



Anderson-Cherokee Community Enrichment Services

## **QUALITY MANAGEMENT PLAN**

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## Overview

ACCESS is dedicated to providing quality care for all consumers in a safe, clean, and wholesome environment. Through continuous assessment and improvement of systems and processes, ACCESS improves its services to consumers, stakeholders, and the community.

The performance improvement program provides an objective and systematic approach to the quality of services provided by ACCESS. Improvement activities are focused on process and outcome indicators intended to demonstrate increased access and choice while preserving or enhancing the quality of services and supports that are delivered in the most cost-effective and efficient manner. An integrated and collaborative approach increases the probability of desired consumer outcomes by assessing and improving governance, managerial, clinical, and support processes.

### ACCESS Mission, Vision, Core Values

The foundation of the ACCESS Quality Management Plan is the Center's Mission, Vision, and Core Values Statement, articulated by the Board. A task force consisting of consumers, family members, ACCESS employees and Board members formulated these overarching principles. The recommendations of the task force were subsequently adopted by the ACCESS Board of Trustees in 1999.

**Mission:** People can count on ACCESS

- to work hand in hand with those around us to assure a choice of effective, efficient programs and caregivers; and
- to offer excellent services that enhance quality of life.

**Vision:** ACCESS strives to promote holistic care and education that empowers resilience, wellness and positive outcomes with dignity and respect to individuals served, employees and our communities.

**Values:** Respect for the individual

Service to the customer

Respect for the dignity of risk

Pursuit of excellence in all that we say and do

Commitment to personal integrity in every facet of every relationship

## Mission of ACCESS Quality Management Program

The overall mission is to assure continuous performance improvement toward the delivery of quality care that is efficient, cost effective, and consistent with the mission of ACCESS. When issues in client care and service delivery can be anticipated, it is essential that quality improvement activities of a proactive nature occur. Quality improvement is integral to improving client outcomes and service delivery, and it is necessary that it be integrated in all programs at all levels. Problem identification is an important aspect of quality improvement, but its importance is based upon the effectiveness of the subsequent process of problem resolution. The ACCESS Quality Management Program promotes delivery of quality care through leadership involvement in assessment and improvement activities, in order to:

- **Provide an effective mechanism to design, measure, assess, and improve** the performance of the system.
- **Improve the quality of care** through service monitoring, resolution of problems, and ongoing pursuit of opportunities to improve care.
- **Implement a preventive approach** toward problems and risk factors, and to monitor actions taken to assure that desired results are achieved and sustained.
- **Promote communication** about performance improvement activities among all stakeholders.
- **Promote safety and to prevent liability** through systematic monitoring of the environment and center activities.

## **Governance and Leadership**

Ultimate responsibility for the processes designed to monitor the quality of care, outcomes, and important processes and functions performed by internal and external providers is retained by governance and leadership who ensure the Quality Management Program is implemented system-wide and that oversight of the Quality Management Program is provided by professionals with adequate and appropriate experience in quality management.

- The leadership of ACCESS serves as the locus of consumer and family input, quality management, and other data used for decision-making.
- Leaders serve as agents for change. They set expectations and priorities for systemic improvement activities designed to improve organizational and clinical outcomes and processes.
- The leadership allocates adequate resources for improvement and assures that staff are educated about assessing and improving processes that contribute to achieving organizational outcomes.
- Leadership entrusts operational managers with assuring that all staff participate in the Quality Management Plan by being aware of the outcomes of quality management activities in their service areas and are given opportunities to suggest improvement activities.
- Leadership fosters communication among individuals and components of the organization to improve the coordination of activities.

Both internal and external providers are expected to assess the delivery of services in their areas and to implement changes to improve service delivery. Many quality improvement activities occur at the service delivery level. Staff persons identify an opportunity for improvement, analyze the problem, and make recommendations to managers for change.

## **ACCESS CENTER-WIDE GOALS**

### **I. Regulatory Compliance**

To comply with regulations of relevant oversight and funding bodies.

### **II. Quality Services**

To provide quality services to consumers, family members, and the community.

### **III. Increased Efficiencies**

To work within declining resources, to stretch resources through collaboration with others, and to seek out new sources of revenues, using strategies for increased efficiency.

### **IV. Effective Infrastructure**

To maintain and enhance an effective infrastructure and to develop resources that support the Center in fulfillment of its mission.

### **V. Accurate, Reliable Data**

To implement and maintain data resources that prove accurate and reliable, for use in decision-making and monitoring.

## **Quality Management Goals**

**Goal 1:** Support ACCESS in meeting all applicable regulatory requirements and standards.

### **Objectives:**

- Review any new applicable Texas Administrative Codes.
- Review State contract requirements regularly.
- Review ACCESS' policies and procedures as needed.

### **Measurable Outcomes:**

- All new applicable Texas Administrative Codes are reviewed within thirty days.
- A review of requirements for State Contracts is completed monthly.
- ACCESS Policies and Procedures are reviewed on an ongoing basis to assure conformity with contracts, codes, and laws.

**Goal 2:** Monitor and evaluate system processes to support the Center in providing quality services.

**Objectives**

- Complete 100% of HHSC audits within the required time frame.
- Submit any Plans of Improvement on time and carry out improvement steps within specified time frame.
- Monitor and evaluate outcomes from consumer surveys, public forums, or other stakeholder input.
- Report results of audits, plans of improvement, and stakeholder input to Executive Director and Executive Team.
- Complete all studies as required by State Contracts.

**Measurable Outcomes:**

- All HHSC audits are completed within specified time frames.
- Plans of Improvement are submitted and completed within specified time frames.
- Results of audits, plans of improvement, and stakeholder input are reported to Executive Director and Executive Council.
- All studies required by State Contracts are completed on time.

**Goal 3:** Develop processes for efficient communication with staff and other stakeholders.

**Objectives:**

- Submit outcomes on Performance Contract measures to the Executive Team.
- Keep Board of Trustees informed of Performance Contract outcomes and results of Quality Management and Corporate Compliance activities.
- Report on contract performance to Sponsors once a year.
- Offer training for staff at least annually.

**Measurable Outcomes**

- Performance Contract outcomes are submitted to Executive Team monthly, or as indicated.
- A report is given to the Board of Trustees annually on Performance Contract results and results of Quality Management and Corporate Compliance activities.
- A report is presented to Sponsors once a year.
- Training is offered to staff once a year.

**Goal 4:** Implement continuous improvement practices.

**Objectives**

- Measurable results will be incorporated into plans for improvement.
- Available benchmarks will be reviewed by Corporate Compliance/QM Committee.

**Measurable Outcomes**

- Results from monitoring activities are utilized for continuous improvement.
- Benchmarks available from State reports, ETBHN Committees, and online resources are reviewed by Executive Team and Corporate Compliance/QM Committees.

**Goal 5:** Develop processes to identify and track health disparities at a population level

**Objectives**

- Identify social determinants of health and non-medical factors that influence health outcomes.
- Incorporate findings from needs assessments to respond to changes within the local communities to reduce health care disparity gaps.

**Measurable Outcomes**

- Results from disaggregated data collection will be reviewed by Executive Team and Corporate Compliance/QM Committee and incorporated into plans for improvement.
- Results from the disaggregated data will inform Center decisions regarding allocation of resources and changes to programs and services.

