QUALITY MANAGEMENT
and LOCAL PLAN
Fiscal Years 2021– 2022

Texas Panhandle CENTERS
Behavioral & Developmental Health
Making Lives Better

Revised August 2020

Texas Health and Human Services Commission

Intellectual and Developmental Delay Services

Table of Contents

Mission, Vision, and Values

The mission of Texas Panhandle Centers (TPC) is to respond to the behavioral and developmental health needs of individuals by creating an accessible system of care that supports individual choice and results in lives of dignity and independence.

The vision of Texas Panhandle Centers is **"Making Lives Better."**

Values –

- *Individual Worth -* We affirm that the individuals we serve share with us common human needs, rights, desires and strengths. We appreciate our cultural diversity and individual uniqueness and commit ourselves to support and enable each person's choices and preferences.

- *Quality -* We commit ourselves to the pursuit of excellence in everything we do.

- *Integrity -* We believe that our personal and professional integrity is the basis for public trust.

- *Dedication -* We take pride in our commitment to public service and to the care of the people we are privileged to serve.

- *Innovation -* We are committed to developing an environment which inspires and promotes innovation, fosters dynamic leadership and rewards creativity among our staff, volunteers, and the people we serve.

- *Teamwork -* We believe that teamwork is essential for providing comprehensive and professional services. Teamwork relates to the individuals we serve and staff, as well as collaboration with other service agencies, family members, etc.

- *Accountability -* We believe in being accountable to the public, our payers, and those we are responsible to serve. This accountability encompasses fiscal, contractual and system of care performance.

QM Authority and Overview

The Executive Director of TPC acts on behalf Texas Department of Health and Human Services (HHSC) as its representative and as such, has the authority and responsibility to establish an integrated Quality Management Program within the Center. The Executive Director has designated the responsibility for coordinating Quality Management activities within the Center to the Director of Quality Management. The Rights Protection Officer, Coordinator of Compliance and Planning and Director of Utilization Management / Medical Practice Coordinator are key participants in the Quality Management Program and work closely with the QM Director. Quality Management activities are prioritized and planned to ensure compliance with regulatory requirements and to promote continual improvement processes for TPC. To allow for a more objective analysis of processes and program improvements, the Quality Management and Utilization Management Programs are organizationally independent from other TPC programs.

QM - UM Organizational Chart:

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                    │ Executive Director  │
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                    │ Director of Quality │
                    │   Management &      │
                    │    Compliance       │
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│ Director of  ││QM Coordinator││ Coordinator  ││Rights        │
│ Utilization  ││& Safety      ││of Compliance ││Protection    │
│ Management   ││Director      ││& Planning    ││Officer       │
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QM Program Functions

The primary purpose of the Quality Management Program is to assure the highest quality services are provided to eligible individuals in the most cost-effective manner. Integral to this cause is the concept of continuous quality improvement and focus on progressively improving

administrative and clinical efficiencies as well as outcomes of care and services. Since performance of important organizational functions significantly affects service outcomes of care and customer satisfaction, the QM Program's primary focus is to achieve these goals by monitoring, analyzing, evaluating, reporting and recommending improvements in organizational functions. Specific Quality Management Program processes are detailed in this bi-annual plan.

Stakeholder Involvement

The QM Program provides for input from various stakeholders including the individuals that we serve, family members, community members, staff, contractors, committees, and the Board of Trustees. The following bulleted items are ways in which the QM Program involves stakeholders in the improvement processes.

- On a monthly basis, QM and/or UM provide written reports of departmental activities to the Board of Trustees. As requested, "live" program presentations are also provided. Feedback is given directly to the Executive Director and the Director of Quality Management.

- As needed, public forums are held for community input. Such forums play a key role in local planning and network development. Information and recommendations are gathered from forums and disseminated to the appropriate programs including Quality Management. Planning and process improvements are developed using this information.

- Surveys are conducted on a regular basis to obtain input from providers (internal and external) as well as from the individuals who receive services and their families.

- The Compliance Program is closely integrated with both the QM and UM programs. Any person including citizens, external providers, staff, and individuals receiving services can report compliance issues, which are investigated and trended within the Quality Management Program. Process improvements can be implemented from the trending and analysis of this compliance data.

- Individuals receiving services, family members and external providers are encouraged and do participate on various committees. Those committees can suggest ideas for improvement through Quality Improvement recommendations which are reviewed by the Director of Quality Management and presented to the Executive Management Team.

- Coordination with various primary care facilities to improve continuity of care for persons with behavioral health and medical needs. Cross-training about available services improves access as well as crisis response times. Communication among providers ensures effective prescription management and a more holistic treatment approach.

- In order to provide status reports and gain input on crisis redesign (including diversion from jails and hospitals) and provider network expansion, TPC management staff meet periodically with law enforcement, judges, and hospital administrators.

- MCOT (Mobile Crisis Outreach Team) staff work closely with the Amarillo Police Department's Crisis Intervention Team, Sheriffs' Departments and county judges to solicit feedback on the effectiveness of crisis redesign services. The IDD Crisis Intervention Specialist (CIS) works closely with this team to provide appropriate feedback and intervention related to individuals identified as being within the IDD population. Recommendations are addressed during regularly scheduled staff meetings and process improvements are implemented in a timely manner.

- The TPC Continuity of Care Case Managers work closely with the state supported living centers local and state psychiatric hospitals to coordinate discharge planning and timely transition to less restrictive treatment settings.

Committees receive their authority from the Board of Trustees and are appointed by the Executive Director. Committee members demonstrate leadership in their designated areas, provide data analysis and information as needed, conduct reviews as requested and effectively communicate information and committee findings to stakeholders. As applicable, the committees operate according to the guidelines outlined in the current HHSC Contract. Committee minutes are submitted to the Quality Management Department. The minutes are reviewed for any quality improvement recommendations, which are then forwarded to the Executive Management Team. All recommendations are considered with the outcome communicated to the originating committee.

