QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT PLAN

Fiscal Years 2019 – 2020

Revised April 2019

Texas Health and Human Services Commission
Behavioral Health Services

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I. Mission, Vision, and Values

The mission of Texas Panhandle Centers (TPC) is to *respond to the diverse needs of all people who require behavioral and developmental health services by creating an accessible system of care which supports choices 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 our clients and staff, as well as collaboration with other service agencies, family members, etc.

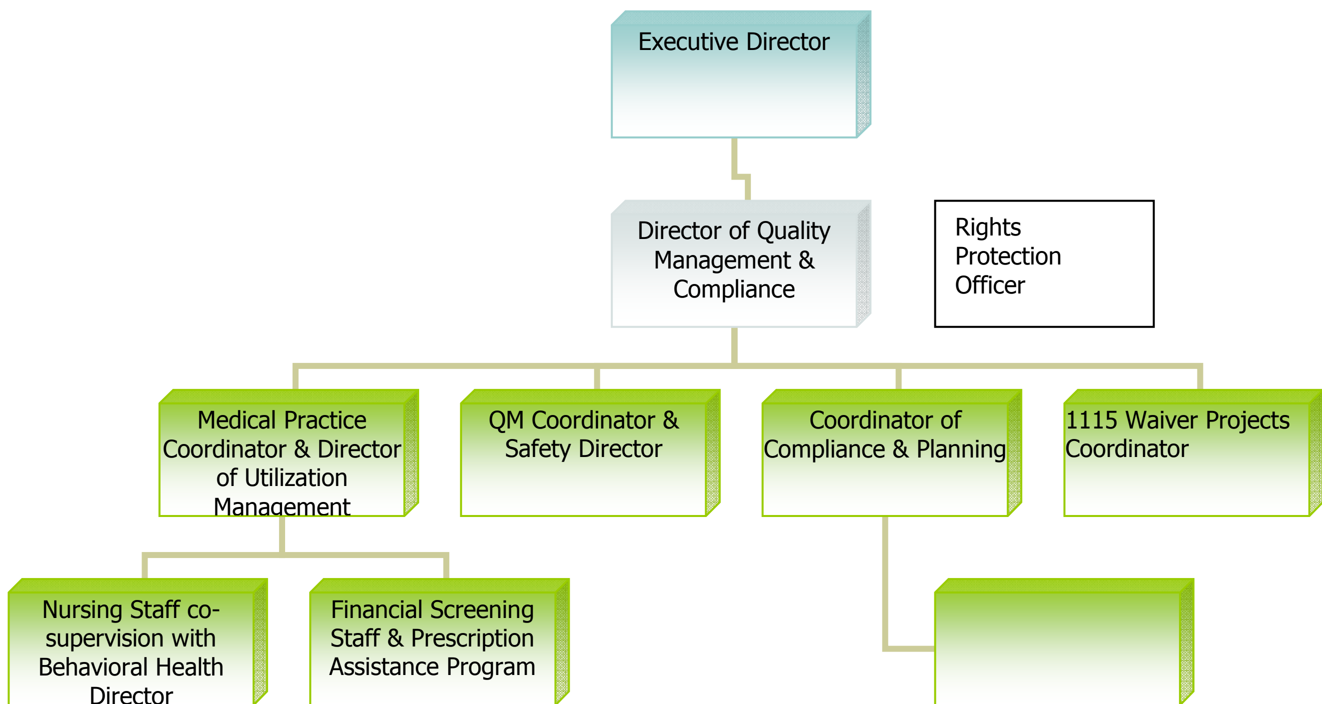
- ***Accountability -*** We believe in being accountable to the public, our payers, and those we are responsible to serve. This accountability encompasses fiscal, contractual and system of care performance.

II. QM-UM Authority and Overview

The Executive Director of TPC acts on behalf of the Texas Health and Human Services Commission (HHSC) as its representative and as such, has the authority and responsibility to establish an integrated Quality Management and Utilization 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, Director of Utilization Management, and Coordinator of Compliance and

Planning 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:



III. QM–UM Program Functions

The primary purpose of the Quality Management and Utilization Management Programs 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-UM Programs primary focus is to achieve these goals by monitoring, analyzing, evaluating, reporting and recommending improvements in organizational functions. Specific Quality Management-Utilization Management Program processes are detailed in this bi-annual plan.

Stakeholder Involvement

The QM-UM Program provides for input from various stakeholders including clients, family members, community members, staff, contractors, committees, and the Board of Trustees. The following bulleted items are ways in which the QM-UM 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. The Board also approves the QM-UM Plan.

- 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 clients and their families.

- The Compliance Program is closely integrated with both the QM and UM programs. Any person, including citizens, external providers, staff, and clients 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.

- Clients, family members and external providers are encouraged and do participate on various committees. Those committees can suggest ideas for improvement through QIC recommendations which are reviewed by the Director of Quality Management and presented to the Executive Management Team (EMT).

- 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.

- BH Program Managers coordinate with PATH (Projects for Assistance in Transition from Homelessness) providers to offer joint outreach activities. Community outreach aids in identifying those in the homeless population who might benefit from outpatient mental health treatment.

- 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 police – CIT (Crisis Intervention Team) to solicit feedback on the effectiveness of crisis redesign services. Recommendations are addressed during regularly scheduled staff meetings and process improvements are implemented in a timely manner.

- MCOT and the TPC Continuity of Care Case Manager work closely with the local and state psychiatric hospitals to identify high needs and/or difficult to engage clients. Frequent communication and thorough discharge planning facilitates timely intake to determine the appropriateness for TPC services including transitional services if needed.

- Extensive collaboration with Randall and Potter counties (e.g. judges, district attorneys, Veterans Administration, substance use providers, area churches, etc) to improve continuity of care and other services. Communication with the judicial departments and various community providers aids in successful jail diversion, hospital diversion and engagement in outpatient services following incarceration.

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 Director. 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 and Utilization Management have 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 the Executive Management Team to specific tasks or projects to carry out the warranted improvement(s). 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 client deaths 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, client care 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.

Infection 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.

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 or any significant error(s).