## **Quality Management Program Description**

### **Board of Trustees**

The Board of Trustees has ultimate responsibility for the policies and governance of the Center. The Board delegates to the Executive Director the responsibility for development of procedures and practices to carry out the Board policies. The Board of Trustees is accountable to the sponsoring entities and to the communities served:

- to assure quality services to eligible consumers
- to seek input and involvement of all stakeholders
- to plan for the future
- to maintain viability of the center through its oversight of budget, policies, and the Executive Director

### **Executive Council**

The senior leaders of the Center serve on the Executive Council: Executive Director, Chief Administrative Officer, Chief Program Officer, and Chief Financial Officer. The Executive Council meets at least monthly and may review any of the following quality management items:

- Any new legislative items that impact the Center
- Any new Texas Administrative Codes that impact the Center
- Performance Contract requirements
- Program status reports
- Cost Accounting reports
- Data Warehouse reports
- Audit reports
- Productivity indicators
- Risk assessments
- Management reports
- Financial reports
- Policies and procedures for review and revision

The Chief Administrative Officer, in addition to providing direction to the Quality Management Program, also serves as the Center's Corporate Compliance Officer and is charged with operating and monitoring the compliance program to assure that services, including Medicaid and Medicare, are needed, authorized, appropriately documented and of benefit to the consumer and that Center staff receive mandated compliance training.

## **Corporate Compliance/Quality Management Committee**

The Corporate Compliance/Quality Management Committee is structured to minimize duplication of effort and to maximize information flow across internal and external providers and services and is embedded as part of ongoing Management Team meetings. Findings are analyzed to identify trends, patterns, and opportunities for improvement. Intensive assessment is initiated when statistical analysis indicates undesirable variations in performance and mechanisms are established to effectively resolve identified problems or improve existing processes.

Because the same people are involved, multiple committee functions are performed concurrently. The Quality Management Committee for ACCESS is also the Corporate Compliance Committee, the Utilization Management Committee, and provides oversight to the ACCESS Safety Committee. Membership includes, but is not limited to, the following: Executive Director, Chief Administrative Officer, Chief Program Officer, Chief Financial Officer, Quality Management Specialist, Human Resources Coordinator/Consumer Relations Officer, Coordinator of IDD Essential Services, Coordinator of MH Community Programs, Coordinator of Crisis/YES/SA Services, Reimbursement Coordinator, Clinical Records Coordinator, Controller/Data Reporting Manager, Safety Officer, and the MIS Coordinator.

The Committee focuses on clinical/programmatic oversight activities that address issues unique to HHSC and/or HHSC. In addition to the formal quarterly meetings, ad hoc Quality Improvement Teams may meet to address interim quality concerns. This allows for the additional participation of program management staff and facilitates “real-time” planning and problem resolution for program/service-specific issues as they are identified.

In its function as Quality Management committee, members perform the following activities:

- Review audits and other monitoring activities
- Participate in self-assessment activities
- Prioritize improvement activities
- Develop, implement, monitor, and review plans of improvement
- Integrate quality efforts among service areas
- Oversee implementation of the goals and objectives of the Center and for the Quality Management Plan
- Assist with development of annual CQI Projects/Goals
- Review updates and revisions to the Quality/Utilization Management Plan, the Local Service Area Plan, ADA Plan, and other plans for the Center

In its function as Corporate Compliance Committee, members review the following:

- Incident Log (abuse and neglect allegations, complaints, accidents, in-house investigations, deaths, incidents)
- Human Resource reports (background checks, personnel actions, staff training issues)
- Program Reports (survey results, program data)
- Administration Reports (billing reports, data security and integrity issues, productivity reports)
- Cost Accounting Reports

In its function as Utilization Management Committee, members are responsible to perform the following:

- Identify trends, outliers, and problems for the Center, using Data Warehouse and internal database reports
- Establish practice and provider guidelines consistent with State fidelity requirements
- Review and approve processes for making resource allocation determinations
- Review results of ETBHN Regional UM Committee data reports to identify and address areas of concern

In its function as Safety Committee, members are responsible to perform the following:

- Coordinate and assist in the development of safety rules and practices for the Center
- Review reports of specific incidents, including any infection control related or accessibility concerns, to ensure corrective actions are implemented when indicated
- Address safety and preventive maintenance issues and document corrective action with regard to reports of problems or potential problems relating to the safety of consumers, staff and ACCESS property.
- Follow up on steps taken to remedy identified problems
- Analyze risk factors for disaster/emergency preparedness

### **Regional Utilization Management Committee**

Member Centers of East Texas Behavioral Healthcare Network send representatives to the Regional Utilization Management Committee. This committee meets the membership requirements outlined in the UM Guidelines and has developed a set of by-laws to govern the committee. The committee members meet at quarterly intervals either in Lufkin, or through videoconference. The physician, Mark Janes, M.D., Medical Director for Bluebonnet Trails Community MHMR, and through contract, for ACCESS, meets with the

Committee. The regional group prepares and reviews UM data from each of the member centers. The data provides comparison among centers that are geographically proximate and that share common concerns. Data analysis includes identification of outliers and trends, both in program areas and in cost centers. Discussion among the representatives may also address practice issues or guidelines for providers. Clinical determinations and appeals may be brought to the committee for consideration, upon request from a member center.

### **Professional Review Committee**

Professional Review Committee is called as needed and provides a mechanism for clinical review of sentinel events and oversight for issues related to the quality and appropriateness of service provided by licensed clinical staff. This committee carries out the duties as assigned in the ACCESS policies and procedures.

### **Regional Planning Network Advisory Committee**

Member centers of the East Texas Behavioral Healthcare Network have established a Regional Planning Network Advisory Committee (RPNAC), which meets quarterly in Lufkin, Texas or by videoconference. The RPNAC contributes to the development and content of the Network Plan, including the process of Local Planning and Network Development, which assures appropriate procurement of goods and services and reviews and makes recommendations that consider public input, best value and client care issues to ensure consumer choice and best use of public money. The RPNAC performs a variety of other functions, including the following:

- Reviews aggregate data from the member centers on a variety of topics, in order to identify trends
- Makes recommendations to the centers based on their reviews
- Performs evaluations of various providers (in-house or contracted) for a program or service, in order to determine best value, upon request of a member center
- Performs review and evaluation activities for provider networks of centers
- Provides review of local and regional planning activities.
- As part of the Local Planning and Network Development planning process, provides a framework for a regional assessment of and comparison of each member Center's community stakeholders' satisfaction with Center practices and service delivery, and includes feedback from consumers, advocates, law enforcement, hospitals and referral sources.

Each center sends one or more consumer representatives for mental health and/or intellectual and developmental disabilities, as well as a staff liaison. Results of RPNAC activities are reviewed by the Corporate Compliance/Quality Management Committee and its recommendations, if any, are also reported to the ACCESS Board of Trustees.

