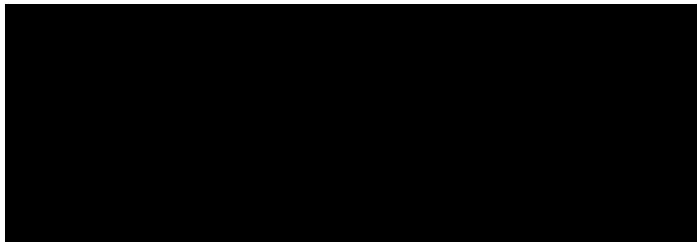




Tri-County Behavioral Healthcare

**Intellectual and Developmental Disabilities (IDD)  
Quality and Utilization Management Plan  
For Fiscal Years 2026-2027**



**Evan Roberson, Executive Director**

8/29/2025  
Date

# **Tri-County Behavioral Healthcare IDD Quality and Utilization Management Plan**

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## INTRODUCTION

### Quality and Utilization Management (QM/UM) Overview

Tri-County Behavioral Healthcare operates a QM/UM program guided under the general principle that quality improvement is ongoing, and continuous evaluation and adjustments are needed in order to ensure continued quality care and compliance with established regulations.

The QM/UM Program includes an organizational structure with defined and ongoing activities implemented system-wide and described throughout this plan. The QM/UM Departments work closely with program managers and direct care staff to ensure the provision of quality services with continuous quality improvement efforts to ensure compliance with rule and contract requirements. Through utilization of quality management best practice, including continuous measurement, assessment, and analysis, Tri-County is able to focus on improving local authority services and functions while ensuring proper management of resources.

Tri-County uses information and data from a number of sources to ensure that our stakeholders receive the highest possible quality of service in compliance with contract expectations. Accurate, consistent and timely information to oversight entities is provided as required or requested.

### IDD Quality and Utilization Management Plan

#### **Purpose:**

The Intellectual and Developmental Disabilities (IDD) Quality and Utilization Management (QM/UM) Plan provides a framework of activities designed to ensure that individuals receive quality services provided by culturally competent and adequately trained staff in a manner that is financially responsible, person-directed and provided within an organized program structure developed to support ongoing improvement efforts.

The IDD QM/UM Plan is developed using input from the following:

- Individuals served and their family members/significantly involved persons;
- Texas Health and Human Services Commission (HHSC) (i.e. through Performance Contract, audits, program manuals);
- Tri-County Board of Trustees;
- Tri-County Committees and Staff;
- Center and State Plans (i.e. Strategic Plans, Local Provider Network Development Plan, Needs Assessment);
- East Texas Behavioral Healthcare Network (ETBHN);
- Intellectual and Developmental Disabilities Planning Network Advisory Committee

- (IDD PNAC);
- Regional Planning Network Advisory Committee (RPNAC);
- Guiding rules and regulations (i.e. Texas Administrative Code (TAC); Texas Health and Safety Code (THSC); Federal and State law);
- Other stakeholders.

### **Scope:**

This plan applies to all intellectual and developmental disability services and supports provided by Tri-County staff and outlines expectations of employees and contractors to include monitoring expectations.

### Quality Defined

For the purposes of this plan, ‘Quality’ is defined as the consistent delivery of person-directed and coordinated services that promote the health, safety, rights, and self-determined goals of individuals with intellectual and developmental disabilities, resulting in improvements in their well-being, inclusion, and quality of life while maintaining rule and contract expectations.

### Mission, Vision, and Philosophy Statement

#### **Mission:**

The mission of the Quality and Utilization Management (QM/UM) Program is to ensure the provision of quality services for individuals with mental illness, substance use disorders and intellectual/developmental disabilities that are linguistically and culturally appropriate, person and family directed, 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, and trauma informed staff.

#### **Vision:**

The vision of the QM/UM Program at Tri-County 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-directed 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 coordination of care for those we serve;
- Uphold the rights of individuals served; and
- Continuously monitor, adjust and track data that can be used for continuous quality improvement efforts as well as to meet reporting requirements.

### **Philosophy Statement:**

The QM/UM Program is based on the premise that the provision of quality services at Tri-County is the responsibility of all staff and that participation in quality activities facilitates improved outcomes for those we serve as well as enhancing job performance and satisfaction of staff. Continuous monitoring, feedback and training are believed to be key to ensuring the availability of competent, trauma informed staff, and that quality services are most effective when provided in the most appropriate setting and include culturally and linguistically appropriate services. Dignity and respect are key values of the QM/UM Program as it is understood that individuals thrive in environments where they feel safe. It is believed that when an individual feels empowered, the likelihood of meeting their person-directed goals increases. Person-directed care, that takes into consideration the strengths and 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:**

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

### **Goals of the QM/UM Program**

- To implement ongoing quality improvement activities that monitor, evaluate, analyze and improve:
  - Quality care
  - Rule Compliance
  - Access
  - Service delivery
  - Efficiency
  - Resource management
  - Risk Management
- To ensure the provision of high quality, person-directed care;
- To promote collaboration with community partners, including the local SSLC when appropriate, to maximize resources;
- To develop a strong and stable workforce through both scheduled and needs based

training, aimed at retaining a competent and confident workforce;

- To educate stakeholders, as appropriate, on the Local Intellectual and Developmental Disability Authority (LIDDA) role, responsibilities, limitations and provide accurate information on available resources;
- To advocate for rights, health and safety of all individuals served.

