



**Coastal Plains**

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**Community MHMR Center**

**Quality Management Plan**

Fiscal Years 2005-2008

REVISED for FY 2007

**Quality Management Plan – FY 2005-2008**  
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## INTRODUCTION

Coastal Plains Community MHMR Center (CPMHMR) defines quality as an ongoing collaborative effort with internal customers, external customers and other stakeholders utilizing various forums that afford each group an opportunity to describe and define quality. The concept of quality involves a dynamic attitude that permeates all areas of the organization and has a direct impact on all stakeholders. The ultimate achievement of quality lies in meeting the highest expectations of the individuals served. Quality management integrates fundamental management techniques, existing improvement efforts and technical tools in a planned, disciplined approach which is focused on continuous process and outcome improvement.

In the past year, the Quality Management Department has accomplished many projects. Due to the reduction in FY05 budget, the QM department has been down sized to one employee, the QM Director. Though the QM Department consists of only the QM Director, the Director of Authority Functions supervises the QM Director and provides support through assignment of other Authority Department personnel, e.g. the Data Management and Analysis Coordinator, for special projects and assignments. CPMHMR's QM Department is frequently utilized for agency-wide projects. In addition to these specific projects, the QM Department has continued to complete reports required by the State agencies (Department of Aging and Disability Services – DADS and Department of State Health Services – DSHS) as well as those requested by CPMHMR staff. With the groundwork laid in many areas, the QM Department looks forward to maintaining current projects and focusing on new ones.

## **Mission, Vision, Values and Guiding Principles**

The Quality Management Plan is driven by, and supports the mission, vision, values and guiding principles of Coastal Plains Community MHMR Center. These statements follow, respectively:

### **Mission**

The *mission* of Coastal Plains Community MHMR Center is enhancing personal growth in our community through support, guidance, education and advocacy.

### **Vision**

Coastal Plains Community MHMR Center will be a leader in quality human services as defined by the people it serves.

### **Values**

#### ***Communication***

Communication begins with listening and results in mutual understanding.

#### ***Confidence in People***

People, given the opportunity, will fully participate in decisions affecting their lives, gain skills and define their own success.

#### ***Education – Knowledge – Experience***

The acquisition of skills and knowledge is a lifelong process.

#### ***Individuality – Diversity***

We find harmony in diversity by appreciating differences.

#### ***Optimism***

There is power in positive thinking.

#### ***Trust – Honesty***

Effective partnerships begin with trust and honesty.

#### ***Clarity in What We Do***

Reduction of needless complication helps some people make informed choices.

#### ***Sense of Purpose***

Happiness comes from having a sense of purpose

### **Guiding Principles**

Respect will be demonstrated by consistent application of the following principles:

- We have confidence in people.
- We believe that work enhances a person's stature and provides opportunities for meaningful relationships
- We listen to people's opinions and needs
- We believe the individual is the driving force in service planning
- We address each person's unique preferred lifestyle in productive and meaningful ways.

## **PLANNING**

### ***Planning Process***

The Quality Management Program has implemented a formal agency-wide planning process and has established goals, objectives, performance indicators, responsible staff and time frames for which the improvements need to be accomplished. The agency-wide goals are identified as the Quality Improvement Plan (QIP). The Quality Management (QM) Committee meets quarterly to review progress reports on all of the quality improvement initiatives. From the progress reports, the objectives are evaluated, modified if needed and additional objectives are added, based upon the needs of the Center.

### ***Direction***

The overall goal of the Quality Management Program is to improve the performance of the Center. The Plan has specific goals that result in provision of quality services to the consumers and the community. Quality Management initiatives direct accountability, assessment of agency systems, and evaluation of data that is generated through performance improvement activities.

## **QM GOALS, OBJECTIVES, AND OUTCOMES**

### **Goal 1: Support CPMHMR in meeting or exceeding all applicable requirements and standards.**

#### **Objectives:**

1. Consistently review all new applicable Texas Administrative Codes (TAC's).
2. Distribute TAC's to appropriate personnel to ensure staff receive up-to-date information on standards
3. Request, as appropriate, revision of CPMHMR's policies and/or procedures based upon new TACs.