## **Responsibilities of Quality Management Staff**

- Coordinate planning activities, which include the following:
  - Consolidated Local Service Area Plan (CLSP)
  - Center Goals and Objectives
  - Quality Management Plan
  - Local Network Development Plan
  - Jail Diversion Plan (incorporated into the CLSP)
  - Crisis Services Plan (incorporated into the CLSP)
  - ADA Transition Plan
  - Abuse Neglect Reduction Plan
  - Consumer Benefits Assistance Plan
  - Safety and Disaster Plan
- Verify accuracy of data submitted to State Authorities
- Review of provider treatment to ensure compliance with HHSC evidence-based practices by:
  - Monitoring implementation of Texas Resiliency and Recovery (TRR) through fidelity reviews and other routine monitoring activities to determine the accuracy of assessments and treatment recovery planning
- Monitor compliance with Medicaid (or other pay source) requirements for billing
- Complete reports required by State Authorities
- Monitor confidentiality, consumer rights, complaints, and abuse and neglect issues
- Monitor the quality of crisis services, access to services, service delivery, and continuity of services
- Identify and address other clinical and organizational risk issues to improve performance of provider services and outcomes for individuals served
- Provide technical assistance to providers to improve the quality and accountability of provider services
- Ensure, if applicable, that Health Department inspections are scheduled for programs serving meals to ten (10) or more consumers
- Ensure that all deaths of ACCESS consumers are reviewed in compliance with state regulations.

## **Management Team**

Many of the functions related to quality and utilization management are also reviewed on a daily basis by the members of the Executive Council and Management Team. The Management Team consists of all Service Area and Administrative Function Coordinators, who are also members of the Center's Corporate Compliance/Quality Management Committee.

Critical data are reviewed to ensure timely response to and resolution of risk issues. Areas reviewed include, but are not limited to, the following: abuse, neglect, or exploitation; consumer and staff incidents and injuries; medication errors; employee Workers Compensation events; vehicle usage and accidents; rights violations;

complaints, suicide attempts; completed suicides; fatal and non-fatal overdoses; deaths due to other causes; serious health related incidents; infection control/infectious disease incidents; and results of on-site safety/environmental inspections.

Other resources committed to quality improvement practices include Center employees with responsibilities for reviewing internal accounting data, reimbursement functions, employee training information, program compliance, review and audit of the Medicaid Administrative Claiming data, clinical records reviews, and credentialing.

## **Quality Management Processes**

The ACCESS QM Program is integrated with other organizational functions, including areas of service delivery, fiscal and business functions, data and information systems, utilization management, contracting, and human resources. ACCESS continually seeks to assess itself through methods that are appropriate, timely, efficient and reliable. The ACCESS QM Program is based on a continuous quality improvement model with elements that focus on the design, monitoring, analysis, and improvement of processes that are integrated throughout the organization.

The following are essential stages in ACCESS' continuous quality improvement processes:

- Design of processes that:
  - Are consistent with Center's mission, vision and values
  - Meet requirements of State Authorities
  - Reflect unique cultural, linguistic, demographic, or other characteristics of local service area
  - Meet needs of local service area through ongoing community needs assessments
- Monitoring of performance, by review of
  - Performance indicators related to standards
  - Risk factors
  - Organizational performance indicators
  - Stakeholder satisfaction
- Analysis of current performance, through
  - Level of performance
  - Effectiveness of processes
  - Need for improvements
- Improve or sustain performance, through
  - Establishing baseline criteria
  - Developing written plans of improvement when criteria are not met
  - Implementing plans of improvement, with collaboration of all parties involved
  - Following up on plans of improvement

## **Data Collection**

Data is available through the following resources:

- Local database (Credible EHR), including:
  - Server reports
  - Services provided reports
  - Billing reports
- ACCESS financial software
  - General Ledger
  - Accounts Payable and Receivable
  - Cost Accounting
- Regional data from East Texas Behavioral Healthcare Network, comparing measures from member centers, including but not limited to the following:
  - Program evaluations
  - Server productivity
  - Cost of services
- Statewide and center specific data from MBOW (State data warehouse), including but not limited to the following:
  - Performance contract measures
  - Assessments measures
  - Financial measures
- Encounter data
- CARE data
- Social Determinants of Health from Social Needs Screening data
- Critical Issues data
- Local risk assessments
- Data on primary care and physical health outcomes
- State Consumer Satisfaction Surveys, if available
- Satisfaction data gathered from interaction with community leaders and complaints to the Consumer Relations Officer, as well as from surveys gathered during the Local Planning and Network Development planning processes
- State audits of programs and authority areas
- Local productivity reports

## **Analysis and Evaluation of Data**

Quantitative analysis is conducted using audit tools to look for presence or absence of information. Qualitative analysis is performed by measuring actual results against quality indicators. Statistical analysis and evaluation are performed depending on the type of data involved. Monitoring systems, processes, and outcomes is part of the process of analysis and evaluation. Improvement activities are enacted when substandard performance is identified, or a negative trend identified, and continued data collection and analysis is made until acceptable performance is obtained.

Sanctions are imposed for continued non-compliance and may include any of the following actions: written warnings to personnel file, ineligibility for financial increases or other financial incentives, ineligibility for promotion, ineligibility for continued referrals, probation, administrative reassignment of personnel, and/or termination of a contract or from employment. The desired outcome is that evaluation of data will show that the Center's service delivery systems provide appropriate, efficient, and cost-effective services.

### **Identification of Trends**

Strengths and areas of need are identified from analyzing data collected. Strengths within a program are assessed for applicability to positively influence programs. Areas of needs within a program require either a formal or informal plan of improvement, with strategies for improvement.

### **Best Practices and Evidence-Based Service Delivery**

ACCESS participates in Best Practices identified in its Performance Contracts with HHSC. Through collaboration with East Texas Behavioral Healthcare Network, the Center also has the opportunity to learn about best practices and innovative programs from other centers in the region.

ACCESS implemented service packages outlined in Texas Resiliency and Recovery model (TRR), a treatment model based on research and evidence about the best practices for service delivery. QM staff monitor fidelity of implementation through routine chart reviews to ensure compliance with TRR processes and provision of high- quality targeted case management services.

ACCESS staff participates in TRR implementation activities, including conference calls, webinars, required staff training, and in-house testing of system interfaces required to facilitate the batching of data to CMBHS. Management staff and consumer representatives also participate in initiatives aimed at increasing knowledge of recovery principles and expanded integration of peers into services provided by the organization.

### **Benchmarking**

The use of statewide data from the Data Warehouse is a valuable tool for benchmarking with other Centers. Other sources for benchmarking include the ETBHN reports, publications in the behavioral health field, CCBHC outcomes, HEDIS Measures of effectiveness and access to care, and State reports

Trends identified in reports for local data are reviewed by the Executive Council and the Corporate Compliance Committee/Quality Management Committee. Benchmarks are identified, with the objective of improving affected areas. Recommendations from the

Committee are reviewed by the appropriate Service Area Managers/Coordinators, and in some cases by the Executive Council, for approval and implementation.

## **Stakeholder Involvement in Quality Management**

ACCESS endorses the involvement of consumers, advocates, family members, and other stakeholders in the design, delivery, implementation, and evaluation of services.

The Board of Trustees includes opportunity for Citizen Comment at their meetings. Additionally, time is set aside for “consumer focus” at many of the meetings. At these times, a presentation is made to the Board about some program or activity for consumers; consumers or family often participate in these presentations.

Consumers and other stakeholders participate in the Regional Planning Network Advisory Committee, composed of representatives from each member center of the East Texas Behavioral Healthcare Network, and also participate in the ACCESS Developmental Disabilities Planning Advisory Committee.