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.

Behavioral Health Committee
This committee's purpose is to support successful implementation of mental health programs and services to include Texas Resiliency and Recovery (TRR). A primary focus is consistent review of data to identify strengths as well as need areas. In turn, process improvements

are developed and implemented in a timely manner. Committee membership includes program managers and emphasis is placed on effective management strategies necessary to ensure accountability and to foster provider best practices.

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 clients 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
Reference description under UM Specific Program Functions

IV. UM Specific Program Functions

***** For additional information reference TPC Policy and Procedure.

Purpose of Utilization Management Committee:
The primary function of the UM Committee is to monitor utilization of the Center's clinical resources to ensure they are being expended effectively and efficiently. The UM Committee assists the promotion, maintenance and availability of high quality care through the evaluation of clinical practices, services and supports delivered by TPC and its contracted providers using clinical, encounter and administrative data and performance measures. Based on review of utilization data, the committee makes recommendations for improvements in provider practices and agency processes. The Committee consults with physicians, providers and others from appropriate specialty areas to ensure processes and decisions are accurate and consistent. The committee meets at least quarterly or on an ad hoc basis and reviews:

- Appropriateness of eligibility determinations;
- Use of exceptions and overrides to service authorization ensuring rationale is clinically appropriate and documented in the administrative and clinical record;
- Over- and under-utilization;
- Appeals and denials;
- Fairness and equity; and
- Cost-effectiveness of all services provided.

Composition of the Utilization Management Committee:
Required membership includes:
- Utilization Management Physician
- Utilization Management Representative
- Quality Management Representative
- Financial Services Representative
- Client Rights Officer

Participation by others as needed may included:
- Executive Managers
- Contracts Management
- Network Development
- Information Systems
- Medical Records
- Intake/Eligibility Staff
- Continuity of Care Staff
- Clinical/Professional staff or Providers

Committee Membership Credentials:
UM staff functions are outlined in TPC Policy and Procedure. Job functions are also outlined in staff's job descriptions and documentation of licenses, training, and supervision are maintained in staff's personnel record.

UM Physician: A fully trained (board eligible or certified psychiatrist) who possesses a license to practice medicine in Texas and provides clinical oversight of the UM Program.

UM Director-Manager: An RN, RN-APN, PA, LMSW-ACP, PhD Psy, LPC, or LMFT licensed in the State of Texas who has at least five years experience in direct care of persons with a serious mental illness and/or children and adolescents with serious emotional disturbance, which may include experience in an acute care or crisis setting; has demonstrated understanding of psychopharmacology and medical/psychiatric comorbidity through training and/or experience; has one year experience in program oversight of mental health care services; and has demonstrated competence in performing UM and review activities.

Utilization Reviewer: Minimum qualifications of a Qualified Mental Health Professional – Community Services (QMHP-CS) as defined in the most current version of the Texas Administrative Code (TAC)-Mental Health Community Services Standards requires that the individual have at least three (3) years experience in the treatment of persons with serious mental illness and/or children and adolescents with serious emotional disturbance and must also be directly supervised by a qualified utilization manager.

Training Members of the Utilization Management Committee:
TPC will ensure that all UM Committee members receive appropriate training to fulfill the responsibilities of the committee. Training will be conducted at least annually, when needed, or when a new member is added. The UM Director will provide each member of the

committee information and materials (e.g. UM P&P, HHSC Utilization Management Guidelines) necessary to perform their function. The Utilization Management Physician, or his/her designee, will discuss with each new member of the committee: the role of the UM Committee, type of cases, data and information reviewed by the committee, and clarify the UM program and processes. All participants in the Utilization Management process are subject to strict confidentiality practices, as defined by the state and other applicable rules. All committee members will sign a confidentiality statement prior to participation on the committee.

Conflicts of Interest:

No UM committee member may participate in the review of a case in which he/she has a conflict of interest or has been professionally involved. If a conflict occurred, the center would arrange for a non-involved medical provider to review the case. The UM Director will identify other potential conflict of interest situations and include such situations in training for UM staff and UM committee members.

V. 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 consumer 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 consumer concerns and ensure satisfaction; ensure the competency and capacity of the provider network and ensure accountability. Authority functions identified by Authority Attachment of the HHSC Performance Contract are:

- Local Planning
- Policy Development and Management
- Coordination of Service System with Community and HHSC
- Resource Development and Management
- Resource Allocation and Management
- Oversight of Authority and Provider Functions

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.

Local Planning
The QM Program is responsible to provide a systematic method of reviewing, maintaining and monitoring all TPC plans. The QM Program 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 the Planning Network Advisory Committee (PNAC). 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.

Texas Panhandle Centers as the designated Local Mental Health Authority (LMHA) is responsible for developing, updating and maintaining the Local Provider Network Development Plan (LPND) and the Consolidated Local Service Plan (CLSP) in compliance with the Performance Contract. The LPND is designed to develop a network of mental health service providers that will meet local needs and priorities, allow for more consumer choice, improve access to services, and make the best use of available funds, and promote consumer, provider, and stakeholder partnerships. The CLSP incorporates local service planning, crisis planning and jail diversion. PNAC participates in the development of the LPND and CLSP. In addition to required plans, the EMT and management staff participates in strategic planning to develop specific center-based goals and objectives.

Planning activities have successfully guided Texas Panhandle Center in achieving its goals of providing the Center, its Board of Trustees, and its staff focus and direction. The Center educates staff, consumers, 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. Through the development of local plans, the Center's mission, vision, and values were developed, all of which remain the focus of Texas Panhandle Center's operations today.