Quality Management has representatives on most standing committees and quality management functions are inherent within each committee. If an area has been identified as needing a process improvement, the Executive Director assigns committees and/or Executive Management Team specific tasks or projects to complete. The following list of TPC internal committees describes each committee and the function of that committee.

Compliance/HIPAA Committee
This committee is responsible for implementing and monitoring the compliance program. Activities include reviewing existing policy and procedure and updating when necessary to meet regulatory obligations. This committee reviews compliance trending data and assists in the development of preventive and corrective action plans. This committee meets at least quarterly.

Credentialing Committee
This committee reviews internal and external provider credentialing application packets to ensure that minimal credentialing standards are met. External stakeholders participate in this committee's activities. Since voting can be conducted via email, the committee meets on an as-needed basis.

Death Review Committee
This committee (claiming peer review privilege) appointed by the Executive Director in consultation with the Chief Medical Director, reviews the deaths of individuals served to identify and address any administrative and clinical issues. An external provider participates in this committee's activities.

Executive Management Team
This management committee receives, evaluates, and when indicated, requests reports from all service/programs responsible for quality improvement activities. Through its activities and review of audit findings, the committee ensures the program is comprehensive in scope, the care of individuals is of optimal quality and services are delivered in a safe, cost-effective manner. The committee is responsible for implementation of program improvements on a center wide basis. The committee generally meets twice each month.

Human Resources Committee
This committee guides the efforts of the Human Resources Department to increase employee's job performance and capabilities through educational offerings. This committee meets on an ad hoc basis, pending feedback during evaluation period.

***In*fection Control Committee**
This committee establishes and reviews methods for investigating, reporting, preventing and controlling infection in the service delivery environment. The committee makes recommendations regarding procedures for management and follow-up of infectious diseases within Center programs. This committee also reviews and updates the Infection Control Plan as necessary but at least annually. Committee meetings are held on a quarterly basis.

IDD Committee
The committee reviews, recommends and clarifies processes for IDD related programs as well as monitors peer review activities for IDD programs.   This committee meets quarterly.

Medication Error Committee
This committee reviews medication errors for corrections, actions and trends. The committee usually meets monthly unless there are (4) four or less errors.

Nursing Peer Review Committee
This committee evaluates the merits of complaints concerning RN's and LVN's (among others). This committee meets on an ad hoc basis, pending feedback during evaluation period.

Provider Advocate Committee
This committee is required as part of the Board of Nursing Rules on delegation. The committee acts as the CRA (Client's Responsible Adult) only in the situations in which the individual cannot make decisions regarding health care and does not have a single identified adult that is willing and able to participate in decisions about the overall management of an individual's health care. The committee must consist of at least the assessing RN, CEO/designee and a person employed by the provider who is responsible for service delivery oversight.

Rights Committee

This committee reviews practices and proposed programs to ensure that the rights of individuals being served by TPC are not limited without due process. This committee meets on a monthly basis.

Trauma Informed Care Committee

This committee is comprised of staff from various departments of TPC. The committee is tasked with transitioning TPC into a Trauma Informed Organization. This includes surveying, identifying, implementing and reviewing organizational procedures, facilities, training, treatment, and strategies for community outreach to address effects of trauma upon those we serve and work alongside.

Risk Management/Safety Committee

This committee reviews trends of incidents and injuries. The committee also makes recommendations for addressing identified needs and correction of problems, and monitors the implementation of such recommendations. The committee also provides monitoring and evaluation of risk events, investigation of the circumstances of risk events and evaluation of the effectiveness of corrective actions in order to prevent similar occurrences with other individuals or staff. Meetings are held at least quarterly.

Wellness Team

This committee promotes and implements healthy initiatives for TPC to reduce absenteeism, increase productivity, and encourage the health and wellness of TPC employees. Specific initiatives also impact the health and wellness of those receiving center services. The team meets on an as needed basis.

Utilization Management Committee

This committee reviews the Center's resource utilization data with the ultimate goal of establishing the most cost-effective treatment interventions for persons receiving direct services. Outlier practices are studied to make recommendations for improvement. This committee meets at least quarterly or more often as needed.

IV. Measuring, Assessing and Improving Authority Functions

An authority is defined as a publicly accountable entity that holds the single point of responsibility for planning, policy development, resource development and allocation, oversight, network development and individual empowerment within a specified geographic area. Local authority functions include the business operations/processes by which a local authority will manage system operations; ensure the clinically and economically efficient use of resources; address the individual's concerns and ensure satisfaction; ensure the competency and capacity of the provider network and ensure accountability. Authority functions identified by the HHSC Performance Contract are:

- Local Planning
- Policy Development
- Coordination of Services within the Local Service Area
- Resource Development

- Resource Allocation
- Oversight of IDD Services

Principal oversight components of authority functions include reviews and planning, management assessments, training, systematic planning of projects, data assessments and follow up. Data review is of utmost importance throughout quality improvement processes. Data based decision making provides the basis for recommending improvements in organizational functions and in analyzing the strengths and/or weaknesses of such improvements. As such, QM and UM focus on managing agency resources through the review of utilization data needed for identification of best provider and business practices.