### **Measures of Success:**

- ✓ The Quality and Utilization Management (IDD QUM) Committee will review quality, utilization, and risk management activities and reports at least quarterly that outline monitoring, evaluation and improvement efforts. Corrective actions will be implemented for identified systemic or health and safety issues and those scoring under 90% of the established target, where applicable. Compliance will be expected within 60 days for routine items and immediately, or as approved by the Executive Director, for any health and safety concerns.
- ✓ Stakeholder satisfaction will be assessed throughout the year through review of 100% of complaints. Review of quality management satisfaction initiatives and information gathered will be combined, biannually, with local planning feedback obtained through stakeholders such as the Planning and Network Advisory Committee (PNAC), providers, and community partners to include the local State Supported Living Center (SSLC).
- ✓ On a semi-annual basis, Quality Management staff will obtain a list of new hires over the past six months and will randomly sample 10% of the list for review. The reviewer will ensure all checklists and certificates are appropriately located in the learning management system (LMS) per procedure. Corrective actions will be made within 30 days, unless required sooner, and recommendations will be made to the Director of Quality Management & Support related to quality improvement of staff development.
- ✓ The Rights Protection Officer (RPO) will follow up on 100% of inquiries and allegations of abuse, neglect, exploitation or rights violations and provide quarterly reports to the IDD QUM Committee for review and recommendation. The RPO will advocate for individuals served and educate stakeholders at each appropriate opportunity.
- ✓ The Risk Manager will investigate 100% of the health and safety concerns and provide timely information and reporting to appropriate staff as outlined in procedure. Trends and concerns will be reported quarterly to the IDD QUM and Safety Committees.
- ✓ As a part of Tri-County's ongoing quality assurance activities, the Administrator of Quality Management will review 100% of all monthly quality assurance tools biannually to ensure reviews remain in compliance with the most current rules and guidelines. Programs will be selected for Internal Program Survey audits as trends are identified through ongoing quality assurance activities.
- ✓ The Administrator of Utilization Management, in coordination with the Administrator of Quality Management and IDD Authority Administrators, will ensure that contract targets and Performance Measures are met as outlined below. Data measures will be reviewed during IDD Quality and Utilization Management Meetings and for more qualitative service measures (i.e. service timelines), monthly quality assurance tools will be updated to reflect

the new monitoring targets and ensure ongoing evaluation and improvement as needed:

<b>No.</b>	<b>Performance Measure</b>	<b>Outcome Target</b>
1	Percent of all enrollments into HCS completed within 90 calendar days from the date of HHSC's slot notification for a person.	At least 95% for each quarter
2	Percent of all enrollments into TxHmL completed within 90 calendar days from the date of HHSC's slot notification for a person.	At least 95% for each quarter
3	Percent of all CFC ID/RC assessments completed and submitted to the appropriate HHSC system within 90 calendar days of receiving a referral, or as otherwise agreed	At least 95% for each quarter
4	Percent of Permanency Plans completed within 20 calendar days after the first business day a person's name first appears as never been done on report HC021395.W Reviews Needed.	At least 95% for each quarter
5	Percent of Permanency Plan reviews completed within six months after the initial plan or previous review was completed.	At least 95% for each quarter
6	PASRR Evaluations (PEs) or resident reviews completed and entered into the Long-Term Care Online Portal (LTCOP) within seven calendar days after receiving a copy of the PASRR Level 1 (PL1) screening from the referring entity or notification from the LTCOP as required by TAC.	At least 95% each quarter
7	Percent of compliance with assigning a habilitation coordinator to an eligible individual within two business days after the PE is entered in the LTCOP as described in Section 4200 of the IDD PASRR Handbook (Assignment of Habilitation Coordinator).	At least 95% for each quarter
8	Percent of HCS and TxHmL interest lists population contacted for biennial review as described in Section 7500 of the LIDDA Handbook (Biennial Contact).	At least 50% by the end of State Fiscal Year (FY) 26; 100% by the end of FY 27 At least 50% by the end of FY 28; 100% by the end of FY 29
9	Quarterly IDD Community Service Target	106
10	Percent of compliance adhering to the deliverable dates described in A-7: IDD Submission Calendar.	At least 95% for each quarter

11	Percent of compliance with conducting Community Living Options (CLO) during the PE and at least every six months thereafter as required by 26 Tex. Admin. Code §303.601(c)(1)(B)(i).	At least 95% for each quarter
12	The Contracted LIDDA, as specified in Section 10000, Definitions, of the LIDDA Handbook, will provide community living options information to all individuals living in the assigned SSLC or their LAR, or both, a minimum of one time per year.	95%
13	The Contracted LIDDA will complete the Community Living Option Information Process (CLOIP) instrument and provide a written report to the SSLC and Designated LIDDA, as specified in Section 10000 of the LIDDA Handbook, no later than 14 calendar days prior to the individual's SSLC annual planning meeting.	95%
14	Percent of all SSLC Transition Reporting completed for individuals on community placement status following discharge from an SSLC. See Section 9000 of the LIDDA Handbook.	At least 95% for each quarter
15	Percent compliance with conducting in-person SSLC transition monitoring visits once every 90 days as described in Section 9000 of the LIDDA Handbook.	At least 95% for each quarter

In addition to the goals above, other Quality and Utilization responsibilities of Tri-County to ensure best quality include:

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

## SYSTEM-WIDE QUALITY MANAGEMENT STRUCTURE

Tri-County is dedicated to promoting a team approach to serving individuals with mental illness, substance use disorders, and IDD and understands the importance of open and accurate communication between levels of management, quality related committees and staff. While Tri-County's philosophy includes shared responsibility for quality, the structures outlined in this section are intended to support ongoing monitoring, evaluation and improvement system-wide.

