Tri-County Behavioral Healthcare

Healthy Minds. Meaningful Lives.

Tri-County Behavioral Healthcare
Mental Health and Substance Use Disorder
Quality and Utilization Management Plan
FY 2022 – 2023

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Date

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INTRODUCTION

The Mental Health Quality Management and Utilization Management (MH QM/UM) Program provides a framework of activities designed to ensure that Individuals, who are receiving assistance 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, focused on recovery and is Person and Family Centered where appropriate.

The MH QM/UM Program 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 Plan, the Mental Health Planning Network Advisory Committee (MHPNAC), the Regional Planning Network Advisory Committee (RPNAC), Certified Community Behavioral Health Clinic (CCBHC) Guidelines and other selected best practice and accreditation guidelines. The Utilization Management Department is under the direction of the Utilization Management Psychiatrist and in consultation with the MH QM/UM Committee, assumes responsibility for the UM activities of the Center.

The Quality Management and Utilization Management Departments work closely with program managers and direct service staff to ensure the provision of quality services to those we serve while remaining compliant with contract requirements, State and Federal regulations, and by following best practice and selected accreditation guidelines. Quality Improvement is considered an ongoing effort through continuous measurement and assessment, outlined in the Continuous Quality Improvement (CQI) Plan, to ensure that our stakeholders receive the highest quality of services possible while maintaining contract compliance. The accuracy, consistency and timeliness with which service provision information is maintained are key focuses of our Quality Management and Utilization Management programs.

MISSION, VISION AND PHILOSOPHY STATEMENT

Mission

The mission of the Quality Management Program is to ensure the provision of quality services for Individuals with mental illness, substance abuse disorders and intellectual/developmental disabilities that are Linguistically and Culturally appropriate, are Person and Family Centered, enhance the quality of life in our community, and are provided in a cost effective and timely manner in the most appropriate settings by trained, competent, Trauma Informed staff.

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Chapter1: Introduction to Quality Management

Vision

Our vision is to support the behavioral healthcare system to ensure the provision of effective and efficient quality services to meet the needs of our community and improve the lives of those we serve.

To achieve our vision, we will:

- Partner with the community to expand the availability of new and existing resources;
- Follow Evidence Based and Trauma Informed Care Principles including ensuring related staff training.
- Provide technically, Linguistically and Culturally competent staff and services
- Train, encourage and monitor Person Centered and Family Centered Care
- Train, monitor and improve workforce skill and competence with respect to suicide risk assessment, prevention and response.
- Train and monitor privacy practices that follow State and Federal regulations and encourage information sharing when appropriate consent can be obtained for proper Care Coordination of those we serve.
- Uphold the rights of Individuals served.
- Continuously monitor, adjust and track data that can be used for CQI efforts as well as to meet reporting requirements.[1]

Philosophy/Values

The Quality Management Program is based on the premise that the provision of quality services at TCBHC is the responsibility of all staff and that participation in quality activities facilitates improved outcomes for both staff and those we serve. Continuous monitoring, feedback and training are believed to be key to ensuring the availability of competent staff who are trauma informed and that quality services are most effective when they are provided in the most appropriate setting and include culturally and linguistically appropriate services. Dignity and Respect are key values of the Quality Management Department as it is understood that Individuals thrive in environments where they feel safe and that when an individual feels empowered their likelihood of recovery increases. Recovery oriented care that takes in to

[1] CCBHC 1.C (Cultural Competence and Other Training)
TCBHC Procedure 6.40 (Required Training);
CCBHC 1.D (Linguistic Competence)
TCBHC Procedure 15.09 (Use of Interpreters and Assistive Aids);
CCBHC 3.A (General Requirements of Care Coordination)
TCBHC 10.15 (Coordination of Services by Responsible Staff)
CCBHC 5.A (Data Collection, Reporting and Tracking)
TCBHC Procedure 19.07 (Data Collection, Reporting, and Tracking)

account personal choice through Person Centered and Family Centered concepts are seen as an integral part of empowering those we serve toward improved quality of life.

DIRECTION OF THE QUALITY/UTILIZATION MANAGEMENT (QM/UM) PROGRAMS

The QM/UM Programs at Tri-County are designed to be systematic, objective, and continuous. These programs focus on monitoring, evaluating, and improving the quality of services at our organization. Through this design, Tri-County is able to continuously evaluate the cost effectiveness, appropriateness, and timeliness of service delivery systems. The QM/UM Program assists Tri-County in assuring existing standards of care are met and accurate information is reported to HHSC and accrediting organizations as requested. These Departments, provide the framework to appropriately communicate with and obtain feedback from stakeholders on customer care and the manner in which the Center conducts its business.

Tri-County values shared responsibility for quality of care and QM activities. Departments throughout the Center participate in designated QM activities, such as the submission of frequent quality assurance reviews conducted by managers to the QM Department. These reviews are conducted as a means of supplementing the formal review processes conducted by QM staff. In addition to these reviews, QM staff continue to review records from varying departments on a regular basis. These reviews allow QM staff to provide feedback to managers and staff related to a variety of areas to include, but not limited to:

- Fidelity to Evidence-Based Practices;
- Medical Necessity;
- Appropriateness of Level of Care;
- Trauma Informed Care;
- Person and Family Centered Care;
- Recovery Oriented Care;
- Fidelity to State Assessments;
- Referrals;
- Follow up/Care Coordination;
- Safety;
- Rights Protection; and
- General Quality Care Issues.

Quality staff are also involved in an ongoing process to ensure that additional trainings are offered to staff as needed and that appropriate trainings are present in staff HR files. The Training Department continues to look for opportunities to assist our Center make enhancements to

provide Person Centered Recovery focused services for those we serve. Additionally, Quality staff work closely with Utilization Management staff to continue to monitor performance measures and other quality data that can help us monitor outcomes, identify patterns and make needed improvements to our system.

MENTAL HEALTH AUTHORITY RESPONSIBILITIES

Tri-County continues to make efforts to develop and manage a network that offers individual choice to the highest extent possible. Tri-County contracts with outside providers when practical. Contractors are required to meet the same professional qualifications as Center employees.[2] The East Texas Behavioral Healthcare Network, our local Mental Health Planning Network Advisory Committee, and the Regional Planning Network Advisory Committee provide best value analysis for Center services. In addition, we analyze Cost Accounting Methodology data and Medicaid Administrative Claiming results to identify areas where improvements are needed.

To expand our service capacity, Tri-County is writing grants and pursuing service contracts whenever feasible. We are also actively pursuing appropriate fundraising opportunities and soliciting donations. Additionally, Tri-County is continuously analyzing and improving Center processes in order to maximize the use of resources while ensuring the continued provision of quality services.

GOALS AND INITIATIVES OF THE QUALITY AND UTILIZATION MANAGEMENT PROGRAMS

The goals of the Quality Management and Utilization Management Programs are designed to ensure that Tri-County's QM and UM activities are measuring, assessing and improving the key elements of the Center's services. These goals are meant to be a foundation for the QM and UM Departments and are not intended to be the only activities of the department. The Continuous Quality Improvement Plan and Utilization Management Plan in combination with the other chapters in this manual serves as the Quality Management Plan for the Center and outline the specifics of these goals and objectives. In addition to the goals and objectives highlighted by the CQI Plan, the QM/UM Department continues to focus on the following ongoing initiatives:

ONGOING INITIATIVES OF THE QUALITY MANAGEMENT PROGRAM

1) Direct the internal program survey process to consistently, effectively and efficiently monitor and evaluate programs at Tri-County Behavioral Healthcare.
2) Direct additional reviews and quality improvement initiatives as need arises.

[2] CCBHC 1.d.5 (Linguistic Competence) – See Protected Health Information Procedure 7.02, p. 6 & 22

3) Successfully coordinate the Center's organizational self-assessment activities as a part of the ongoing evaluation and monitoring process of Tri-County Behavioral Healthcare.
4) Support Tri-County in meeting or exceeding all applicable requirements and standards.
5) Ensure Individuals served are treated with dignity and respect.
6) Ensure that the MH QM/UM committee meets at least quarterly and that key information is communicated out to staff and Management as appropriate.
7) Incorporate the above aspects of care into the activities of other agency committees (i.e. Junior Utilization Management, Safety, MH QM/UM and CQI Committees) and continue to collect and review program information needed to monitor, evaluate and implement needed changes.

ONGOING INITIATIVES OF THE UTILIZATION MANAGEMENT PROGRAM

1) Ensure Tri-County's compliance with HHSC approved Utilization Management Guidelines, contract requirements, CCBHC Guidelines and other accreditation standards, as applicable.
2) Assure that Individuals are provided with notice of their right to appeal in line with requirements surrounding the notification and appeals process.
3) Monitor service delivery outcomes for both children and adults to ensure they are meeting targets specified by HHSC, CCBHC and other accreditation guidelines as applicable.
4) Assure effective management of clinical and financial resources and ongoing improvement of the UM process by reviewing items such as eligibility, appropriateness of services, and fairness and equity of services.
5) Assure effective management of authorizations and reauthorizations of local care for outpatient services, to ensure that they follow processes and procedures set forth in the HHSC approved UM guidelines.
6) Assure that continuity and coordination of services among community service providers is monitored according to the HHSC approved UM guidelines, CCBHC Guidelines and applicable accreditation standards.
7) Monitor the HHSC Submission Calendar and notify staff of upcoming submission dates to ensure timely entry to the State or other accreditation organizations.

REVIEWING AND UPDATING THE MH QM/UM PROGRAM AND CQI PLAN

The Mental Health Quality Management and Utilization Management Program will be reviewed semiannually by the Administrator of Quality Management and needed changes will be communicated to the Director of Quality Management and Support. Potential changes to the program, procedures, and/or the CQI plan will be discussed with at least one Management Team staff. At least annually, the CQI and the Mental Health Quality Management/Utilization

Management Plans and goals are re-evaluated for their effectiveness.[3] If any component of the program is determined not 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 Mental Health Quality Management/Utilization Management Plan (including the CQI Plan and Procedure Manual) is reviewed and approved each biennium, in line with the Centers Local Plan, by the Management Team.[4] This plan will be amended, as needed, if any portion of the plan is modified or discontinued. Should the State's local planning process be formally delayed by HHSC, this plan will remain in effect until which time the Local Plan is updated to ensure that the planning processes continue to align.

[3] CCBHC 5.b.1 (Continuous Quality Improvement (CQI) Plan)
[4] TCBHC Quality Management Plan Chapter 5 (Continuous Quality Improvement Plan)

Chapter 2: Quality and Utilization Management Related Responsibilities: Management and Committees

Tri-County is dedicated to promoting a team approach to serving persons with mental illness, substance use, and intellectual and developmental disorders. Tri-County continues to work diligently at increasing the lines of communication between levels of management, quality-related committees, staff, as well as community partners integral to the overall health of those we serve when appropriate consent can be obtained. 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 individuals and groups of people identified to focus on specific aspects of the Center. Individual, group and committee responsibilities at Tri-County include:

THE BOARD OF TRUSTEES:

- Responsible for the provision of a comprehensive program of services related to mental health, substance use, and intellectual and developmental disabilities in its service area.
- Strives to obtain the highest quality of service for the lowest cost.
- Establishes services for mental health, substance use, and intellectual and developmental disabilities 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 management program that provides for appropriate review systems which monitor client care.
- Reviews and approves the CQI and umbrella QM/UM Plan in it's entirety each biennium.
- Reviews monthly reports of programmatic and fiscal activities.
- Promotes the goals and objectives of the Center to the community by utilizing the media and other forms of communication.
- Appoints, charges and supports a Planning and Network Advisory Committee that is representative of individual's being served by the Center.[1]

THE EXECUTIVE DIRECTOR:

- Ensures the Executive Management Team (Management Team) implements, oversees and reviews Quality Management activities.
- Ensures the Management Team receives and evaluates internal and external reports for Quality Management activities.

[1] CCBHC 6.b.1 (Governance)

- Ensures that program operations and Policies and Procedures are in compliance with local, state and federal statutes and regulations.
- Evaluates and monitors Quality Management and CQI 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.
- Appoints staff to ensure the development and ongoing monitoring of annual CQI goals.
- Implements Board Policies through the development of operational procedures.
- Responsible for overall operations of the Center and compliance with the Performance Contract and applicable accreditation standards.