Planning $\longrightarrow$ Implementation $\longrightarrow$ Assess/Improve

Local Planning
The QM Program is responsible to provide a systematic method of reviewing, maintaining and monitoring all plans. TPC develops and implements the Local Plan consistent with the HHSC strategic priorities referenced in the Health and Human Services System Strategic Plan and ensures the timely submission of plans as appropriate. The QM Director supervises the Coordinator of Compliance and Planning and provides oversight of planning activities. The Coordinator of Compliance and Planning takes the lead role in planning for the center and serves as the agency facilitator for TPC's Planning Network Advisory Committee (PNAC). TPC's Planning and Network Advisory Committee is a combined IDD and behavioral health committee. Per the HHSC Performance Contract (Performance Contract), PNAC requirements are followed and PNAC reporting and recommendations are provided to the Center's Board of Trustees at least quarterly.

Planning and Network Advisory Committee
The Planning & Network Advisory Committee (PNAC) serves both MH and IDD interests meets quarterly and on an as-needed basis to provide broad-based community input into the planning process and Center's growth. The Center strives for committees' membership that reflects the ethnic, cultural, and social diversity of the community and includes representation of individuals served and family memebrs of individuals served. The role of the PNAC is to reflect the perspectives of individuals, family members and other stakeholders on the provisions of services and supports.

The "Guidelines for Local Service Area Planning" received by the Center on February 28, 2005 provides expected outcomes for the PNAC. The Board shall establish outcomes and reporting requirements for the PNAC. The expected outcomes of the PNAC include:

- The PNAC operates according to the charge assigned by the local board; and
- Individuals receiveing adult behavioral health, children's behavioral health, and intellectual and developmental disabilities services and their families or guardians, are represented and their views are explicitly incorporated into recommendations of the PNAC

The PNAC is charged with the following:
- Identify the needs and priorities of the local service area;
- Submit recommendations to the Center staff and Board regarding the content, development, and implementation of the Local Service Area Plan and budget strategies to meet the community needs and priorities; and
- Provide input in assembling a network of available and appropriate service providers to meet the needs of individuals in the local service area while considering public input, ultimate cost-benefit, and individual care issues to ensure the individual's choice and the best use of public money.
- Receive a written copy of the final annual budget and biennial plan for each program area as approved by the Board of Trustees, and a written explanation of any variance from the PNAC's recommendations.
- Receive information regarding total funds available through the Performance Contract document for services in each program area and required performance targets and outcomes.
- Reports to the Board of Trustees at least quarterly on issues related to: the needs and priorities of the local service area; implementation of plans and contracts; and the PNAC's actions that responds to special assignments given to the PNAC by the Board of Trustees.

The Center provides initial and ongoing training to the committee members. The training provides members with information they need in order to perform the tasks and fulfill the purpose of the committee. The Center will attempt to recruit family members of children or adolescent individuals to serve on the PNAC.

Planning activities have successfully guided Texas Panhandle Centers in achieving its goals of providing the Center, its Board of Trustees, and its staff focus and direction. The Center educates staff, individuals, family members, committees, government officials, advocacy groups, and other interested individuals and agencies on the planning process. Updates to additional resources are also posted on the center's website as needed. The Executive Management Team (EMT) and management staff participate in strategic planning to develop specific center-based goals and objectives. Through the development of local plans, the center's mission, vision, and values were developed, all of which remain the focus of our operations today.

Policy Development
The QM Department maintains Policy & Procedure and provides technical assistance to Program Managers as requested in developing Operation Manuals. Notice of revisions to Policy and/or Procedure is provided to the appropriate directors. The responsibility rests with each director to ensure policies and procedures are implemented in the respective programs. The QM Program monitors implementation via training documentation sheets, staffing and committee meeting minutes. All Administrative Policies and Procedures are available on-line to provide ease of access. Hard copies are also available upon request. Each Policy and Procedure is reviewed and the content checked for compliance with applicable standards by the Director of Quality Management. Policies and Procedures are coded by subject matter by

the QM Department for ready reference. The QM Program coordinates the annual review of Policies conducted by the Board of Trustees. The QM Program also coordinates and ensures all Policies and Procedures are reviewed by the appropriate Executive Managers at least annually.

Coordination of Services within Local Service Area
The QM Program collaborates with directors from crisis services, screening/intake, and service coordination/case management to ensure that persons have access to 24-hour crisis support services, referral information, and disaster assistance when needed. Collaborative efforts also ensure that eligible individuals have a choice of providers and receive timely service based on individual needs and preferences. Cooperation with network providers and other human service agencies facilitates a team approach and quality continuity of care. TPC collaborates with many external providers to include (but not limited to): Community Resource Coordination Groups (CRCG/CRCGA), Outreach Screening Assessment and Referral (OSAR), Amarillo Council on Alcoholism and Drug Abuse (ACADA), Early Childhood Intervention (ECI), Community Services Supervision and Corrections (CSDS), Texas Juvenile Justice Department (TJJD), Texas Department of Family and Protective Services (TDFPS), Amarillo Independent School District (AISD), Canyon Independent School District (CISD), Highland Park Independent School District (HPISD), Randall County Detention Center, Northwest Texas Hospital, and the Panhandle Suicide Coalition. Minutes, training logs, and/or MOUS serve to evidence collaborative efforts. Program reviews, focused reviews, individual served/family surveys and/or data are utilized to measure and assess the following:

- An easily accessed, continuously available, and well publicized crisis hotline to provide screening, information, support, referrals, and crisis intervention
- Participation of the Suicide Prevention Coordinator in required activities to include regular dissemination of prevention information and resources
- Access to Mobile Crisis Outreach Team for assistance with crises
- Efficient use of scheduling to ensure timeliness of intake assessments. Assessment results are available on the day of intake and services are initiated depending on eligibility.
- Consistent monitoring of waiting/interest lists to maintain contact with individuals and provide appropriate support and referrals
- Persons eligible to receive services are provided with information on service options and are encouraged to choose from a variety of providers. Efforts are made to have a individual's providers located within 75 miles of the individual's residence
- Persons not eligible to receive services are informed of community resources
- Person-Centered recovery planning that reflects individual needs and builds on the individual's strengths
- Effective coordination of services (including participation in the development of transition and/or discharge plans) for individuals being transferred to/discharged from other center programs, schools, hospitals, jails and other facilities
- Appropriate notification of adverse determinations, education of individuals in filing appeals and use of objective criteria when making timely appeal determinations
- Effective collaboration with other human service agencies necessary to ensure that individuals receive needed services in the least restrictive setting

To ensure statewide quality improvements, QM and UM staff participate with other centers through consortium meetings, comnets, e-groups, and workgroups.