ACCESS has a consumer feedback phone line that is answered by the ACCESS Consumer Relations Officer and is a local call throughout the entire service area. This number is displayed in all service locations and in the Notice of Privacy Rights given to all consumers at intake and again, at least, annually. Information received through these calls is relayed to the appropriate Service Area Manager/Coordinator or to the Executive Director.

The Consumer Relations Officer investigates all reported problems, complaints, and rights violations, and reports any findings to the Executive Director and other relevant members of management. These and other items are included in the Corporate Compliance Log, which is reviewed by Committee.

The Center provides support and assistance to the Cherokee County Peer Support Group, the local consumer-operated peer support program. Members provide feedback on issues to the Consumer Relations Officer, who relays information to appropriate staff. Members also participate in the development and review of local planning efforts.

Public forums on Mental Health and Developmental Disabilities Issues are held in each county for individuals and their families who receive services, in order to discuss ways the Center might better serve their needs.

Reports are presented annually to the Sponsors of ACCESS: Anderson County and Cherokee County. Feedback is received from these governmental entities during these presentations.

Information may be shared with internal/external providers and stakeholders through both formal (audit results, written reports, and program evaluations) and informal means (on-the-spot problem solving, discussions, and meetings).

Consumer and Stakeholder Satisfaction Surveys in English and Spanish are distributed to ensure those groups feedback is included during revisions to the Center's Local Service Area Plan. A Suggestion Box is located in each lobby. Comments/suggestions are reviewed and acted upon.

State Mental Health Consumer and Family Satisfaction Surveys for adults and for children are distributed, when available, to consumers. Results are reviewed by management.

Focused Consumer Interviews or Surveys may be used at intervals to solicit information about a particular service area or population. Results will be provided to the Executive Director, who may provide a summary of findings to management with recommendations for action.

### **Measuring, Assessing and Improving Service Capacity, Access to Services, and Continuity of Services**

ACCESS has open intake/access in each clinic, where people can walk in for an intake without an appointment. If the intake assessment indicates that the individual is not a member of the priority populations served by ACCESS and that their needs would better be met through services of another agency or community resource, those individuals are given information about how to contact other resources.

The assessment processes use the CANS/ANSA, which identifies the Recommended Level of Care. In most cases the recommended level becomes the level of care authorized. However, sometimes a consumer chooses a less intense level of care.

The following items are monitored by Service Area Management and Quality Management staff, in order to evaluate service capacity, access to services, service delivery, continuity of services, and quality of crisis services:

- The length of time between screening and intake
- The length of time between intake and initial service delivery
- No show and cancellation rates
- Override rates (LOC-A compared to LOC-R)
- Server productivity (direct service time)
- IDD Service Coordination Type A & B Encounters
- Hospital beddays for State Mental Health Facilities and for local psychiatric beds on contract with the center
- Completion of hospital pre-admission screenings

- 30 day hospital psychiatric or substance use readmissions
- Suicide attempts, completed suicides
- Completion of aftercare/continuity of care functions after hospital discharges
- Unit service costs
- Outlier information

Local information is compared to targets set by HHSC and by ACCESS and to benchmarking information from ETBHN and other centers, when available. The statewide database (MBOW) has facilitated benchmarking by making data available on a variety of measures for all centers.

### **Measuring, Assessing, and Improving Organizational and Authority Outcomes**

ACCESS assesses organizational and authority outcomes through a variety of measures. Once an area has been determined to be an area of need, action plans can be developed for improvement in that area. Following are some of the reports and indicators used to measure and assess organizational and authority outcomes

#### **Security Risk analysis (HIPAA)**

- An analysis is completed at least annually by MIS staff about computer security issues, relevant to HIPAA and information systems data integrity.
- An action plan is developed to correct any identified issues, and the plan is reviewed in Corporate Compliance Meetings.

#### **Cost Accounting Reports**

- Executive Council and Corporate Compliance Committee review the Cost Accounting reports, when available.
- Outliers on the report are analyzed for possible corrective action.

#### **Encounter Data**

- Executive Council and Corporate Compliance Committee review reports on Encounter Data quarterly.
- Outliers on the report are analyzed for possible corrective action.

#### **State & Local Consumer Satisfaction Surveys**

- Results of statewide satisfaction surveys for adults and children, when available, are reviewed by Corporate Compliance Committee and Local Planning and Advisory Committees on a quarterly basis.
- Local satisfaction surveys are routinely distributed to individuals served, assessing satisfaction with ACCESS services and services of contracted providers. Results are regularly reviewed by Management and Executive Team to identify areas of potential concerns or need for additional services.

#### Performance Contract Measures from CARE and Data Warehouse

- Executive Council, Management staff, QM staff, and the Corporate Compliance/QM Committee review key indicators from the Performance Contract and Data Warehouse reports.
- Areas not meeting requirements are analyzed for possible corrective action.

#### Local Financial Reports

- Monthly reports on revenues and expenses, and a balance sheet are prepared for Board of Trustees and Executive Staff and reviewed at the Board meetings

#### Monitoring of contracted services

- Monitoring is performed to ensure continuous quality services to consumers receiving contracted services. Contracted providers are monitored for clinical outcomes and contract compliance in support of the delivery of efficient, effective, and quality care to consumers served. Indicators focus on accuracy and timeliness of provider documentation including clinical documentation, billing submissions, and reporting of required contract performance measures.
- Providers' adherence to applicable rules, regulations, standards, and laws is monitored. Providers are credentialed to ensure they are adequately trained and meet required qualifications for the services to be performed. Personnel policies, training practices, safety and infection control compliance, costing information, and fiscal accountability of providers are also monitored.
- Technical assistance is provided to contractors to ensure that outcomes are appropriately managed and to assist the Contractor in meeting the requirements of the Contract.
- Results of monitoring activities are evaluated to determine appropriate action, which may be related to a single event or to a trend and pattern identified in a particular area of client care. Contractors are required to submit Corrective Action Plans (CAPs) in response to findings, submission

of requested reports and data, and any other compliance information requested by Authority. Identified areas of non-compliance are monitored until corrected or until the contract is terminated, either by mutual agreement or for continued non-performance.

#### Pharmacy and purchasing reports from ETBHN

- ACCESS achieves cost reduction through collaboration in ETBHN.
- The ETBHN pharmacy reduces medication costs. Pharmacy reports are reviewed by the billing and purchasing staff.
- Quarterly Pharmacy Reports are reviewed by the Regional Utilization Management Committee, Regional Planning Network Advisory Committee, and the ACCESS Utilization Management Committee.
- The ETBHN purchasing plan reduces cost of equipment and supplies. The purchases are reviewed by local purchasing and accounts payable.

### **Measuring, Assessing and Improving Services Provided**

ACCESS assesses service outcomes through a variety of measures. Once an area has been determined to be an area of need, action plans can be developed for improvement in that area. Following are some of the reports and indicators used to measure and assess service outcomes.