THE MANAGEMENT TEAM:

The Management Team, which is responsible for implementing, overseeing and monitoring Quality Management activities in their respective areas, consists of the Executive Director, Chief Financial Officer, Chief Operating Officer, Chief Compliance Officer, Medical Director, Director of Quality Management and Support, Director of Information Systems, Director of IDD Authority Services, Director of IDD Provider Services, Director of Adult Outpatient Services, Director of Child and Youth Outpatient Services, and the Director of Strategic Development. The Executive Director may appoint additional expanded Management Team members to ensure informed decision making and ongoing quality care. The Expanded Management Team meets regularly and is responsible for:

- Communicating and discussing important Center topics and updates (i.e. includes but not limited to: program implementation, safety, quality, upcoming changes/guidelines, or other concerns related to Center processes or quality care etc.)
- Review and discussion surrounding progress toward Annual Board Goals.
- Reviewing and discussion related to Center Budget and areas of concern.
- Review and discussion of Emerging issues at the Center.
- Dissemination of key information to respective areas.

In addition to serving as liaisons to all agency committees and working with quality management staff to continuously improve services for those we serve, Management Team members attend meetings with the Board of Trustees and receive regular reports on quality improvement activities and initiatives.

THE ADMINISTRATOR OF QUALITY MANAGEMENT:

The Administrator of Quality Management's duty, in coordination with the Management Team, is to ensure oversight of a quality management plan that describes the on-going method for assessing,

coordinating, communicating, and improving the quality management functions, processes and outcomes of the Center. The Administrator of Quality Management:

- Co-chairs the Mental Health Quality Management/Utilization Management (MH QM/UM) Committee.
- Co-chairs the Continuous Quality Improvement (CQI) Committee.
- Serves as a member of the Junior Utilization Management Committee.
- Serves as a member of the Infection Control Committee.
- Serves as a liaison to the Mental Health Planning Network Advisory Committee.
- Serves as a liaison to the Regional Planning Network Advisory Committee.
- Serves as a member of the Safety Committee.
- Coordinates activities and information between the Quality Management and Utilization Management programs.
- Works closely with utilization management staff and program managers to measure, analyze and improve service capacity and access to services.
- Provides the Management Team with reports, upon request, so they can oversee and review Quality Management activities.
- Completes program survey audits as needs are identified throughout the year.
- Serves as the Rights Protection Officer (RPO) for the Center or assists the RPO with monitoring trends in client abuse, neglect and exploitation and assigns follow-up responsibilities to appropriate staff.
- Serves as the Center's Primary Random Moment in Time Study (RMTS) Contact.
- Develops and ensures stakeholder surveys are distributed in all three local service areas on an as needed basis and monitors results of program specific surveys.
- Monitors the Performance Contract for compliance.
- Assists the Management Team in CCBHC and other applicable accreditation activities.

THE UTILIZATION MANAGER/DIRECTOR:

The Utilization Manager and the Administrator of Quality Management work closely together on the effectiveness in meeting goals and contract requirements in different programs. The Director of Quality Management & Support for Tri County is a Licensed Professional Counselor (LPC) and, prior to working in Quality and Utilization Management, has had over seven years of clinical experience working with both the child and adult populations and serves as the Utilization Manager as outlined in the HHSC performance contract. The Utilization Manager:

- Co-chairs the MH QM/UM Committee.
- Co-chairs the CQI Committee.
- Serves as a member of the Junior Utilization Management Committee.
- Serves as a member of the Regional Utilization Management Committee.

- Monitors and tracks the performance targets for Tri-County.
- Works closely with the Administrator of Quality Management and program managers to assure quality, cost effective, timely and appropriate service provisions.
- Monitors the Performance Contract and applicable accreditation standards, including CCBHC Guidelines, for compliance.

THE RIGHTS PROTECTION OFFICER:

- Chairs the Rights Review Team.
- Serves on the Center's MH QM/UM Committee.
- Serves on the Center's CQI Committee.
- Receives and follows up on complaints until there is resolution.
- Works in coordination with utilization management staff with various appeal processes and discharge reviews, as needed, and serves as the advocate for the individual served.
- Monitors rights, abuse, safety, and health data for trends, and provides information regularly to Management Team representatives to inform program development and improvement activities.
- Assists with the completion of internal audits, as needed.
- Coordinates with the State Ombudsman's office as needed or requested and reports requested information to HHSC within timelines.

THE RISK MANAGER:

- Chairs the Center's Safety Committee.
- Co-Chairs the Center's Corporate Compliance Committee.
- Serves as a member of the Infection Control Committee.
- Serves as a member of the MH QM/UM Committee.
- Serves as a member of the CQI Committee.
- Reviews aggregate critical incident data and ensures it is reported to HHSC in a timely manner.
- Ensures a 24 hour/7 day a week on call process for reporting incidents.
- Oversees Center Risk Data and reports trends to program managers through the QM/UM Committee and the respective Management Team members as needed.

THE RIGHTS REVIEW TEAM (RRT):

The Rights Review Team has been established to assist the Rights Protection Officer with protecting, preserving, promoting, and advocating for the health, safety, welfare, legal, and human rights of individuals served, as needed. The RRT members include the Center's Rights Protection Officer, and two members who have knowledge of current behavior management strategies. Other persons may be included at the meetings, as necessary, to conduct business. The RRT is responsible for:

- Ensuring due process for when a limitation of rights is being considered.
- Reviewing behavior modification plans to ensure that rights are protected.
- Reviewing medication changes for some individuals served, if necessary.

Recommendations from the RRT are reviewed with appropriate Management Team representatives when adverse trends, patterns or barriers are identified.

THE SAFETY COMMITTEE:

In conjunction with the Safety Officer, the Safety Committee creates, implements, and maintains a system of tracking, and reporting. The Safety Committee meets at least quarterly and as often as necessary to conduct business.

THE INFECTION CONTROL COMMITTEE:

The Infection Control Committee has been established and charged with the responsibility for **surveillance** (the continuing scrutiny of all those aspects of the occurrence and transmission of infections that are pertinent to effective control), **prevention** (strategies to reduce the probability of an individual acquiring an infection), and **control** (preventing the transmission of identified infections) of infections. The Infection Control Committee, under the guidance of the Medical Director, has the authority to institute any surveillance, prevention, and control measures if there is reason to believe that any individual served or staff member is at risk.

THE RISK MANAGEMENT TEAM:

The Executive Director or designee, is responsible for the development, implementation, support, monitoring, and evaluation of the comprehensive Risk Management program. Through frequent communication with Management Team members related to risk (i.e. critical incidents, safety, rights and abuse), the Executive Director or their designee, is able to delegate and assign resources to address needs at the Center in accordance with the level of risk (i.e. immediate, high, moderate and low).

THE CONTINUOUS QUALITY IMPROVEMENT COMMITTEE (CQI):[2]

The Continuous Quality Improvement (CQI) Committee meets regularly to provide ongoing operational leadership of continuous quality improvement activities at Tri-County. The Director of Quality Management and Support and the Administrator of Quality Management serve as the committee chairs with consultation and direction provided by the Executive Director and other Center Management Team members. Other members include the Chief Operating Officer, the Director of Child and Youth Outpatient Services, the Director of Adult Outpatient Services, the Director of Crisis Services, the Director of

[2] CCBHC 5.b.1 (Continuous Quality Improvement (CQI) Plan)

Information Technology or designee, the Risk Manager or designee, a Financial representative as needed, IDD Services Representative as needed, and the Rights Protection Officer if not already holding one of the previously named positions. Other staff may be called to serve on the CQI committee depending on the specific initiatives of the Committee (i.e. staff managing scheduling and front door services). The Responsibilities of the Committee include:

- Developing the quality improvement plan to include measurable goals and objectives based on priorities that meet established criteria outlined by the committee.
- Identifying and ranking indicators of quality and intermittently evaluating services based on these indicators.
- Establishing quality improvement initiatives based on Center need, trends, and/or other risk or quality factors evaluated by the Committee.
- Utilizing a PDSA Cycle to ensure improvements are managed through an evidence-based approach.
- Developing a standardized plan for communicating and sharing Quality Improvement information with the Board of Trustees, staff, individuals served and other stakeholders as appropriate.

THE MENTAL HEALTH QUALITY MANAGEMENT/UTILIZATION MANAGEMENT COMMITTEE (MH QM/UM):

The MH QM/UM Committee has a multidisciplinary membership. The Director of Quality Management and the Administrator of Quality Management are the committee chairs. Members include the Medical Director, the Director of Management Information Services, the Billing Manager, the Rights Protection Officer, the Risk Manager, representatives from Adult MH services, Child and Adolescent services, Medication services, and Crisis services and other Financial or services staff as needed. A Management Team member also attends the meetings and serves as a liaison to the Management Team. The committee will meet at least quarterly. To fulfill its responsibility, the MH QM/UM Committee will:

- Review data for MH and SUD services, complaints from individuals served, deaths of individuals served, abuse/neglect allegations, incident reports, safety committee recommendations, program satisfaction surveys, updates and findings from the CQI Committee, and any other data or reports that reflect compliance with quality standards.
- Review clinical records from MH or SUD programs as part of a more comprehensive record review to ensure that all required documentation is present in the chart and is up to quality standards.
- Provide program information about the types of problems found in charts that were reviewed so that process/performance issues can be corrected.
- Review any recommendations of the local Mental Health Planning Network Advisory Committee (MHPNAC) and participate in and submit information to the Regional Planning Network Advisory Committee (RPNAC) as needed.
- Review results of internal audits and program surveys as indicated.

- Ensure the provision of Trauma Informed, Person and Family Centered and Linguistically and Culturally Competent Services.

After review of the above, the MH QM/UM 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 Executive Director or representative Management Team members for review.

The MH QM/UM Committee's duty is also to ensure the Center is effectively managing its clinical resources and improving the efficiency of the UM process. To fulfill its responsibility, the MH QM/UM Committee will:

- Review reports that address eligibility determination, level of care assignment, service authorization and reauthorization, staff productivity, inpatient admissions, and cost of services.
- Monitor performance in relation to HHSC defined contract performance including targets, performance measures and outcomes.
- Review summary level appeal information.
- Make 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.
- Make recommendations, as necessary, to the Management Team on how to efficiently and effectively meet the requirements for various contracts.
- Propose consideration of a variety of strategies that may lead to better use of available resources and possible ways of increasing resources.

THE JUNIOR UTILIZATION MANAGEMENT COMMITTEE (JUM):

The Director of Quality Management and Support chairs this committee. The Junior Utilization Management Committee (JUM) consists of the Administrator of Quality Management, the Quality and Utilization Specialist, the Manager of Management Information Services, the Controller and other agency clinical staff as needed. The JUM meets multiple times a month (usually 2-3) to analyze factors that might be affecting Tri-County's ability to meet contract performance expectations, outcome improvement measures, and to review other data that may help to inform the provision of quality services at the Center. To fulfill its responsibilities, the JUM Committee:

- Reviews a list of contract expectations, outcome improvement measures, and other identified metrics (i.e. Social Drivers of Health) and performance up to the date of the meeting.
- Updates the Tri-County Data Point Report which is a document that is accessible to managers, that reflects agency performance on target measures and outcomes.
- Sends emails to managers of programs that are below contract or performance expectations or when data indicates a quality/utilization issue needing to be addressed to inform them of program

areas that are not in compliance with contract or performance expectations and/or that need to be reviewed and/or addressed with staff.

- 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 quality of care, contract compliance or compliance with CCBHC guidelines or other applicable accreditation standards.
- Scrutinizes data that is submitted to determine possible problems that might be affecting performance and/or quality of care.
- Coordinates with other committees as necessary (i.e. MH QM/UM or CQI) and invites program managers to present compliance concerns to the committee so that the JUM can assist with problem-solving activities.

THE SOFTWARE MANAGEMENT TEAM (SMT):

As part of the upkeep of our clinical software, Tri-County developed a team of staff dedicated to improving our software to reflect complete and accurate data. The Software Management Team meets as needed to review software issues and to correct the billing and data issues that arise from time to time. The team's focus is to ensure that the software meets the needs of our clinical staff and that our data meets both internal and external reporting requirements.

THE GRID REVIEW TEAM (GRT):

- Sets up encounter data modalities to ensure correct submission to HHSC.
- Reviews the Chargemaster Report to ensure that charges are accurate and up to date.
- Reviews the MH 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, Performance Contract and other accreditation standards.
- Meets annually or as needed.