#### **Measurable Results:**

1. Review applicable Texas Administrative Codes within 30 days of receipt.
2. New TACs are distributed to appropriate personnel and management staff have provided training to employees.
3. Policies and/or procedures are revised, as appropriate, per new TACs and submitted to appropriate committee/board for approval
4. All applicable staff are trained on any new policies and/or procedures

#### **Outcomes:**

1. QM department reviewed all new applicable Texas Administrative Codes.
2. Employees are complying with standards set by the State
3. Policies and procedures are followed, ensuring quality services that meet state standards

**Goal 2: CPMHMR will conduct monitoring and compliance oversight to ensure that the highest quality of services are provided.**

**Objectives:**

1. Conduct Data Verification and Encounter Verification Reviews on a quarterly basis per Data Verification Criteria (DVC), to include submission of findings and subset samples/supporting documentation as required by State Authorities.
2. Develop Plans of Improvement for any Data Verification or Encounter Verification review where the Center falls below 95% accuracy.
3. Conduct monitoring and compliance reviews per Center plan
4. Monitor outcomes from State surveys
5. Conduct internal surveys
6. Conduct TIMA study annually and per DSHS contract (e.g. 06 1<sup>st</sup> quarter).
7. Develop Plans of Improvement with appropriate management staff for any significant deficiencies.
8. Monitor Plans of Improvement

**Measurable Results:**

1. 100% of Data Verification audits are completed and reported to State and Senior Management within the required timeframe.
2. Monitoring and Compliance reviews are completed
3. State and internal survey outcomes are reported to management and PNAC
4. TIMA studies are completed annually and per DSHS contract.
5. Plans of Improvement are developed for Data Verification reviews or other monitoring and compliance reviews where results are below standards.
6. Plans of Improvement monitored by Executive Director/Executive Management Team as needed.

**Outcomes:**

1. Data Verification and Encounter Verification reviews are conducted on a quarterly basis, meeting/exceeding the 95% compliance standards. Results and documentation submitted to State Authority within designated time frames.
2. Monitoring and Compliance reviews result in meeting of targets/benchmarks set by Senior Management.
3. If targets/benchmarks are not met, Plans of Improvements are developed and implemented. Plans are monitored and improvements are noted
4. Survey results indicate consumer satisfaction with services.
5. TIMA studies indicate improved compliance with TIMA protocols and at least 90% compliance with DSHS review per contract requirements.

**Goal 3: Implement continuous improvement practices.**

**Objectives:**

1. Evaluate the results from satisfaction surveys, monitoring activities, focused reviews (internal and external) and data analysis for continuous quality improvement activities.
2. Present risk indicators, outliers and trends to the Quality Management Committee and/or Senior Management staff to identify benchmarks for services.

### **Measurable Results:**

1. Quality Management Team and/or Senior Management will develop benchmarks and/or improvement targets
2. Plans of Improvement will be developed and/or objectives will be added to the Quality Improvement Plan to meet and/or exceed overall performance requirements.
3. Benchmarks and/or targets are met.

### **Outcomes:**

1. Results from DVC, performance targets, focused reviews, monitoring and compliance reviews and other data reflect achievement of benchmarks/targets.
2. A decrease in outliers will be noted in data management reports (internal and external) resulting in a decreased need to focus on specific areas of service

### ***RESPONSIBILITIES OF QM DEPARTMENT***

- Coordination, development, and monitoring of CPMHMR Planning to include:
  - Local Service Area Plan (formerly the Strategic Plan)
  - Quality Improvement Plan
  - Network Development Plan
  - Provider of Last Resort Plan
  - Diversion Action Plan (formerly the Jail Diversion Plan)
  - ADA Transition Plan
  - Abuse Neglect Reduction Plan
  - Consumer Benefits Assistance Plan
- CPMHMR Monitoring and Compliance Reviews
- Data Verification and Encounter Verification Reviews for State Authority
- Monitoring of the Texas Implementation of Medication Algorithms (TIMA)
- Monitor Other Initiatives
- Complete reports required by State Authorities (DADS and DSHS)
- Complete reports requested by CPMHMR staff
- Rights Officer/Ombudsman for Consumers of CPMHMR Services

### ***QUALITY-RELATED RESPONSIBILITIES OF MANAGEMENT AND COMMITTEES***

#### **BOARD OF TRUSTEES**

The Board of Trustees of Coastal Plains Community MHMR Center has ultimate responsibility for the quality of services, practices, and outcomes of the organization. The Board delegates responsibility for the development, implementation, oversight, and evaluation of the Quality Management Plan to the Executive Director and his leadership team. The Board maintains the following responsibilities:

- to maintain the viability of CPMHMR through Board actions in the allocation of resources;
- to hold ultimate responsibility for the quality of the CPMHMR care/outcomes and the services, practices and outcomes of the contracted providers;
- to review, to provide input for, and to approve the Center's planning activities, as outlined within this plan;

- to ensure the involvement of stakeholders including consumers, families, advocates and interested citizens in the planning process through the Planning and Network Advisory Committee; and
- ensures that CPMHMR and its contract providers deliver the highest quality services to consumers and families in our communities.