Data Warehouse Business Objects Reports and Prompts, such as, but not limited to, the following:

- Level of Care Minimum Hours
- UM Appropriateness
- UM Completion
- General Revenue Earned
- Potential Lost Medicaid
- Assessments Set to Expire
- Served But Not Assessed
- Server and Service Mix Drill
- Follow-up Service Report for Clients Discharged
- Follow-up Service Report for Closed Assignments
- Rejection Report
- Campus Based Assignments for a Specific Period
- Service Detail Report
- Crisis Community Linkage Report
- Crisis Activity Report

CARE/MBOW Data Reports, such as, but not limited to, the following:

- TRR Assessments Summary
- Monthly entry into Credible is reconciled with CARE reports
- Hospital Funding Report

- Readmissions Reports, including 30-day psychiatric hospital readmissions
- MH & IDD Monthly Outcomes
- Expired CANS/ANSA Report
- Auto closures Report

Credible Reports, such as, but not limited to, the following:

- Denial/Pending Claims Report
- Exception Report
- Assessment Listing Report
- Client Services Detail Report
- Suspense Report
- Social Needs Screening

Fidelity Review Audits for Texas Resiliency & Recovery Best Practices

- Audits to check for structures in place.
- Audits of services for fidelity to the TRR model.
- CANS/ANSA Super User Training to ensure assessment competency of staff

Reports on Credentialing of Staff

- Credentialing records are maintained by the Human Resources Department.
- The Corporate Compliance Committee and Quality Management Staff review the status of credentials for staff for whom credentialing is required. This review includes monitoring of provider competencies for serving persons with co-occurring psychiatric and substance use disorders (COPSD).

Reports on Training of Staff

- Staff assigned to complete the CANS/ANSA will achieve a passing score on the competency test, prior to assuming those duties.
- Staff assigned to crisis services will achieve a passing score on the in-house competency test, prior to assuming those duties.
- Staff will complete the mandatory on-line training annually, including training on abuse/neglect/exploitation, confidentiality, on consumer rights protection, cultural competency, on military competency, business continuity and on consumer rights protection.
- Staff will complete other mandatory training as required by the position and HHSC and by CCBHC and other regulatory and/or accrediting/certifying organizations.

Medicaid Audits

- In-house 100% pre-billing audits to assure that billed services are eligible and documented appropriately. Results of audits are presented to

Management Team for review and to providers for any needed corrections, prior to billing.

- State audits of paid Medicaid claims

#### New Generation Medication Audits

- In-house audits to track changes in CARE
- State audits, when scheduled

#### Crisis Service Delivery Audits

- QM staff review crisis hotline calls to ensure they are properly coded as to type and that response times meet requirements.
- QM staff review crisis data in the internal data system, as well as in the Data Warehouse, to ensure crisis follow-up contacts and community linkages are occurring as required.
- QM staff provide technical assistance and training to MCOT and other staff performing crisis functions.
- Reports on crisis activities and MCOT implementation are presented to the ACCESS Board of Trustees, as well as to the Corporate Compliance/Utilization Management Committee.

#### COPSD and Single SUD Diagnosis Monitoring Activities

- QM staff monitor Data Warehouse reports on improvements in clinical functioning related to Co-occurring Psychiatric and Substance Use Disorders (COPSD)
- QM staff monitor for evidence of appropriate treatment response during routine clinical record reviews to be sure that a person with COPSD or receives services that address both disorders
- QM staff monitor for evidence of appropriate treatment response during routine clinical record reviews to be sure that a person with a single SUD diagnosis is receiving necessary services
- Results are reviewed by the Corporate Compliance/Quality Management Committee

#### IT Monitoring Services

- All Servers are rebooted weekly
- Antivirus software checked weekly and complete virus sweep run monthly
- Bandwidth monitored daily to identify usage trends and identify problems.
- All data is backed up daily to preserve continuity of business and clinical functions.
- All backups checked daily.

#### Safety Measures and Disaster Preparedness

- The Safety Committee conducts on-site walk-through inspections of ACCESS sites to reduce and prevent injury. The Committee's report is submitted to the Executive Council, Management Team, and site managers for required corrections. Reports of activities and findings are reviewed by the Corporate Compliance Committee.
- Follow-up monitoring is done by Safety Officer to determine that deficiencies have been corrected.
- The Corporate Compliance/Safety Committee review Incident Reports to determine trends inconsistent with the safe practices and operation of the agency's physical locations and vehicles. Trends are noted and reported to Executive Council for recommendation, and follow-up action is required.
- The committee reviews disaster and emergency preparedness periodically and reports concerns, if any, to the Corporate Compliance Committee.

## **YES Waiver Implementation**

- QM and Program Management Staff collect data, measure, assess, and work to improve dimensions of performance through focus on timely access to YES services and timely enrollment of Waiver participants. Plans of care and services are monitored to ensure they are based on underlying needs and outcome statements and that services are provided according to the Waiver participant's approved individual Plan of Care as developed and revised. Services are monitored to ensure the participant receives at least one billable service per month, or monthly monitoring if the need for service(s) is less than monthly. Continuity of Care planning is monitored to ensure implementation and optimal outcomes for the Waiver participant. Provider participation in child and family and team meetings is monitored to ensure inclusion and input into the planning process.
- Health and safety risk factors affecting YES Waiver participants and/or program are identified and updated along with collection and analysis of critical incident data, also ensuring Critical Incident Reports are submitted to HHSC within 72 hours of an incident's occurrence.
- Human Resources and QM and Program Staff ensure providers are appropriately credentialed and trained.
- Adherence to established policies and procedures as stipulated in the Program Manual is monitored for compliance.
- Participate in desk or onsite reviews conducted by YES QM Department or wraparound fidelity reviews conducted by HHSC or HHSC Agency Designee at any time designated by HHSC.
- Areas of concern are reported to the Executive Council and Management Team for follow-up and required corrections. QM Staff monitor corrective actions to ensure adherence to standards and also monitor implementation of any Plans of Correction resulting from HHSC provider reviews to ensure compliance and remediation of any identified areas of concern.
- The Corporate Compliance/QM Committee reviews compliance activity reports to identify trends, recommend improvements when indicated, and monitor for continued compliance.

## **Measuring, Assessing, and Reducing Consumer Abuse, Neglect, and Exploitation**

- Reports on Client Abuse and Neglect
  - All reports from DFPS are reviewed by the Executive Director, the Chief Administrative Officer, Chief Program Officer, and the appropriate Service Area Manager.
  - Staff perform the Client Abuse and Neglect Record System (CANRS) data entry and maintain a log of all reported incidents. The log contains the date, provider, type, and finding for each entry.
  - Quarterly, the data is examined by the Corporate Compliance Committee to look for trends. If trends are found, the data is referred to the relevant Service Area Manager for corrective action. Corrective action and follow-up, if needed, are reported back to the Corporate Compliance Committee.
  - All employees receive training in prevention of abuse, neglect, and exploitation as new hires, in annual refresher training, and at other times, when review activities indicate a need for additional refresher training.
  - All consumers receive notification of their rights, as well as information on reporting abuse, neglect, or exploitation, at their intake to services, and at least annually thereafter.
  - ACCESS policy requires that any employee accused of client abuse, neglect or exploitation be placed on administrative leave until completion of the investigation by DFPS. The employee may return to work if the DFPS finding is that the allegation is either unconfirmed or unfounded.
  - If the finding is confirmed, disciplinary action is taken as outlined in ACCESS Procedures, as follows:

“Disciplinary action shall include the following appropriate penalties for employees or agents:

**Class I Abuse:** termination of employment, or of agent's contract.

**Class II Abuse:**

First Violation:

Minimum action: One (1) day on suspension.