Policy Development and Management
The QM Department maintains Policies and Procedures 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 Service System with Community and HHSC
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, Preadmission Screening and Resident Review (PASRR), and disaster assistance when needed. QM, along with program managers monitor the 1915(i) Long Stay report to identify individuals who may be eligible for services within the Home and Community Based Services-Adult Mental Health services array. 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), The Pavilion at Northwest Texas Hospital, Amarillo Council on Alcoholism and Drug Abuse (ACADA), Region 16 Early Childhood Intervention (ECI), Community Services Supervision and Corrections (CSDS), Texas Juvenile Justice Dept (TJJD), Texas Dept of Family and Protective Services (TDFPS), Amarillo Independent School District (AISD), Canyon Independent School District (CISD), Care Today Urgent Health Clinics, Highland Park Independent School District (HPISD), Randall County Detention Center, Texas System of Care, Networking 4 Kids, Baptist St. Anthony's Hospital (BSA), Regence Health Network (the local Federally Qualified Health Care Center), Family Support Services, the Military Veteran Peer Network, Recovery Oriented Systems of Care (ROSC) and the Panhandle Suicide Coalition. Minutes, training logs, contracts and/or MOUs, serve to evidence collaborative efforts. Program reviews, focused reviews, client/family surveys and/or data are utilized to measure and assess the following:

- An easily accessible, 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
- Use of Open Access to facilitate timely intake assessments and service initiation
- As warranted, consistent monitoring of waiting lists to maintain contact with clients 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 consumer's providers located within 75 miles of the consumer's residence
- Persons not eligible to receive services are informed of community resources
- Individualized recovery planning that reflects client needs and builds on client strengths
- Effective coordination of services (including participation in the development of transition and/or discharge plans) for clients being transferred to/discharged from other center programs, schools, hospitals, jails and other facilities
- Appropriate notification of adverse determinations, education of clients 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

QM reviews the Clients' Benefits Plan to ensure compliance with Performance Contract requirements. This plan outlines necessary services for eligible clients to include applying for Medicaid and Supplemental Security Income, navigating appeals/denials and providing information on employment options.
To ensure statewide quality improvements, QM and UM staff also participate with other centers through consortium meetings, comnets, e-groups, and workgroups.

Resource Development and Management

The QM Director works closely with the Chief Financial Officer, Chief Administrative Officer, Information Services and the Coordinator of Compliance and Planning to ensure that strategies are developed to optimize earned revenues and maximize monies to provide services. Collaboration with other centers is also used to assist with efficiencies. Regular program reports and data reviews occur during committee meetings and managers' meetings to assess administrative/overhead costs and plan strategies for cost-containment.

The Contracts Management and Planning Programs through the Planning and Network Advisory Committee facilitates network Development. The Executive Director and Chief Administrative Officer 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 may occur with 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
- HHSC-approved Assessment (UA) and Utilization Management
- Policy and Procedure
- HIPAA
- Compliance
- Risk/Liability
- Other requested subjects

Resource Allocation and Management

The Utilization Management Program and Quality 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 such as level of care assignment/service capacity, over-utilization, under-utilization, practice variation, appeals determinations and hospitalizations. UM also discusses trends and patterns as well as procedural revisions in the UM Committee. 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 consistent application of UM Guidelines
- UM procedural revisions and consultation among UM staff to address authorization for challenging cases.
- 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

Oversight of Authority and Provider Functions

**This section not only describes Service Oversight as an authority function but also addresses measuring, assessing and improving services provided by TPC.*

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/QM	Annually
Data Accuracy Review	Information Services	Monthly
Compliance Investigations	Director of Quality Management & Compliance	As Reported
Compliance-UM Reviews	Compliance Team	Prior to Claims and Encounter Submissions - Bi-Monthly
COPSD Review	Quality Management	Annually
Compliance Plan Review	QM/Compliance Committee	Annually
Outcome Measures – MBOW Reports	Program Managers	Bi-monthly
Facility Infrastructure Review – Safety Review	Building Coordinators	Annually
Infection Control Monitoring	Infection Control Designee and Committee	Monthly
Infection Control Surveys for High Risk Areas	Program Managers and Committee	Annually
ADA Plan Review	Director Human Resources	Annually
Mechanism	**Person/Entity Responsible**	**Time Frame**
Quantitative Records Review	Medical Records Staff	Annually
Rights Review and Approval	Rights Protection Officer	Quarterly and needed
Complaints/Appeals	Rights Protection Officer and Director of UM	Quarterly
Client Satisfaction Surveys (adult and child)	Quality Management	On-Going
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	As Occurs
Infection Control Monitoring	Infection Control RN and Committee	Monthly
Productivity Monitoring – iSERV Reports and Intelliprocess/Pivotek	Information Services Program Managers Quality Management	Monthly
Access to Services/Mystery Caller	Quality Management	Bi-Annually
TCOOMMI	Program Director	Annually
Survey of Contract Services	Chief Administrative Officer and Contracts Management	Annually
Rider 65 – MBOW Reports Progress Note Review	Quality Management Utilization Management Program Manager	Monthly Quarterly
Crisis Redesign - MBOW Reports, Progress Note Review	Quality Management Program Manager	Monthly
ANSA/CANS Quality Assurance Training	Program Managers/ QM	Bi-Annually
Waiting List – MBOW Reports, Progress Note Review	UM Staff Intake – Crisis Director Executive Manager	Weekly (if Waiting List implemented)
New Gen Medication Review	Director of UM	Monthly
Mechanism	**Person/Entity Responsible**	**Time Frame**
Prescribing Practices Review	Quality Management Nursing Staff Medical Director	Annually
Review of Financial Status and Budget	Executive Director Chief Administrative Officer Board of Trustees Program Managers	Monthly
1115 Medicaid Transformation Waiver / DSRIP-Outcome Measures	Quality Management Special Projects Coordinator Program Directors I.T.	Bi-Monthly
Recovery Plan Review and Progress Note Review	Quality Management Program Managers	Quarterly
PASRR Review	Program Manager/QM	Annually
House Bill 13	Program Managers/ QM	Monthly

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 plans of correction.

VI. Evidence Based Practices and Utilization Data in Provider Profiling

As a move towards improved services and efficient stewardship of taxpayer money, HHSC requires contractors/providers to implement approved Evidence-based Practices (EBP) in treating persons with behavioral health needs. EBPs help bridge the gap between research and practice and promote quality mental health services. They are approaches to treatment that are based in theory and have undergone scientific evaluation. Research indicates that such treatments produce substantial gains in the form of improved symptoms and functioning. EBPs have a number of advantages including specific training programs to facilitate consistency in treatment provision, proven treatments which facilitate faster recovery, and evaluation of outcomes through data.