### Leadership

The Tri-County Board of Trustees is responsible for ensuring the effective administration of Tri-County to include the review and approval of a biannual Quality Management Plan for Mental Health, Intellectual/Developmental Disabilities and other funded programs. The overall management and authority for implementation of programs, including the Quality Management program, is delegated to the Executive Director who is responsible for performance and administrative functions which assure that services are available, accessible and acceptable to the citizens served by Tri-County. Coordination and oversight for the development and implementation of the Quality Management Plan at Tri-County has been delegated to the Director of Quality Management and Support. 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 Medical Operations, Director of Quality Management and Support, Director of Management Information Systems, Director of IDD Authority Services, Director of IDD Provider Services, Director of Adult Behavioral Health, Director of Child and Youth Behavioral Health, and the Director of Crisis Access. The Executive Director may appoint additional expanded Management Team members to ensure informed decision making and ongoing quality care. Management Team Members serve as liaisons to all agency committees to ensure effective communication and follow up at the appropriate organizational levels.

The responsibility of quality, including implementation of practices, procedures, monitoring and corrective action are considered the responsibility of all levels of staff in the organization (i.e. directors, managers, supervisors, direct care providers and apply to both employees and contractors) and quality activities are incorporated into agency committees, contracts, and job descriptions to ensure system-wide structure to support the quality management program. While all staff hold some level of responsibility for quality at Tri-County there are a select number of positions, in addition to the leadership structure outlined above, that work closely with one another to carry out the QM/UM Plan. These roles and responsibilities include, but are not limited to:

### **The Administrator of Quality Management**

- Co-Chairs the IDD Quality and Utilization Management (QUM), Junior Utilization Management (JUM), and Continuous Quality Improvement (CQI) Committees and provides the Management Team liaison with reports to ensure oversight and follow up of QM/UM activities;

- Serves as a liaison to the IDD and Regional Planning Network Advisory Committees (PNACs);
- Serves as a member of the Safety Committee;
- Coordinates activities and information between the Quality Management, Utilization Management, Compliance, Training and provider programs as needed;
- Works closely with other QM and agency staff to carry out recommendations from the Corporate Compliance Committee;
- Works closely with Utilization, Risk Management and IDD program managers to measure, analyze, and improve service capacity and access to services;
- Conducts and guides quality management staff through ongoing quality assurance activities outlined in this plan;
- Monitors outcomes and ensures corrective actions following internal and external reviews;
- Develops and ensures stakeholder surveys are distributed as a part of Local Provider Network Development (LPND) Planning or as needed for monitoring, evaluation and improvement;
- Monitors the Performance Contract for compliance.

#### **The Administrator of Utilization Management**

- Co-Chairs the IDD QUM and JUM Committees and serves as a member of the Regional Utilization Management Committee;
- Serves as a member of the CQI Committee;
- Monitors and tracks performance targets and outcomes of the LIDDA;
- Works closely with other Center QM/UM staff, as needed, to ensure proper implementation of the Utilization Management Plan including, but not limited to, quality, cost effective, timely, and appropriate service provisions;
- Monitors the Performance Contract, Utilization Management Guidelines, and other applicable standards for compliance.

#### **The Rights Protection Officer (RPO)**

- Protects the rights of individuals served through monitoring, review, investigation and advocacy;
- Communicates concerns to the Management Team Liaison;
- Receives and follows up on complaints until there is a resolution;
- Monitors rights and abuse data for trends and communicates this information to designated agency committees and Management Team;
- Ensures accurate complaint and rights data is reported to HHSC upon request;
- Participates in appropriate consultation and rights review as needed related to any restrictions or interventions.

## **The Risk Manager**

- Chairs the Center Safety Committee and consults with medical, quality and rights protection staff as needed to include, but not limited to, infection control;
- Co-Chairs the Center Corporate Compliance Committee;
- Monitors safety and health data for trends and provides information to the appropriate committees and Management Team representatives as needed;
- Assists the Compliance Department conduct investigations and reports quality concerns back to the Quality Management Department;
- Ensures critical incident data for IDD services is reported accurately and in a timely manner to HHSC.

## **Committees**

In addition to the ongoing quality management activities listed in this plan, Tri-County has an established committee structure that supports these activities and allows for both expert analysis and system-wide collaboration and communication as needed to carry out the IDD QM Plan. The following is an outline of the committees established at Tri-County that support the framework described in this plan:

### **The IDD Quality and Utilization Management (IDD QUM) Committee**

The IDD QUM Committee is responsible for monitoring, evaluating, and guiding the delivery of safe, effective, and person-directed services while ensuring compliance with regulatory requirements and promoting continuous improvement in care quality and outcomes. The Administrator of Quality Management and the Administrator of Utilization Management chair the QUM Committee with the Director of Quality Management & Support, as a member of the Tri-County Management Team, serving as a liaison to the Management team and executive leadership.