Maximum action: Termination of employment.

Second Violation: Termination of employment, or of agent's contract.

**Class III Abuse:**

First Violation:

Minimum action: A written reprimand by the Service Area Director which shall become part of the

employee's personnel file or agent's consultant file.

Maximum action: Termination of employment, or of agent's contract.

Second Violation:

Minimum action: One (1) day on suspension.

Maximum action: Termination of employment, or of agent's contract.

**Neglect:**

First Violation:

Minimum action: A written reprimand from the Service Area Director which shall be placed in the employee's personnel file or agent's consultant file, and one day on suspension.

Maximum action: Termination of employment, or of agent's contract.

Second Violation:

Minimum action: Ten (10) days on suspension.

Maximum action: Termination of employment, or of agent's contract."

## **Quality Improvement and Oversight of Prescribing of Psychoactive and Other Medications**

ACCESS Operating Procedures on Psychiatric Medication Services and Delegation direct the implementation of prescribing practices in compliance with §415.12 of the TAC. Oversight of the Center's prescribing and medical practices is provided through contract with Mark Janes, MD, as Medical Director and consultant. Dr. Janes also serves as the UM psychiatrist for the ETBHN Regional UM Committee, of which ACCESS is a member. The Regional UM Committee reviews Pharmacy Reports which look at the number and types of medications prescribed by physician associated pharmacy costs. The Center UM Committee and Management also review the reports to identify practice concerns and any outliers.

Nursing staff review all medication orders and documentation both before and after each clinic medication visit to ensure documentation is completed as required and that lab tests are obtained as ordered. ACCESS QM staff monitor psychoactive medication related services through routine chart reviews of service delivery documentation and when completing New Generation Medication studies. Inadequate documentation, polypharmacy outside approved guidelines, emergency and PRN use of psychoactive medications, medication errors, and adverse drug reactions, if found, are reviewed and corrected by medical staff and reported to the Corporate Compliance/QM Committee through the Corporate Compliance Log.

### **Monitoring the Effectiveness of the QM Plan**

The Quality Management Plan is reviewed and updated annually. New or modified targets and outcomes for each year are established by the Executive Council and/or Corporate Compliance/QM Committee, based on State contracts and local goals and objectives. All available input from consumers and the public, as well as employees and pay sources, is incorporated into the Plan. Quality Management staff ensure the completeness and relevancy of the QM Plan through ongoing reviews of changes to standards, laws, Rules, regulations, licensing and/or accrediting requirements, to determine if a revision to the QM Plan is needed. The ACCESS Board of Trustees, Executive Director, and the Corporate Compliance/QM Committee approve the plan annually, or at each revision.

The Quality Management Plan is posted on the "public" drive on the center's computer network, which is available to all employees. The Plan is also posted on the ACCESS website.

## Key Quality Indicators, FY26-27

| Indicator                                                                   | Method                                                                                                                                                                                   | Frequency                               | Target                                                                                                 |
|-----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|--------------------------------------------------------------------------------------------------------|
| Targets and measures from State Performance Contracts                       | Reports from CARE, MBOW, local data                                                                                                                                                      | Quarterly or as indicated               | Meet standards                                                                                         |
| Protocols for Medicaid reimbursement                                        | In-house audits                                                                                                                                                                          | Monthly                                 | 95%                                                                                                    |
| Data accuracy                                                               | Audits                                                                                                                                                                                   | Variable                                | 95%                                                                                                    |
| Direct service/billing time (service delivery & access to services measure) | In-house report from local database                                                                                                                                                      | Semi-Annual ,or more often              | >50%                                                                                                   |
| Staff Mandatory On-line Training                                            | Record of completion                                                                                                                                                                     | Annual                                  | 100%                                                                                                   |
| Staff Training on Crisis Services                                           | In-house test over information needed to perform crisis duties                                                                                                                           | Prior to duties assigned                | Passing score                                                                                          |
| Staff Training for CANS/ANSA                                                | Completion of on-line training                                                                                                                                                           | Prior to duties assigned & annually     | Passing score on CANS/ANSA test                                                                        |
| Complaints; Allegations of Abuse and Neglect                                | In-house investigations and reporting to state agencies                                                                                                                                  | Per occurrence; monthly reports to HHSC | Within designated time frame                                                                           |
| TRR implementation (service delivery measure)                               | Reports from MBOW; QM/UM oversight & audits; fidelity reviews of Evidence Based Practices                                                                                                | Variable                                | Meet standards & State audit compliance                                                                |
| Texas Resiliency & Recovery (TRR) Activities                                | HHSC CANS/ANSA calls & training; in-house monitoring of CMBHS batching; Peer Specialist Integration                                                                                      | Ongoing                                 | Meet required deadlines and training requirements; increase integration of Peers into Center functions |
| New Generation Medication Compliance                                        | QM staff chart reviews, as requested                                                                                                                                                     | Ongoing                                 | Meet HHSC standards                                                                                    |
| Certification of residential and other service programs by State Agencies   | Survey and audit process                                                                                                                                                                 | Per State schedule                      | Re-certification                                                                                       |
| Crisis Redesign Services                                                    | QM review of crisis call logs; crisis response times & follow-up/linkages; suicides, suicide attempts; hospital readmissions: CARE reports, MBOW, internal reports, satisfaction surveys | Ongoing                                 | Meet standards                                                                                         |
| Continuity of Services                                                      | Reports from CARE; review by QM staff                                                                                                                                                    | Monthly                                 | Meet standards                                                                                         |
| CCBHC Certification and DPP Implementation Activities                       | Reports on Waiver activities/outcomes; Expansion of Peer Support Activities and                                                                                                          | Monthly, or per schedule                | Meet HHSC/CMS Benchmarks                                                                               |

|                                                |                                                                                                                                               |           |                                                                                |
|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------|--------------------------------------------------------------------------------|
|                                                | COPSD and SUD Services                                                                                                                        |           |                                                                                |
| YES Waiver Compliance                          | MBOW Reports; QM & Mgmt program audits; HHSC POCs                                                                                             | Monthly   | Meet HHSC standards                                                            |
| ADA Compliance                                 | Review/update of ADA Plan& implementation                                                                                                     | Annual    | Meet standards                                                                 |
| Veterans Service Program Implementation Plan   | Service delivery reporting to TexVet; HHSC                                                                                                    | Quarterly | Meet HHSC standards                                                            |
| CMS Emergency Preparedness Plan Implementation | Review/Revise Safety Plan                                                                                                                     | Ongoing   | Meet CMS standards                                                             |
| Mystery Caller Compliance                      | Conduct mystery calls to front desk staff; training                                                                                           | Quarterly | Meet HHSC standards                                                            |
| Primary Care and Physical Health Activities    | QM/Nursing Review of High BP and referrals for follow-up; QM/Nursing Review of nutritional counseling and any referrals for out-of-range BMIs | Quarterly | Meet approved medical standards of care and CCBHC measure reporting guidelines |

## CQI Projects:

### Rationale for CQI Project 1:

Recent clusters of suicides of individuals not known to ACCESS raised concerns that there is a lack of local awareness of supports and services available to assist individuals experiencing extreme stressors and that there is a need to identify where gaps in knowledge exist and how to best address those gaps.