THE CORPORATE COMPLIANCE COMMITTEE:

The Corporate Compliance Officer chairs this committee. The Corporate Compliance Committee is comprised of the Corporate Compliance Officer, the Administrator of Compliance, the Director of Quality Management and Support, the Chief Financial Officer, the Billing Coordinator, the Director of IDD Provider Services, the Director of Information Systems, the Adult Outpatient Services Program Director and other program managers as designated by the Management Team. 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, services and/or billing. To fulfill its responsibility, the Corporate Compliance Committee will:

- Provide oversight of the Center's Corporate Compliance Plan.
- Review results of internal and 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 MH QM/UM Committee.
- Review findings of any Corporate Compliance and Privacy investigations.
- Assure that staff are provided education regarding corporate compliance issues at least quarterly.
- 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 modification 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.

THE MENTAL HEALTH PLANNING NETWORK ADVISORY COMMITTEE (MHPNAC):

The purpose of the MHPNAC 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 Mental Illness, Substance Use Disorders, or other populations served (i.e. Veterans). The MHPNAC is charged with providing input for the Local Plan regarding local needs and best value. One member of the MHPNAC is asked to sit on the Regional Planning Network Advisory Committee (RPNAC) for the East Texas Behavioral Healthcare Network. Staff from Tri-County serve as liaisons of the MHPNAC to provide support and information, as necessary and appropriate, for the MHPNAC to conduct its business. Liaisons have a voice, but no vote at MHPNAC meetings. Tri-County will make a concerted effort to replace MHPNAC members within 3 months of their leave. The MHPNAC is always given the opportunity to make recommendations to the Board through the Board liaison or the Director of Quality Management and Support. The responsibilities of the MHPNAC 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 advocacy projects related to individuals served and/or the Center.
- Reviewing and providing input on the Local Provider Network Development and Consolidated Local Service Plans.

- Assisting in promoting Tri-County in the community through education efforts, presentations and contact with key community and political leaders.
- Meeting at least 6 times a year.
- Providing an annual report to the Board of Trustees.

THE REGIONAL PLANNING NETWORK ADVISORY COMMITTEE (RPNAC):

Tri-County, as a member of the East Texas Behavioral Healthcare Network (ETBHN), collaborates with member Centers for the provision of certain administrative support. ETBHN formed a Regional Planning Network Advisory Committee made up of at least one (1) MHPNAC member from each ETBHN member Center (although it can be as many as two from each Center). At least one of Tri-County's MHPNAC members, and a Center liaison attend the RPNAC meetings. Tri-County MHPNAC members who are on the RPNAC, Leadership staff and 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 individuals through prudent mediation by network leadership.
- To continuously activate mechanisms to proactively evaluate efforts to improve clinical outcomes and practices.
- To identify and support best value and administrative efficiencies.
- To maintain a process by which unacceptable outcomes, processes and practices can be identified.
- Evaluations shall take place one Center program 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

In addition to the Center's Continuous Quality Improvement (CQI) Plan, outlined in Chapter 5, there are several ongoing Quality Review processes and activities that must remain in place to ensure the system of care itself remains interconnected and improvement focused. The following is an outline of additional processes and activities in place at Tri-County Behavioral Healthcare (Tri-County) and should be taken in context with the other chapters of the Quality Management Plan:

USE OF THE MENTAL HEALTH QUALITY MANAGEMENT/UTILIZATION MANAGEMENT COMMITTEE (MH QM/UM)

The Director of Quality Management and Support or designee chairs the MH QM/UM, CQI, and Junior Utilization Management (JUM) Committees while serving as a standing member of the Management Team and the Safety, Infection Control, and Corporate Compliance Committees. This ensures that information is passed between each committee, so that each committee can continue to be effective in meeting the quality assurance goals of the agency. These committees analyze data related to the Center's MH and SUD services to individuals, standards, compliance, and financial resources. Through this involvement, outliers can be determined and improvement plans written. Any needed plans of improvement will be communicated to the representative Management Team member and acted upon in a timely manner. The MH QM/UM Committee will ensure implementation and oversight of improvement initiatives.

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. 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, select staff review encounter data warnings so that corrections can be made in Tri-County's clinical system that might affect batching accuracy. 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 for possible billing errors.
- The billing department looks for diagnosis errors as a part of their weekly billing review.

- Monthly billing suspense reports are provided to clinical staff to correct billing errors. These reports are reviewed by the Software Management Team (SMT) as needed.
- Substance Use Prevention and Substance Use Treatment Data:
  Data for persons in the Substance Use Prevention and Substance Use Treatment Programs is captured in the Center's local data system (Anasazi), and in the Clinical Management for Behavioral Health Services system (CMBHS) as required by our contracts with HHSC. Reports from these systems will be monitored by Tri-County staff to determine accuracy and consistency. Data issues will be addressed as they are found and reports will be provided to the Center's Quality Management and Utilization Management Committee.
- Through the Center's CQI Plan and other Center processes outlined in Chapter 2, Center data is assessed and analyzed to ensure that applicable State and National measures are being monitored for improvement. Through this process the Center ensures that measures required by contracts, grants, funding sources, or other applicable accreditation organizations are stable and valid.

INTERNAL PROGRAM SURVEY PROCESS

One of Tri-County's self-assessment initiatives is the program survey process. The Administrator of Quality Management, the Rights Protection Officer, and other Quality Management and Center Staff complete this process. This internal auditing process looks at an identified program's compliance with the MH and/or SUD Contracts, CCBHC guidelines and other applicable standards. The program survey process is continuously analyzed and redeveloped, as needed, to be in line with the current evidence-based practice models, and other acceptable guidelines. Chart audits, interviews with program staff, interviews with the program manager, interviews with individuals served, inspection of the facilities, review of satisfaction surveys, and review of training materials are all a part of this process. Additionally, program outcomes, quality and satisfaction endeavors, financial reports, personnel development, and compliance with privacy standards (i.e. HIPAA and 42 CFR Part 2) are reviewed during this process. A summary of findings from the survey is maintained in the QM Department. Each Summary includes: strengths, weaknesses, and recommendations for improvement.

Each documentation/chart review conducted by quality management staff takes into account applicable evidenced based practices, appropriateness of placement, adequacy of services provided, and quality of individual continuum of care (continuity of care). Documentation and chart review tools used in these audits are developed from a variety of sources, including but not limited to:

- State manuals;
- Fidelity Guidelines;
- HHSC Performance Contracts;
- Texas Administrative Code;
- CCBHC guidelines;
- Evidenced-Based Practices and accreditation standards;

- Other applicable State or Federal or funding source guidelines.

The tools will continue to be changed as necessary to ensure we are measuring compliance with the most current standards and guidelines. The results of each program survey audit are shared with the program manager and designated Management Team member who ensures a Plan of Correction, if necessary, and submits it to the Administrator of Quality Management. Consideration of items needing ongoing quality assurance are reviewed by QM as a part of the corrective action process to ensure continuous quality improvement is addressed as needed. The Center's MH QM/UM Committee also reviews key findings and makes recommendations as needed.

SATISFACTION SURVEY

The Quality Management Department conducts phone surveys with individuals served during each internal program survey in order to monitor and assess satisfaction. Recommendations are made to program managers when indicated. In addition, satisfaction surveys are completed as part of the Center's self-assessment process. Each program conducts their own satisfaction surveys on a quarterly basis using either a standardized questionnaire or a survey they have approved through the Quality Management Department. The results are requested to be reviewed during program survey and are used to make reasonable changes/improvements to the program. In addition, the Administrator of Quality Management facilitates the distribution of additional satisfaction survey, on an intermittent schedule and/or as indicated, to further evaluate services.

STAKEHOLDER INVOLVEMENT AND INPUT

Area organizations in which Tri-County participates and/or collaborates include, but are not limited to:

- Community Resource Coordinating Groups (CRCG)
- Independent School Districts
- Hospitals
- Law Enforcement Agencies
- Homeless Coalitions
- United Way
- Specialty Courts (i.e. MH; Veterans)
- Mental Health Planning Network Advisory Committee (MHPNAC)
- Regional Planning Network Advisory Committee (RPNAC)
- Child Fatality Review Teams
- Montgomery County Behavioral Health and Suicide Prevention Taskforce
- Various other community partnerships.

Tri-County continues to develop community relationships with local independent school districts, hospitals and emergency departments, law enforcement and the criminal justice system as well as other agencies integral to the coordination of care for those we serve. Additionally, Tri-County strives to engage individuals served, their family members, providers, advocates, local officials, volunteers, staff, and other members of the general public in planning initiatives to identify service gaps and priorities for our community and those we serve. Participating in these groups enables Tri-County staff to build relationships through networking and collaboration with representatives from other area agencies.

CORPORATE COMPLIANCE

Tri-County continues to implement and monitor initiatives that are outlined in the Center's Corporate Compliance 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 continues to serve as the Corporate Compliance Officer and the Corporate Compliance Committee meets at least quarterly.

To ensure compliance with regulations, Tri-County's Corporate Compliance program includes the following:

- A Corporate Compliance Policy that includes reference to the Corporate Compliance Action Plan as the guide for Corporate Compliance activities in the Center along with a requirement that that training includes information on:
    - The Federal False Claims Act
    - The State Medicaid False Claims Act
    - Qui Tam
- A Corporate Compliance Action Plan which guides the activities of the Corporate Compliance Program at Tri-County.
- A Community Based Services Agreement that requires any contractors entering into this agreement with Tri-County to either:
    - Participate in the Tri-County Compliance program, or
    - Provide their Corporate Compliance information to our committee for review and approval.
- Corporate Compliance Training at hire, 90 days after hire and annually to ensure a positive culture of compliance as well as a solid understanding of and compliance with regulation.

- An updated Agency Employee Handbook that reflects Corporate Compliance Program requirements.

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 training. Included in this training is a Corporate Compliance training review.

As program managers have identified problems or potential problems in their departments, the Training Coordinator and/or Clinical Trainer have developed specific CBT modules as well as provided face-to-face specific training to the program staff.

Tri-County staff may also receive training from the Texas Council Risk Management Fund and other regional and statewide conferences. The Training Department ensures that all staff are current on their training and no lapse occurs. The Human Resource Department, in coordination with the Billing Department, ensures that professional clinical staff licensing and credentials are current. Tri-County is committed to on-going professional training. Through the Clinical Trainer and other staff certified as train the trainers, our Center provides a variety of experts to provide training on such topics as trauma informed care, cultural diversity, customer service, psychological first aid, responsible care, best practices, and engagement and teaching strategies for persons with mental illness and/or substance use diagnoses. The need for and development of additional trainings is an ongoing commitment of the Tri-County Training Department.

It is required by Tri-County that Utilization Management Staff are properly trained and supervised, as required by HHSC or by other policy, law or regulation. It is the responsibility of the Quality Management Department, in consultation with the Utilization Psychiatrist and the Training Department, as necessary, to ensure documentation and supervision are properly maintained.

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 by the Rights Protection Officer. Tri-County protects the health and safety of individuals served, families and staff through immediate action when warranted, the on-going monitoring and reporting of critical incidents, medication errors, infection control events, maintenance, and safety reports. The MH QM/UM Committee reviews the Critical Incident Reporting (CIR) data quarterly looking for trends in all aspects of the data. If trends are found, improvement plans are requested from the appropriate program. The Safety Committee reviews those incidents involving maintenance and safety issues and communicates concerns to the appropriate Management Team representative. Immediate action is taken when needed and corrective actions may be developed to address less urgent matters and

to ensure ongoing quality improvement. 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, the Rights Protection Officer, the Administrator of Quality Management, and the appropriate program manager/Management Team Representative, 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, neglect, exploitation. Often these trainings are customized for other programs in an attempt to proactively reduce the incidents of abuse, neglect and exploitation before it occurs. Should any trends or patterns arise this information will be shared with the MH QM/UM and CQI Committees for analysis and recommendation.

PLAN FOR REDUCING CONFIRMED INSTANCES OF ABUSE AND NEGLECT

The Rights Protection Officer continuously monitors information relevant to abuse and neglect of persons served and reviews relevant data quarterly or more frequently as needed. This data includes not only confirmed allegations, but also unconfirmed and inconclusive allegations. The data are reviewed and analyzed by the MH QM/UM Committee for trends or patterns involving particular programs, certain staff or persons served. If trends or patterns are identified, the information is shared with Management Team and the CQI Committee and recommendations for improvements are made and improvement plans are requested if necessary. Tri-County Quality Management 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 current employees. The Safety Committee Chair serves on the MH QM/UM Committee, reviews the data to determine any trends or patterns related to safety that may need review by the Safety Committee for further recommendations.