Fidelity reviews are conducted and include provider participation. Such reviews ensure treatment/documentation consistency and allow continuous quality improvement through peer review. Reviews are scheduled as noted in the following table.

Evidence-Based Fidelity Reviews:

Adult Services	**Person/Entity Responsible**	**Time Frame**
Assertive Community Treatment	Program Manager/QM	Annually
Supported Employment	Program Manager/QM	Annually
Supported Housing	Program Manager/QM	Annually
Illness Management & Recovery	Program Manager/QM	Annually
Cognitive Behavioral Therapy	Program Manager/QM	Annually
Children & Adolescent Services	**Person/Entity Responsible**	**Time Frame**
Required Monitoring		
Trauma Focused-CBT	Program Manager/QM	Annually
Seeking Safety	Program Manager/QM	Annually
Aggression Replacement Techniques	Program Manager/QM	Annually
YES Waiver	Program Manager/QM	Annually
Recommended Monitoring		
Wraparound Planning	Provider/Program Manager/QM	Annually
Nurturing Parenting	Program Manager/QM	Annually

Data Accuracy
Reviews occur bi-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.

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.

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 TRR services. 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. 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.

Utilization Data

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 successful implementation and quality client care.

Methods used to influence provider practice include:

- Implementation of TRR and consistent application of the UM Guidelines
- 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

Outcome Monitoring

Service targets, performance measures and outcomes for both Adult Services and Child and Adolescent Services 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 UM program monitors accuracy in UA assessment administration and provides training as necessary. The Behavioral Health Director meets with management staff bi-monthly to monitor performance levels.

The Executive Management team monitors TRR processes and practices as well. Targets and outcomes are reviewed regularly to ensure compliance. Resources are made available to program managers so that TRR may be successfully implemented as prescribed in the HHSC Performance Contract.

VII. Monitoring of External Providers and Contracts

The Quality Management Program, Contracts Management and Program Directors are all responsible for monitoring and providing oversight to external providers. Programs such as STAR, PATH, Shelter Plus Care, System of Care, and TCOOMMI as well as individual contractors are reviewed by the Contracts Management program and QM. These reviews are forwarded to Quality Management for oversight. On the Program level, contractors who provide TRR services receive training on the required evidenced practices and fidelity models. Program managers review individual services to ensure adherence to the model. Contractors needing additional training are referred to Quality Management.

VIII. Reduction of Incidents of Consumer Abuse, Neglect and Exploitation –

The Director of Client Relations, who serves as the Rights Protection Officer is the liaison between TPC and the Texas Department of Family and Protective Services. The Director of Client Relations coordinates any investigations involving the care and treatment of those the agency serves, including TDFPS investigations.

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. These reports contain the following elements:

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

These reports are distributed to the Executive Management Team and appropriate department heads, including the Director of QM. These reports are compiled in an annual report. 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 2017, there were 5 allegations involving individuals receiving Behavioral Health Services, with **0** confirmations. For persons receiving Intellectual and Developmental Disability Services, there was a 28% reduction in confirmations from 7 in 2016 to 5 in 2017.

The goal for 2018 is a 10% reduction in confirmations. TPC is addressing the goal to decrease the number of confirmations in part, via additional training on topics such as

professional and interpersonal boundaries, *stress management* and *professional communication*.

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

- Continue the collection and distribution of quarterly data
- Continue to offer supplemental training such as Stress Management, Ethical Behavior, Time Management, etc.
- Continuation of 95% training compliance of REO Abuse/Neglect Training
- Be aggressive in providing additional face to face training for employees.
- Track employee information for trends

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

IX. Quality Improvement Processes for Mental Health Initiatives

PFEP

TPC will continue to monitor the Patient and Family Education Program (PFEP) and provide training related to the rationale for and delivery of required evidenced-based services. Training will include how to access the PFEP materials online and at the clinic sites, how to provide PFEP to our clients and their families and how to document that service delivery.

Crisis Redesign Initiative

Quality Management will provide oversight to the crisis redesign initiative by monitoring and reviewing crisis services provided and documentation practices. Training on crisis documentation and service delivery is available to staff and technical assistance is provided as needed. Quality Management staff will also coordinate and participate in any onsite HHSC reviews related to crisis services. TPC believes that crisis intervention services and intervention will increase as we continue to build our collaborations with local law enforcement agencies who are sometimes the first responders to psychiatric crises.

Jail Diversion

As a function of jail diversion, TPC provides TCOOMMI services to the adult population and the child and adolescent population in our service area. Quality Management provides oversight to the TCOOMMI program and participates in internal and external reviews. Quality Management and Program Managers also provide training related to service delivery and documentation of the services to TCOOMMI staff. In addition, through the 1115 Medicaid Transformation Waiver, TPC and the Randall County Sheriff's Office have collaborated to provide jail diversion interventions at the Randall County Detention Center. The project is monitored by the Quality Management Department

Mental Health Docket Program (MH Docket)

The Mental Health Docket is a program aimed at diverting individuals who have a behavioral health diagnosis which may have been a significant factor in their arrest, from incarceration and/or criminal charges. Services are initiated within the first few days of an individual being booked into jail (Randall and Potter County). The goal is to help the individual get back into the community, where they can receive appropriate outpatient mental health treatment. This program focuses on individuals who are involved with the criminal justice system due to their mental illness. Many of the individuals served through the MH Docket have a history of reoccurring arrests that can be attributed to their behavioral health disorder. Qualifying individuals must have a mental health disorder and at least one previous jailing within the past year. Once identified, individuals are screened by the mental health docket case manager. They are then placed on a specialized docket which expedites the arraignment process.

Rider 65

During the 81st legislative session 55 million dollars (also know as Rider 65) was appropriated to local mental health authorities for implementation of engagement, transition, and increased capacity for intensive ongoing community-based services. Quality oversight is needed to ensure the success of new and enhanced services and to support the need for continued funding. As part of the monitoring process, data is reviewed on a regular basis and shared with program managers to ensure ongoing engagement of under-served or hard to engage clients. Following transitional services, client cases are staffed with providers to aid in transitioning clients into appropriate levels of care. Periodic meetings are held with "Rider 65" staff and managers to analyze data, review budgets, and discuss any quality improvement recommendations.