Resource Development
The QM Director works closely with the Chief Financial Officer, Chief Administrative Officer, and Coordinator of Compliance and Planning to ensure that strategies are developed to optimize earned revenues and maximize monies to provide services. Regular program reports and data reviews occur during committee meetings, and program meetings and Executive Management Team (EMT) meetings to assess administrative/overhead costs and plan strategies for cost-containment.

The Contracts Management Program through the Planning and Network Advisory Committee facilitates network Development. The Director of Human Resources and Contracts Management collaborate with the Director of Quality Management when developing a new contract within the network or when revising current contracts. In general, the Planning and Network Advisory Committee then makes contract recommendations to the Board of Trustees. The QM Program reviews the contracts when necessary to ensure compliance with appropriate contract, state and federal requirements. The QM Program provides coordination and oversight of all reviews and audits that related to these contracts.

TPC provides, encourages and supports opportunities for growth and development to all employees, both individually and collectively. Resources from within the Center, educational institutions, consultants, the community at large, and state and national resources are utilized to enhance staff development and growth. Human Resource Development (HRD) provides training programs to employees, which meet training requirements for all applicable standards. The QM Program works closely with HRD to provide training to staff to ensure compliance with all statutory, regulatory and professional requirements. The following types of training are provided by the QM Program either as a result of an audit, review, or as requested from Program Managers or other interested parties:

- Documentation Training
- Utilization Management
- Policy and Procedure
- HIPAA
- Compliance
- Risk/Liability
- Other requested subjects

The Quality Management Program and Utilization Management Program work closely to ensure that individuals receive the services they need while maintaining equitable distribution of agency resources. UM relies on reports (e.g. iSERV reports, MBOW, Pivotek) to monitor utilization patterns and provider practices. In turn, QM, UM and other administrative programs collaborate to develop and implement the processes necessary to modify inefficient utilization practices. Examples of such are as follows:

- Focused review of individual cases to ensure appropriate authorization and justification for services
- Observation of clinical practices and consultation with program managers regarding provider best practices
- Incorporation of new technologies
- Staff training on the rationale for UM and its role in facilitating access and ensuring efficient resource allocation
- Staff training on the importance of data-based decision making and implementation of sound business practices within a social service agency
- Consistent monitoring of Waiting List/Interest List data
- Collaboration between Behavioral Health and IDD managers to ensure quality care and communication among providers for individuals with dual diagnoses.

Oversight of IDD Services

Quality Management is responsible for oversight of service delivery and design and facilitates improvement activities. All TPC programs and personnel are subject to QM reviews, satisfaction surveys and other audits. TPC contracts with a number of licensed external providers in various disciplines who are also subject to reviews, surveys and other audits as outlined in each provider contract.   The QM Program coordinates all external reviews, audits and surveys that may be conducted by state or federal entities. The following chart/work plan outlines key reviews and audits that are conducted or overseen by the QM Program for both internal and external providers.

Mechanism	Person/Entity Responsible	Time Frame
External Contractors Review	Contracts Management	Annually
Data Accuracy Review	Information Services	Monthly
Compliance Investigations	Quality Management	As Reported
Compliance-UM Reviews	Compliance Team	Prior to Claims and Encounter Submissions Bi-Monthly
Facility Infrastructure Review-	Building Safety Coordinators	Bi-Annually
ADA Plan Review	Director Human Resources	Annually
Critical Incident Data Reporting	QM & Designated Program Managers	Monthly
Quantitative Records Review	Medical Records Staff	Annually
Rights Review and Approval	Rights Protection Officer	Monthly
Complaints/Appeals	Rights Protection Officer (RPO) Director of UM	Quarterly

Mechanism	Person/Entity Responsible	Time Frame
Peer Review – Assigned Quarterly via QM	Program Directors and Providers	Annually
Consumer Satisfaction Surveys	Rights Protection Officer (RPO) Quality Management	Annually
Provider Profiling – iSERV Reports, MBOW Reports, Unit Progress Reports, Intelliprocess/Pivotek	Data Management/Contracts Quality Management	Continuous process
Utilization Management – MBOW Reports, Hospitalization Data, Appeals, CAM/MAC, Crisis	Medical Director Director of UM Quality Management	Continuous process
Safety/Risk Monitoring	Quality Management Safety/Risk Committee	Quarterly
Death Reporting	Director of UM & RPO	As Occurs
Infection Control Monitoring	Infection Control Designee and Committee	Monthly
Infection Control Surveys for High Risk Areas	Program Managers and Infection Control Committee	Continuous
Productivity Monitoring – iSERV Reports and Intelliprocess/Pivotek	Quality Management Information Services Program Managers	Monthly
Survey of Contract Services	Contracts Management	Annually
Waiting Lists/Interests List	Coordinator of Authority Services	At Least Monthly
Type A and B Service Coordination Services	Coordinator of Authority Services	At Least Monthly
Trust Fund Reviews	Assigned Supervisor	Monthly
Mechanism	**Person/Entity Responsible**	**Time Frame**
HCS and TxHmL Service Utilization Reports	Coordinator of Provider Services	Monthly
HCS ICAPs and ID/RCs	Coordinator of Provider Services	As Due
Review of Financial Status and Budget	Chief Administrative Officer Chief Financial Officer Board of Trustees Program Managers	Monthly
Performance Contract Review	Quality Management Program Directors EMT	Bi-Yearly
Authority Services	Program Managers, Quality Management EMT	Bi-Monthly
PASSR	Quality Management Program Directors	Bi-Monthly

