, rights, safety, and health processes. These areas are reviewed through, continuous quality improvement, using available data, in order to ensure that our stakeholders receive the highest quality of services possible. In addition, the program remains committed to ensuring contract compliance including the accuracy, consistency, and timeliness with which service provision information is provided to HHSC.

MISSION, VISION AND PHILOSOPHY STATEMENT

Mission

Our mission is to enhance the quality of life for those we serve and our communities by ensuring the provision of quality services for individuals with mental illness, substance use disorders and intellectual and developmental disabilities.

Vision

Our vision is to develop a mental health and intellectual developmental disabilities care system with adequate resources that ensures the provision of effective and efficient services to meet the need of our community.
To achieve our vision, we will partner with the community to:

- Expand the availability of new and existing resources; and
- Assure the availability of technically and culturally competent staff.

Mission of the Quality Management Department

The mission of the Quality Management Department is to ensure that the highest possible quality of services is provided to our stakeholders through continuous quality improvement.

Direction

The Quality Management Program focuses on a systematic, objective, and continuous process for monitoring, evaluating, and improving the quality and appropriateness of service delivery systems within our organization. The QM Program assists Tri-County in assuring existing standards of care are met and provides the framework to obtain feedback from stakeholders on the manner in which the Center conducts its business.

Intellectual and Developmental Disabilities Authority Responsibilities

Tri-County continues to ensure that we are developing and managing a network that offers consumer choice to the highest extent possible. Tri-County contracts with outside providers when practical and requires contracted providers meet the same professional qualifications as providers employed by the Center. ETBHN, our local IDDPNAC, and the RPNAC provide best value analysis for Center services on a regular basis. In addition, we analyze Cost Accounting Methodology data and other areas as needed to identify areas where improvements can be made.

To expand our service capacity, Tri-County continues to seek opportunities for grant funding and service contracts. We are also actively pursuing fundraising opportunities and soliciting donations. Additionally, Tri-County continues to analyze and improve productivity so that more services can be provided with existing resources.

Goals of the QM Program

The goals of the QM Program are designed to ensure that Tri-County's QM activities are measuring the key elements of quality services provided to individuals with IDD. These goals are meant to be a foundation for the QM Department and are not intended to be the only activities of the department.

Goal 1: Direct the internal program survey process to consistently, effectively, and efficiently monitor and evaluate the provision of services to individuals with IDD.

Performance Standards:

1. Initiate selected internal program surveys as needed throughout the year and produce reports for programs reviewed.

Measurable Activities:

1. Update, as necessary, all program survey tools to be in compliance with TAC, Medicaid rules, state performance contracts, other state and federal regulations, and any accreditation guidelines as applicable.
2. Complete program surveys for selected programs annually.
3. Provide feedback to reviewed programs that include department strengths, weaknesses, and recommendations for improvement.
4. Provide the program survey report to program managers and the Management Team liaison within four (4) weeks of report completion.
5. Follow up with program managers regarding plans of correction as needed.
6. Provide updates from program surveys to the IDD Quality and Utilization Management (QUM) Team for evaluation.
7. Continually monitor the program survey process and make modifications as needed to ensure that the process is measuring critical program elements.

Outcomes:

1. All tools used in the program survey process are being reviewed and updated, as necessary, prior to each program survey.
2. Reports are completed for each program and are shared with program managers for their input before being submitted to the Management Team liaison.
3. Reports have been provided within four (4) weeks of completion.
4. The QM Department has followed up with program managers regarding their plan of correction as needed.
5. The current program survey process includes a QM audit of the monthly chart reviews submitted by managers to include a follow up review with managers. This enables the program manager to assess the strengths or weaknesses of their staff in completing person directed plans, progress notes and other areas by viewing areas of focus throughout the year. This process is completed in addition to ongoing review and feedback provided throughout the year on submitted monthly quality assurance audits.

6. Program managers have provided training to program staff when weaknesses are noted during the program survey.
7. The QM Department has presented program results for evaluation, as necessary, at the QUM meetings.

Goal 2: Successfully coordinate the Center's organizational self-assessment activities as a part of the ongoing evaluation and monitoring process of Tri-County.

Performance Standards:

1. At intervals designated by HHSC, ensure that organizational self-assessment activities are completed and submitted.
2. At intervals designated by HHSC, ensure that applicable improvement plans are completed, submitted, and reviewed.

Goal 3: Support Tri-County in meeting or exceeding all applicable requirements and standards.

Performance standards:

1. Review all new Texas Administrative Codes (TAC) that apply to services for persons with IDD.
2. Review Tri-County's Policies and Procedures and program desk procedures as a part of the internal program survey process.
3. Assure that all programs know how to quickly access the applicable requirements and standards.