## **LEADERSHIP/SENIOR MANAGEMENT**

The leadership (Senior Management) of Coastal Plains MHMR is comprised of the Executive Director, the Deputy Director (Support Services), the Director of Authority Functions, the Director of Access and Intake, the Director of Mental Health Services, the Director of Mental Retardation Services, and the Chief Financial Officer. This Team meets weekly and is responsible for:

- Review of any new legislative action that may impact the Center
- Review of financial reports
- Review of data management reports
- Monitoring of individual program status, to include upcoming reviews, state audits, etc.
- Review of Medicaid and other reimbursement reports
- Implement, oversee and review Quality Management activities
- Monitoring for Compliance of Contract and Standards.
- Monitor indicators of service provision.
- Monitor Cost Accounting Methodology (CAM) and Data Warehouse.
- Monitor CPMHMR Risk Assessment
- Reviewing management reports to ensure that issues related to both staff and consumer needs are properly handled.

## **QUALITY MANAGEMENT COMMITTEE**

To provide for its quality program, Coastal Plains Community MHMR Center utilizes a Quality Management Committee (QMC) comprised of a chairperson or representative from various Center committees and/or service areas.

The **Quality Management Committee**, chaired by the Director of Quality Management, includes the following members:

- Director of Mental Retardation Services
- Director of Mental Health Services
- Risk Manager
- Director of Access and Intake
- Director of Authority Functions
- Deputy Director

The Executive Director is an ex officio member of the QMC.

The **Quality Management Committee**, authorized by the Executive Director, is responsible for the overall oversight of quality management activities. Such activities include, but are not limited to, the following:

- Participation in the development of the agency-wide organizational self-assessment;

- Identification of performance indicators and prioritization of improvement activities;
- Evaluation of the results of ongoing measurement processes;
- Review of data collected and identification of trends;
- Coordination and integration of agency quality efforts;
- Oversight of the Quality Management Program;
- Identification of best practices within its network of providers;
- Development of the agency's Plan of Improvement
- Monitoring of improvement plans; and
- Oversight of the implementation of the goals and objectives of the Local Area Service Plan.

### **SAFETY COMMITTEE**

The **Safety Committee** is chaired by the Risk Manager and includes representatives of each Regional Safety Committee. This committee is responsible for reviewing the following:

- Plan for disasters
- Preventive maintenance issues
- Analysis of risk indicators to identify trends
- Compliance with Safety Plan

### **UTILIZATION MANAGEMENT COMMITTEE**

The **Utilization Management Committee**, chaired by the Director of Access and Intake, meets at least quarterly (monthly meetings are scheduled). Core membership includes the following:

- Contract Psychiatrists
- MH Director
- Director of Access and Intake
- Director of Authority Functions
- Quality Management Director
- Executive Director

Ad hoc committee members attend as dictated by the meeting agenda.

This committee is responsible for the following:

- monitoring data, analyzing trends and identifying outliers related to both internal and external providers;
- reviewing practice guidelines regarding the delivery of treatment in the most effective and efficient manner; and
- providing oversight of the processes for making utilization/resource allocation determinations (including the formal determination of medical necessity) based on clinical data, practice guidelines, and information regarding the client's needs with consideration of the client's and the LAR's treatment preferences and objectives.

## **HUMAN RIGHTS COMMITTEE**

Established as mandated by the TDMHMR Administrative Code, to protect, preserve, promote and advocate for the health, safety, welfare, legal and human rights of consumers. The Human Rights Committee is responsible for

- Ensuring that consumer rights restrictions utilize the least restrictive alternative.
- Ensuring that restrictions implemented are addressed using established guidelines.
- Meeting upon submission of any request for review of rights restrictions.
- Ensuring that minutes are maintained, which include date, place of meeting, individuals present, recommendations, actions taken and unresolved issues.