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:

- Peer support, advocacy and employment programs
- Crisis Hotline services
- Interpretation services
- Dual-diagnosis therapy
- Pharmacy services
- Nursing services
- Emergency Residential Care/Respite services
- Lab Services
- School-Based Behavioral & Mental Health prevention and early detection services

- Primary medical care services (including urgent care)
- Behavioral Health Crisis Respite Services
- Dietician Services
- Yoga
- Cognitive Behavioral Therapy
- Art Therapy
- Music Therapy
- Equine and Canine Therapy
- Inpatient Psychiatric Services
- Out of Home Respite Services (child and adolescent)

To ensure that contracted providers are meeting requirements, the Quality Management program will perform reviews of documentation to further ensure fidelity to TRR models and documentation standards. Over and under utilization patterns and clinical outcomes will also be monitored to further assess fidelity and success of providers' clinical interventions. Additional assessments of provider competence and fidelity to TRR models 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 a Corrective Action Plans (CAP) to comply with any findings by Texas Panhandle Centers or HHSC for lack of adherence to any rules, regulations, and requirements.

Continuous Quality Improvement (CQI)
In an effort to continuously improve services and TPC's QM/QA operations, QM will employ the PDSA cycles (which we are currently using to identify and implement quality improvements within the 1115 Waiver Transformation Waiver).
CQI is based on the basic scientific model of discovery. As we continue to learn and employ the concepts and strategies behind the PDSA Cycle, we will be able to instill our healthcare services backgrounds and experiences into our programs and operations. By conducting PDSA Cycles, innovation and positive results will follow. The results may include improved quality and efficiency of service delivery and increased rates of client satisfaction. In addition, QM monitors client satisfaction via Patient Satisfaction Surveys which are completed by individuals who present for services. The surveys are reviewed during quarterly staff meetings. QM then communicates the results to management to encourage quality improvements and recognition of staff who demonstrate exemplary customer service skills.

1115 Transformation Waiver
In December 2017, The Centers for Medicare & Medicaid Services (CMS) approved the request from HHSC to extend Texas' section 1115(a) Waiver demonstration project. The approval is effective from January 1, 2018 through September 30, 2022. This extension reflects changes to the Demonstration for both Texas' Delivery System Reform Incentive Payment (DSRIP) program

and its Uncompensated Care (UC) funding over the five-year demonstration period. CMS will provide Texas with four years of additional federal matching funding for its DSRIP program. The funding through the 1115 Waiver has shifted from a focus upon projects toward implementation of National Outcome Measures. TPC has chosen six approved measures to address population health issues affecting the individuals we serve in the Texas Panhandle.

TPC will address the following National Outcome Measures through the 1115 Waiver Extension:

- Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
- Preventive Care & Screening: Body Mass Index (BMI) Screening and Follow-up
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- Controlling High Blood Pressure
- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
- Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-CH)

Although DSRIP funding is tied exclusively to National Outcome Measures, due to the demonstrated benefit to the community, TPC chose to continue indefinitely, the projects outlined below:

Primary and Behavioral Health Integration

Patients with concomitant mental health and primary care needs will receive care in a more integrated model, resulting in improved patient outcomes and experiences. In addition, this integration will also enhance the work life of providers and staff at both primary care and behavioral health clinics by facilitating their ability to obtain needed services for their patients in a more coordinated and accessible manner.

Care Today Urgent Care Centers, and West Texas A&M University to provide integrated care services in the Texas Panhandle. Our telemedicine program has expanded to include the Crisis Respite facility an additional jail and hospital emergency department.

Criminal Justice Diversion Program

In Texas, and all across the United States, a broad systemic problem has evolved over the years: *the overrepresentation of people with mental illnesses who come into contact with the criminal justice system*. According to a 1999 U.S. Department of Justice study, the prevalence of mental illness is three to four times higher among inmates in jail and prison than in the general population. Almost half of inmates with mental illnesses are incarcerated for non-violent crimes. Though statistics on the prevalence of mental illness are most easily obtained from correctional institutions, the impact on law enforcement and the courts has also been well documented.

This program addresses current gaps in diversion services. By working in coordination with existing diversion services, persons diagnosed with mental illness who have repeat contacts with the criminal justice system will be less likely to return or not return as frequently, thereby decreasing the rates of recidivism for individuals whose involvement in the criminal justice system is for a non-violent offence and is due, in large part to their lack of access or follow-up with mental health treatment in the community.
The three pronged approach includes key staff as follows:

- *Crisis Transitional Worker* – works as part of the Randall County Prisoner Re-entry Program. This is a successful local diversion program that addresses recidivism and substance abuse, and focuses on treating repeat offenders reentering the local community.
- *Court/Jail Liaison*- works to ensure that clients with mental illness can be treated in the least restrictive treatment environment that is feasible and pursues incremental reductions in the number of law enforcement contacts, jail days, probation violations, or new charges for program participants.
- *Service Coordinator*- provides increased engagement for clients who have been historically hard to engage and have ended up in a "revolving door" of encounters with law enforcement, mental health agencies, hospitals, etc.

<u>Child & Adolescent Wraparound and Intensive Services Programs</u>
A program designed to expand wraparound services focusing on early behavioral health service delivery for children and families with behavioral health needs throughout the top 21 counties of the Texas Panhandle. Expansion will include (1) Placing mental health professionals within schools (with the possibility of Integrated Health Centers) , (2) Outreach to refugee population, including refugee mental health professionals specifically dedicated to refugee issues, interpreters, peer advocates, life skills education (including classes for family members) , (3) More involvement in truancy court (social worker in court), (4) More intensive services /"deepening" of services, and (5) Prevention and Life skills Education expansion. The programs are currently in place within the Amarillo, Highland Park, and Canyon Independent School Districts.