Measurable results:

1. Review all new TAC posted in the TAC Registry within two (2) weeks.
2. Forward relevant TAC to programs within two (2) weeks of review.
3. Look at each program's training materials (whether maintained in hard copy or electronically) as part of the program survey process to ensure programs have the most current information.
4. Review applicable policies and procedures as part of the program survey process and make recommendations for revision to ensure compliance with current requirements.

Outcomes:

1. The QM Department reviews all new TAC posted in the TAC Registry within two (2) weeks.
2. The QM Department continues to forward all new TAC to appropriate programs within two (2) weeks of review.
3. The QM Department looks at the program training materials during each program survey and assists the manager as needed to ensure that current TAC requirements are included in staff training.

4. The QM Department includes recommendations for policy and procedure updates in the final report as needed.

Goal 4: To ensure individuals served are treated with dignity and respect.

Measurable activities:

1. Monitor allegations of abuse, neglect, and exploitation.
2. Ensure relevant training is provided to staff when trends are noted.
3. Ensure all individuals served are provided with a copy of the rights handbook, that it is explained to them in a way they understand, and is documented in the individual's clinical record.
4. Ensure that all staff know who to contact in the event of an allegation of abuse, neglect, and/or exploitation.
5. Investigate all rights complaints in a timely manner and ensure that these complaints are handled with confidentiality.
6. Make reasonable improvements to programs resulting from complaints of individuals served.
7. For a deficiency identified by HHSC related to critical health, safety, rights, or abuse and neglect, the deficiency will be corrected immediately, and within five (5) business days after receipt of a request from HHSC, a corrective action plan (CAP) will be developed that adequately addresses the correction of the deficiency.

Outcomes:

1. The Rights Protection Officer (RPO) monitors, reports on, and makes recommendations to management regarding abuse, neglect, and exploitation allegations and investigations.
2. When appropriate, the RPO provides or recommends additional training to program staff resulting from allegations in an attempt to reduce instances of abuse, neglect, and exploitation during the fiscal year.
3. The RPO reviews the provision of the rights booklets as a part of the program survey process to ensure that individuals served receive this information upon admission, as well as annually, and that documentation is maintained in the individual's clinical record.
4. During program survey audits, the RPO asks staff questions related to how, where and when to report events of abuse, neglect, and exploitation. The ability of staff to answer these questions correctly is part of the program survey process and the RPO provides feedback to program managers within a reasonable amount of time.
5. The RPO ensures that all complaints are handled with confidentiality and in a timely manner.
6. The RPO and the program managers collaborate to ensure that complaints from individuals served and/or other stakeholders are taken seriously and reasonable changes are made as a result of complaints, if necessary.

7. Tri-County strives to work collaboratively with HHSC to ensure that individuals served receive the best care possible.

Goal 5: To ensure that Contract Targets and Performance Measures are met.

Performance Measures:

1. Serve 120 non-waiver individuals with IDD per quarter.
2. Ensure that 95% of enrollments into HCS meet timelines.
3. Ensure that 95% of enrollments into TxHmL meet timelines.
4. Ensure that 95% of Permanency Plans are completed within the correct timeline.
5. Ensure that 100% of individuals on the HCS and TxHmL interest list are contacted each biennium for review (50% the first contract year).
6. Ensure that 95% of PASRR evaluations or resident reviews meet timeframes.
7. Ensure 95% compliance with assigning PASRR habilitation coordinator within timeframes.
8. Ensure 95% compliance with Community Living Options (CLO) timeframes.
9. Ensure 95% of completed PL1s in which the "Alternative Placement (Disposition)" field is complete within PASRR timeframes.
10. Ensure 95% of referrals are completed when the PASRR evaluations indicate that an individual would like to live somewhere else besides a nursing facility within timeframes.
11. At least 95% of required submissions are completed within timeframes.
12. Ensure 95% of individuals living in an assigned SSLC receive community living options information within timeframes.
13. Ensure 95% of CLOIP's are completed and submitted within timeframes.
14. Ensure 95% of SSLC annual planning meetings are attended unless requested not to.

Measurable Activities:

1. Monitor Tri-County's status on all performance measures in the Quality and Utilization Management (QUM) and Junior Utilization Management (JUM) Committees.
2. Issue warnings from the JUM or QUM committees if any of the measures trend low or fall below contract expectations.
3. Ensure that reports used by HHSC to monitor our agencies performance are identified and made available to program staff.

Outcomes:

1. Tri-County continues to ensure performance within the required expectations.
2. UM staff continue to share information about ways non-program departments can assist program staff in meeting targets.
3. UM staff continue to share the status of performance measures with the Management Team liaison.

In addition to the goals above, other QM Responsibilities of the Center to ensure best quality include:

- Effectively monitoring the Center's interest list program.
- Effectively administering the Center's local planning process.
- Effectively monitoring and maintaining contract guidelines.
- Effectively collaborating with Program Staff to ensure continuous quality improvement.