Tri-County continues its efforts to safeguard the well-being of the individuals they serve. Tri-County has a toll free 1-800 line, which goes directly to the Rights Protection Officer, and 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 individuals in their message on how to reach the 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 may contact the after-hours on call phone which ensures that reports can be made to a live caller 24 hours a day, 365 days a year. If the individual seeks an operator after hours by pressing zero during the voicemail message, instructions will be given on how to contact our afterhours crisis service. We continue to pursue a diligent education program on how to exercise rights and contact the Rights Protection Officer as well as the Department of Family and Protective Services when there is a need.

Additionally, Quality Management Department staff conduct interviews with program staff during the program survey process of each department to ensure that staff members are knowledgeable in key areas. Interviews include verification that staff understand areas concerning rights, abuse, neglect, and exploitation issues and how/when to report such information. Also, during the review process, each

facility is checked to ensure that proper information on how to contact the Rights Protection Officer and the Department of Family and Protective Services is posted with easy to understand directions on how to utilize the information.

The Center continues to focus on best hiring practices in order to reduce the turnover rate of our workforce. Significant efforts to retain staff have been taken in the last few years and the Center continues in its commitment to explore new ways to provide quality services to the individuals we serve with our available resources.

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC (CCBHC)

In addition to routine monitoring of clinical outcomes and organizational indicators, continuous quality review activities are monitored to ensure compliance with CCBHC certification and overall adherence to CCBHC standards are formally assessed through the incorporation of CCBHC criteria into the Center's ongoing quality assurance tools and processes. Through the Continuous Quality Improvement (CQI) Plan, CCBHC criteria inclusion in Center audit tools and other Quality Management structures and activities, CCBHC is continually monitored throughout many quality review activities at Tri-County.

ADDITIONAL ONGOING QUALITY REVIEW ACTIVITIES FOR SPECIALTY PROGRAMS

Specific programs at Tri-County require additional focus from the Quality Management Program due to the intensity and/or specialty of the services provided. The following sections outline additional Quality Management activities for these services and should be read in context with the larger Quality Management Plan. The structures explained in umbrella Quality Management Plan are used for monitoring, assessing, and improving all services at the Center and include, but are not limited to, the following:

- The use of the MH QM/UM Committee;
- Measuring, Assessing, and Improving the accuracy of data reported by the Local Authority;
- Internal Program Review process;
- Satisfaction Survey;
- Stakeholder Involvement and Input;
- Staff Development;
- Rights, Abuse/Neglect, Safety, and Health Data; and
- Plan for reducing confirmed instances of Abuse and Neglect.

QUALITY MANAGEMENT OF YOUTH EMPOWERMENT SERVICES (YES) WAIVER

In FY 2016, under direction from the 83rd Legislature, Tri-County Behavioral Healthcare began providing comprehensive and community-based mental health services to children and youth at risk of institutionalization and/or out-of-home placement due to their serious emotional disturbances. The population served includes children and youth ages three (3) to eighteen (18) that reside in Montgomery, Walker, and Liberty counties. In addition to providing Wraparound services (including Intensive Case Management and Individual Skills Training) children and youth enrolled in YES Waiver can receive contracted services including:

- Respite;
- Adaptive Aids and Supports;
- Community Living Supports (CLS);
- Employment Assistance;
- Family Supports;
- Minor Home Modifications;
- Non-Medical Transportation;
- Paraprofessional Services;
- Supportive Employment;
- Transitional Services; and
- Specialized Therapies including Animal-Assisted Therapy, Art Therapy, Music Therapy, Recreational Therapy and Nutritional Counseling.

The program Director for the YES Waiver is a Licensed Professional Counselor with over 20 years of experience in the mental health and social services setting. As required by the Texas Health and Human Services Commission contract, all Tri-County policy and procedure that governs security of confidential information, discrimination, individual rights, use of tobacco, and the participant's right to file a grievance will be followed by the YES Waiver program.

The program staff along with various agency committees including JUM and MH QM/UM will monitor YES Waiver performance target numbers as required by HHSC. Tri-County's Utilization Management staff will assist program staff with the completion of these activities and results will be communicated to the Tri-County Management Team as needed. Additional audit requests will be completed by the Tri-County Quality/Utilization Management staff in cooperation with program staff. Plans of improvement and supporting documentation will be submitted to HHSC as required. Plans of improvement will be monitored by the Quality Management Department. If HHSC makes specific recommendations related to staff training, self-monitoring activities or CMBHS and/or MBOW performance reports, Tri-County staff will implement required changes.

Goals for providing Quality Management of Youth Empowerment Services

Goal 1: The Quality Management Department will collect data, measure, assess, and work to improve dimensions of performance through focus on the following aspects of care:

a. Timeliness of Services
b. Timely Enrollment of Waiver Participants
c. Plans of Care and Statements are based on underlying needs and outcome statements
d. Services are provided according to the Waiver participant's Individual Plan of Care.
e. Provider participation in child and family and team meetings
f. Assuring development and revision of Individual Plans of Care
g. Health and Safety risk factors are identified and updated
h. Collection and analysis of critical incident data
i. Providers are credentialed and trained
j. Adherence to established procedures
k. Continuity of Care

Performance Standard

Quality Management staff will incorporate the above aspects of care into the activities of other agency committees (i.e. Junior Utilization Management, Safety, MH QM/UM Committee) and will continue to collect and review quality assurance of documentation of YES Waiver services in order to monitor, evaluate, and implement needed changes.

Measurable Activities

1. Update, as necessary, review tools to be in compliance with the HHSC YES Waiver contract, the Texas Administrative Code, current evidence-based practice and the YES Waiver Policy and Procedures.
2. Evaluate and assess the program according to the aspects of care listed above.
3. Provide feedback to reviewed programs that include department strengths, weaknesses, and recommendations for improvement.
4. Provide review reports to program managers and the Management Team upon completion
5. Follow up with program managers regarding plans of correction as needed.
6. Provide key updates from internal review to the Mental Health Quality Management/Utilization Management Committee (MH QM/UM), for evaluation.
7. Continually evaluate the quality improvement process for YES Waiver and make modifications as needed to ensure that the process is measuring critical program elements.

Goal 2: The Quality Management Department will ensure that the YES Waiver procedures and processes are in compliance with state regulations.

Performance Standard

Review written procedures applicable to the YES Waiver program to ensure that they are in-line with the YES Waiver manual and that all YES staff review these procedures.

Measurable Activities

1. Upon development, review and as changes are made, ensure that written procedures are maintained in compliance with the Texas Administrative Code, YES Waiver contract, YES Waiver Policy and Procedures and objectives related to the program's mission.
2. Ensure that all staff working in the YES Waiver program are aware of procedural changes and are provided with and read the procedures applicable to their position.
3. Ensure that procedures applicable to YES Waiver are reviewed as a part of the internal program review process for YES Waiver services.
4. Provide feedback to program managers when there are indications that changes may be warranted.

QUALITY MANAGEMENT OF SUBSTANCE USE DISORDER (SUD) SERVICES

Youth Prevention Substance Use and Misuse Services, Selective (YPS) and Universal (YPU)

Tri-County began providing substance use education classes to youth who were at risk of substance use in our three county service area in Fiscal Year 2009. The YPS program uses the Rainbow Day's Kid's Connection (ages 6-11) and Youth Connection (ages 12-17) evidence-based curriculum to provide education to 'at risk' children in Liberty, Montgomery and Walker Counties. The Rainbow Days curriculum is a Curriculum-Based Support Group (CBSG) which has been approved by the Texas Health and Human Services Commission (HHSC) to be presented in schools, after-school programs, head start programs, and other community-based settings. Tri-County provides services in a variety of environments but services will primarily be provided in area Elementary, Intermediate, Junior High and Senior High Schools to children that the schools feel are appropriate for the program. Other potential service locations include homeless shelters, family violence shelters and after-school youth service programs.

In Fiscal Year 2020, Tri-County expanded the prevention program to include youth in the general public through the Youth Prevention Universal (YPU) Contract and is currently providing the All Stars Evidence Based Curriculum to hundreds of youth.

As required by the HHSC contract, all Tri-County policy and procedure that governs security of confidential information, discrimination, individual rights, use of tobacco, and the participant's right to file a grievance will be followed for the Prevention Programs.

The programs will provide participants with the opportunity to complete a satisfaction questionnaire at the conclusion of YPS and YPU services. These questionnaires and other data from the program will be reviewed during internal Program Survey audits and by the Center's MH QM/UM Committee, as needed.

The program staff will report YPS and YPU performance target numbers to the JUM Committee and MH QM/UM Committee and these committees will monitor quarterly performance as required by HHSC. If a waiting list has to be started for the program, this information will also be shared with these committees who will review the information to ensure fairness and equity in the access of services.

Tri-County's Utilization Management Staff will assist Program Staff with the completion of these activities and results will be communicated to the Tri-County Management Team representative for review. Additional audit requests will be completed by Tri-County Quality Management Staff in cooperation with Program Staff. Plans of improvement and supporting documentation will be submitted to HHSC as required and monitored by the QM/UM Departments. If HHSC makes specific recommendations related to staff training, self-monitoring activities, or CMBHS performance reports, Tri-County staff will implement required changes.

Substance Use Disorder Treatment Program (SUDTP)

After receiving local funding and state licensure for 12 adult slots in 2009, Tri-County implemented a SUDTP and later gained licensure for 12 additional slots to include adolescents. Currently, Tri-County holds state licensure for 180 slots for both adults and adolescents. In June 2010, Tri-County was awarded state funding to provide adult and youth outpatient substance use treatment services including treatment of individuals having Co-occurring Psychiatric and Substance Use Disorders (COPSD).

The Substance Use Treatment Program Manager for both Adults and Youth is an LCDC with two years of supervised post-licensure experience. In the outpatient SUDTP at Tri-County, individuals participate in group processing, education on addiction through lectures, films, books, pamphlets, and support groups. Tri-County's substance use treatment program is currently utilizing the evidence-based practices of the Matrix Intensive Outpatient Model, and Cannabis Youth Treatment (CYT) for adolescents.

As required by HHSC contract, all Tri-County policy and procedures that govern security of confidential information, discrimination, individual rights, use of tobacco, and the participant's right to file a grievance will be followed for the SUDTPs.

The SUDTP Director will provide updates to the Center's MH QM/UM Committee as needed. The Program Staff will report SUDTP performance target numbers to the JUM and MH QM/UM Committees and these committees will monitor quarterly performance as required by HHSC, CCBHC or other accreditation organization as applicable. If a waiting list has to be started for the program, this information will also be shared with these committees who will review the information to ensure fairness and equity in the access of services.

Tri-County's Utilization Management staff will assist program staff with the completion of these activities and results will be communicated to the Tri-County Management Team representative for review. Additional audit requests will be completed by Tri-County Quality Management Staff in cooperation with program staff. Plans of improvement and supporting documentation will be submitted to HHSC and/or other accreditation organizations as required. Plans of improvement will be monitored by the Utilization Management and/or Quality Management Departments. If HHSC or applicable accreditation organizations makes specific recommendations related to staff training, self-monitoring activities or CMBHS performance reports, Tri-County staff will implement required changes.

Goals for Providing Quality Management of SUD Treatment and SUD Programs

Goal 1: The Quality Management Department will implement a process to monitor SUDTP services and Prevention services for appropriateness, review progress toward goals, monitor compliance with the HHSC Substance Use Performance Contract, and ensure a documented process to implement improvements as needed.

Performance Standard

Quality Management staff will incorporate the above aspects into ongoing quality assurance activities and other agency committees (i.e. JUM, MH QM/UM) and will continue to collect and review quality assurance of documentation of SUDTP services in order to monitor, evaluate, and implement needed changes.

Measurable Activities:

1. Update, as necessary, review tools to be in compliance with the HHSC Substance Use Performance Contract, The Texas Administrative Code, applicable Memorandums of understanding, CCBHC and current evidence – based practices (i.e. The Matrix Model, Cannabis Youth Treatment (CYT), Rainbow days, Kids and Youth Connections).
2. Evaluate and assess these programs according to aspects of care listed above and outlined throughout the umbrella Quality Management Plan.
3. Provide feedback to reviewed programs that include department strengths, weaknesses and recommendations for improvement.
4. Provide the findings to program managers and the Management Team representative upon completion.
5. Follow up with program managers regarding plans of correction as needed.
6. Provide key updates from internal reviews to the MH QM/UM Committee for evaluation.
7. Continually evaluate the quality improvement process for SUDTP and make modifications as needed to ensure that the process is measuring critical program elements.