## **PLANNING AND NETWORK ADVISORY COMMITTEE**

The **Planning and Network Advisory Committee (PNAC)** includes consumers, family members, community members and advocates. (Note: the consumers/family members will representatives of both Mental Retardation and adult/child Mental Health services equally.) The role of the Planning & Network Advisory Committee is to advise CPMHMR on strategic planning, the development and evaluation of the provider network, and to respond to special assignments given by the Board of Trustees. The function of the Planning & Network Advisory Committee is to develop a Network Plan. The plan includes the designation of services to be open for providers. The Planning & Network Advisory Committee meets at least quarterly.

The Planning and Network Advisory Committee is responsible for assuring that local stakeholders have direct input and involvement in assessing and determining the service needs of CPMHMR. The PNAC is responsible for

- identifying the most important service needs in the community,
- providing input regarding the community's feedback for the purpose of Local Service Area Planning (formerly the Strategic Plan),
- providing input and feedback regarding the Center's budget on an annual basis;
- reviewing consumer feedback regarding services, via satisfaction survey results, and making recommendations on improvement activities (e.g. objectives for the Quality Improvement Plan); and
- advising the Board of Trustees on the Committees recommendations regarding network development and other planning initiatives.

## **Quality-Related Initiatives**

### ***Overview***

Over the last several years, the Mental Retardation Quality Assurance Improvement System (QAIS) Team was intensely involved in their own quality initiatives, as directed by the State Authority. In this system the QAIS team conducted interviews and completed an annual QAIS self-assessment and conciliation for consumers receiving mental retardation services. The QAIS team used *Personal Outcomes Measures (2000)* books as a guide. In FY2004, QAIS was omitted from the State contract. Initially, the Director of MR Services continued having quarterly meetings, with smaller reviews of records and fewer interviews. By the summer of FY 2004 it was determined that many people were to be provided the option to participate into the Texas Home Living (TxHmL) program and Home and Community-based Waiver program. With the rollout of this program, the enrollment and transition process, and the development of new service plans the priority was to meet the needs of the consumers and not to continue to have an MR Steering/QAIS Committee.

The Quality Management Director assisted by incorporating the major goals/objectives for Mental Retardation Services into the Quality Improvement Plan. At the beginning of FY 2005, the QM Committee agreed that the most efficient way to monitor plans, is to have all major goals and objectives on one plan, the Quality Improvement Plan. This provides management one document to review. Also, as the QIP is a living document, with the exception of the formal plan submitted to the State Authority, the working document will always have a section by each objective for a status report. This allows for tracking of progress on an ongoing basis.

The QM Department will continue to focus on the TIMA studies, Risk Assessments, Encounter Data, Data Warehousing, Data Verification Criteria, the Prevention and Reduction of Abuse and Neglect of the people we serve, Fidelity to Resiliency and Disease Management, Outcomes for both Mental Health and Mental Retardation services, increasing identification of Best Practices, Contract Compliance and implementing new monitoring tools.

### ***Co-Occurring Psychiatric and Substance-abuse Disorders***

One of the new mandates last year was the need to ensure identification, treatment and/or referral of individuals with Co-Occurring Psychiatric and Substance-abuse Disorders (COPSD). All staff that were employed in mental health services at that time were trained on this topic. CPMHMR then developed training for all new employees, to ensure that they are aware of the signs and symptoms of substance abuse, but also of intervention techniques and local resources. The Quality Improvement Plan continues to address this issue, as there is a continued need for services for people with dual diagnosis. Though CPMHMR has identified resources that are available in the community and provides referrals for ongoing services as necessary to address any unmet substance abuse needs, resources are limited due to the rural service area.

## ***Texas Implementation of Medication Algorithms***

Coastal Plains Community MHMR Center's Texas Implementation of Medication Algorithms (TIMA) program has been implemented for several years. This program, mandated by the State, is for consumers of mental health services and involves algorithms for prescribing psychiatric medications and an education and support program for consumers and family members. CPMHMR began implementation of the Children's Medication Algorithm Project (CMAP) during FY05. Our Center's Director of Access and Intake is a state certified TIMA trainer and provides training and support to Center staff as needed.