Chapter 2: Quality-Related Responsibilities of Management and Committees

Tri-County is dedicated to promoting a team approach to serving persons with mental illness, substance use disorders, and IDD. Tri-County continues to work diligently at increasing the lines of communication between levels of management, quality-related committees, and all staff. We continue to strive to enrich the lives of individuals served and their families. Although we adhere to the team philosophy, there must also be groups of people identified to focus on specific aspects of the Center. The leadership groups and committees of Tri-County are the following:

The Board of Trustees:

- Responsible for the provision of a comprehensive program of mental health, substance abuse, and IDD services in its service area.
- Strives to obtain the highest quality of service for the lowest cost.
- Establishes mental health, substance abuse, and IDD services directly and/or through contractual arrangements stressing accessibility, availability, acceptability, and continuity of care, based on the financial capability of the Center.
- Develops and executes plans for the continued financial stability and the acquisition of adequate resources to accomplish the purposes and objectives of the Center.
- Establishes an on-going quality assurance program that provides for appropriate and ongoing review systems which monitor client care.
- Reviews, at least quarterly, monthly reports of programmatic and fiscal activities.
- Promotes the objectives of the Center to the community by utilizing the media and other forms of communication.

The Executive Director:

- Ensures the Executive Management Team implements, oversees, and reviews QM activities.
- Ensures the Management Team receives and evaluates internal and external reports outlining QM activities as appropriate.
- Ensures that program operations and policies and procedures are in compliance with local, state, and federal statutes and regulations.
- Evaluates and monitors QM performance outcomes to ensure compliance with the QM plan.
- Appoints members to agency committees.
- Ensures that Center goals and objectives are developed annually and that progress toward goals is monitored on at least a quarterly basis.
- Implements Board Policies through the development of operational procedures.
- Responsible for overall operations of the Center and compliance with the performance contract.

The Management Team:
The Management Team consists of the Executive Director, Chief Operating Officer, Chief Financial Officer, Chief Compliance Officer, Medical Director, Director of Quality Management and Support, Director of IDD Provider Services, Director of IDD Authority Services, Director of Adult Behavioral Health Services, Director of Child & Youth Behavioral Health Services, Director of Strategic Development, Director of Management of Information Systems, Director of Nursing, and Director of Crisis Access.

The Management Team typically meets monthly or as needed and is responsible for:

- Implementing, overseeing, and reviewing QM activities as needed.
- Reviewing and evaluating internal and external reports of QM activities as appropriate.
- Reviewing committee reports to ensure that issues related to individual's needs are properly addressed.
- Monitoring and assuring compliance to all contract requirements, standards, and codes.
- Ensuring that changes in contracts and standards are provided to the relevant program staff.
- Serving as liaisons to all agency committees.
- Reviewing financial reports on a monthly basis.
- Monitoring trends in risk data for employees and individuals served.
- Monitoring results of internal program survey audits for their respective areas of responsibility.

The Administrator of Quality Management:
The Administrator of Quality Management's duty, in cooperation with the Management Team, is to ensure oversight of a QM plan that describes the on-going method for assessing, coordinating, communicating, and improving the QM functions, processes, and outcomes of the Center. The Administrator of Quality Management:

- Co-chairs the IDD Quality and Utilization Management (QUM) Committee.
- Co-chairs the Continuous Quality Improvement (CQI) Committee.
- Serves as a member of the Junior Utilization Management (JUM) Committee.
- Works closely with the Director of QM and Support to carry out recommendations from the Corporate Compliance Committee.
- Works closely with Utilization, Risk Management and IDD program managers to measure, analyze, and improve service capacity and access to services.
- Provides the Management Team liaison with reports for the purpose of oversight and review QM activities.
- Completes all program survey audits for each selected program.
- Monitors QM outcomes on a regular basis.
- Serves as the Rights Protection Officer while monitoring trends in client abuse, neglect, and exploitation and assigns follow-up responsibilities to appropriate staff.
- Coordinates the agency's Random Moment in Time Study (RMTS) program.
- Develops and ensures stakeholder surveys are distributed in all three local service areas as a part of the Local Network Development Process or as needed, and

monitors results of program specific surveys.
- Monitors the Performance Contract for compliance.

Rights Protection Officer:
- Acts as the Center's Rights Protection Officer.
- Receives and follows up on complaints until there is resolution.
- Assists the Director of Quality Management and Support with various appeals and fair hearing processes, as needed.
- Monitors rights and abuse data for trends and communicates this information to designated agency committees and Management Team.
- Assists with the completion of all program surveys conducted throughout the year.
- Communicates concerns or trends to the Management Team Liaison.