<u>Crisis Respite Program</u>
The Crisis Respite (Respite and Recovery) Program is a 24 hours per day- 7 days per week program for people residing in the upper 21 counties of the Panhandle of Texas and serves as a community care alternative to inpatient hospitalization and incarceration, focusing on continuity of care ("step-down" from inpatient hospitalization or "step-up" for individuals in need of more intensive short-term care) and averting future crises. This program fills a treatment gap in the community. Primary care services will be provided as part of TPC's Primary and Behavioral Health Care Integration Project.

<u>Whole Health Peer Support</u>
Texas Panhandle Centers has implemented a Whole Health Peer Support program which employs consumers of mental health services who have made substantial progress in

managing their own illness and recovery while living successful life in the community, to provide peer support services.

Building on the theories and principles of Via Hope, originally established under the State's Mental Health Transformation grant, consumers are being trained to serve as peer support specialists. In addition to the basic peer support specialist training and certification, additional training is provided related to "whole health" principles. The training in whole health helps peer supporters learn to work with other consumers to set achievable goals to prevent or self-manage chronic diseases such as Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Hypertension, and issues such as an abnormal BMI/Overweight-Underweight.

Military Veterans Peer Network (MVPN)

TPC, in collaboration with Central Plains Center, is a service provider within the Military Veterans Peer Network. The purpose of the Military Veterans Peer Network (MVPN) is to establish camaraderie and trust with other Service Members, Veterans, and their Families by identifying and vetting community resources, providing peer support, trainings, and volunteering within the community. The network is made up of military veteran volunteers.

MVPN collaborates with agencies and organizations who also offer veteran friendly assistance with Post Traumatic Stress Disorder (PTSD), Military Sexual Trauma (MST), Traumatic brain Injury (TBI), Depression, Anxiety, Anger, Alcohol/Substance Abuse treatments, reintegration, marital/family issues, financial/legal assistance, education/job training, homelessness, Veterans Administration claims/benefits, counseling, and holistic therapies as well.

Access Redesign

Driven by Healthcare Reform, the statewide Access Redesign initiative (sponsored by the National Council for Community Behavioral Healthcare and MTM Services) began in the summer of 2012. The overall goals were to improve the ease of access to care and to ensure timely service provision necessary to facilitate client engagement and improved outcomes. In order to reach these goals, quality service documentation is necessary to remain financially viable in a fee-for-service environment. The Rapid Cycle Change Team (RCCT) worked to identify best practices and introduce new procedures in areas such as Collaborative Documentation, No-Show Management, Open Access, and Utilization Management. Rapid change, which included PDSA Cycles were critical to the implementation of TPC's Access Redesign efforts. As weak processes were identified and addressed, procedural changes were rolled-out agency wide. All decisions are grounded in data analysis and review. As a result, No-show rates and wait times from presentation to first service have significantly decreased.

Tobacco Free Campus

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, TPC employees and clients 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- our clients, 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 providers to a regional training to learn the motivational interviewing technique as it relates to tobacco cessation. 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 consumers and employees.

As part of our move towards a tobacco-free agency, staff will be provided with support in their efforts to quit smoking and using other tobacco products. Tobacco cessation programs and other support will be available at low or no cost to employees who want to stop using tobacco products. We do this for the benefit of everyone- our clients, families, volunteers, and staff.

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

YES Waiver

The Youth Empowerment Services (YES) Waiver provides comprehensive home and community-based mental health services to youth (ages 3-19th birth day) at risk of institutionalization and/or out-of-home placement due to a serious emotional disturbance (SED). The program provides flexibility in the funding of intensive community-based services and supports for youth and their families.

To be eligible for YES Waiver services an individual must meet all of the following criteria:

- Child or Adolescent between the ages of 3 years and 19 years old;
- Child or Adolescent must be Medicaid eligible;
- Child or Adolescent must have a mental health diagnosis;
- Child or Adolescent must reside with legally authorized representative (not in foster care, juvenile detention center, or state hospital setting);
- Outpatient services must have been attempted and proven unsuccessful;
- Child or Adolescent is a danger to self/others.

Interested parties must call the inquiry line at: 1-844-207-7630. Return contact information should be left on the inquiry's voicemail. The interested party will receive a return call within 24 hours. If the child is eligible they will receive an assessment by a LPHA within 7 days.

Once enrolled in YES Waiver, all services will be monitored by a QMHP-CS, who has received extensive training in Wraparound service delivery, as approved by the Texas Health and Human Services Commission (HHSC). Wraparound facilitator to client ratio for the provision of Intensive Case Management = 1:10

In addition to Wraparound services YES Waiver participants may be eligible to receive the following services: Adaptive Aids and Supports; Community Living Supports (CLS); Employment Assistance; Family Supports; Minor Home Modifications; Non-Medical Transportation; Paraprofessional Services; Pre-Engagement Service (for non-Medicaid applicants); Respite (In-Home and Out-of-Home); Supported Employment; Supportive Family-Based Alternatives; Transitional Services and Specialized Therapies: Animal-Assisted Therapy, Art Therapy, Music Therapy, Nutritional Counseling, and Recreational Therapy.

Annual renewal is required for continued enrollment in the YES Waiver program.

First Episode Psychosis (FEP) Program

The FEP Program is based upon a multidisciplinary based approach which address the needs of individuals between the ages of 15 – 30 years old, who are no more than two years into a diagnosis of a perception disturbance. Individuals who have been diagnosed with substance induced psychosis are excluded from this program. The multidisciplinary treatment team is comprised of various roles such as Supported Employment and Education Specialist (SEES), Peer Support Specialist, a psychiatrist, a nurse and a licensed counselor. The team uses a shared decision making model, where each client collaborates with the treatment providers in their recovery. The life goals, aspirations and ambitions of the individual receiving services drive treatment planning. The focus of the program is on developing functional recovery goals such as returning to school, and/or to work and community, with recovery-oriented services.