### **Membership:**

Member representation is selected to ensure individuals in attendance have the ability to make needed changes and communicate effectively with all relevant staff across organizational levels and include:

- Quality Management Staff
  - The Administrator of Quality Management
  - The Administrator of Utilization Management
  - The Director of Quality Management and Support
- IDD Local Authority Staff
  - The Director of IDD Authority Services
  - The Administrator of IDD Intake Services
  - The Administrator of IDD Non-Waiver Services
  - The Administrator of IDD Waiver Services
  - The Administrator of PASRR & ECC-DC Services
- IDD Provider Staff

- The Director of IDD Provider Services
- Risk Management Staff
  - The Administrator of Compliance
- Other
  - Staff are invited based on subject matter expertise as needed

**Responsibilities:**

- Meets quarterly or as needed to conduct its business;
- Reviews performance data - findings of internal or external audits, clinical outcomes, data related to complaints, risk, health and safety, client satisfaction or other data - to ensure quality care and compliance with applicable rules, regulations and contracts;
- Monitors, evaluates and provides recommendations for improvement of contract performance indicators;
- Reviews and responds to recommendations from other Committees related to quality (i.e. the local or regional Planning Network Advisory Committee (PNAC), the Continuous Quality Improvement Committee, the Safety Committee);
- Reviews Utilization Management data (i.e. reports regarding appeals, eligibility utilization and provision of services);
- Proposes consideration of a variety of strategies that may lead to better use of available resources and possible ways of increasing resources;
- Reviews and provides feedback for relevant CQI goals and activities at the Center - additional information on the Center’s CQI Committee and Plan can be found in the Tri-County Mental Health Quality and Utilization Management Plan;
- Ensures corrective actions are implemented when problems are found;
- Makes recommendations to managers and leadership, as necessary, regarding changes needed to current procedures, processes, service delivery or data collection to ensure:
  - Timely and efficient service provision that adheres to performance expectations and produces quality outcomes;
  - Contract compliance through efficient and effective strategies;
  - Corrective actions for administrative and service delivery systems as needed;
- Ensures communication of corrective actions and other recommendations to appropriate staff. The Committee’s Management Team member will be responsible for presenting the committee recommendations to the Management Team for review and approval as needed.

**The Continuous Quality Improvement Committee (CQI)**

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 & Support and the Administrator of Quality Management serve as the Committee chairs with consultation and direction provided by the Executive Management Team (i.e. the Medical Director is consulted for any medical components).

## **Membership:**

- Quality Management Staff
  - The Administrator of Quality Management
  - The Administrator of Utilization Management
  - The Director of Quality Management and Support
- Program Provider Staff
  - The Chief Operating Officer
  - The Director of IDD Authority Services
  - The Director of IDD Provider Services
  - The Director of Adult Behavioral Health
  - The Director of Child and Youth Behavioral Health
  - The Director of Crisis Access
- Compliance Staff
  - The Administrator of Compliance
- Information Technology Staff
  - The Director of Management Information Systems
- Other individuals, such as financial representatives, are invited on an ‘as needed’ or ‘project specific’ basis

## **Responsibilities:**

- 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 based on priority 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;
- 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 Safety Committee**

The Safety Committee is responsible for protecting the health, safety and well-being of clients, staff and visitors by identifying, assessing, and reducing risks in the environment and throughout service delivery. Through the monitoring of safety practices to include but not limited to:

- Surveillance, prevention, and control of infection control measures;
- Investigating incidents, addressing hazards, and ensuring regulatory compliance, the Committee works to foster a culture of safety across all levels of the organization. The Administrator of Compliance serves as the Center’s Risk Manager and chairs Tri-County’s

Safety Committee as the Safety Officer. The Risk Manager is responsible for communicating trends and recommendations to the Management Team Liaison for review and decision making.

### **Membership:**

- Risk Management Staff
  - The Administrator of Compliance
  - Chief Compliance Officer
- Quality Management Staff
  - The Administrator of Quality Management
- Service Delivery Staff
  - Coordinator of Provider Services
  - Administrator of Crisis Services
- Administrative Staff
  - The Director of Medical Operations
  - Senior Human Resource Specialist
  - Conroe Facility Coordinator
  - Maintenance and Service Manager

### **Responsibilities:**

- Meets quarterly or as needed to conduct its business;
- Reviews risk data from a variety of sources to identify situations that pose a risk to individuals served, the community, employees, and/or the Center;
- Creates, implements, and maintains a system of tracking, reporting, and evaluating safety plans at Tri-County;
- Review of surveillance, prevention, and control of infection trends and control measures;
- Recommends corrective actions to properly address trends or other risk.

A member of the Quality Management Department serves on the Committee and regular reports are provided to the Quality Management Committee (QUM). Additionally, the Chief Compliance Officer serves as the Management Team liaison for the Safety Committee and ensures communication of key recommendations and concerns to the Executive Management Team.

### **The Risk Management Team**

The comprehensive Risk Management Team is established in order to oversee the identification, evaluation and mitigation of organizational risks and to ensure proactive measures are put into place to include compliance with legal and regulatory requirements through a culture of safety, accountability and continuous improvement.

### **Membership:**

Executive management staff serve as permanent members of this team, with additional staff servicing an as-needed basis.

### **Responsibilities:**

- Meets as often as necessary to conduct its business;
- Develops, implements, supports, monitors, and evaluates the comprehensive Risk Management Program to ensure proactive identification, assessment and reduction of risks that could negatively affect the organization, clients, staff, operations, or resources;
- Identifies and directs staff to carry out corrective actions and changes to procedures or practices as needed.

### **Consumer Rights Review Team (Human Right Committee)**

The Human Rights Committee has been established to ensure the rights of individuals receiving services are not restricted or limited without review by appropriate staff and the Rights Protection Officer (RPO).