Risk Manager:
- Chairs the Center's Safety Committee.
- Monitors safety and health data for trends, and provides information to appropriate committees and Management Team representatives as needed.
- Serves as a member of the Corporate Compliance Committee.
- Assists the Compliance Department conduct compliance investigations and reports quality concerns back to the Quality Management Department.
- Ensures aggregate critical incident data for IDD services is reported accurately and in a timely manner to HHSC.

Human Rights Committee (HRC):
The Rights Protection Officer (RPO) is mandated by the Texas Administrative Code for the protection, preservation, promotion, and advocacy of the health, safety, welfare, legal, and human rights of individuals served. The HRC assists the RPO, as warranted, for collaborative reviews. The responsibilities of the HRC and/or RPO may include:

- Ensuring due process for individuals when a limitation of rights is being considered.
- Meeting as requested by the RPO to conduct business.
- Reviewing behavior modification plans to ensure that individual rights are protected.
- Reviewing medication changes for some individuals if necessary.
- Reviewing the Critical Incident Report (rights, abuse, safety, and neglect) data and making recommendations as appropriate.

Recommendations from the HRC and/or RPO are submitted to the Management Team liaison when adverse trends, patterns, or barriers are identified.

Safety Committee:
The Risk Manager chairs the Center's Safety Committee. The Safety Committee is comprised of selected members who review data from a variety of sources to identify situations that pose a risk to individuals served, the community, employees, and/or the Center. In conjunction with the Safety Officer, the Safety Committee creates, implements, and maintains a system of tracking, reporting, and evaluating the Center Safety Plan.

Trends, recommendations, and decisions made or identified by the Safety Committee are sent to the Management Team for review. The Safety Committee meets at least quarterly, and as necessary, to conduct business.

Risk Management Team:
The comprehensive Risk Management Team is responsible for the development, implementation, support, monitoring, and evaluation of the comprehensive Risk Management Program. Executive management staff serve as permanent members of this team, with additional staff serving on an as-needed basis. Information on rights and abuse will be presented to the Risk Management Team. A designated Management Team liaison is responsible for ongoing monitoring of trends in risk management at the Center and presents information to the Management Team as often as is necessary to conduct its business.

Quality and Utilization Management (QUM) Committee:
The QUM committee has representation from an array of staff in IDD services. The Director of QM & Support and the Administrator of QM are the committee chairs. Members include the Director of IDD Provider Services, the Director of IDD Authority Services, the Risk Manager (or designee), the Administrator of IDD Authority Services, the Assistant Administrator of IDD Authority Services, and the Assistant Administrator of PASRR & COC. The Director of QM and Support acts as a liaison for the Management Team. The duty of the QUM Committee is to ensure the Center is effectively managing its resources and improving the efficiency of the QUM process. To fulfill its responsibility, the QUM Committee will meet at least quarterly, and will:

- Work to review and coordinate internal auditing of services and programs to ensure compliance with the Texas Administrative Code, the Center's Performance Contracts, the Texas Health and Human Services Commission (HHSC), other state agencies as applicable, and any MOU relevant to the provision of IDD services.
- Review data for IDD Services (i.e. complaints, risk data, abuse/neglect allegations, voter registration activities, staff productivity, interest lists, program satisfaction surveys, and any other data or reports that reflect compliance with quality standards).
- Review any recommendations of the local IDD PNAC and participate in and submit, as requested, information to the RPNAC.
- Review results of program surveys.
- Monitors performance in relation to defined contract performance measures, including outcomes.
- Reviews reports regarding appeals of eligibility for services.
- Makes recommendations to managers, as necessary, regarding changes to the current service delivery and/or data collection system to ensure timely and efficient adherence to required performance measures, including outcomes.
- Makes recommendations, as necessary, to the Management Team on how to efficiently and effectively meet the requirements for various contracts.
- Proposes consideration of a variety of strategies that may lead to better use of available resources and possible ways of increasing resources.
- Review and provide feedback for relevant CQI goals and activities at the Center

(additional information on the Center's CQI Committee and Plan can be found in the Tri-County Mental Health Quality and Utilization Management Plan).

After review of the above, the QUM committee will determine whether there are indications that changes are needed in the delivery of services, to policies and procedures, or to the training needs of staff. The committee's Management Team member will be responsible for presenting the committee recommendations to the Management Team for review and approval as needed.