### Goal: Increase awareness of available community crisis services and supports

**Objective 1:** Identify available community crisis services and supports

#### Milestones:

- Seek individuals to participate in identifying available resources
- Establish committee structure
- Provide training on suicide awareness to individuals participating in project
- Develop marketing materials for community distribution
- Identify locations and disseminate marketing materials

**Implementation Date:** 2<sup>nd</sup> Quarter FY 23 & Ongoing

**Staff/Area Responsible:** MH Program Managers, Staff, QM, Community Representatives

**Objective 2:** Expand community outreach of projects through community events and education opportunities

**Milestones:**

- Plan and publicize suicide awareness event(s)
- Hold at least one event every 6 months
- Collect feedback and suggestions from event attendees to incorporate into future events
- Establish in-house CQI Team
- Analyze data and develop report for distribution to stakeholders
- Develop action plan to initiate any needed changes in crisis service delivery systems to address any identified gaps

**Implementation Date:** 3rd Quarter & ongoing

**Staff/Area Responsible:** QM, CQI Team, MH Managers, Suicide Awareness Committee Members

**Objective 3:** Sustain improvements or initiate additional improvement activities

**Milestones:**

- Initiate “Check” sequence of PDCA cycle to evaluate impact of CQI activities
- If additional improvements are indicated, develop a Driver or other Diagram to identify other factors that may be limiting impact of awareness activities
- Implement activities and continue PDCA cycle until objectives are achieved and sustained

**Implementation Date:** 4<sup>th</sup> Quarter & ongoing

**Staff/Area Responsible:** QM, CQI Team

**Rationale for CQI Project 2:**

Data obtained through multiple needs assessments consistently identify lack of access to needed services and supports in the 2 Counties served by ACCESS. Due to lack of public transportation and the widely dispersed rural population needing those services and supports who may be unable to get to the clinics located in each County, Management considered whether there would be increased participation in services if outlying practice sites could be established.

**Goal:** Determine whether there would be sufficient interest to establish any outlying service sites.

**Objective 1:** Identify areas where there would be enough clients who might be interested in attending a remote service site.

**Milestones:**

- Run lists of individuals by zip codes to determine clusters large enough to justify a remote site
- Review data to identify clusters large enough to consider a remote service site

- Develop and send letters to individuals living in potential service site areas to determine interest
- Review responses to establish level of interest
- Identify locations for a remote service site in each County based on responses

**Implementation Date:** 2<sup>nd</sup> Quarter FY 24 & Ongoing

**Staff/Area Responsible:** Administration, Program Managers, QM

**Objective 2:** Implement remote service site in each County

**Milestones:**

- Obtain and establish service site
- Hire and train staff
- Identify and obtain technology necessary to run the sites
- Determine opening date
- Publicize availability of services to existing clients and to the local communities
- Collect feedback, suggestions, and satisfaction with services and service site
- Establish in-house CQI Team for review of data
- Analyze data and develop report for distribution to stakeholders
- Develop action plan to initiate any needed changes in service delivery to address any identified gaps

**Implementation Date:** 3<sup>rd</sup> Quarter FY 25 & ongoing

**Staff/Area Responsible:** Administration, QM, CQI Team, MH Managers

**Objective 3:** Sustain improvements or initiate additional improvement activities

**Milestones:**

- Initiate “Check” sequence of PDCA cycle to evaluate impact of CQI activities
- If additional improvements are indicated, develop a Driver or other Diagram to identify other factors that may be limiting attendance at remote sites
- Implement activities and continue PDCA cycle until objectives are achieved and sustained

**Implementation Date:** 4<sup>th</sup> Quarter & ongoing

**Staff/Area Responsible:** Administration, QM, CQI Team

## **ACCESS Utilization Management Plan**

This Utilization Management Plan (UM Plan) describes the Utilization Management (UM) program of ACCESS Center, hereafter "the Center", and is written to be consistent with the Center's policies and procedures and applicable regulatory and contractual requirements. The Center's Utilization Manager, under the direction of a UM psychiatrist and in consultation with the UM Committee, assumes the responsibility for execution of this UM Plan. This Utilization Management Plan shall be reviewed and revised annually or more frequently, as necessary.

- **Psychiatrist Oversight of UM Program**

The psychiatrist who provides oversight of the responsibilities of the UM Program and Committee, through East Texas Behavioral Healthcare Network (ETBHN), is Mark Janes, M.D, Bluebonnet Trails Community MHMR Center Medical Director, and Medical Director also, through contract, for the Center.

- **Utilization Manager Designation**

The Center has delegated authorization activities, through contract, to ETBHN's comprehensive Regional Utilization Management System, directed by a licensed and appropriately credentialed Master's level clinician, having extensive experience in the provision of UM activities. All Regional UM services are delivered by qualified individuals to provide implementation, coordination, and authorizations for clinical services, as well as consultation services for the regional authorization process and to the Center. The delegation of the authorization activities from the Center to ETBHN requires that sufficient controls are in place to ensure that all Department of State Health Services (DSHS) and member center contractual and regulatory requirements are met including 25 TAC 4120 Mental Health Community Services Standards, §41.2.313(b).

- **Utilization Review Activities**

- **Procedure for Eligibility Determination:** The Center conducts screenings of each consumer to determine whether the requirements are met for admission to services and initial Service Package assignment using Texas Department of State Health Services (DSHS) criteria. Determinations are conducted to ensure the Center's practice guidelines deliver treatment in the most effective and efficient manner.
- **Procedure for Level of Care Assignment, Authorizations and Reauthorizations:** The Center initially assigns each consumer to the appropriate Level of Care according to DSHS UM guidelines and requests authorizations and reauthorizations from the Regional UM staff of the recommended Level of Care (LOC-R). ETBHN UM staff either approve the LOC-R or request additional information until satisfied that the requested

authorization meets DSHS UM Guidelines. The Regional UM Committee conducts retrospective oversight of initial and subsequent level of care assignments to ensure consistent application of DSHS UM guidelines. These processes ensure sufficient utilization and resource allocation determinations based on clinical data, practice guidelines, and

information regarding the consumer's needs with consideration of the consumer's (and LAR's on the consumer's behalf) treatment preferences and objections. The Center QM staff provides retrospective oversight of initial and subsequent level of care assignments to ensure consistent application of DSHS Utilization Management guidelines.

- **Procedure for Outlier Review:** The Center and ETBHN, as designated by the Center, by and through its Regional Utilization Management Committee, will conduct Outlier Review. This process will consist of a review of data to identify outliers and to determine any need for change in level of care assignment processes, service intensity or other Utilization Management activities. These reviews are conducted to ensure provider treatment is consistent with practice guidelines as is the process for making utilization/resource allocation determinations.
- **Procedure for Inpatient Admissions, including State Hospitals and Discharge:** The Center conducts reviews of inpatient admissions to ensure the most clinically effective and efficient length of stay at an inpatient facility and reviews discharge plans to ensure timely and appropriate treatment following an inpatient stay. These reviews are conducted to ensure continuity of services for coordinating the delivery of mental health community services by multiple providers.

- **UM activities Fulfilled by persons other than Utilization Manager**

At a minimum, each ETBHN UM staff who is not licensed is a QMHP-CS with three years' experience in direct care for adults with serious mental illness or children and adolescents with serious emotional disturbances and have all UM activities directly supervised by the qualified ETBHN Utilization Manager. The UM activities conducted by these persons are: authorizations and reviews.