The psychiatrists utilize the TIMA patient visit forms when seeing the consumers; the consumers complete a symptoms rating scale prior to their visit with the doctor (and when their TRAG is due) and consumer run TIMA support groups have been formed in each service area. CPMHMR employees have been trained on the education aspect of TIMA. CPMHMR has obtained educational materials to be handed out to consumers by staff providing mental health services. The QM Department will conduct thorough studies of TIMA in compliance with the DSHS Performance Contract guidelines. CPMHMR will evaluate the TIMA studies and use the data to implement Plans of Improvement, based upon the result of these studies.

## ***Resiliency and Disease Management***

In conjunction with TIMA, CPMHMR continues to work towards fidelity to Resiliency and Disease Management (RDM). In order to determine if our agency is meeting the key structural elements of the service models, in the spring of 2005 we conducted a rapid review for the State Authority. This review was conducted at each clinic site and helped us determine where our areas of strength and areas of need were. The results were submitted to DSHS Quality Management Department for review. The local clinic directors were also enlightened on areas of improvement needed. CPMHMR will monitor fidelity to the service models through the development of an objective in the quality improvement plan. This objective will evolve, based upon the internal rapid and focused reviews conducted, in order to improve on the Center's fidelity to the models.

## ***Abuse, Neglect and Exploitation Reduction***

During the past two fiscal years (FY's 04 and 05), Coastal Plains Community MHMR Center has not had any confirmed cases of Abuse, Neglect or Exploitation of a person served by a staff member. As this was the case, instead of measuring, assessing and reducing incidents of abuse/neglect, our Center took the approach of working towards maintaining zero incidents of confirmed abuse cases. Our approach to this was through increasing awareness of what constitutes abuse as well as proper reporting procedures. Due to feedback from the State Authorities (DADS and DSHS), the Center revised the plan to analyze and review all allegations of abuse/neglect, even if unconfirmed. All allegations will be reviewed to assess possible risk factors. Findings will be shared with appropriate management staff with the intention of reducing future allegations and possible situations of abuse. CPMHMR is committed to improving client care and maintaining a record of zero confirmations.

## ***Cost Accounting Methodology***

Cost Accounting Methodology (CAM) provides CPMHMR with a consistent, standardized, industry normed method to determine the cost of service provision. This information is used to analyze the cost effectiveness of providing services by employed staff. It can also be used to evaluate collective staffs' performance. The CAM provides objective management reports.

## ***Risk Assessment***

The State Authority provides CPMHMR with a quarterly risk assessment report which assists in the contract management process. This report illustrates CPMHMR's performance on a variety of indicators. The Management Team uses this information to identify potentially adverse trends in performance data of Mental Health, Child & Adolescent, and Mental Retardation Services.

## ***Data Verification Reviews***

Data Verification Reviews provides CPMHMR with a process to evaluate our service provision, and the quality of the documentation of our services. These quarterly reviews provide the Center with an opportunity to thoroughly review client charts and services, and assist us to identify any training issues. Frequent monitoring contributes to the continuous improvement of our services and documentation of our data. Results of Data Verification Reviews are forwarded to the State. Summary data provides the Center with an opportunity to compare ourselves to other Community Centers.

## ***Encounter Data***

Provides a system for capturing several data elements about each service we provide, including the level of need of consumers, diagnosis of consumer, actual length of service, consumer name, staff member, means of delivery, location of service, first billed payors. We are able to analyze no show rates, cancellation rates and amounts of service provided. Reports based on these submissions are used to supplement other data retrieved from our clinical software.

## ***Data Warehousing***

Provides many reports that summarize our service encounters. These reports assist us to monitor service delivery and assessment practices. Specific reports track our performance on Outcomes. Other reports identify outliers that are reviewed by utilization management process. Reports also provide a comparison of service delivery across Community Centers.

## **Quality Management Process**

### ***Collection of Quantifiable Data***

Data is collected through surveys, DVC and subset sample, Data Warehousing, Encounter Data, Risk Assessment, Critical Issues Data, Care Data and reports. The

QM Department has determined several methods of data collection to be preferable in achieving results efficiently. Hand-delivering surveys, utilizing the sample size methodology, and utilizing streamlined audit tools are such preferable methods.