Junior Utilization Management Committee (JUM):
The Director of Quality Management and Support chairs this committee. The Junior Utilization Management Committee (JUM) includes quality management, utilization management, program, and IT representatives. Additional Center staff, such as financial representatives or other clinical or administrative staff are brought to JUM meetings as deemed necessary. The JUM Committee typically meets at least three times a month to analyze factors that might be affecting Tri-County's ability to meet contract performance or quality service expectations. To fulfill its responsibilities, the JUM Committee:

- Reviews a list of contract expectations and performance on these issues up to the date of the meeting.
- Updates a document that is accessible to all managers, that reflects agency performance on target measures.
- Sends emails to managers of programs that are below contract expectations, informing them of program areas that are not in compliance with contract expectations or that may benefit from quality improvement recommendations.
- Reviews contract due dates and sends reminders to staff about upcoming contract deadlines.
- Creates custom reports for problem areas so staff can be more knowledgeable about factors that are affecting contract compliance.
- Scrutinizes data that is submitted to determine possible data problems that might be affecting performance.
- Invites program managers to present concerns to the committee so that the JUM can assist with problem-solving activities.

Grid Review Team (GRIT):

- Sets up encounter data modalities to ensure correct submission to the HHSC data warehouse.
- Reviews the Charge Master report to ensure that charges are accurate and up to date.
- Reviews the IDD service array to ensure that we are in compliance with the performance contract.
- Reviews service code definitions to ensure that they are in line with the service array and the performance contract.
- Meets as often as necessary to conduct its business and/or when changes are made to relevant documents and contracts.

Corporate Compliance Committee:
The Chief Compliance Officer and the Administrator of Compliance co-chair this committee. The Corporate Compliance Committee is comprised of the Chief Compliance Officer, Administrator of Compliance, the Chief Financial Officer, Billing Manager, Director of Quality Management and Support, and other Center staff as designated by Chief Compliance Officer. The Corporate Compliance Committee is scheduled to meet at least quarterly, but the meetings may be scheduled more frequently, as determined by the existing needs of the Center.

The Corporate Compliance Committee is responsible for reviewing corporate compliance issues on both a systems level and an individual provider level to determine whether there are changes that the Center needs to make to ensure compliance with rules and laws related to ethics, service, training, and/or billing. To fulfill its responsibility, the committee will:

- Provide oversight to the Center's Corporate Compliance Program.
- Review results of external audits and make recommendations for corrective actions (i.e. changes to policies and procedures, staff training) as necessary to assure compliance with federal funding rules.
- Coordinate information and actions with the QUM Committee.
- Review findings of any Corporate Compliance investigations.
- Assure that staff are provided with education regarding corporate compliance issues at least quarterly.
- Evaluate the Charge Master Review, which is completed by the Grid Review Team as needed.
- Review Corporate Compliance Programs of Tri-County's large contractors who do not wish to participate in the Tri-County Compliance Program.
- Review the Corporate Compliance Action Plan at least annually to determine if modifications or additions are needed.
- Report all Corporate Compliance allegations, findings, and dispositions (e.g. increased employee training, termination of employment, corrected billing/financial reports) to the Board of Trustees on at least a quarterly basis.

Intellectual and Developmental Disabilities Planning Network Advisory Committee (IDD PNAC):
The purpose of the IDDPNAC is to advise the Board of Trustees on planning, budget, and contract issues, as well as the needs and priorities for the service area. Members are appointed by the Board of Trustees and represent persons with IDD. The IDDPNAC is charged with providing input on local needs, best value, and local planning. One member of the IDDPNAC is asked to sit on the RPNAC for the East Texas Behavioral Healthcare Network. The IDDPNAC is composed of nine members, at least 50% of which are individuals served, or family members of persons with IDD. Staff from Tri-County serve as liaison members of the IDDPNAC to provide support and information, as necessary and appropriate, for the IDDPNAC to conduct its business. Liaison members have a voice but

no vote at IDDPNAC meetings. Tri-County will replace IDDPNAC members within 3 months of their leave. The IDDPNAC is always given the opportunity to make recommendations to the Board through the Director of Quality Management and Support. The responsibilities of the IDDPNAC include, but are not limited to:

- Advising the Board of Trustees on planning, budgeting, and contract issues, as well as the needs and priorities in Tri-County's service area.
- Obtaining stakeholder input on service needs and delivery, and presenting this information to the Board of Trustees and the Executive Director.
- Assisting with stakeholder and Center advocacy projects.
- Reviewing and providing input on the local plan.
- Assisting in promoting Tri-County in the community through education efforts, presentations, and contact with key community and political leaders.
- Meeting at least quarterly.
- Providing an annual report to the Board of Trustees.