Goal 2: The Quality Management Department will ensure that Substance Use Treatment and Substance Use Prevention procedures and processes are in compliance with state regulations.

Performance Standard:

Review written procedures applicable to SUDTP and/or Prevention Programs on an annual basis and ensure that all staff review these procedures.

Measurable Activities:

1. Upon development, review, and as changes are made, ensure that written procedures are maintained in compliance with the Texas Administrative Code, the Substance Use Performance Contracts, CCBHC criteria, and include goals and objectives that relate to the program's mission.
2. Ensure that all staff working in the Substance Use Treatment Program and the Youth Substance Use Prevention Program are aware of procedural changes and are provided with and read the procedures applicable to their position.
3. Ensure that procedures applicable to substance use service provision are reviewed as a part of the internal program review process for substance use services.
4. Provide feedback to program managers when there are indications that changes may be warranted.

Chapter 4: Utilization Management Plan

Utilization Management (UM) is the vehicle through which Tri-County Behavioral Healthcare (Tri-County) ensures people receive quality, cost-effective services in a timely manner and in the most appropriate setting. By implementing UM activities, Tri-County strives to achieve a balance between the needs and quality of life of Individuals seeking services and the demand for services while taking into account the availability of resources. Tri-County, through contract with HHSC, participates in the Texas Resilience and Recovery System of care design which establishes who is eligible to receive services through a uniform assessment that determines the appropriate services through a 'Level of Care (LOC)' designation, establishes guidelines for 'Utilization Management' of Individuals assigned to an LOC, measures particular clinical outcomes to determine the impact of services and outlines the expected cost of services. The following is an outline of the key UM activities that Tri-County participates in to gain information and data in order to better inform management decisions and assist with overall improvement of the system of care. This outline should be read along with the other sections of the QM Plan in order to obtain a full picture of the UM program at Tri-County (i.e. UM related responsibilities and committees are outlined in Chapter 2). The Center's Utilization Manager, under the direction of a UM Psychiatrist and in consultation with the MH QM/UM Committee, assumes the responsibility for the execution of this UM Plan.

PSYCHIATRIST OVERSIGHT OF THE UM PROGRAM

The psychiatrist who provides oversight of the responsibilities of the UM Program and Committee for Tri-County is Jonathan Sneed, D.O. Tri-County Medical Director. Additionally, through participation in the East Texas Behavioral Healthcare Network (ETBHN), Tri-County participates in the Regional UM Committee which is overseen by Mark Janes, M.D. ETBHN Medical Director.

PROCESS FOR ELIGIBILITY DETERMINATION

Intake staff conducts a screening on each Individual to determine whether the requirements are met for admission to services and initial level of care assignment using HHSC criteria. Determinations are conducted to ensure that Tri-County's guidelines deliver treatment in the most effective and efficient manner. Quality and Utilization Management staff, whichever appropriate, review eligibility information prior to authorization, during relevant ongoing quality assurance activities, and during program survey audits as well as when appeals are requested.

PROCESS FOR LEVEL OF CARE ASSIGNMENT

Tri-County assigns each Individual served to the appropriate level of care according to HHSC TRR UM guidelines and conducts retrospective oversight of initial and subsequent level of care assignments to ensure consistent application of TRR UM guidelines. These processes ensure sufficient utilization and resource allocation determinations based on clinical data, practice guidelines and information regarding the Individual's needs with consideration of the Individual's treatment preferences and objections.

The Quality and Utilization Management Department may put additional oversight activities in place when resources are limited to ensure safety and appropriateness of any overrides.

PROCESS FOR AUTHORIZATIONS AND REAUTHORIZATIONS

Tri-County has a partnership with ETBHN to conduct retrospective oversight, initial and subsequent level of care assignments to ensure consistent application of HHSC TRR Utilization Management Guidelines. A position was added to ensure that Individuals affected by Senate Bill 58, which moved much of their mental healthcare into managed care, continue to receive needed levels of care in line with State guidelines and medical necessity.

PROCESS OF OUTLIER REVIEW

Tri-County and ETBHN, as designated by Tri-County, through its MH QM/UM Management Committee, will conduct outlier review. This process will consist of a review of data to identify outliers and to determine the need for change in level of care assignment processes, service intensity or other UM activities. These reviews are conducted to ensure provider treatment is consistent with practice guidelines as is the process for making utilization/resource allocation determinations.

EXCEPTION/ CLINICAL OVERRIDE PROCESS

Tri-County will maintain a system to override the current authorization guidelines when there is a need to make exceptions to, and manage, the amount of service authorized for an Individual, and will report on exceptions or overrides as required by HHSC. Any deviations from recommended levels of care are reviewed by the ETBHN Authorizer and program managers. Quality Management/Utilization Management is included on reviews as needed to ensure appropriateness of level of care placements. All overrides are reviewed on a regular basis at the MH QM/UM Committee Meetings.

INPATIENT ADMISSIONS, STATE HOSPITALIZATIONS AND DISCHARGE

The Center conducts reviews of inpatient admissions to ensure the most clinically appropriate, medically necessary, and effective length of stay at an inpatient facility and reviews related discharge plans to ensure timely and appropriate continuity of care following an inpatient stay.

APPEAL PROCESS

Pursuant to 25 TAC §401.464, Tri-County is dedicated to providing services which are viewed as satisfactory by Individuals receiving those services and their legally authorized representatives (LAR). The purpose of this process is to assure that Individuals:

1. Have a method to express their concerns of dissatisfaction;
2. Are assisted to do so in a constructive way; and
3. Have their concerns of dissatisfaction addressed through a formal review process.

A request to review decisions described in this section may be made by the Individual requesting or receiving services and/or supports, the Individual's LAR or any other individual with the Individual's consent.

Tri-County shall provide written notification in a language and/or method understood by the individual and/or their LAR, of the Tri-County procedure for addressing concerns or dissatisfaction with services or supports. The individual and/or LAR, shall receive this information at the time of admission into services and on an annual basis. The notification shall explain:

1. An easily understood process for Individuals and legally authorized representatives to request a review of their concerns or dissatisfaction by Tri-County;
2. How the Individual may receive assistance in requesting the review;
3. The timeframe for the review; and
4. The method by which the Individual is informed of the outcome of that review.

Tri-County shall notify Individuals and LARs in writing in a language and/or method understood by the Individual and LAR of the following decisions and of the process to appeal by requesting a review of:

1. A decision to change, reduce, or deny the Individual services or supports, at the conclusion of Tri-County's procedural review, which determines whether the Individual meets the criteria for the priority population; and
2. A decision to terminate services or supports and follow-along from Tri-County or its contractor, if appropriate.

The written notification referred to above must:

1. Be given or mailed to the Individual and the LAR within ten (10) business days of the date the decision was made;
2. State the reason for the decision;
3. Explain that the Individual and LAR may contact Tri-County within thirty (30) days of receipt of notification of the denial or change in services if dissatisfied with the decision and request that the decision be reviewed in accordance with this procedure; and
4. Include names, phone numbers and addresses of one or more accessible staff to contact during office hours.

APPEAL OF DECISION TO REDUCE SERVICES AND SUPPORTS

1. If an Individual or LAR believes that the Center or its contract provider has made a decision to involuntarily reduce services by changing the amount, duration, or scope of services and supports provided and is dissatisfied with that decision, then the Individual may request in writing that the decision be reviewed in accordance with Tri-County's Notification and Appeals Process procedure.
2. The review by the Center or its contract provider shall:
   a. Begin within ten (10) business days of receipt of the request for a review, be completed within ten (10) business days of the time it begins, unless an extension is granted by the Executive Director of the Center;

b. Begin immediately upon receipt of the request and be completed within five (5) business days if the decision is related to a crisis service;
c. Be conducted by an Individual(s) who was not involved in the initial decision;
d. Include a review of the original decision which led to the Individual's dissatisfaction;
e. Result in a decision to uphold, reverse or modify the original decision; and
f. Provide the Individual and/or LAR an opportunity to express his or her concerns in person or by telephone to the Individual reviewing the decision. The review shall also allow the Individual to:
    1) Have a representative talk with the reviewer, or
    2) Submit his or her concerns in writing, through various electronic media (i.e. tape, CD, thumb drive), or in some other fashion.

The notification and review process described in the Notification and Appeals Process procedure:

1. Is applicable only to services and supports funded by HHSC and provided or contracted for by its local authorities;
2. Does not preclude an Individual or legally authorized representative's rights to review, appeal, or other actions that accompany other funds administered through Tri-County or its contractor, or to other appeals processes provided for by other state and federal laws or regulations (i.e. Texas Health and Safety Code, Title 7, Chapter 593 (Persons with an Intellectual Disability Act); 42 USC 1396 (Medicaid Statute))

QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT

The Center's QM staff provide oversight to ensure compliance with and the quality of the implementation of Texas Resiliency and Recovery (TRR) practices, monitor fidelity to service models, monitor performance in relation to HHSC-defined performance measures, and coordinate activities with the UM program.

GOALS OF TRI-COUNTY'S UM PLAN

1. Monitor, assess, analyze, and improve accessibility by monitoring timely authorization of UAs and service provision length related to medical necessity.
2. Assure and improve availability of services by monitoring the time to the first service and proper use of any interest list, regardless of funding source, if applicable.
3. Improve quality of services by monitoring outcomes for both children and adults.
4. Monitor, analyze and frequently communicate any concerns with performance and/or quality measures to the appropriate program and clinical staff.

DELEGATED UM ACTIVITIES AND OVERSIGHT

Pursuant to a written agreement, certain Utilization Management activities have been designated by the Center to East Texas Behavioral Healthcare Network (ETBHN), as have been described in this Quality Management Plan. It is the responsibility of the Center's Utilization Manager to ensure oversight of these delegated activities. To that end, ETBHN will provide all Utilization Management reports, results, and

analysis, of the above-mentioned Delegated Activities to the ETBHN Regional Oversight Committee, as well as to the Center's Utilization Manager.

Chapter 5: Continuous Quality Improvement (CQI) Plan

The following quality improvement plan serves as the foundation of the commitment of Tri-County Behavioral Healthcare (Tri-County) to continuously improve the quality of the treatment and services provided. Tri-County is committed to the ongoing improvement of the quality of care provided to Individuals served.

QUALITY

Quality services are those services that have an increased probability of resulting in improved outcomes and quality of life for individuals served, follow current professional knowledge, and are safe, effective, timely, person/family centered, trauma informed, recovery oriented and are provided within the guidelines of our current legal framework. Tri-County will place continued focus on improvement to ensure:

- Recovery oriented and trauma informed care;
- Services provided are medically necessary and appropriate to the needs of each individual while incorporating appropriate cultural and linguistic care;
- Services are provided at times and in places that are convenient and accessible to individuals served;
- Evidence-based practices are incorporated into treatment whenever feasible;
- Emotional and physical safety of individuals served and staff remains a key focus along with making adjustments to identified issues quickly and effectively to minimize risk;[1]
- Continued prevention, management and reduction of suicide attempts, suicide, and deaths;[2]
- Person and Family Centered Care are respected through empowering and allowing the individual a voice to identify their needs and expectations, as well as those that they designate to collaborate with the treatment team;
- Continued assessment, evaluation and adjustment of care for individuals readmitted to a hospital within 30 days as well as other populations identified to be at higher risk for frequent hospitalizations;[3]
- Processes and Services are provided in a timely and efficient manner and include appropriate coordination and continuity of care with other providers throughout the episode of care; and
- Rights are protected at all times.

[1] CCBHC 5.b.1 (Continuous Quality Improvement (CQI) Plan)
[2] CCBHC 5.b.2 (Continuous Quality Improvement (CQI) Plan)
[3] CCBHC 5.b.2 (Continuous Quality Improvement (CQI) Plan)

QUALITY IMPROVEMENT PRINCIPLES

Quality Improvement is a systemic approach to assessing, evaluating, improving, and measuring processes and services provided by Tri-County through the following principles:

- **Continuous Improvement:** The highest quality organizations understand that there are almost always opportunities for improvement and that processes must be continually reviewed and adjusted over time through small incremental changes in order to produce the most effective improvement.
- **Data Informed Practices:** Successful CQI processes use data to create feedback loops, inform processes, and measure results to determine effectiveness.[4]
- **Proactive Mindset:** An effective Quality Improvement program is continuous and will allow for identification of best practices and processes early on and prevent poor outcomes and wasted time or resources on corrective action.
- **Stakeholder Focus:** Services and programs that that attain the best quality include input from persons served, their designated family and/or support networks, and other involved community members and strive to meet and/or exceed the expectations of these stakeholders by allowing for collaboration and voice.
- **Recovery-Oriented:** Services are provided through a commitment to promoting and preserving wellness, empowering individuals served to play an active role in their recovery, and providing choice to the highest degree.
- **Leadership Involvement:** Strong leadership, direction, and support of quality improvement activities by the governing body and executive director are key to improvement and ensure that quality improvement efforts remain aligned with the organization's mission, vision, and strategic plans.
- **Workforce Empowerment:** Effective programs involve people at all levels of the organization in improving quality.