The RPO for Tri-County chairs this committee and provides experience and expertise in the issues regarding human rights. The team review model is the chosen mechanism of Tri-County to ensure that the rights of individuals served are protected, but limitations and restrictions may only be approved by the RPO. The RPO may assemble the review team at any time in order to make an informed decision.

### **Membership:**

The RPO has discretion of appointing members and additional persons needed to complete each review. A minimum of three members are required and members must be knowledgeable of current behavioral management strategies and may or may not be affiliated with the local IDD Authority or provider.

### **Responsibilities:**

- Meets annually or as needed to conduct its business;
- Review Tri-County procedures related to consumer rights annually and recommend continuation, modification, or new development of procedures to ensure that the Center fulfills its responsibilities in this area;
- Review behavior management restrictions and/or intrusive interventions are included as a part of a behavior management program and either approve or make recommendations to protect the rights and ensure the safety and health of all individuals.

## **Junior Utilization Management Committee (JUM)**

The JUM Committee has been established to analyze factors that might be affecting Tri-County's ability to meet contract performance or quality service expectations. Through regular review and monitoring of service data, the committee evaluates the appropriateness, efficiency, and effectiveness of services provided to ensure quality service provision, compliance with regulatory requirements, procedures, and practices while identifying and implementing strategies leading to positive outcomes and quality improvement.

The Administrator of Utilization Management and the Administrator of Quality Management co-chair this committee with the Director of Quality Management and Support serving as the Management Team representative liaison to the executive team. The JUM Committee typically meets three times a month and provides reports to Center staff on key service data needing attention.

### **Membership:**

- Quality Management Staff
  - The Administrator of Utilization Management
  - The Administrator of Quality Management
  - The Director of Quality Management and Support
  - The Quality and Utilization Management Specialist
- Information Technology Staff
  - The Manager of Information Technology Services
- Additional Center staff, such as financial or other clinical or administrative representatives are brought into JUM meetings as needed
  - The Controller
  - The Director of IDD Authority Services
  - The Director of IDD Provider Services
  - The Director of Crisis Access
  - Others as needed

### **Responsibilities:**

- Reviews contract expectations and current performance on key indicators;
- Updates a document that is accessible to managers, that reflects agency performance on target measures;
- Communicates with managers of programs that are below contract expectations and assists with identification of strategies for quality improvement;
- Prepares or requests custom reports for problem areas so staff can be more knowledgeable about factors that are affecting contract compliance;
- Scrutinizes data that is submitted to determine possible data problems that might be affecting performance;
- Invites program managers to present concerns to the committee so that the JUM can assist with problem-solving activities.

## **Software Management Team (SMT)**

In the beginning of Fiscal Year 2024, Tri-County Behavioral Healthcare transitioned to a new electronic health record. Prior to, and following this transition, an implementation team was established in order to streamline the transition and ensure continuity of care for clinical staff and individuals served.

As a part of the continued development, utilization, and upkeep of our clinical software, Tri-County's implementation team continues to work with our long-standing Software Management Team. The team meets as needed to review software issues with the primary objective of ensuring the software meets the needs of our clinical staff and that our data meets both internal and external reporting requirements.

### **Membership:**

- Information Technology Staff
  - The Director of Management Information Systems
  - The Manager of Information Technology Services
  - The Clinical Applications Administrator
- Quality Management Staff
  - The Director of Quality Management and Support
- Financial Staff
  - The Billing Manager
- Other program and administrative staff are invited on an as needed basis

### **Responsibilities:**

- Ensure improvements to the software to reflect complete and accurate data;
- Ensure efficiencies and best clinical practices are incorporated whenever feasible;
- Make timely corrections to billing and data issues that arise from time to time and report those concerns to the appropriate department for follow up.

## **Grid Review Team (GRIT)**

Chaired by the Director of Quality Management and Support, the GRIT has been established in order to ensure the development of a master list of services (i.e. Service Code Master) that includes defined descriptions, billing and encounter codes, and associated charges. This document is made available to staff and is developed to ensure accurate, consistent, and compliant use of service codes and billing.

### **Membership:**

- Quality Management Staff
  - The Administrator of Quality Management

- The Administrator of Utilization Management
- The Director of Quality Management and Support
- Information Technology Staff
  - The Director of Management Information Systems
  - The Manager of Information Technology Services
- Financial Staff
  - The Controller
  - The Billing Manager
  - The Manager of Accounting
- Other Program Staff as needed

**Responsibilities:**

- Typically meets annually or as needed;
- 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 IDD service array to ensure compliance with the performance contract;
- Reviews service code definitions to ensure that they are in line with the service array, Performance Contract, Texas Administrative Code and other accreditation standards.

**Corporate Compliance Committee**

The Corporate Compliance Committee has been established to oversee the Tri-County’s compliance program and to promote and monitor adherence to laws, regulations, contractual obligations, ethical standards and procedures while fostering a culture of integrity, transparency, and accountability.

The Chief Compliance Officer and the Administrator of Compliance co-chair this committee with the Chief Compliance Officer serving as the Management Team liaison to the Executive Management Team. The Corporate Compliance Committee is scheduled to meet quarterly, but meetings may be scheduled more frequently, as determined by the existing needs of the program.