Regional Planning Network Advisory Committee (RPNAC):
Tri-County, as a member of ETBHN, collaborates with member Centers for the provision of certain administrative support. ETBHN formed the RPNAC to be made up of at least one (1) PNAC member from each ETBHN member Center. At least one of Tri-County's PNAC members and the Administrator of Quality Management attends the quarterly RPNAC meetings. RPNAC members, Management Team, and liaisons such as Quality Management staff work with other ETBHN Centers to meet the following goals:

- To assure that the ETBHN network of providers will continuously improve the quality of services provided to all consumers through prudent mediation by network leadership.
- To continuously activate mechanisms to proactively evaluate efforts to improve clinical outcomes and practices.
- To maintain a process by which unacceptable outcomes, processes, and practices can be identified.
- To facilitate best value determinations and service evaluations (evaluations shall take place one service at a time, as determined by the Regional Oversight Committee (ROC)). ETBHN will collect and compile data and distribute it to member Centers.

Chapter 3: Ongoing Quality Review Activities

Measuring, Assessing, and Improving the Accuracy of Data Reported by the Local Authority:

Tri-County continues to work on perfecting the data that is used for measurement of our activities. Our focus remains to identify areas of weakness and ensure that improvements are made when necessary. Tri-County employs specific staff who work to ensure that the mapping of our internal procedure codes to the state grid code is correct. Our staff are dedicated to re-evaluating and adjusting our system to improve its efficiency, as necessary. Tri-County batches encounter data to the state on a daily basis so that reports from the HHSC data warehouse can be used daily for monitoring our progress toward meeting performance measures. Each day, selected staff review encounter data warnings so that corrections can be made in Tri-County's clinical system that might affect batching accuracy. Data entries completed by clinical staff are monitored to ensure accountability of the accuracy of service data. Additionally, Tri-County staff are doing the following activities:

- CARE reports used for monitoring performance are sent to JUM members, as well as program managers, for review.
- The billing department monitors weekly service reports. In this review, staff review billing for possible billing errors.
- The billing department looks for diagnostic errors as a part of their weekly billing review.
- Monthly billing suspense reports are provided to clinical staff to correct billing errors.

Internal Program Survey Process:

One of Tri-County's self-assessment initiatives is the Program Survey process also referred to as Program Survey. The Administrator of Quality Management, assisted by other Quality Management staff, completes this process. This internal auditing process looks at each program's compliance with the contract and applicable standards. Program outcomes (including program manuals and program descriptions), quality and satisfaction endeavors, progress toward meeting HHSC Performance Measures, financial reports, personnel development, and compliance with the Health Insurance Portability Accountability Act (HIPAA) are measured in this process. Chart audits, interviews with program staff, interviews with the program manager, inspection of the facilities, review of satisfaction surveys, and review of the program manual are all a part of this process. Documentation and chart review tools used in this audit are developed from the Performance Contract, relevant Texas Administrative Code, State-approved self-review tools, and other State and Federal regulations, as applicable. The tools will continue to be changed as necessary to ensure we are measuring compliance with the most current standards and guidelines. A result of each program survey audit is shared with the program manager who makes a plan of correction, if necessary, and submits it to the Administrator of Quality Management. A final report is generated and presented to the applicable Management Team representative. The report is also submitted to the Director of Quality Management and Support in order to ensure that key information is shared with the Center Management Team. The Center's QUM Committee also reviews the results of each IDD program survey audit. Additionally, a summary of the Program Survey is taken to PNAC.

Satisfaction Survey:
Satisfaction surveys are completed as part of the Center's Self-assessment and Program Survey process. Each program has developed its own questionnaire in consultation with Quality Management and utilizes these surveys with individuals served throughout the year. The results are reviewed by Quality Management during Program Survey and used to make reasonable changes to the program. The HCS program continues to complete customer service surveys as required by the HCS program standards. The Health and Human Services Commission HCS survey team typically reviews the results of these surveys annually. Results of satisfaction surveys reviewed during the internal program survey process are also shared with the QUM Committee to ensure that any problem areas have been resolved.

Stakeholder Involvement and Input:
External service providers and other stakeholders will receive information through meetings or other appropriate means of communication. Tri-County staff are involved in community meetings in order to collaborate on issues including quality improvement. Area organizations/groups in which Tri-County participates include, but are not limited to: the Community Resource Coordinating Group (CRCG), United Way, Conroe Coalition for the Homeless, Disaster Recovery Committees including Montgomery County Community Assistance Recovery Efforts and Services (MC-CARES), HCS Advisory Committee, the local Intellectual and Developmental Disabilities Planning Network Advisory Committee (IDDPNAC), the Regional Planning Network Advisory Committee (RPNAC), Healthcare Alliance of Montgomery County, Child Fatality Review Teams, Montgomery County Dispute Resolution, Conroe Noon Lions Club, Montgomery County Civil Service Commissioners, Office of Homeland Security Integrated Preparedness Team, Montgomery County Behavioral Health and Suicide Prevention Taskforce, Montgomery County Crisis Collaborative, Liberty County Mental Health Collaborative Workgroup, Community Resource Collaborations, and a jail diversion workgroup. Participating in these groups enables Tri-County staff to network and collaborate with representatives from other area agencies.