CQI ACTIVITIES

Quality Improvement Activities are an integral part in providing the foundation for an effective system wide quality management program. The following framework is supported by Center Management and includes participation from all levels of the organization in an effort to achieve a CQI structure. The primary focal points of the Quality Improvement Program for Tri-County Behavioral Healthcare include:

1) Assessing, evaluating, and measuring Tri-County's services through the collection and analysis of data.[5]
2) Working through identified quality improvement initiatives using a PDSA cycle with special focus on new or problem areas and continuing to look for ways to improve existing services.

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[4] CCBHC 5.b.1 (Continuous Quality Improvement (CQI) Plan)
[5] CCBHC 5.a.1 (Data Collection, Reporting, and Tracking)

THE CQI COMMITTEE

The CQI Committee meets regularly to provide ongoing operational leadership of CQI activities at Tri-County. The Director of Quality Management and Support and the Administrator of Quality Management serve as the Committee Chairs with consultation and direction provided by the Executive Director and other Center Management Team members as needed. Other members include the Chief Operating Officer, the Director of Child and Youth Outpatient Services, the Director of Adult Outpatient Services, the Director of Crisis Services, the Director of Information Systems or designee, the Risk Manager or designee, a Financial representative as needed, an IDD services representative as needed, and the Rights Protection Officer if not already holding one of the previously named positions. Other staff may be called to serve on the CQI committee depending on the specific initiatives of the Committee (i.e. staff managing scheduling and front door services).

The Responsibilities of the Committee include:

- Developing the CQI Plan to include measurable outcomes based on priorities that meet established criteria outlined by the Committee;
- Identifying and ranking indicators of quality and intermittently evaluating services based on these indicators;
- Establishing Quality Improvement Initiatives based on Center need, trends, and/or other risk or quality factors evaluated by the Committee;
- Utilizing a Plan, Do, Study, Act (PDSA) Cycle to ensure improvements are managed through an evidence-based approach; and
- Developing a standardized plan for communicating and sharing Quality Improvement information with the Board of Trustees, Staff, Individuals served, and other stakeholders as appropriate.

ROLE OF THE PNAC

The Board of Trustees for Tri-County appoints, charges, and supports the Mental Health Planning and Network Advisory Committee (PNAC) to review and provide input related to the local needs and priorities of the local service area, contracts, special assignments and projects such as providing feedback to the CQI Committee on the CQI Plan and initiatives for the Center. The PNAC is made up of at least nine members, 51% of which are Individuals served, family members, or people in recovery from behavioral health conditions and at least one member has lived experience with homelessness or housing instability.[6] The Director of Quality Management and Support serves as the Staff liaison to the PNAC, able to communicate feedback back to the CQI committee and the Board of Trustees in a timely manner.

GOALS AND OBJECTIVES

Annually, following the initial CQI plan, the CQI Committee is responsible for identifying and defining goals and specific outcomes to be accomplished through the PDSA process. The Director of Quality

[6] CCBHC 6.b.1 (Governance)

Management and Support, the Executive Director, the Board of Trustees, the PNAC, HHSC, or accrediting organizations may request additional initiatives for the Committee to evaluate as Center need arises.

LONG TERM GOALS AND OBJECTIVES

The following are the ongoing long term CQI goals for Tri-County and the specific objectives for accomplishing these goals for the term of this plan:

1) To implement quantifiable measurement practices that assess key processes or outcomes;
2) To bring managers and other Tri-County staff together to review quantifiable data, trends, and other risk/areas of concern;
3) To achieve measurable improvement in the highest priority areas;
4) To meet internal and external reporting requirements;
5) To provide meaningful education and training to managers and Tri-County Staff;
6) To develop or utilize tools, such as Evidence-Based Practice Guidelines, Client Satisfaction Surveys and other Quality Indicators and review these tools intermittently for effectiveness;
7) To continuously work to reduce and prevent suicide attempts and completions of Individuals served;
8) To reduce thirty (30) day rehospitalizations related to behavioral health;[7]and
9) To establish Fidelity checkpoints for overall accreditation (i.e. CCBHC) adherence as well as processes to review other evidence-based protocols.

TARGETED GOALS AND OBJECTIVES

The following are the current targeted goals and objectives identified by Tri-County for the remainder of this plan term:

1) The FY 23 annual average No Show Percentage will be reduced by 3% from the FY 22 annual average No Show percentage for at least one of the following: At least one Clinic Location or overall Center average.
2) The FY 23 percentage of individual suicides in a FLOC will be reduced by 10% from the FY 22 annual percentage or the average percentage over the last 3 years.
3) The FY 23 number of individuals in a FLOC who were re- hospitalized within 30 days of admission to an inpatient hospital setting that is known to the Center will be reduced by at least 2 individuals from FY 22.
4) The FY 23 Percentage of individuals receiving an initial evaluation within 10 days of contact with the Center will be increased by 3 % from the FY 22 year end percentage.

[7] CCBHC 5.b.2 (Continuous Quality Improvement (CQI) Plan)

PERFORMANCE MEASUREMENT

Tri-County utilizes Performance Measurement to regularly assess the results produced by a program or by a service through identifying processes, systems, selecting indicators and analyzing information related to these indicators on a regular basis. Tri-County's CQI Team takes action as needed based on the results of the data analysis and the opportunities for performance they identify.

The CQI Team:

- Assesses the consistency of outcomes to determine whether the information is reliable and whether there is a need for improvement;
- Identifies problems and opportunities to improve the performance of processes;
- Assesses the outcome of the care provided; and
- Assesses changes to determine whether a new or improved process meets performance expectations.

The CQI Team uses various Measurement and Assessment tools (**See Appendix A**) in order to:

- Select a process or outcome to be measured;
- Identify Performance indicators or outcomes;
- Gather Data and combined data as needed to measure the process or outcome quantifiably;
- Review Indicators on a planned and regular schedule;
- Take action when issues of statistical reliability, under performance or when opportunity for improvement presents; and
- Report findings to the organization to include conclusions and actions taken.

Selection of a performance indicator:
A performance indicator is a quantitative tool that provides information about the performance of Tri-County's process, services, functions or outcomes. Selection of a performance indicator is based on the following considerations:

- Relevance to mission – whether the indicator addresses the population served.
- Whether it addresses key areas of practice such as high volume, pattern of issue, or high risk.

Additional factors to consider in selecting an indicator include whether it is correlated to the issue at hand, the validity of the indicator, available resources, stakeholder preference, and if it is meaningful or not.

The following tables represents the current performance indicators being utilized by Tri-County:

Measure of Service Quality	
Indicator	Percentage of Doctor Appointment No Shows
Definition	The FY 23 annual average No Show Percentage will be reduced by 3% from the FY 22 annual average No Show percentage for at least one of the following: At least one Clinic Location or overall Center average.
Data to be collected	Number of individuals seen at the Center for a Pharmacological Management Service and the number of No Shows documented will be compared to produce a percentage.
Frequency of analysis or assessment	No show rate is reviewed in the Junior Utilization Management Committee which is typically held 2-3 times per month.
Preliminary ideas for improvement	Examine reminder process and process for identifying and addressing obstacles to treatment such as transportation.

Measure of Service Quality	
Indicator	The number of completed suicide deaths of Individuals served in the FLOC at Tri-County.
Definition	The FY 23 percentage of individual suicide deaths in a FLOC will be reduced by 10% from the FY 22 annual percentage or the average percentage over the last 3 years.
Data to be collected	The number of Individuals in the FLOC and the number of deaths due to completed suicide for Individuals in the FLOC.
Frequency of analysis or assessment	Monthly
Preliminary ideas for improvement	Continue to utilize risk stratification to identify individuals at high risk and connect them with additional supports and services including increased follow up and safety planning.

Measure of Service Quality	
Indicator	Rehospitalization within 30 days.
Definition	The FY 23 number of individuals in a FLOC who were re-hospitalized within 30 days of admission to an inpatient hospital setting that is known to the Center will be reduced by at least 2 individuals from FY 22.
Data to be collected	Number of individuals in a FLOC compared to the number in a FLOC who are re-hospitalized by Tri-County within 30 days of hospitalization.
Frequency of analysis or assessment	Frequent hospitalizations are reviewed in the Junior Utilization Management Committee which is typically held 2-3 times per month.
Preliminary ideas for improvement	Examine follow up, engagement, referrals and care coordination completed with this population to determine areas of improvement.

Measure of Service Quality	
Indicator	Improvement of the I-Eval CCBHC Measure – Time from initial contact to evaluation.
Definition	The FY 23 Percentage of individuals receiving an initial evaluation within 10 days of contact with the Center will be increased by 3 % from the FY 22 year end percentage.
Data to be collected	Dates of Initial Contact compared to dates of evaluation
Frequency of analysis or assessment	I-Eval measure status is reviewed in the Junior Utilization Management Committee which is typically held 2-3 times per month.
Preliminary ideas for improvement	Review factors that may be affecting the measure (i.e. scheduling practices, client no shows, availability).

QUALITY IMPROVEMENT INITIATIVE

Once the performance of a selected process has been measured, assessed, and analyzed, the information gathered by the above performance indicators is used to identify a CQI initiative to be undertaken. The decision to undertake the initiative is based upon TCBHC priorities. The purpose of an initiative is to improve the performance of existing services or to design new ones. The model utilized at TCBHC is PDSA and is outlined briefly below:

Plan:	The process of identifying needed change to be tested or implemented, identifying quantifiable data that can be used to measure the change and recording baseline data.
Do:	The process of testing the change.
Study:	The pre and post comparison of predetermined measurable outcomes to determine the impact of the change, whether it affected what was expected to be affected.
Act:	Planning the next phase of the improvement cycle or moving to fully implement the change if found to be effective. This phase should include actions to maintain changes (follow up) and includes documentation and communication or reports and/or findings.

EVALUATION

An evaluation is completed at the end of each calendar year. The annual evaluation is conducted by TCBHC and kept on file in the Quality Management Department for 7 years (or greater if required by law or accrediting body). These documents may be reviewed by contracting or accreditation agencies and should be organized and easily accessible. The evaluation summarizes the goals and objectives of TCBHC's CQI Plan, activities conducted over the past year, the findings, and any quality improvement initiatives taken in response to the findings and recommendations.[8]

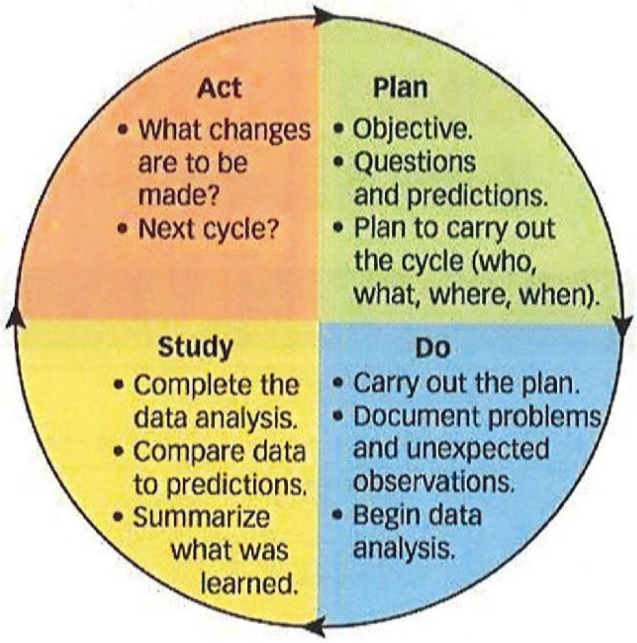
CELEBRATE SUCCESS

When the Evaluation results in positive results and significant improvements, Tri-County will seek ways to provide recognition to employees and programs who were key in making the improvements a success. As well, the information will be shared in a variety of formats that reach employees and stakeholders.