Autism Program	Quality Management, Program Directors	Continuous

Once reviews/surveys/audits are completed, they are presented to the EMT, Board of Trustees and/or the Planning Network Advisory Committee for further input. Feedback loops are established and communication with the QM Program occurs via meetings, emails and phone calls. The QM Program will require plans of correction for reviews that are substandard or score below 90%. The plans of correction will address training needs, technical assistance and necessary follow up to correct any problem or deficit areas. If an external audit requires a plan of correction, the QM Program will review the plan for content so that all deficit areas are addressed adequately. The QM Program also monitors timely submission of all performance contract submission and any plans of correction.

Compliance Team
In response to the initiation of the Recovery Audit Program-Audits (through Centers for Medicare/Medicaid), the Executive Management Team recommended implementation of a Compliance Team in fiscal year 2015. The purpose of the team is to ensure documentation practices adhere to applicable laws, rules, and regulations including compliance with all HHSC IDD services provided through TPC. The team conducts proactive (pre-billing) audits in an effort to confirm that documentation supports medically necessary services as evidenced by the connection of clinical assessment, recovery/treatment planning & service provision. The five-member compliance team is made up of the Team Lead (Coordinator of Compliance and Planning), program managers, supervisors and senior staff representing both IDD and Behavioral Health Services.

A proactive approach minimizes problematic claims submission through early needs identification. Timing is central for communication of findings, submission of correction action, and follow up to ensure corrections are implemented.

Scope & Responsibilities
- Discuss sample to be reviewed. Reviews will be completed within 5 business days of assignment. Completed reviews will be submitted via interoffice mail to the team lead.
- Team lead will compile data from all reviews and complete report to be submitted to Director of Quality Management and Compliance.
- For general issues related to documentation practices, the team will develop and implement a Corrective Action Plan which may include technical assistance by the Quality Management Department.
- For more provider specific errors, the provider and the manager of the department where the documentation error was identified will complete and submit a Plan of Correction to the compliance team lead within 10 business days. Team lead will then submit the Plan of Correction to the Director of Quality Management & Compliance. The appropriate Program Manager/Supervisor will conduct a follow up review within 60-days by use if the compliance audit tool and report the findings to the team lead. The number of cases reviewed will be determined by the compliance team lead who

will then review a sample of the submitted records to measure inter-rater reliability and to ensure improvements have been achieved.

- If the follow-up review is determined to be unsatisfactory, the Program Manager/Supervisor and team lead will discuss possible disciplinary action which team lead will discuss with Director of Quality Management and Compliance.
- If, during a routine audit, serious needs are identified, team members will report their findings to the team lead immediately via phone or email. Serious needs are identified as suspected fraud, waste, or abuse. The compliance team lead will then report findings to the Director of Quality Management and Compliance for further investigation to include notification of the Executive Director.
- The compliance team lead will provide quarterly reports to the Compliance Committee and/or Executive Management Team.

Data Accuracy

Reviews occur monthly to ensure compliance and to measure and assess accuracy in billing and data submission. The Information Systems department reviews all non-covered/non-billable service claims for errors and all covered service claims that were rejected. Business Objects reports are utilized for these reviews. Information Systems staff and Quality Management staff assess the error reports for trends and provide follow up with the programs/staff where errors are occurring. Corrections to data are made when appropriate and Quality Improvement processes are developed to increase data accuracy and improve outcomes. Other data accuracy processes that occur monthly are:

- Program Directors and supervisors evaluate all Texas Home Living Person Directed Plans and quarterly reviews for accuracy and quality.
- Program Directors and supervisors evaluate HCS quarterly reviews and Individual Service Plans for accuracy and quality.
- Program Director and supervisors review Service Coordination documentation practices for accuracy and quality.

Quality improvement activities are indicated when deficit areas are identified. Program Directors can address the deficit areas through training, closer supervision and monitoring. Additional training, technical support and consultation are available through the Quality Management program to correct identified deficit areas.

Outcomes

Quality improvement processes that have been developed to address targets and/or outcomes prescribed by the Performance Contract are as follows:

- The waiting list/interest list is monitored regularly and contact with waiting list participants occurs as required.
- HCS and TxHmL enrollments and Permanency Plans are monitored regularly to ensure completion within required timelines.

- Staff productivity reports are reviewed in staff meetings. Plans of Improvement are developed for anyone not meeting standards.
- Provider incentives as determined by management.
- Budgetary and financial activities are monitored to ensure appropriate use of dollars (i.e. not supplementing and preparation of fee-for-service).

Health and Safety Initiatives

Health and safety improvements are the responsibility of all staff. Several initiatives have been developed to minimize risk incidents and to ensure the health and safety of all staff and individuals. Those initiatives are as follows:

- Medication audits in group home settings are performed monthly by a Pharmacist to ensure accurate med orders, refills and dosing requirements.
- Risk Management committee reviews all injuries and accidents and addresses areas of concern to ensure quality improvements.
- Licensed nursing staff checks documentation related to medications in each group home at least monthly to reduce documentation errors and ensure data accuracy.
- Licensed nursing staff monitor medication delegation practices at least biannually or more frequently if needed.
- Designated supervisory staff surveys each group home on a regular basis for cleanliness, accuracy of medication logs, accuracy of documentation, medication cabinets are locked, individuals are appropriately supervised, and staff are appropriately attending to the individuals. Appropriate television programs are monitored if the TV is on in the home.
- Maintenance department surveys each group home for safety issues such as appropriate lighting, walkways are cleared, smoke detectors are working, etc.
- Service Coordinators utilize resources to ensure smoke detectors are purchased for individuals living in the community.
- All direct care staff persons are required to take van driver training.
- Safety drills are conducted as required in the group homes, day programs and administrative buildings.
- Safety training is provided to individuals in day habilitation settings. The trainings address various topics such as calling 911, what to do in case of a fire, etc.