We continue to strive to engage individuals served, their families, providers, advocates, local officials, volunteers, staff, and the general public in planning initiatives. Information needed to ensure Tri-County identifies community values, service needs, and priorities for the persons in the Health and Human Services Commission priority population is obtained in many different ways. Networking and collaborating with community agencies, as well as distribution of surveys to obtain stakeholder input, have helped us to identify service gaps and priorities.

Tri-County's Home and Community Services (HCS) program has an advisory committee that meets at least quarterly and is composed of individuals served, legally authorized representatives (LARs) of individuals served, community representatives, and family members. The goal of this committee is to assist the program provider to perform the following activities:

- Evaluating and addressing the satisfaction of individuals served, or legally authorized representatives (LAR) of individuals served, with the program provider services.
- Soliciting, addressing, and reviewing complaints from individuals served or their

LAR's about the operations of the program.

- Reviewing all allegations of abuse, neglect, and exploitation in order to ensure ongoing quality of care and prevention efforts as needed.
- Participating in a continuous quality improvement review of the program provider's operations and offering recommendations for improvement for actions by the program provider as necessary.

In addition to the information staff receive through networking and collaboration, our Center developed a survey to obtain information from our stakeholders to determine what Tri-County could do to improve specific IDD services or supports, the types of education the community would like Tri-County to provide, services the Center does not currently provide that are deemed as beneficial to the community, additional comments, and overall satisfaction with Tri-County. The survey was developed by the Administrator of Quality Management, the members of the agency's Quality Management Committee, and the members of the Intellectual and Developmental Disabilities Planning Network Advisory Committee (IDDPNAC). These stakeholder surveys are provided to individuals served, families, community agencies, healthcare organizations, schools, and governmental entities, with the request to complete them and to distribute to other stakeholders to complete. Details on the results of this survey effort can be found in the Center's Intellectual and Developmental Disabilities Local Plan.

Clinical Records Review:
The Program Survey process also looks at clinical records. This process is a structured approach to reflect standard and contract compliance and the quality and quantity of a program's clinical records. This internal auditing process helps programs achieve better overall quality of clinical records. Periodically, the QUM Committee will also review clinical records.

Corporate Compliance:
Tri-County continues to implement and monitor initiatives that are outlined in the Center's Corporate Compliance Action Plan. Corporate Compliance training is part of the new employee orientation. All employees and the Board of Trustees receive annual training on Corporate Compliance. Mandatory training helps protect the Board of Trustees, employees of all levels, and contractors against the negative consequences of federal healthcare fraud and abuse. The Corporate Compliance Procedure requires that the Center develop an improved culture of sensitivity and awareness of federal funding requirements and compliance obligations. All Corporate Compliance allegations are investigated and, if needed, corrective action is taken. Corporate Compliance training issues are discussed with employees by their supervisor on a quarterly basis. An executive level staff member serves as the Chief Compliance Officer and the Corporate Compliance Committee meets at least quarterly.

To ensure compliance with the Deficit Reduction Act of 2005 (DRA), Tri-County has modified our Corporate Compliance Program to include the following:

- The Corporate Compliance Policy has been revised to include:
    - Reference to the Corporate Compliance Action Plan as the guide for Corporate Compliance activities in the Center.
    - Requirement that training includes the following information:

    - The Federal False Claims Act
    - The State Medicaid False Claims Act
    - Qui Tam
- The Community Based Services Agreement was modified to specify that contractors with Tri-County had to either:
    - Participate in the Tri-County Compliance program, or
    - Provide their Corporate Compliance information to the committee for review and approval.
- The Corporate Compliance Training was revised to reflect all changes.
- The Agency Employee Handbook was revised to reflect all Corporate Compliance Program changes.

Staff Development:
To ensure the provision of quality services, Tri-County staff receive on-going training. Training is provided to staff using various media. In addition to computer-based training, the Training Department also provides a variety of face-to-face trainings. Included in this training is a Corporate Compliance training review.

As program managers have identified problems or potential problems in their departments, the Training Department has developed specific computer-based training modules, as well as provided face-to-face training to the program staff. The Training Department has taken on a very proactive collaborative approach to improving the competencies of direct service program staff, which improves the quality of services they provide to the individuals with whom they work.

Tri-County is committed to on-going professional training and has a Clinical Trainer on staff that develops and implements trainings to improve staff competency as needed. The Training Department ensures that all staff are current on their trainings and no lapse occurs. Tri-County staff may also receive training from the Texas Council Risk Management Fund and other regional and statewide conferences. Tri-County ensures that professional clinical staff's licensing and credentials are current. Tri-County is committed to on-going professional training and provides a variety of experts to provide training on such topics as Person Centered care, Trauma Informed Care, cultural diversity, customer service, responsible care, best practices, and teaching strategies for persons with intellectual and developmental disabilities, mental illness and substance use disorders.

