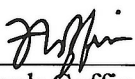




**Spindletop Center
Quality Management Plan
Fiscal Years 2022 - 2023**

Approved By:



Frank Coffin, Jr.
Chair of Board of Trustees

9.27.2021
Date

**Spindletop Center Quality Management Plan
Fiscal Years 2022-2023**

Table of Contents

- I. Introduction & Purpose**
 - II. Mission, Vision and Values**
 - III. Goals of the Quality Management Plan**
 - IV. Strategic Plan**
 - V. Quality Assurance Structure and Design**
 - VI. Collection and Measurement of Data**
 - VII. Monitoring and Evaluation of Data**
 - VIII. Additional Quality Assurance Activities**
 - IX. Conclusion**
- Appendix A: Utilization Management Plan**

Spindletop Center Quality Management Plan

I. INTRODUCTION & PURPOSE

The goal of the quality management program is to improve outcomes for the recipients of Mental Health (MH), Intellectual and Developmental Disability (IDD), and Substance Use Disorder (SUD) services authorized and managed by the Center. To accomplish this, the Center combines the use of information technologies with continuous quality improvement processes to provide quality assurance oversight of authority, administrative, fiscal and service delivery performance. The quality management program ensures that the Center's Executive Management Team (EMT), Board of Trustees, Committees and Advisory Groups have the information needed to make management decisions that support the provision of the highest quality services. Various internal committees are responsible for examining quality issues related to their respective areas and making recommendations for improvement when necessary to the appropriate internal reporting body.

The purpose of the quality management program is to ensure that the Center delivers quality services in an environment of minimal risk, while achieving successful outcomes that are perceived by consumers and families to have the highest value. The QM Plan allows for a systematic, coordinated, and continuous approach to improving performance by using data to target processes and mechanisms.

The quality management process is vital to demonstrating best value, balancing service cost and quality.

II. MISSION, VISION AND VALUES

The QM Plan is driven by and supports the Center's Mission and Vision:

MISSION STATEMENT:

The mission of Spindletop Center is to help people help themselves by providing resources and supports.

VISION STATEMENT:

The Spindletop Center vision is to promote healthy living in our community.

VALUES:

The values of Spindletop Center are:

- ❖ We value all persons and treat them with dignity and respect.
- ❖ We develop services responsive to the needs, values, and desires of our community.
- ❖ We value and respect families for the important role they play in the effective treatment and delivery of services.
- ❖ We embrace self-advocacy and recovery as means of independence.
- ❖ We measure our success by the outcomes of each person and our impact on the community.

- ❖ We educate, motivate and empower staff to accomplish their work with confidence and pride by valuing and respecting them.
- ❖ We recognize and celebrate best practices.
- ❖ We educate people to help our community.
- ❖ We utilize resources in the most efficient manner to minimize our impact on the environment.
- ❖ We accommodate and encourage our staff's community involvement.

III. GOALS OF THE QUALITY MANAGEMENT PLAN

The overall goals of this quality management plan are as follows:

- To ensure that services are accessible, appropriate, timely, and responsive to the needs of our consumers and community
- To identify opportunities for continuous improvement in consumer care and to ensure that actions are implemented to improve services
- To measure and assess programs and services to determine the current performance levels, the need for interventions that are aimed at reducing or eliminating undesirable outcomes and identify opportunities for refining existing processes
- To ensure coordination and communication of quality improvement activities with departments, administration, staff, governing body, consumers, and other stakeholders
- To ensure data integrity including appropriate, accurate, and complete documentation of services
- To ensure compliance with the requirements of all federal, state, regulatory, and accrediting agencies in regard to quality assessment and performance improvement activities

IV. STRATEGIC PLAN

Spindletop Center's Strategic Plan is the system-wide performance improvement plan for all business operations and client services. The planning process and strategic goals are evaluated regularly and updated annually to ensure that goals are in touch with the needs of the business, persons served, and the community. Spindletop Center leadership develops targeted strategic goals to assist the organization in focusing on opportunities for continuous quality improvement in services and to ensure that actions are implemented to improve care in support of the Center's mission. The Center's current strategic plan is an integral part of the quality management program, and made available to all Center employees via the intranet. The Center's progress toward reaching strategic plan goals is monitored by Planning Advisory Committees both locally and through the East Texas Behavioral Health Network and reported to the Board of Trustees regularly.