**Membership:**

- Compliance Staff
  - The Administrator of Compliance
  - The Chief Compliance Officer
- Quality Management Staff
  - The Director of Quality Management & Support
- Financial Staff
  - The Chief Financial Officer
  - The Billing Manager
- Program Staff
- Other staff as designated by the Chief Compliance Officer

## **Responsibilities:**

- Meets quarterly or as needed;
- Provides oversight to Tri-County's Corporate Compliance Program;
- Reviews findings of Corporate Compliance investigations;
- Reviews corporate compliance issues on both a systems and individual level to determine changes needed to comply with rules, laws and ensure adequate service, training and billing;
- Reviews results of external audits and makes recommendations for corrective actions (i.e. changes to policies and procedures, staff training);
- Directs quality improvement activities through communication, training, additional review of internal audits as needed;
- Coordinates information sharing and recommendations for the QUM Committee;
- Assures that staff are provided with education regarding corporate compliance issues at least quarterly;
- Evaluates the Service Code Master, completed by the Grid Review Team as needed;
- Review Corporate Compliance Programs of Tri-County's large contractors who do not wish to participate in the Tri-County Compliance Program;
- Review the Corporate Compliance Action Plan at least annually to determine if modifications or additions are needed;
- Report all Corporate Compliance allegations, findings, and dispositions (e.g. increased employee training, termination of employment, corrected billing/financial reports) to the Board of Trustees on at least a quarterly basis.

## **Intellectual and Developmental Disabilities Planning Network Advisory Committee (IDD PNAC)**

The purpose of the IDD PNAC is to provide a voice for individuals and/or family members of individuals with intellectual and developmental disabilities in the program planning, implementation and services provided by Tri-County. The Committee advises the Board of Trustees on planning, budget, and contract issues, as well as the needs and priorities for the service area. Members are appointed by the Board of Trustees and represent persons with IDD. The IDD PNAC is charged with providing input on local needs, best value, and local provider network development (local planning). The IDD PNAC is always given the opportunity to make recommendations to the Board either in-person or through the Director of Quality Management and Support and regular updates on Committee activities are provided to the Board of Trustees.

## **Membership:**

The IDD PNAC is composed of nine members, at least 51% of which are individuals served, or family members of persons with IDD. Staff from Tri-County serve as liaison members of the IDD PNAC to provide support and information, as necessary and appropriate, for the IDD PNAC to conduct its business. Liaison members have a voice but no vote at IDD PNAC meetings. One member of the IDD PNAC is asked to sit on the RPNAC for the East Texas Behavioral Healthcare Network. Tri-County makes reasonable efforts to replace IDD PNAC members within 3 months of their leave.

### **Responsibilities:**

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

### **Regional Planning Network Advisory Committee (RPNAC)**

Tri-County, as a member of the East Texas Behavioral Health Network (ETBHN), collaborates with member Centers for the provision of certain administrative support. RPNAC members, Management Team, and liaisons such as Quality Management staff work with other ETBHN Centers to meet established goals.

### **Membership:**

ETBHN formed the RPNAC to be made up of at least one (1) PNAC member from each ETBHN member Center. At least one of Tri-County's PNAC members and the Administrator of Quality Management attends the quarterly RPNAC meetings.

### **Responsibilities (Goals):**

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

## QUALITY MANAGEMENT ACTIVITIES

### Methods for Measuring, Assessing and Improving Authority Functions

In an attempt to ensure the provision of quality Authority functions, Tri-County continues to ensure that we are developing and managing a network that offers consumer choice to the highest extent possible. Tri-County contracts with outside providers when practical and requires contracted providers meet the same professional qualifications as providers employed by the Center. Tri-County benefits from best value analysis through ongoing participation with the East Texas Behavioral Health Network (ETBHN), and the IDD PNAC and RPNACs which assists the Center identify areas of needed change. In addition, Tri-County analyzes Cost Accounting Methodology data and other areas, as needed, to identify where improvements can be made.

Ongoing quality improvement efforts described throughout this plan are utilized to ensure methods for measuring, assessing, and improving Authority functions to include, but not limited to:

- Improvement initiatives are identified through internal and external review and incorporated into ongoing quality assurance activities;
- Quality assurance reviews of IDD documentation by Quality Management staff are reviewed at each IDD QUM Meeting;
- Monthly quality assurance of service documentation reviewed by IDD Program Managers are submitted to the Quality Management Department;
- Solicitation and use of feedback from stakeholders outlined in the ‘Client Satisfaction Survey’ section of this plan along with client complaint data and other information maintained by the Rights Protection Officer are reviewed and incorporated into various processes and Committees to ensure ongoing monitoring, assessment and improvement;
- Internal Program Surveys conducted by Quality Management to review trends or concerns in specific programs. These reviews provide a more comprehensive format focused on identifying and correcting areas of needed improvement (See ‘Ongoing Quality Activities’ section of this plan for a more detailed outline of this process);
- Quality and Utilization Management Staff track performance measures and submissions to HHSC to ensure timely and accurate reporting that meets outcome expectations;
- Recommendations for procedure revisions are made as needed changes are identified through Quality Management reviews and initiatives;
- After action reviews are conducted by Executive Leadership Team following local disasters to review and revise Disaster Response and Continuity Plans as needed.