Trauma Informed Care

Texas Panhandle Centers embraces the perspective and life experiences of those we serve and employ. We strive to utilize strengths-based language along with culturally sensitive practices, engaging others respectfully in light of possible traumas.

Utilization Data and Provider Profiling

A primary focus of UM is to influence provider practice to meet specific management and clinical goals and to minimize unwanted practice variation while maintaining quality service. This includes analysis of utilization data and a mechanism to influence provider practice patterns. The ability to understand utilization data and use it to impact provider practice is the best way to manage the utilization of resources. Although data plays a vital role in process improvements, a team approach and communication among providers is central to the successful provision and quality care for individuals served by TPC.

Methods used to influence provider practice include:
- Utilization review with consistent feedback to managers and providers
- Thorough communication with Continuity of Care worker for transition from inpatient to outpatient treatment
- Provider profiling to include review of data with providers
- Consistent review of utilization data by unit managers including review with providers
- Regular review of utilization data by management and feedback loops for reporting back on results of process changes
- Provider incentives as determined by management

Service targets, performance measures and outcomes are monitored by several different layers of management. Redundancies of data review are built into staff meetings and committee meetings to ensure accurate data analysis. At the program level supervisors are monitoring caseload data for accuracy in service provision, amounts of service provided and appropriate authorization for those services.

The Executive Management team monitors targets and outcomes regularly to ensure compliance. Resources are made available to program managers so that services may be successfully implemented as prescribed in the HHSC Performance Contract.

Network Development and Monitoring of External Providers and Contracts
The Contracts Management Program through the Planning and Network Advisory Committee facilitates network development. The Director of Human Resources and Contracts Management collaborates with the Director of Quality Management when developing a new contract within the network or when revising current contracts. In general, the Planning and Network Advisory Committee then makes contract recommendations to the Board of Trustees. The QM Program will review the contracts when necessary to ensure compliance with appropriate Contract, state and federal requirements. The QM Program will provide coordination and oversight of all reviews and audits that may occur with these contracts.

The Quality Management Program, Contracts Management and Program Directors are all responsible for monitoring and providing oversight to external providers. Programs including HCS, TxHmL, PASRR, Crisis Respite, CFC, as well as individual contractors are reviewed by the Contracts Management program. These reviews are forwarded to Quality Management for oversight. At the Program level, contractors who provide services receive training as required. Program managers review individual services to ensure quality and adherence to all requirements. Contractors needing additional training may be referred to Quality Management.

Reduction of Incidents of Individual Abuse, Neglect and Exploitation
The Rights Protection Officer (RPO) is the liaison between TPC and the Texas Department of Family and Protective Services (TDPRS). The RPO coordinates any investigations involving the care and treatment of those the agency serves, including TDFPS investigations. The RPO is also responsible for handling other individual/LAR complaints or appeals. Data is maintained and is reviewed by the UM Committee, Executive Management Team, and Board of Trustees.

The RPO is responsible for the development of an annual Abuse/Neglect Reduction Plan. This plan is based on data gathered during the year in quarterly reports. The reports contain the following elements:

- Number of allegations by class, location, funding source, and individual served
- Number of confirmations by class, location, and disciplinary action
- Comparison data from previous months and years
- Findings
- Analysis
- Recommendations

Reports are distributed to The Board of Trustees and the TPC Executive Management Team (to include the Director of Quality Management and Compliance) quarterly. An annual report is developed, additionally. The annual report is compared to the reports from previous years and those comparisons are also used in the development of the Abuse/Neglect Reduction Plan. After review of all information and results of the work plan from the previous year, a goal for the next year is developed.

In FY 2018, TPC had a goal of reducing confirmations by 1% from the previous fiscal year which was not achieved, as there was a 1% increase in confirmations.

In FY 2019, TPC set a goal of reducing confirmations by 1%. There was only one confirmation involving a client receiving developmental health services, which is a 3% reduction from the previous year.

The following strategies were developed to assist in achieving this goal:

- Continue the collection and distribution of quarterly allegation and confirmation data

- Continue to offer supplemental training such as Stress Management, Ethical Behavior, Time Management, etc.

- Continue a 95% compliance goal related to staff training on Abuse, Neglect and Exploitation Prevention and Reporting

- Monitor trends related to staff involved, and report any concerning trends to the Director of QM and Compliance for further action if necessary

- Continuation collection of daily client injury, and unusual activity data.

- Continuation to improve new employee training on abuse, neglect and exploitation.

- Continue to proactively provide new specific training and retraining for staff, as warranted.

- Continue to implement all recommendations from DFPS and client rights investigations.

The Abuse/Neglect Reduction plan is reviewed annually by the Executive Management Team and more often as appropriate. The plan is maintained in the Offices of the RPO and the Director of Quality Management and Compliance.

Quality Improvement Processes for Center Initiatives

Balancing Incentive Program (BIP)
Federal law established the Balancing Incentive Program (BIP) which increases the Federal Matching Assistance Percentage to participating states in exchange for making certain structural reforms to increase access to Medicaid community based long-term services and supports (LTSS). The required structural reforms include implementing a "no wrong door" eligibility and enrollment system; developing core standardized assessment instruments; and ensuring case management activities are conflict free.