Mental Health Arraignment Court

The Mental Health Docket (Mental Health Arraignment Court) is for individuals with serious mental illness (SMI) who, due to the symptoms of their illness, have frequent interaction with the criminal justice system. The goal of the Mental Health Arraignment Court is to reduce recidivism by helping individuals engage in mental health treatment, access other community resources, and quickly exit the criminal justice system. The target population includes individuals over the age of 18 who have pending charges in Randall or Potter County, Texas, or within the Amarillo Municipal Court. The project has two primary sites which include the Potter County Detention Center and the Randall County Detention Center. The program began on November 1, 2015. The Mental Health Docket for arraignment hearings allows magistrates to offer defendants the option of Public Recognizance Bonds or Mental Health Bonds, which do not require collateral, in exchange for a commitment to engage in behavioral and/or mental health services, as well as other needed social services which may address the root causes of recidivism. Expected outcomes of the program include decreased

recidivism, increased mental health treatment for those in need, and decreased jail costs for local taxpayers.

Outreach, Screening, Assessment and Referral (OSAR)
OSAR centers may be the first point of contact for those seeking substance use disorder treatment services. Regardless of ability to pay, Texas residents who are seeking treatment or information for a substance use disorder may qualify for services based on need. The screening process is used to gather information regarding alcohol/drug use. Assessment is used to discover whether the individual meets the criteria for having a DSM V substance use disorder and if substance abuse treatment or recovery support services are needed. Provided the above qualifications are met, the individual is then referred to the most appropriate treatment available.

Parenting Awareness & Drug Risk Education (PADRE)
PADRE is a program designed to provide education and intervention for fathers at risk of substance use or abuse. This program is designed to help expecting, new and current fathers overcome the challenges that often come with parenting. The goal of PADRE is to provide 'intervention through education'. Education includes, but is not limited to reproductive health education, parenting education, fetal and child development, HIV and STDs education and awareness, nurturing parenting values and skills, and alternatives to corporal punishment. Alternative activities are offered to participants and their family members that are focused on helping families address communication, family roles, and stress management, while supporting family relationships. TPC provides appropriate community referrals to cooperating agencies for help with parental needs, counseling, employment, clothing, and additional family needs.

PPI/Project APPLE (Assisting Parents with Prenatal & Postpartum Learning and Education)
The target population for PPI/Project APPLE is pregnant or postpartum females who are Texas residents and are identified as having or are at risk of having a substance use disorder. Others who receive servicers through PPI/Project APPLE include women identified as having a substance use disorder with children under the age of six and women who have been identified as being at risk of developing a substance use disorder and have children under the age of six. This program does accept the individuals who have an open case, one that is in the investigative stage, or a closed case by the Department of Family and Protective Services (DFPS). PPI/Project APPLE meets the requirements as specified and set forth by DFPS for Parenting Classes.

Pre-Admission, Screening and Residential Review (PASRR)
The PASRR program was established to provide individuals in nursing facilities the opportunity to be evaluated for additional specialized services while residing in a nursing home. Specialized services offered by this program include community mental health care. When an individual with a mental health diagnosis (or suspected mental health diagnosis) is placed in a nursing facility, the Local Mental Health Authority (LMHA) is alerted of the

individual's need for an assessment. LMHA is required to assess the identified individual within 72 hours.

Projects for Assistance in Transitioning from Homelessness (PATH)
The PATH program offers outreach services to individuals in the community who are experiencing homelessness. Referrals are made to appropriate programs and services. Case management, psychiatric and medication services are also available. PATH serves individuals who are homeless or at imminent risk of becoming homeless, as defined by the United States Department of Housing and Urban Development (HUD). Eligible individuals include those who not only live in shelters or on the streets, but also those who are "doubled up" in overcrowded units or are temporarily living with family or friends.

Psychiatric Emergent Service Center (PESC) / Rapid Stabilization Program
Individuals who reside outside the Amarillo Hospital District who are assessed as being in an emergent crisis by Texas Panhandle Centers and in need for inpatient hospitalization, but have no payer source, may be eligible to participate in the Local Inpatient Rapid Stabilization Program if they also meet criteria for admission into the Northwest Texas Hospital Psychiatric Pavilion. Once deemed eligible for admission, Texas Panhandle Centers may grant up to five (5) paid hospital bed days to those that qualify for Rapid Stabilization funds.

Psychiatric Emergent Service Center (PESC) / State Hospital Diversion Program
Individuals who are inpatient at the local psychiatric hospital, who are then court-ordered to the State Hospital, may qualify for the State Hospital Diversion Program if there will be an extended delay before admission into the State Hospital. Admission into State Hospital Diversion allows an individual to remain hospitalized locally until:

1. There is a vacancy at the State Hospital ***OR***
2. The patient is no longer in need of inpatient care and can be safely and appropriately discharged into the community.

Shelter Plus Care
Shelter Plus Care serves chronically homeless individuals in the community who also have a behavioral health diagnosis. Shelter Plus Care, which is administered through The United States Department of Housing and Urban Development (HUD), provides qualified individuals with a dwelling and Texas Panhandle Centers provides behavioral healthcare. The goal of this program is to help and aid those served to obtain and maintain stable housing and gain independence within the community.

House Bill 13
House Bill 13 consists of two projects working collaboratively to serve members of the Amarillo community. Project 1, also known as Intercept, consists of two mental health providers paired with law enforcement offices with specialized crisis intervention training. The teams arrange their schedules during peak times for crisis calls for service. The team responds to engage clients and intervene as necessary to meet the needs of the individual.

Clients may elect to remain engaged in Project 1 services and receive periodic visits by the team, to include referrals to community resources, case management, crisis prevention, and assistance with transportation to psychiatric appointments as needed. Clients may be linked to substance abuse treatment, counseling, peer support, supported housing, and many other programs offered in the community as well as Texas Panhandle Centers. The goal of Project 1 to engage clients in crisis services as well as provide services to prevent future crises. The interventions and supports are to reduce client hospitalizations, arrests, and improve overall quality of life.