Rights, Abuse/Neglect, Safety, and Health Data:
Rights related issues, as well as abuse and neglect information, is tracked, reviewed, and reported on a regular basis through the Rights Protection Officer. Tri-County safeguards the health and safety of individuals served, families, and staff through the ongoing monitoring and reporting of critical incidents, medication errors, infection control events, maintenance, and safety reports (risk data). The QUM Committee reviews the risk data quarterly, looking for trends in all aspects of the data. If trends are found, improvement plans are requested from the appropriate program and any ongoing issues are shared with the Continuous Quality Improvement Committee for evaluation of future goals or activities. The Safety Committee reviews those incidents involving maintenance and safety

issues and the Management Team liaison reviews these reports at least quarterly and takes remedial action as appropriate. Complaints are tracked through all levels of the organization, and each complaint continues to be tracked until it is resolved.

When an allegation is confirmed by the Rights Protection Officer, the Administrator of Quality Management, Risk Manager, and the appropriate program manager determine what the Center can do to keep incidents from happening again. Occasionally, staff have received more in-depth, face-to-face training on topics such as positive behavior management, customer service, and abuse and neglect. Often these trainings are customized for other programs in an attempt to proactively reduce the incidence of abuse, neglect, and exploitation before it occurs.

All individuals served or their legally authorized representatives (LARs) will be provided information on all available providers of IDD services in the area, including the State Supported Living Centers, and will be informed of all choices. No efforts will be undertaken to persuade families to choose one option over the other.

PLAN FOR REDUCING CONFIRMED INSTANCES OF ABUSE AND NEGLECT

On a quarterly basis, the Rights Protection Officer presents information relevant to abuse and neglect of persons served. This data includes not only confirmed allegations, but also unconfirmed and inconclusive allegations. The data is reviewed and analyzed by the QUM Committee for trends or patterns involving particular programs, certain staff or persons served. If trends or patterns are identified, recommendations for improvements are made, and improvement plans are requested if necessary. Tri-County QM Department staff have worked closely with the providers to assist with increased staff training to include documented annual updates in all training areas for new employees, as well as for current employees. The Safety Committee also reviews the data to determine any trends or patterns related to safety and makes necessary recommendations.

Tri-County continues its efforts to safeguard the well-being of the individuals they serve. The 1-800 line routed directly to the Rights Protection Officer continues to be a helpful tool to both individuals served and staff. Individuals served may stay in touch with the Rights Protection Officer without having to make a long-distance phone call. Although the 1-800 line is picked up by voicemail after hours, the Rights Protection Officer instructs callers in the message on how to reach the 24-hour Crisis Hotline for assistance if in crisis and Department of Family and Protective Services (DFPS) 1-800 line in cases of abuse, neglect, or exploitation. If DFPS is contacted about potential abuse, neglect, or exploitation, they will contact the Rights Protection Officer or the agency on-call phone after hours, which is routed directly to the Risk Manager who will then notify the Right Protection Officer. We continue to pursue a diligent education program on how to exercise rights and contact the Rights Protection Officer, as well as the DFPS, when there is a need. We ask that each department include a small portion of rights training in their staff meetings on a regular basis.

In identifying improvement opportunities, it is important to note the significance of quality staff training. Our staff receive both face-to-face and computer-based training upon date of hire, with strict completion dates. Retraining in these areas continue on an annual basis via computer based and face-to-face training. In addition, the Rights Protection Officer may conduct training with specific program staff as needed.

Additionally, the QM Department has interviews with program staff during the program survey process of each department to ensure that staff members are knowledgeable in reporting rights, abuse, neglect, and exploitation issues. During the review, each facility is checked to ensure that proper information on how to contact the Rights Protection Officer and DFPS is posted with easy to understand instructions on how to utilize the information.

The Center continues to focus on best hiring practices in order to reduce the turnover rate of our employees. Significant efforts to retain staff continue to be explored and utilized when financially viable for the Center, including pay increases, higher quality health insurance, and increases in our match of retirement funds. The Center continues in its commitment to seek and identify new ways to provide quality services to individuals with resources that are available.

REVIEWING AND UPDATING THE IDD QM PLAN

The IDD QM Plan will be reviewed as needed by the Administrator of Quality Management and potential changes will be discussed with at least one Management Team staff. At least annually, the QM Plan is re-evaluated for its effectiveness. If the plan is not determined to be effective, new activities including intensified monitoring efforts, re- assignment of staff, and/or the appointment of additional committees or improvement teams will be considered. The IDD QM Plan is reviewed, revised and approved every 2 years by the Board of Trustees. This plan will be amended, as needed, if any portion of the plan is modified or discontinued.