- **Conflict of Interest**

It is the policy of the Center that providers of mental health services may conduct screening and eligibility determination functions on behalf of the Center, as well as other business functions. However, providers of mental health services may not grant authorizations.

- **UM Documentation of Training and Supervision**

It is the policy of the Center that UM staff are properly trained and supervised as required by DSHS or by other policy, law or regulation. It is the responsibility of the Center, through its

contract with ETBHN and in consultation with the UM psychiatrist, to ensure documentation of training and supervision are properly maintained by ETBHN UM staff.

- **UM Committee**

The Center maintains a Utilization Management Committee through ETBHN (Attachment A). The primary function of the UM Committee is to assist the promotion, maintenance and availability of high quality care in conjunction with effective and efficient utilization of resources. ETBHN will facilitate a UM Committee to ensure

compliance with applicable contractual and regulatory UM requirements. Activities and reports from the Regional UM Committee are reviewed for outliers and opportunities for improvements to service delivery. The UM Committee includes processes to:

- Assure the overall integrity of the utilization management process to include timely and appropriate assignment of DSHS Mental Health levels of care based on the DSHS UM Guidelines;
- Approve and oversee the appeal system for adverse determination decisions;
- Analyze utilization patterns and trends throughout the ETBHN region, to include gaps in services, rates of no shows for appointments/services, billing issues, underdeveloped and frequently requested services, existing services that are under- and over-utilized, and barriers to access;
- Establish mechanisms to report quantitative and qualitative information on service utilization and service delivery to ETBHN Regional Oversight Committee members, and the Center's management and staff; and
- Analyze data on hospital utilization, including factors such as rates of admissions by county, diagnosis, and length of stay.

The ETBHN Regional UM Committee meetings are held quarterly or more frequently as needed at a designated time and include a physician, UM staff, Quality Management staff, and fiscal/financial services staff. The UM Committee will maintain representation from all Member Centers of ETBHN. UM Committee members are appointed by each ETBHN Member Center's respective Executive Director/CEO. ETBHN is responsible for taking, distributing, and storing minutes of every UM Committee meeting.

- **Exception/Clinical Override Process**

The Center, in conjunction with ETBHN UM staff, will maintain a system to override the Texas Resilience and Recovery (TRR) UM Authorization Guidelines for Adults and for Children and Adolescents when there is the need and to make exceptions to and manage the number of units of service authorized for a consumer and will report on exceptions and overrides as required by DSHS.

- **Appeal Process**

Pursuant to 25 TAC 401.464, the Center is dedicated to providing mental health services which are viewed as satisfactory by persons receiving those services and their legally authorized representatives. The purpose of this procedure is to assure that these persons:

- ( I ) have a method to express their concerns or dissatisfaction;
- are assisted to do so in a constructive way; and
- have their concerns or dissatisfaction addressed through a review process.

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

At the time of admission into services and on an annual basis thereafter, the Center shall provide to persons who receive services and their legally authorized representatives written notification in a language and/or method understood by the individual of the

Center's policy for addressing concerns or dissatisfaction with services/supports. The notification shall explain:

- (1) an easily understood process for persons and legally authorized representatives to request a review of their concerns or dissatisfaction by the Center;
- how the person may receive assistance in requesting the review;
- the timeframes for the review; and
- the method by which the person is informed of the outcome of that review.

The Center shall notify persons and legally authorized representatives in writing in a language and/or method understood by the individual of the following decisions and of the process to appeal by requesting a review of those decisions:

- (1) a decision to deny the person services/supports at the conclusion of the Center's procedure which determines whether the person meets the criteria for services; and
- (2) a decision to terminate services/supports and follow-along from the Center or its contractor, if appropriate.

The written notification referred to above must:

- 1 . be given or mailed to the person and the legally authorized representative within ten working days of the date the decision was made;
- state the reason for the decision;
- explain that the person and legally authorized representative may contact either the Center within 30 days of receipt of notification if dissatisfied with the decision and request that the decision be reviewed in accordance with this procedure; and
- include name(s), phone number(s) and address(es) of one or more accessible staff to contact during office hours.

If a person or legally authorized representative believes that the Center has made a decision to involuntarily reduce services by changing the amount, duration, or scope of services/supports provided and is dissatisfied with that decision, then the person may request in writing that the decision be reviewed in accordance with this procedure.

The review by the Center shall:

- begin within ten working days of receipt of the request for a review and be completed within ten working days of the time it begins unless an extension is granted by the CEO of the Center;
- begin immediately upon receipt of the request and be completed within five working days if the decision is related to a crisis service;
- be conducted by an individual(s) who was not involved in the initial decision;
- include a review of the original decision which led to the person's dissatisfaction;
- result in a decision to uphold, reverse, or modify the original decision; and
- provide the person 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 person to:
  - have a representative talk with the reviewer; or
  - submit his or her concerns in writing, on tape, or in some other fashion.

Following a review, either the Center shall explain to the person and legally authorized representative in writing and also in person or by telephone, if requested, the action it will take or, if no action will be taken, why it will not change the decision or believes such action would not be in the person's best interest. This is the final step in the review process.

The notification and review process described in this procedure:

(1) is applicable only to services/supports funded by DSHS and provided or contracted for by its local authorities;

(2) does not preclude a person or legally authorized representative's right to reviews, appeals, or other actions that accompany other funds administered through the Center or its contractors, or to other appeals processes provided for by other state and federal laws, e.g., Texas Health and Safety Code, Title 7, Chapter 593 (Persons with Mental Retardation Act); 42 USC §1396 (Medicaid statute); and Texas Human Resources Code, Chapter 73 (Chapter 621 of this title (relating to Early Childhood Intervention)), Early Childhood Intervention programs as funded by the Texas Interagency Council for Early Childhood Intervention.

- **DSHS UM Oversight Activities**

The Center will participate in UM oversight activities, including submitting any requisite Appeal Reports, as defined and scheduled by DSHS.

- **Quality Management and Utilization Management**

The Center's Quality Management (QM) provide oversight to ensure compliance with and the quality of the implementation of Texas Resilience and Recovery Services (TRR), monitor fidelity to service models, monitor performance in relation to Department of State Health

Services-defined performance measures, and coordinate activities with the regional UM program.

- **Provider Profiling**

The Center will utilize provider profiling to review, identify, and analyze current mental health community services, providers, and utilization patterns in order to educate clinicians and facilitate practice improvement.

- **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 as such in this Utilization Management Plan. It is the responsibility of the Center's contracted Utilization Manager to ensure oversight of these delegated activities, in conjunction with the Center's Quality Management staff. To that end, ETBHN will provide all Utilization Management reports, results, analysis, of the above- mentioned Delegated Activities to the ETBHN Regional Oversight Committee, as well as to the Center's Quality Management Department.

- **Utilization Management Program Evaluation**

The UM program of the Center is evaluated at least annually to determine its effectiveness in facilitating access, managing care, improving outcomes, and providing

useful data for resource allocation, quality improvement, and other management decisions and what improvements may be made. Any Utilization Plan Evaluation conducted by the Center will include an evaluation of the Center's Performance Contract measures. UM Program Evaluation activities will be reflected in the UM Committee meeting minutes.