### Methods for Measuring, Assessing and Improving LIDDA services

The Quality and Utilization Management Departments at Tri-County participate in a number of methods to measure, assess, and improve LIDDA Services. Each month, quality management staff conduct reviews of documentation of services in the clinical record. Findings are reviewed with both the program manager and in each IDD QUM meeting to ensure follow up, corrective action, and improvement. Additionally, should any ongoing issues present, Quality Management staff have an ongoing monthly quality assurance process that uses approved tools for continuous

monitoring, assessment, and improvement. When issues are found, these tools are updated to reflect the item of non-compliance. Monthly quality assurance is submitted by program managers to the Quality Management Department and random samples are reviewed intermittently for interrater reliability. Should trends continue or concerns present, related to the overall performance of a service or program, the Administrator of Quality Management may select to conduct a more in-depth Program Survey of the identified program (see additional information on the Program Survey process in the ‘Other Quality Related Activities’ Section later in this plan).

### Methods for Measuring, Assessing and Improving Access to Services and Service Capacity

Tri-County continuously looks at ways to improve access to and capacity for services. Through established committee structures and the use of data available to Tri-County, through local and state systems for analysis, staff regularly monitor service access and issues that may be impacting capacity for possible quality improvement initiatives. In 2025, the IDD Department, as a part of a Strategic Board Goal aimed at ensuring a more efficient, streamlined, and client-centered experience, improved timely access to IDD services. By June of 2025, IDD Authority successfully eliminated the intake backlog and significantly streamlined the intake process, noting a 14% reduction in clients waiting for a Determination of Intellectual Disability (DID) and 97% decrease in clients waiting to be assigned an IDD Case Manager. As a part of the assessment and improvement process, staff collected 73 satisfaction surveys, which demonstrated high levels of satisfaction with the changes made to the intake process, including satisfaction with wait times, scheduling flexibility, person-centered focus, and the overall process and provided insight into ongoing quality improvement needs.

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

### Methods for Measuring, Assessing and Reducing Critical Incidents of Individual Abuse, Neglect, and exploitation and improving the individual rights protection process

#### **Plan for reducing confirmed instances of abuse and neglect**

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

Tri-County continues its efforts to safeguard the well-being of the individuals they serve. The 1-

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

### **Rights, Abuse/Neglect, Safety, and Health Data**

Rights related issues, as well as abuse and neglect information, is tracked, reviewed, and reported on a regular basis through the Rights Protection Officer. Tri-County safeguards the health and safety of individuals served, families, and staff through the ongoing monitoring and reporting of critical incidents including:

- Medication errors;
- Serious physical injury;
- Behavior intervention plan that authorizes restraint;
- An emergency personal restraint;
- An emergency mechanical restraint; or
- An emergency psychoactive medication restraint.

Additional areas monitored and assessed for needed reporting or quality improvement include: infection control events, maintenance, and safety reports (risk data). For a deficiency identified by HHSC related to individuals' critical health, safety, rights, or abuse, neglect, and exploitation, Tri-County will immediately correct the deficiency and within five business days after receipt of a request from HHSC, develop a Corrective Action Plan (CAP) that adequately addresses the correction of the deficiency that includes a description of local oversight activities to monitor and maintain the correction of the identified problem, and submit, in accordance with the IDD Submission Calendar, to HHSC for approval.

Within 30 calendar days after receipt of a request from HHSC, Tri-County will develop a CAP that adequately addresses the correction of a deficiency other than one related to critical health, safety, rights, or abuse, neglect and exploitation that was identified by HHSC during oversight activities and that includes a description of local oversight activities to monitor and maintain the improvement of the identified problem, and submit, in accordance with the IDD Submission Calendar, to HHSC for approval.

The IDD QUM Committee reviews the risk data quarterly, looking for trends in all aspects of the data. If trends are found, improvement plans are requested from the appropriate program and any ongoing issues are shared with the Continuous Quality Improvement Committee for evaluation of future goals or activities. The Safety Committee reviews those incidents involving

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

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

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

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

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

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

#### [Methods for Assessing and improving the Process for reviewing Rights Restrictions](#)

As outlined previously in this plan, The Human Rights Committee (HRC) has been established to ensure the rights of individuals receiving services are not restricted or limited without review by appropriate staff and the Rights Protection Officer (RPO). While the Rights Protection Officer is solely responsible for approval or denial of any limitation or restrictions, Tri-County has chosen to team model to ensure a more thorough assessment and evaluation of each case believing that it would lead to greater accountability and improvement. This Committee meets annually or as needed to conduct its business and reviews Tri-County procedures related to consumer rights on an annual basis and makes recommendations to continue, modify, or develop new procedures to ensure the Center fulfills its responsibilities in this area.

#### [Methods for Measuring, Assessing, and Improving the Accuracy of Data reported by the LIDDA](#)

Tri-County continuously works to improving the data that is used for measurement of our

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

- CARE reports are regularly monitored for performance (typically weekly) and target outcomes and data are reviewed at the QUM meetings for quality improvement purposes;
- The Billing Department regularly reviews billing information in the electronic health record for accuracy and to identify and correct any possible billing errors;
- The Billing Department reviews month end billing data and communicates with clinical staff as needed to ensure correction of billing errors;
- If trends or concerns arise, issues may be reviewed with Quality Management and additional reviews or training may be conducted for quality improvement purposes;
- Information Technology, Billing, and Quality Management staff are members of the Software Management Team and serve on the Quality and Utilization Management Committee and regularly review and discuss opportunities for quality improvement.

#### Other Quality Related Activities

In addition to the ongoing quality management activities listed in the above sections, Tri-County has established ongoing quality improvement activities that supports the goals outlined by this plan.