A high rate of return is important when conducting surveys in order to increase the weight of responses and to increase input overall. Consumer surveys are hand delivered when possible in an effort to improve the return rate. Staff surveys are distributed by supervisors with pre-labeled envelopes to ease the return of the survey. Increased education about the surveys and use of the results is being implemented in an effort to improve the return rate of staff surveys in the future. Some community surveys are mailed due to the challenging logistics of hand delivery, however, some are hand-delivered at meetings, focus groups or other gatherings. Continued implementation of the community education plan to address CPMHMR's role in the community will increase the return rate of community surveys in the future.

CPMHMR Quality Management Program uses the follow data to evaluate the Center's efficacy, by collecting and analyzing information on critical issues. Anasazi reports detailing service delivery, timeliness of documentation, productivity and revenue are reviewed at least monthly. The result of the Data Verification audits are reviewed quarterly. Data is also gleaned from CARE reports. Encounter Data is submitted monthly and the Data Warehouse is looked at each month (multiple times a month). The State compiles a risk assessment that is examined quarterly for adverse trends and validation of quality improvement activity. The QM Department can determine the frequency of data collection based on internal and external standards.

### ***Analysis and Evaluation of Data***

Once data have been collected, the Senior Management and/or the QM Department reviews the data. Quantitative analysis is conducted using audit tools to look for presence or absence of specific information. Qualitative analysis is completed by measuring actual results against quality indicators. Statistical analysis and evaluation are performed depending on the type of data involved. While analysis generally involves a review of detailed service and assessment data, our evaluations also include a review of systems, processes, and outcomes. The result of these processes is a reporting mechanism that holds CPMHMR accountable for providing appropriate, efficient, and cost-effective services and supports.

### ***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 other programs. Areas of need within a program require either a formal or informal Plan of Improvement describing strategies for improvement.

The QM Process assists in identifying and monitoring programs' benchmarking practices for possible implementation in other programs. Routine collection of data will assist in the initial identification of benchmarking practices.

## ***Benchmarking***

Trends are identified in reports that are reviewed by the Senior Management Team. Appropriate teams and committees then analyze identified information with the objective of renovating affected service areas. Recommendations from the teams and committees are reviewed by the Management Team for approval and implementation.

Benchmarking practices will drive the quality, efficiency and utilization of community resources.

## **Continuous Improvement Process**

Coastal Plains Community MHMR Center's system for process design, performance measure analysis and improvement is based on a continuous quality improvement model. The Center's approach to improving its performance includes the following essential processes:

- Designing processes
- Monitoring performance through data collection
- Analyzing current performance
- Improving and sustaining performance

### **Design**

Quality improvement processes are designed consistent with the Center's mission, vision, values, principles, needs of the local area, as well as requirements/priorities of the State Authority. As stated previously, the quality management program measures key indicators in identified areas. These performance indicators, developed through collaboration with stakeholders, reflect the unique cultural, linguistic, demographic, and regulatory requirements of the service area.

### **Monitor**

Coastal Plains MHMR collects data to monitor the stability of existing processes and identify opportunities for improvement. Data used to monitor performance includes, but is not limited to, the following:

- Performance indicators related to standards
- Stakeholder satisfaction
- Organizational performance measures
- Risk indicators

### **Analyze**

Collected data is aggregated and analyzed to effectively assess the Center's performance and to determine the following:

- Effectiveness of designed processes
- Level of performance
- Improvement needs

## **Improve / Plans of Improvement**

The Center develops performance indicators to establish criteria to be met. Though there are many occasions in which criteria is met, targets will be raised to improve performance. When performance does not meet criteria, a formal, written plan of improvement is submitted to Quality Management. Subsequent performance will then be evaluated to determine the effectiveness of each Plan of improvement.

Plans of Improvement (POI) are implemented to increase quality, efficiency and utilization of resources. This process utilizes a retrospective examination to assess effectiveness. POI's are a direct result of the monitoring of quality indicators and are a pivotal point. Analysis and evaluation of the data alerts the QM Department to the need for plans of improvement. A POI is developed when data or a review results in a less than the desired performance threshold. POIs require a goal, area of problem or concern, cause of problem/concern, strategy(s) for how improvements will be made, responsible staff and expected completion date/time line.

The Service Director (e.g. MR or MH Service Director) is responsible for working with the QM Director in development of the Plan of Improvement, based upon the need. The Executive Director will review the final POI and, if required will provide written approval prior to submission to the responsible State agency. The Service Director will be responsible for implementation of Plans of Improvement. The Senior Management Team reviews and evaluates progress towards the goals of POIs to determine if desired outcomes are achieved.