Project 2 consists of a licensed professional counselor as well as an Integrated Care navigator located at Heal the City. The clinic provides health care to the uninsured members of the community. Both providers provide mental health screenings on Monday during clinic hours. Clients are able to receive counseling services, referrals to Family Support Services, Nurse Family Partnership, or Daily Recovery, and assistance in obtaining medical services in the community as needed. This integrated approach addresses the whole person with medical and mental health needs. The Integrated Care navigator assists in linking the client with the appropriate resources and medical clinics in the community based on needs and individual circumstances. Services are provided in the client's home as needed to reduce barriers to care in the community. Project 1 and Project 2 work collaboratively to provide the optimum amount of services and supports to each person based upon individual need.

System of Care

System of Care (SOC) is a philosophy or framework that is designed to create a network of effective community-based services and supports to improve the lives of children and youth who are at risk of serious mental health conditions. The concept is based on a philosophy that emphasizes services that are not only community-based, but family-driven, youth-guided, individualized, coordinated, and culturally and linguistically competent. These values are woven into the entire organization.

Examples of SOC work at Texas Panhandle Centers include Wraparound Services, Children's Mental Health Awareness Activities, Trauma-Informed training, school-based early intervention and referral programs, and ongoing efforts towards creating a database of resources to be used throughout the community.

X. COPSD

The QM Program provides oversight of COPSD services. Initial training is provided via the HHSC approved training site, www.centralizedtraining.com. Following completion of the modules, staff complete an on-line test and receive a certificate of completion. Continued competency is supported yearly through Centralized Training and in-person training by Licensed Chemical Dependency Counselors. QM provides technical assistance as requested to address appropriate documentation related to COPSD. Program Managers ensure that training includes the importance of access and referrals for individuals not eligible under state

target and/or priority population criteria as well as key components of the Texas Administrative Code regarding client rights. These components are noted below:

In determining an individual's initial and ongoing eligibility for any service, a provider may not exclude an individual based on the following factors:
(1) the individual's past or present mental illness or substance use diagnosis or services;
(2) the individual's past or present involvement in the criminal or juvenile justice system;
(3) medications prescribed to the individual in the past or present;
(4) the presumption of the individual's inability to benefit from treatment;
(5) the individual's use or continued use of alcohol, tobacco, or other drugs; or
(6) the individual's level of success in prior treatment episodes.

Further, a provider must ensure that an individual's refusal of a particular mental health community service (e.g., psychoactive medication) does not preclude the individual from accessing other medically necessary mental health community services.

The Quality Management Program will perform a review of COPSD services to ensure that staff have been trained adequately and are documenting COPSD services accurately and appropriately. To complete the review, a sample will be used to verify that COPSD needs are being identified and included in the recovery planning process for those clients who have substance use issues. Findings will be reviewed, analyzed and reported to the Director of Behavioral Health Services and the Executive Director to ensure further process refinements and training needs.

XI Quality Improvement Processes for Utilization Management

Clinic Efficiencies

TPC has expanded its contract with the East Texas Behavioral Healthcare Network (ETBHN) to include authorization as well as psychiatric services including access to the Medical Director’s services. ETBHN is a network comprised of eleven communities mental health and developmentally disability centers that cover 70 Counties in Texas. The network allows for the consolidation of services which results in cost-savings and improves collaboration among centers.

In order to develop improved clinic efficiencies, the UM Director was promoted to also serve as the Medical Practice Coordinator. Her UM experience compliments her work in assessing clinic processes and in recommending best practices. Given the uniqueness of each clinic (especially within the rural areas), she will travel throughout the catchment area to work directly with providers. Regular updates will be provided to the Executive Management Team for implementation of procedural changes.

UM Measures
The Medical Practice Coordinator-UM Director will work closely with the Medical Director in identifying the most reliable data for assessing the required utilization measures:

- Appropriateness of eligibility determinations;
- Use of exceptions and overrides to service authorization ensuring rationale is clinically appropriate and documented in the administrative and clinical record;
- Over- and under-utilization;
- Appeals and denials;
- Fairness and equity; and
- Cost-effectiveness of all services provided

The ETBHN contract allows for collaboration with other UM Directors and Committees which aids in assessing available data sources (e.g. MBOW, CARE, CMBHS). In turn, this will facilitate improved consistency for UM outcomes measures across centers.

ANSA/CANS Super Users

TPC has Super Users for the Adult Needs and Strengths Assessment (ANSA) and the Children's Needs and Strengths Assessment (CANS). The Quality Management Super User is a Super User for both the ANSA and CANS. The other Super Users are providers within the Adult and Child and Adolescent behavioral health units. The CANS/ANSA Super Users are credentialed as QMHP–CS and keep current the training requirements indicated in Information Item A.
The Super Users perform quality assurance training activities at least two times annually with a minimum of 40% of the practitioners who are certified to administer the CANS/ANSA as part of their primary functions. The purpose is to ensure accurate use of both the ANSA and CANS, identify need areas, and to support inter-rater reliability between individuals using the assessment tools, as well as appropriate Level of Care (LOC) assignments and service provision.

Review of East Texas Behavioral Health Network (ETBHN) Authorizations:
ETBHN authorizes approximately 95% of TPC assessments. TPC UM authorizes approximately 5% of all assessments, reviews those for whom discharge is requested and conducts periodic random reviews of authorizations completed by ETBHN. TPC UM staff coordinates with ETBHN staff regarding implementation of consistent UM practices. Concerns are reviewed with the ETBHN UM Director.

Training and Provider Relations:
A UM education program is implemented for UM staff, providers, and center staff. HHSC training materials are included within the agency UM curriculum and UM materials and UM Guidelines are posted on the intranet page. Through regular training, the agency ensures that providers and clinical staff have the information they need to provide care within the UM Guidelines. It aids staff in understanding the role of UM in improving access to service and quality service outcomes. In turn, this leads to improved communication and working relationships. Training will be conducted an annual or as needed basis.

XII Monitoring the Effectiveness of QM – UM Plans

The Director of Quality Management and the Executive Director review the QM-UM 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 situations and processes which are identified as adverse to quality are:

- Prevented
- Identified 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- to include 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 Program encourages staff at all levels to establish, maintain and continually improve communications with clients, family, staff and other community stakeholders. A clear line of communication leads to better services and supports by identifying problems and implementing effective solutions.