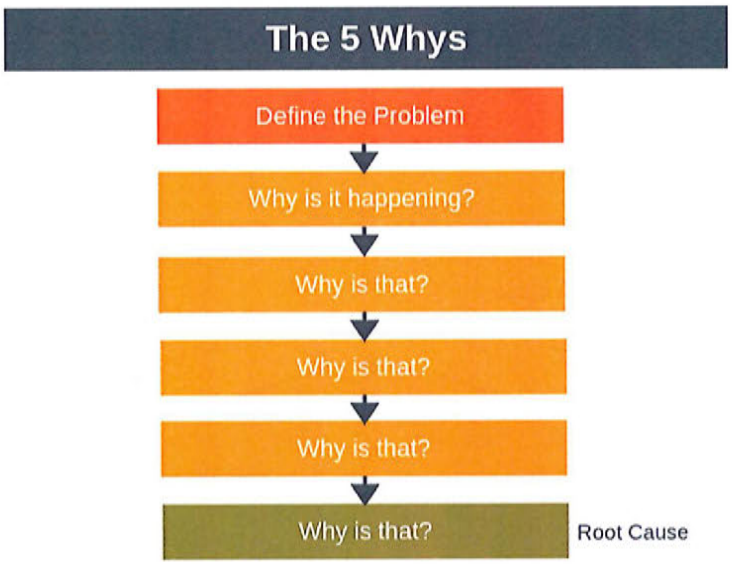
[8] CCBHC 5.b.1 (Continuous Quality Improvement (CQI) Plan)

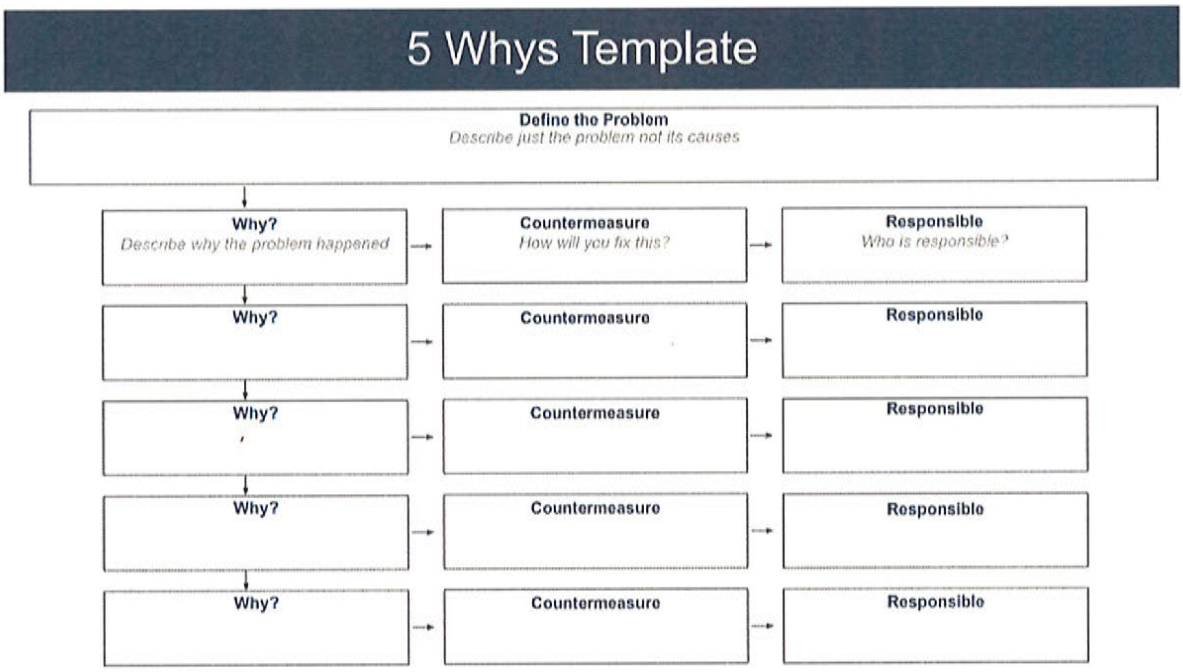
Appendix A

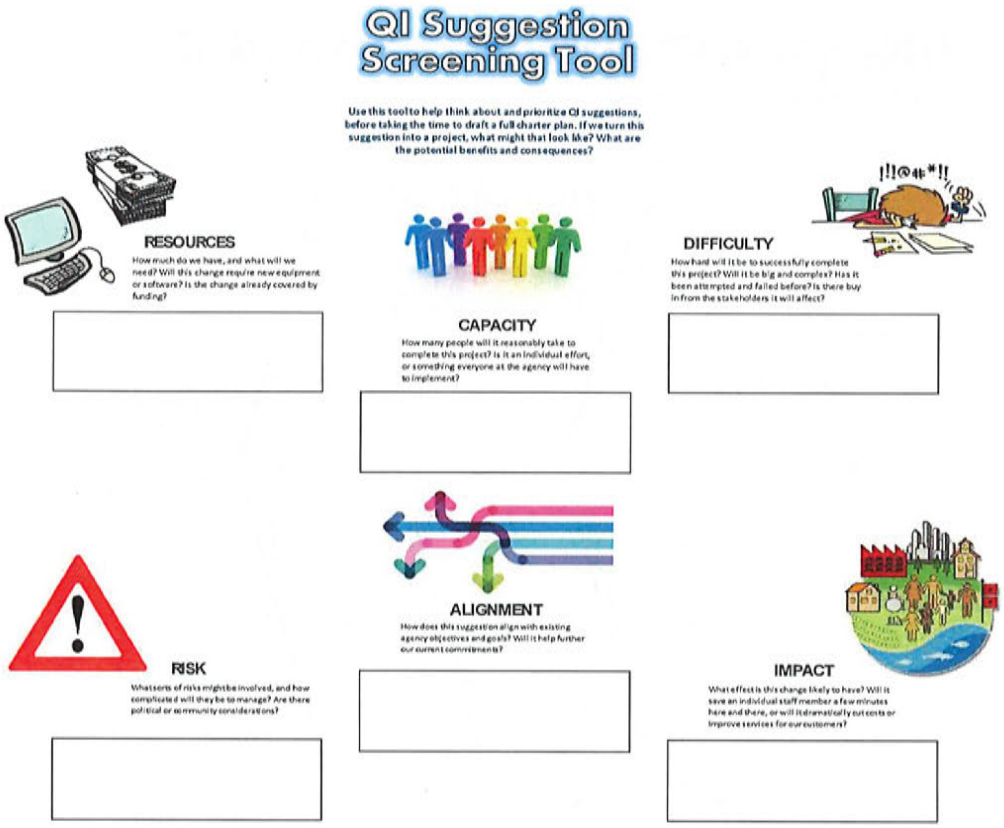
The following is a visual of the PDSA cycle:



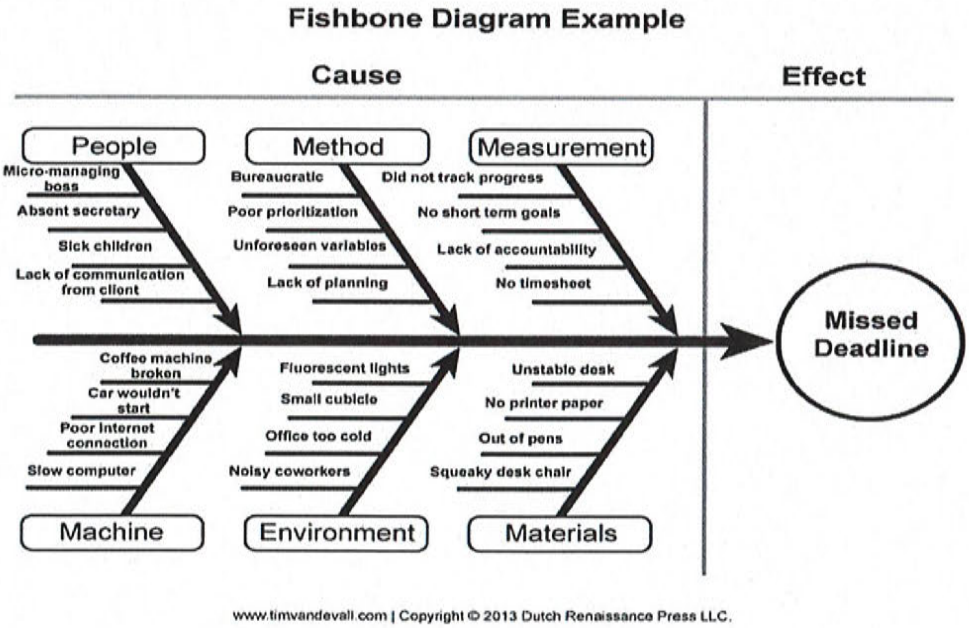
The Following are examples of Tools that the CQI Committee or Programs may use during the Screening Planning phase of PDSA:
Below is a sample of the 5 Why's Tool followed by a template 5 Why's and Screening Tool that can be used by the CQI Committee:

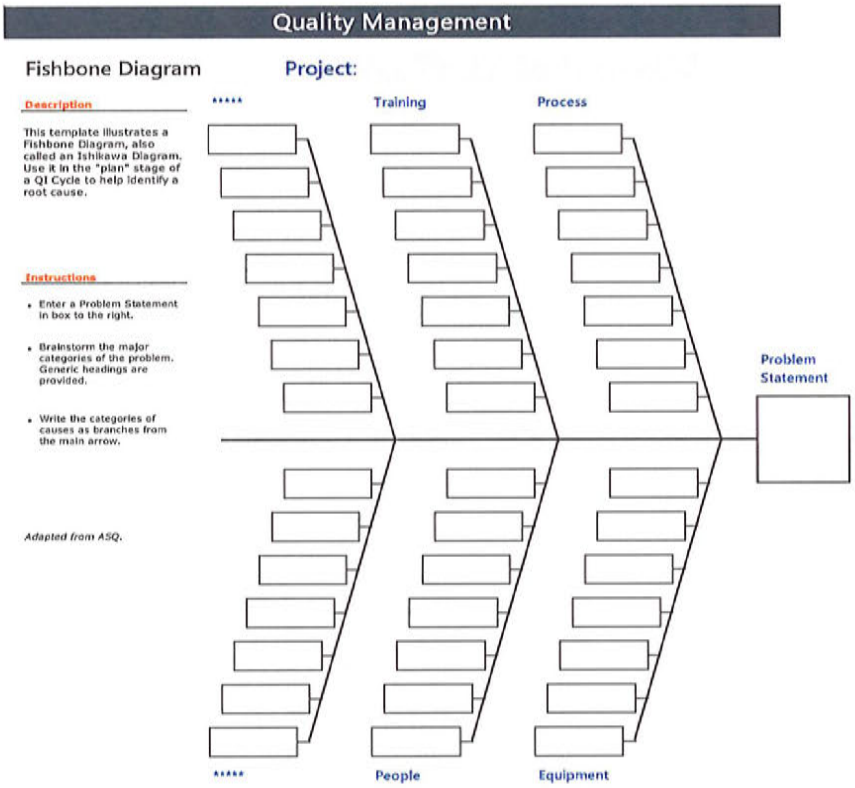

The 5 Whys
Define the Problem
Why is it happening?
Why is that?
Why is that?
Why is that?
Why is that?
Root Cause


5 Whys Template
Define the Problem
Describe just the problem not its causes
Why?
Describe why the problem happened
Countermeasure
How will you fix this?
Responsible
Who is responsible?
Why?
Countermeasure
Responsible
Why?
Countermeasure
Responsible
Why?
Countermeasure
Responsible
Why?
Countermeasure
Responsible



The Fishbone diagram can be used during the planning stage to help identify a root cause. Below is a sample of how it is used followed by a template:



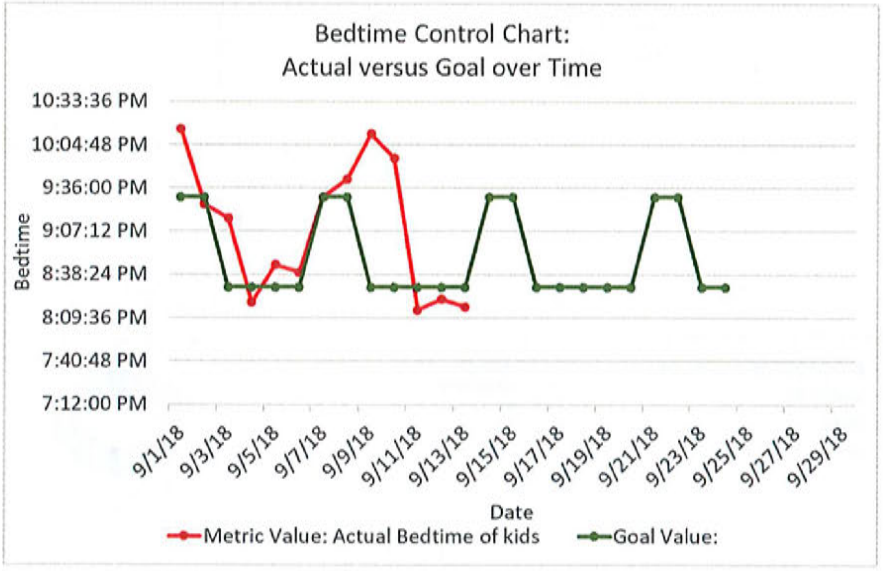


The CQI Events Log can be used to track what you have done and the overall duration of each PDSA cycle as well as the project duration:

CQI Events Log

Description	When?	What did we do?	Who was there?	What was decided/output?	What happens next?
This template is to help you track what you've done, as well as the duration of each PDSA cycle and the total project duration.	9/10/2018	Initial meeting to discuss problem	Tanya B., Sara B., Melissa Z.	Drafted problem statement, identified team	Complete project charter
Instructions					
• Fill in the table. Just the basics, keep it to a sentence or a few					
• Add more rows as needed. This is helpful for keeping track of what's happened. Could also use Asana for action item tracking in conjunction with this tool.					