The collection and analysis of data leads to the development of Plans of Improvement and, over time, will reduce negative trends. Additionally, this planning process lends itself to identifying best practices. These identified best practices serve as benchmarks for leading Coastal Plains MHMR and its network of providers in the continual quality improvements planning process.

### **REVIEW/REVISION OF THE PLAN**

The Quality Management Plan for Coastal Plains MHMR Center is intended to be a functional and dynamic document that evolves over time. Thus the QMP will be reviewed, at least on an annual basis, and will be revised as directed by identified needs. At a minimum, it is expected that the plan will be revised to reflect changes in quality indicators and performance expectations.

## Attachment 1

### CONSUMER SERVICES

The QM Director will be responsible for the continuous monitoring of the following Consumer Services.

These summaries do not reflect the whole of services and their limitations, however, they do provide basic information about the services. Consumers of services must meet eligibility criteria, based upon the services, there must be medical necessity and based upon the service area, treatment plans, service packages approved, assessment completed, etc...

#### *Mental Health Services*

**Case Management** is provided to people who are eligible to receive services. The Case Manager assists individuals in accessing resources and services necessary to reach and maintain an optimal level of functioning in their community. This is done through linking, referring, and monitoring of services. There are various **service packages** in which case management services can be provided to people; based upon the service package, the case manager may also provide skills training to the individual.

**Medication Services** encompasses contracted psychiatric, contracted laboratory services and in-house nursing services. These services include prescribing of medications and periodic monitoring of the effectiveness of medications. Staff work to ensure that undesirable side effects are minimized and that medication is being taken as prescribed.

**Psycho-Social Rehabilitation Programs (PSR) and/or Skills Training** provide skills training and interventions designed to assist people with severe psychiatric disorders in learning how to identify and build upon strengths and abilities. Services also help people develop coping skills to better deal with factors which may contribute to mental illness. These skills can be taught in groups or on an individual basis, based upon the person's individual needs and service package.

**Supported Employment** provides customized training, placement, and on-going employment consultation services for people who are motivated and able to perform in a working environment. This service is provided to eligible people, based upon their service package or as an add-on service, based upon medical necessity.

**Supported Housing** provides assistance to enable individuals to succeed in chosen housing situations. These supports are based on the specific needs of each person, including location of affordable housing, negotiating leases, acquiring household items, obtaining subsidies, moving into residences and training on how to successfully maintain their homes. This service is provided to eligible people, based upon their service package or as an add-on service, based upon medical necessity. This service is typically a short-term service.

**Assertive Community Treatment (ACT) Alternative Program** is an intensive, rehabilitative case management program that provides services for people who have a history of intensive needs, as reflected in their use of the system. These services are used to reduce crisis and hospitalizations. Services are provided in the person's natural environment. A person would need to be in a specific service package, based upon risk factors and high needs to qualify for this intensive service. There are a minimum number of skills training service hours that are required to be provided to people in this service package, and many people do not wish to have this intense of contact with MHMR staff, as much of the training is in the home and community.

### **Youth & Family Program (Y&F)**

**Case Management** is provided to children who are eligible to receive services. The Case Manager assists the child and his/her Legally Authorized Representative in accessing community resources and services necessary to reach and maintain an optimal level of functioning in their community. This is done through linking, referring and monitoring of services and supports. Many of the case managers, based upon the child's service package, also provide skills training to the child and family. This training occurs in the home, school, office and community and is based upon a structured curriculum specified by the State Authority.

**Medication Services** encompasses contracted psychiatric, contracted laboratory services and in-house nursing services. These services include prescribing of medications and periodic monitoring of the effectiveness of medications. Staff work to ensure that undesirable side effects are minimized and that medication is being taken as prescribed.

**Skills Training** provides training and interventions designed to assist children, adolescents and their parents in learning how to identify and build upon strengths and abilities. Services also help them develop coping skills. With the service package requirements, skills training is curriculum based per diagnosis and is required for both the child and the Legally Authorized Representative.

### **Mental Retardation Services**

**Service Coordination** is provided to all people who receive services. The Service Coordinator assists individuals in accessing resources and services necessary to reach and maintain an optimal level of functioning in their community. This is done through referrals, monitoring of services and advocacy.