#### Monthly Quality Assurance Reviews

IDD Program Managers are required to participate in monthly quality assurance of service documentation. Tools are created in collaboration with the Quality Management Department and a sample of staff documentation are reviewed and submitted monthly to the Quality Management Department. Intermittent samples and independent reviews are then reviewed by Quality Management Staff and feedback is provided as issues are found and reviewed during regularly scheduled QUM meetings.

#### 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 IDD contract 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/consultation with program managers, 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 and feedback on the strengths, weaknesses, and recommendations for improvement are provided to the program administrator at the conclusion of the review.

Programs are selected for review based on trends and other quality assurance results indicating a need for a more in-depth review. Each documentation/chart review conducted by Quality Management Staff consider applicable evidence-based practices, least restrictive principles, adequacy of services provided, and quality of individual continuum of care (i.e. continuity of care). Documentation and chart review tools used in these audits are developed from a variety of sources, including but not limited to:

- HHSC Performance Contracts;
- Texas Administrative Code;
- Texas Health and Safety Code;
- State Manuals;
- Evidence-based practices; or
- Other applicable State, Federal or funding source guidelines.

The tools will continue to be changed as necessary to ensure accurate measurement, assessment and improvement using 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 IDD QUM Committee and the IDD PNAC also review key findings and make 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 a part of the Center's planning and self-assessment processes. 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 selected Program Surveys and are used to make reasonable changes and improvements to the program. In addition, the Administrator of Quality Management facilitates the distribution of additional satisfaction surveys, as needed, to further evaluate services.

## **Involving Stakeholders in the Quality Management Program**

Tri-County communicates with individuals served, family members of individuals served, internal and external service providers and other stakeholders on a regular and ongoing basis while complying with information sharing guidelines. Through services, meetings, collaborations with community partners, and other appropriate outreach and means of communication, Tri-County utilizes input to reduce barriers and improve quality. Tri-County participates and collaborates with many community organizations and groups to include, but not limited to:

- Community Resource Coordinating Groups (CRCGs)
- Independent School Districts
- Hospitals and SSLCs
- Law Enforcement Agencies
- Criminal Justice Programs
- United Way
- Coalition for the Homeless
- Office of Emergency Management and other disaster recovery organizations
- Advisory Committees
- Advocacy Agencies
- Planning Network Advisory Committees
- Child Fatality Review Teams (CFRTs)
- Behavioral Health and Suicide Prevention Taskforce
- Crisis Collaboratives
- Various other community partnerships

Participation in these groups enables Tri-County staff to network and collaborate with representatives from other area agencies. Tri-County continues efforts to engage individuals served, their families, providers, advocates, local officials, volunteers, staff, and the general public in planning initiatives. Information received through stakeholders is obtained through a variety of ways including but not limited to:

- Scheduled Planning meetings
- Surveys (i.e. local planning, HCS, self-assessment, ongoing quality focused)
- Outreach
- Feedback provided to Provider and Quality Management through face to face interactions, written communication or via the Tri-County website.

This information is utilized to ensure Tri-County identifies community values, service needs, and priorities for individuals with IDD in our communities. This feedback facilitates future planning that is meaningful and quality focused.

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

committee is to assist the program provider to perform the following activities:

- Evaluating and addressing the satisfaction of individuals served, or legally authorized representatives (LAR) of individuals served, with the program provider services;
- Soliciting, addressing, and reviewing complaints from individuals served or their LAR's about the operations of the program;
- Reviewing all allegations of abuse, neglect, and exploitation in order to ensure ongoing quality of care and prevention efforts as needed;
- Participating in a continuous quality improvement review of the program provider's operations and offering recommendations for improvement for actions by the program provider as necessary.

As mentioned in the previous section, Stakeholder feedback is solicited through satisfaction surveys completed as a part of Tri-County's directed planning efforts, required program standards (i.e. HCS) and ongoing self-assessment practices and results of satisfaction surveys are reviewed by Quality Management staff and shared with the QUM Committee and IDD PNAC to ensure that any problem areas have been resolved and that the perspectives of individuals served are considered as a part of quality improvement efforts.

### **Corporate Compliance:**

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

To ensure compliance with regulations, Tri-County's 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 training includes information on:
  - The Federal False Claims Act
  - The State Medicaid Fraud Prevention 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 the committee for review and approval;
- The 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.

### **Contract Monitoring:**

Through Tri-County's Community Based Services Agreement (CBS), Contractors are required to follow the same standards and requirements as the Center and are required to sign the Data Use Agreement and participate in the Corporate Compliance Program as a condition of participation. The CBS addresses requirements related to HHSC performance contract, TAC, and laws and regulations related to areas of risk such as reporting of ANE, critical incidents, rights and privacy. The CBS allows Tri-County to monitor, assess and recommend improvements for contractors through requests for information and audits as deemed necessary and sanctions may be applied should they be needed in line with regulations. In addition to the above, Tri-County seeks feedback from individuals served and families of individuals served through respite providers and collects post discharge satisfaction surveys from all individuals coming out of State funded local psychiatric hospitals contracted through Tri-County and these surveys are reviewed by the Quality Management Department for ongoing evaluation and needed improvements.

### **Staff Development:**

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

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

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

for persons with intellectual and developmental disabilities, mental illness and substance use disorders.

## ACCESSIBILITY OF THE IDD QM PLAN

This plan is accessible to all staff, contractors, stakeholders and oversight agencies. Once approved, the current IDD QM Plan is posted on the Tri-County website in an effort to ensure transparency with the public and oversight agencies.

## PLAN REVIEW AND CONTINUOUS IMPROVEMENT

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