The following are examples of Tools that may be used during the Measure and Study phase of PDSA. This is the phase where pre and post comparison of predetermined measurable outcomes are reviewed to determine the impact of the change, whether it affected what was expected to be affected:



Control Chart

Key Performance Metric: <Enter brief description of metric here.>

Description

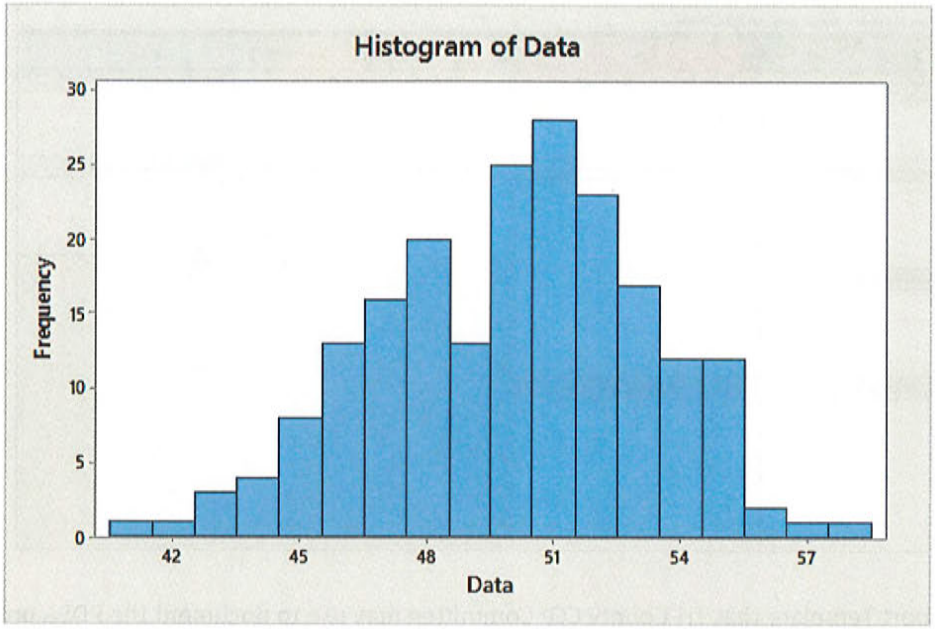
This template is to help you track performance on a key performance metric over time to see trends and the impact of interventions.

Instructions

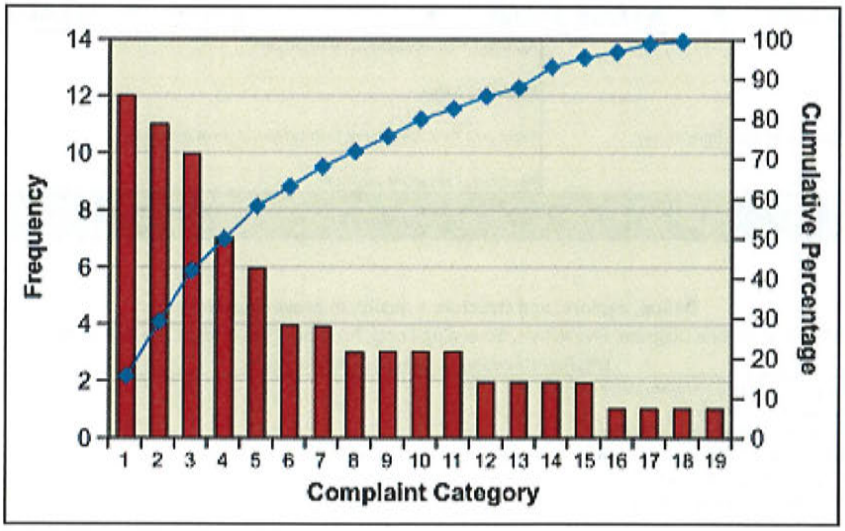
- Enter a brief description of the key performance metric at the top.
- Add goal values for each day - can be the same or different.
- Add actual values as you go, and track over time. Note when interventions implemented and the result. Take action when out of range.

Date	Metric Value: Actual Bedtime of kids	Goal Value:	Intervention?
9/1/2018	10:15 PM	9:30 PM	Yelling
9/2/2018	9:25 PM	9:30 PM	Begging
9/3/2018	9:16 PM	8:30 PM	Pleading
9/4/2018	8:20 PM	8:30 PM	Bribing
9/5/2018	8:45 PM	8:30 PM	Reminding
9/6/2018	8:40 PM	8:30 PM	Nagging
9/7/2018	9:30 PM	9:30 PM	Game
9/8/2018	9:42 PM	9:30 PM	Game
9/9/2018	10:12 PM	8:30 PM	[Movie Night]
9/10/2018	9:56 PM	8:30 PM	Nothing
9/11/2018	8:15 PM	8:30 PM	Bedtime Bonus Day 1
9/12/2018	8:22 PM	8:30 PM	Bedtime Bonus Day 2
9/13/2018	8:17 PM	8:30 PM	Bedtime Bonus Day 3
9/14/2018		9:30 PM	Bedtime Bonus Day 4
9/15/2018		9:30 PM	Bedtime Bonus Day 5
9/16/2018		8:30 PM	
9/17/2018		8:30 PM	
9/18/2018		8:30 PM	
9/19/2018		8:30 PM	
9/20/2018		8:30 PM	
9/21/2018		9:30 PM	
9/22/2018		9:30 PM	
9/23/2018		8:30 PM	
9/24/2018		8:30 PM	
9/25/2018			
9/26/2018			
9/27/2018			
9/28/2018			
9/29/2018			
9/30/2018			

Commonly used to present Quality Improvement Data, histograms work best with small amounts of data that vary considerably so that the information can be used to identify which portions of the data did not meet specifications. This can be helpful when multiple PDSA cycles are conducted on a quality improvement project and you are trying to identify the most effective changes:



A Pareto chart can be helpful in identifying the most important among a large set of factors. For example, it may be helpful in identifying the most frequent reasons for customer complaints:



A storyboard for each successful CQI project will be completed by the CQI Committee as a means of sharing information about successful CQI Projects and to facilitate replication in other areas:

Quality Improvement Project Storyboard

Project Title: Improving the QI Project Process
Team Members: Tanya, Sara, Melissa, Diane,...

PLAN	DO	STUDY	ACT
What was the issue/problem?	What we did to address the problem.	What results did we find?	Did our change solve the problem?
This is my problem statement.	Explain the intervention. How did we change the process?		
What was our objective?	Challenges we encountered	Did we need additional QI Cycles?	Lessons Learned and Future Steps
0			
Our measurements for success		Insert graphs or visuals here.	
0			
QI Tools Used	Material Results		

Below is CQI Report Template that Tri-County CQI Committee may use to document the PDSA process:

Tri-County Behavioral Healthcare

EXAMPLE CQI PROJECT PLAN

STAGE 1: PLAN • STAGE 2: DO • STAGE 3: STUDY • STAGE 4: ACT

Project Title:	Agency: Tri-County Behavioral Healthcare
Project Start Date:	Reporter's Name:
Project End (or expected end) Date (mm/dd/yy):	Reporter's Title: Director of Quality Management & Support
County or Facility:	Reporter's Contact Information:

STAGE 1: PLAN

Define, explore, and structure a quality improvement project.

HELPFUL TOOLS: Fishbone Diagram, Five Why's, Screening Tools, Program Evaluation, Data Collection, Customer and Employee Feedback, previous PDSA results.

1. What problem are you trying to fix (Problem Statement)?
2. What is the root cause of the problem?
3. What evidence (current data) supports you problem?
4. What change do you want to see in the process or problem to correct (Global Aim statement)?
5. What are you trying to acheive (specific aim)?
6. Define a timeline for the following project stages:
   - Plan:
   - Do:
   - Study:
   - Act:
7. Select the affected population(s) check all that apply: __Individual Served __Employee/Agency __General Public __Other
8. Select the areas where this project aims to impact the goals and stratigic priorities of Tri-County:

Impact Area	Program	Tri-County
Access to Care		
Care Coordination		
Communication and Education		
Complainace		
Customer Satisfaction		
Employee Communication and Collaboration		
Employee Engagement/Satisfaction		
Employee Productivity		
External Stakeholders		
Facilities		
Financial		
Health Outcomes/Behaviors		
Information Technology		
Public Perception		
Use of Resources		
Other		
Other		
Other		
Other		
9. Do you have resources to fix the issue?		
10. What resources (new and existing) will you requrie and how will you		
11. Does the project aim align with the Program's Goals?		
12. Does the project aim align with Tri-County's strategic Goals?		

CQI Committee Members by Name	Role/Title
Tanya Bryant	Director of Quality Management & Support

14. Incorporating the information gathered throughout the planning process, describe the action plan:
15: Begin constructing a CQI Storyboard. Date Started:

STAGE 2: Do

Define, explore, and structure a quality improvement project.

HELPFUL TOOLS: Benchmarking, Change Implementation, Communication, Data Collection, Pilot Testing, PDSA, Process mapping, Program Assessment, Program Evaluation, Sampling, Customer Feedback, etc.

16. Who will implement the Change?
17. How and to whom do you plan to implement the change and how will this be communicated?
18. Will you cinduct a pilot sutdy prior to full-scale implementation?
19. How will you track and measure change (describe data measurment systems)?
20. How will you spread and maintain the new process/change?
21. Incorporating the information gathered throughout the implmentation process, describe the implementation plan:

STAGE 3: STUDY

Define, explore, and structure a quality improvement project.

HELPFUL TOOLS: Benchmarking, Data Collection, Measurement Analysis, Measurement Tools, PDSA, Process Mapping, Program Evaluation, Sampling, Control charts, etc.

22. How will you monitor progress and how often?
23. Define how you will check and verify accuracy of the results:
24. Who will be responsible for maintaining the change?
25. How often will you review the process for needed improvements?
26. How will you address any new areas for improvement?
27. Incorporating the information gathered throughout the evaluation process, describe the evaluation plan:

STAGE 4: ACT
Finalize the documentation of the quality improvement project and plan for future projects. HELPFUL TOOLS: Communication, Culture of Quality, PDSA, etc.
28. Share the status and results of the project with team members/leadership/stakeholders. Date Completed (mm/dd/yy): 29. Discuss the future of this project/change (i.e. future projects, varying approaches etc.): 30. Update the organizational policies and procedures to reflect change(s). Date Completed (mm/dd/yy): 31. Finalize the CQI Storyboard submit and share. Date submitted: (mm/dd/yy): 32. Below, outline the steps taken in each of the PDSA stages that were taken to complete the CQI Project (use this as your place to document detail that was not captured above to finalize the report:
Background
Specific AIM:
Stage 1: Plan
Stage 2: Do
Stage 3: Study
Stage 4: Act
CQI Storyboard