Medication Practices – Nursing
The Nursing Department will focus its quality initiatives in the areas of training and delegation, medication monitoring practices, and increasing contact with individuals served. Delegation training and medication education and monitoring will be of utmost importance for providers. Simplifying forms will reduce the likelihood of errors. Medication monitoring improvements will address security practices, especially for controlled substances, pill tracking, and associated documentation. Nursing staff will conduct routine quality checks and QM will assist in periodic reviews.

LPND
Contracting with private providers is not a novel process for Texas Panhandle Centers. The Center has a history of outsourcing services. Other than a full time Medical Director, all physician services are contracted out, and seventy-five percent of CBT services are contracted out. Texas Panhandle Centers also has contracts in place with many other providers, including providers of:
- Crisis Hotline services
- Interpretation services
- Dual-diagnosis therapy
- Pharmacy services
- Nursing services
- Peer support, advocacy and employment programs
- Emergency Residential Care/Respite services
- Lab Services

To ensure that contracted providers are meeting requirements, the Quality Management program will perform reviews of documentation to ensure standards are met. Additional assessments of provider competence will include surveys and profiling, credentialing and compliance with federal and state laws.

Should Texas Panhandle Centers incur a sanction by HHSC for failure to meet a contract requirement and it is determined the provider's action or lack of action caused Texas Panhandle Centers to receive the sanction, the external provider will be responsible for the amount of the sanction. In addition, the external provider will be responsible for completing

plans of action to comply with any findings by Texas Panhandle Centers or HHSC for lack of adherence to any rules, regulations, and requirements.

Community First Choice (CFC)
CFC is a federal Medicaid benefit allowing states to provide home and community-based services and supports to Medicaid recipients with disabilities under 1915(k) of the Social Security Act. Texas is implementing CFC as a new Medicaid State Plan benefit. Texas Panhandle Centers began the implementation of CFC on June 1, 2015. CFC services include, Personal Assistance Services, Habilitation, Emergency Response Services (ERS), and Support Management. Individuals enrolled in a 1915(c) waiver are eligible to receive CFC Services. Individuals not in a 1915(c) Medicaid waiver may also be eligible for CFC and would receive services through a managed care organization.CFC services are only available to individuals residing in their own home or a family member's home (OH/FH). Individuals who would otherwise be eligible to receive Supported Home Living (SHL) or Community Support (CS) will transition to CFC personal assistance services and habilitation services (PAS/HAB).

Tobacco Free Campus
Texas Panhandle Centers Health is committed to providing a safe, clean, and healthy environment for individuals served, staff, and visitors, and is dedicated to promoting health, wellness, prevention and the treatment of diseases within our Texas Panhandle communities.

As part of this commitment, on November 15, 2012, in coordination with the American Cancer Society's Great American Smokeout, all Texas Panhandle Centers campuses became tobacco-free.

As part of our tobacco-free campus, staff are provided with support in their efforts to quit smoking and using other tobacco products. Tobacco cessation programs and other support are available at low or no cost to employees who want to stop using tobacco products. We do this for the benefit of everyone- the individuals receiving TPC services, families, volunteers, and staff.

As a means to assess the success of the program, managers will monitor anonymous employee data related to tobacco use as provided by the center's health insurance provider.

In April, 2015, Texas Panhandle Centers joined a cancer prevention initiative lead by the Cancer Prevention & Research Institute of Texas entitled, Taking Texas Tobacco Free. Our involvement thus far has involved sending a trainer to Rutgers University and an additional 12 provider staff to a regional training to learn the motivational interviewing technique. TPC plans to use the information and techniques learned to encourage and support individuals and staff who have verbalized or indicated a desire to be involved in tobacco cessation to move towards non-use, and identify and educate individuals who are in the pre-contemplation phase regarding the risks associated with tobacco use and the benefits of cessation. TPC's goal is to make quitting tobacco use a part of an overall approach to wellness for individuals served and employees.

Crisis Respite Services
Crisis Respite provides short-term intervention strategies to individuals in crisis. By doing this we aim to protect the person, caregiver, and/or others living in the home. This program also serves to provide interventions that prevent or decrease hospitalization/state supported living center admissions. Individuals with a diagnosis of Intellectual or Developmental Disorder (IDD) and/or a related condition, who are experiencing a crisis that cannot be stabilized in a less intensive setting, qualify for Crisis Respite Services. A crisis is defined as a situation in which: the individual presents as or believes they are an immediate danger to self/others, or when the individual's mental or physical health is at risk of serious deterioration. Individuals who present in an 'emergent' psychiatric crisis are not eligible and will be referred to an inpatient setting.

Out-of-Home Crisis Respite
Therapeutic support provided in a safe environment with specially trained staff providing 24-hour supervision to an individual experiencing a crisis that cannot be stabilized in a less intensive setting (such as an HHSC-authorized crisis respite facility or crisis residential facility). These services are can be accessed 24 hours a day, 7 days a week, with a maximum stay of up to 14 days.

In-Home Crisis Respite
Therapeutic support provided in the individual's home, when it is deemed clinically appropriate for the individual experiencing the crisis to remain in his/her natural environment, and it is anticipated that the crisis can be stabilized within a 72-hour period. Services are available Monday-Friday, 8:00 a.m. - 6:00 p.m. Services are provided in weekly sessions (more often when needed) and scheduled with the family and/or the individual. Skills training is provided to help the family and/or staff learn how to handle crisis situations appropriately and to be better able to cope with them in the future.
Services are available to qualified individuals residing in the 21 counties served by Texas Panhandle Centers.