**Psychological Services** includes psychological assessments and consultation to facilitate adaptive behaviors, as well as consultations with psychiatrist and other providers, as needed.

**Nursing Services** include medical assessments, physician referrals, health and safety education and consultation with specialists, as needed.

**Respite Care Services** provide short-term, temporary relief from and/or for the individual's primary care giver(s). Individuals who stay at the agency's respite house or receive respite in their home, are provided with assistance and supervision with their activities of daily living and medications. The length of respite can vary from a few hours to a month.

**Site-based Habilitation Program** offers a more structured setting for individuals to learn independent living skills. The program's emphasis is to provide meaningful activities for people, teaching skills such as money management, kitchen management, computer skills, socialization skills, etc.

**Home and Community-based Services (HCS)** program is a Medicaid-waiver program that enables people to live in the community by providing needed supports and services. The program can provide assistance with residential care, supportive employment, nursing, day habilitation and therapeutic services, such as speech or occupational therapy services.

**Texas Home Living (TxHmL)** is a Medicaid-waiver program that provides less intense support services than HCS services to people with mental retardation residing in the community. This program can provide limited assistance with supported employment, nursing, day habilitation, dental and a variety of other services, not to exceed a limit defined by the State.

**In-Home & Family Support (IHFS)** is special funding made available to eligible individuals and/or their families to support them in participation in the community. Funds may be used to purchase services or items that will assist people in living independently in the community, with friends or with family. The services or items must relate to the unique needs of each person as related to their diagnosis.

### **Bay-to-Bay Early Childhood Intervention Program**

**Assessment** includes screening and evaluation to assess cognitive, speech/language, fine and gross motor, self-help, hearing, vision, nutrition and social/emotional development in children birth to three (3) years of age.

**Service Coordination** is offered to all families who receive services. The service coordinator assists the family with service planning, monitors service provision and progress on individualized goals. The ECI service coordinator assists the family in accessing services in and outside the ECI program.

**Specialized Services** includes both in-house and/or contracted occupational, physical and speech therapy as well as nutritional consultations, audiological and visual impairment teachers, nursing services and educational activities, based on need. These services are provided in the home or other community settings (such as day care). Instruction in community settings enables the parents and caregivers to receive instruction and guidance to foster the development of the child. This program serves the counties of Aransas, Bee, Live Oak and San Patricio.

**Attachment 2**  
**Quality Indicators Fiscal Years 2006-2007**

<b>Indicator</b>	<b>Methodology</b>	<b>Frequency</b>	<b>Target</b>
State profiling elements (indicators)	From reports sent out periodically by State Authority	As distributed by SA	Low risk No outliers
Compliance with Medicaid billing and reimbursement protocols	Collected by QM Director through random sample reviews using a standard protocol	Per Center Schedule	95%
Direct service hours for each direct service staff	Collected from Anasazi reports	Monthly	As per Center Performance Indicators
Outcome targets for ALL service areas (Adult & Child MH Services – DSHS and MR Services – DADS)	DATA Warehouse	Monitor monthly, Quarterly reporting to State	Per Contracts (DADS and DSHS)
Provider complaints addressed within two working days	Collected by Authority staff	Annually	100%
Continued Implementation of TIMA	Collected by QM Director through TIMA Studies Review	Annually/per contract requirements	Increased compliance compared to previous studies (90% for focused review – DSHS Form W)
New Generation Medications	Collected by QM Director based upon ‘focused review’ results for DV audits for State Authority	Twice a year or per State Data Verification reviews	95%
Continued implementation of COPSD services	Collected by QM Director through random sample reviews using standard protocol	Twice a year	95% compliance = referrals/monitoring of COPSD issues
Fidelity to Resiliency and Disease Management Models	Collected and Monitored through QM Director and UM Director	Quarterly Monitoring	Increased compliance
All State Reviews result in re-certification of program(s) reviewed	Monitored by QM Director and Senior Management Staff	Per State Review Schedule	Meet all Re-Certification requirements
Reporting and Monitoring of the MR Services Critical Incident Data	Collected by MR Services Director	Submitted Quarterly	No outliers No serious incidents
Maintain low incidence of Abuse, Neglect and Exploitation of Consumers by Staff	Collected by QM Director and CARE Reports	Quarterly Reports	Ultimate Goal: 0 confirmations per quarter