Autism Program
The purpose of the Autism program is to respond to the needs of individuals diagnosed with Autism Spectrum Disorder. The aim is to cultivate reasonable expectations of behavior and behavior change in the individual, and to train the parent/guardian on how to carry out behavioral interventions or skills training. The goal is to support individual choices and to replace troublesome and challenging behaviors with adaptive behaviors. Individuals receiving services through Texas Panhandle Centers (aged 3 and up) who have a diagnosis of Autism Spectrum Disorder may qualify for this program.

Behavioral Support services are provided and consist of the following: individual behavior sessions, social skills groups, counseling sessions, parent (LAR) sessions/classes and parent training (to increase the individuals skills between training sessions).

The program helps individuals and/or LARs establish short-term goals and strategies that support the outcome provided in the Person Directed Plan. All goals are individualized and based upon a functional analysis and assessment of the individual. As the individual achieves their goals, training sessions occur less frequently, allowing the individual more time to practice the acquired skills in their natural environment. Once the individual has attained the

outcome in the Person Directed Plan and have practiced the learned skills without Behavioral Support for a minimum of six months, they are considered to have graduated the program. If the individual needs further training after practicing in the natural environment, the LAR, guardian or individual may contact the Service Coordinator who will begin the referral process for additional Behavioral Supports.

Pre-Admission Screening and Resident Review (PASRR)
Pre-Admission Screening and Resident Review (PASRR) is a federally mandated program that requires all states to pre-screen all individuals, regardless of payor source or age, seeking admission to a Medicaid certified nursing facility (NF). It was created in 1987 as part of the nursing home reform; through language in the Omnibus Budget Reconciliation Act (OBRA). It has three goals:
1) To identify individuals with an Intellectual or Developmental Disability (IDD) or Related Conditions.
2) To ensure they are placed appropriately, whether in the community or in a nursing facility, and
3) To ensure that they receive the services they require for their disability.

The purpose of PASRR is to provide options for individuals to choose where they live, who they live with and to give them access to the training and therapy needed to live as independently as possible. PASRR services are for individuals 21 years of age or older with an intellectual disability and/or a related condition or a developmental delay. PASRR services are provided in the NF or if and when a resident decides to transition out of the NF, services are provided at the new community home. After the transition is complete, Enhanced Community Coordination will begin providing services. Specialized Services are also provided in the community such as day habilitation and skills training. Behavioral Support Services can be accessed at any time and can be provided at nursing facility or in the community. There is also Physical Therapy, Occupational Therapy and Speech Therapy if a habilitation need is identified.

Enhanced Community Coordination (ECC)
Enhanced Community Coordination promotes successful community living for individuals with an Intellectual or Developmental Disability (IDD). Its focus is to divert, where appropriate, eligible individuals from a nursing facility (NF) or a State Supported Living Center (SSLC). The goal of the ECC Program is to ensure a successful transition from a facility into the community.
ECC provides services for any individual with IDD that is eligible to divert or transition from a nursing facility or a State Supported Living Center. The Enhanced Community Coordinator provides intensive service coordination which includes (but is not limited to) pre/post-transition monitoring, development of the Person Directed Plan (PDP), providing education about residential options and living arrangements and organizing tours with various residential programs. The Enhanced Community Coordinator can arrange for support needed to prevent and manage a crisis, such as utilizing the Transition Support Team or the Crisis Respite facility. The individual's interdisciplinary team (IDT) will develop the Individual Plan of Care for the selected waiver program, during which they will identify all necessary waiver program services and non-waiver services in the initial PDP. Designated funds are available to enhance an individual's natural supports and promote successful community living.

Medicaid Community First Choice (CFC) Services
The purpose of the CFC program is to foster improvement of/facilitate an individual's ability to perform daily living activities and to help preserve the family unit and prevent/limit out-of-home placement. CFC services are personal attendant and habilitation services for people with intellectual and/or developmental disabilities who reside in their own home or in a family home. CFC services are available to individuals who are enrolled in the HCS, Texas Home Living waiver programs or General Revenue Services, who are also Medicaid recipients with an institutional level of care. Services include:

CFC Personal Assistance Services
Services to help people perform activities of daily living (such as eating, toileting, grooming, dressing, and bathing), activities related to living independently in the community (such as meal planning and preparation, managing finances, shopping for food, clothing, and other essential items), and health-related tasks based on the person-directed plan.

CFC Habilitation
Acquisition, maintenance and enhancement of skills necessary for people to accomplish activities of daily living, activities related to living independently in the community, and health-related tasks.

CFC Support Management
Training on how to select, manage and dismiss attendants.

CFC emergency response services
Back-up systems and supports including electronic devices to ensure continuity of services and supports.

Monitoring the Effectiveness of the QM Plan
The Director of Quality Management and the Executive Director review the QM Plan annually. The Executive Director ensures that personnel implementing the Quality Management Plan have sufficient authority as well as access to programs, managers, documents and records AND the organizational freedom to:
- Identify deficit areas
- Identify best practices
- Independently facilitate necessary corrective actions

The Quality Management Program will improve its own quality system by ensuring that conditions that are adverse to quality care are:
- Prevented
- Identified and reported promptly including a determination of the nature and extent of the problem
- Corrected as soon as practical, including implementing appropriate corrective actions and actions to prevent reoccurrence
- Documented all corrective actions
- Tracked to ensure proper corrective action was implemented

It is the role and responsibility of the QM Program to serve as a quality and compliance umbrella for all of TPC's programs. The QM Department at Texas Panhandle employs the Plan-Do-Study-Act (PDSA) continuous improvement methodology to encourage continuous quality improvements within Center programs and initiatives The QM Program encourages staff at all levels to establish, maintain and continually improve communications with individuals served, family, staff and other community stakeholders. A clear line of communication leads to better services and supports by identifying problems and implementing effective solutions.