Input from consumers, staff, advocates, other provider organizations, and community members is encouraged in the development of the Strategic Plan through participation in planning and advisory committees, focus groups, surveys, and various Center committees. These stakeholders are involved in regular informal as well as formal processes of obtaining their suggestions and comments on the quality of services and need for services, and their comments are regularly reviewed by all levels of leadership throughout the organization. Program units conduct

satisfaction surveys to gather information for improvement in operation processes. All the stakeholder input mechanisms are designed to assist with the improvement in quality of Center services and to ensure that service design is based on consumer preference, cultural diversity and community needs. Annually, the Center prepares an operating budget and staffing plan that focuses its limited resources on the needs indicated by these processes.

Formalized means of involvement include staff support for peer support groups, the Planning and Advisory Committee discussions of Center services and community needs, program unit consumer satisfaction surveys, the Texas Health and Human Services Commission (HHSC) consumer satisfaction surveys, as well as the annual external consumer experience survey process that involves consumers, family members, advocacy groups, and other providers of community services in the four-county catchment area served by the Center.

V. QUALITY ASSURANCE STRUCTURE AND DESIGN

The quality assurance structure within the Center involves numerous internal improvement functions and processes supported by staff and regularly reviewed by external consumers and leadership. Committees are utilized as mechanisms for internal and external communication, involving stakeholders, consumers and families in decision-making and guiding performance improvement activities. This structure provides ongoing communication and reporting to executive management and the governing Board for final decision regarding the many suggestions for improvement in operational processes. These varied functions are designed to gather data on the diverse operational aspects of the Center, analyze the data for trends, and prepare reports and recommendations for final approval by senior management and ultimately the governing Board.

The Center has designated the EMT, the membership of which includes the Chief Executive Officer, Chief Human Resource Officer, Chief Clinical Officer, Chief Intellectual and Developmental Disabilities Officer, Chief Financial Officer, Chief Medical Officer, and Chief Information Officer, to oversee internal quality assurance activities. The role of the EMT is long-term in nature and places a heavy emphasis on leadership and motivation.

The Center utilizes a number of standing Committees to review and monitor client service activities and functions. Committees carry out a major portion of quality assurance activities and impact policy, procedures and practices. Committees include representation from all involved service areas in order to make use of the varied expertise and experience of Center staff, providers and other stakeholders. Current Center committees include, but are not limited to, the Medical Council, Compliance Committee, Utilization Management (UM) Committee, Regional Planning Network Advisory Committee (RPNAC), Intellectual and Developmental Disability Planning Advisory Committee (IDDPAC), and the Safety Committee.

Quality Assurance Department – The Quality Assurance Department reports directly to the Chief Executive Officer and serves as the lead internal quality improvement authority group to assist with the integration of quality principles in operations, provide training and education in continuous quality improvement principles, and serve as quality consultants to Center staff. QA staff also assist the leadership of the Center in establishing and implementing this quality plan. The Center’s QA department is staffed with a Director who is also the UM Manager, QA

Program Coordinator, QA Generalist, QA Training Specialist, three (3) QA Specialists, Rights Protection Officer, and Consumer Relations Specialist.

The responsibilities and functions include the following:

- Communicate with the Board of Trustees concerning quality improvement issues and at least quarterly on performance metrics
- Coordinate external audits, reviews and surveys of the Center and its various programs and services
- Facilitate internal program response to external audit recommendations
- Develop a summary of findings of audits for review by Center leaders and the Board
- Facilitate Center-wide implementation of staff training in quality improvement principles and various evidence-based or best-practice models of care
- Coordinate overall Center monitoring and evaluation of program units to include:
 - Implement unit monitoring and evaluation processes, including required quality related reports
 - Facilitate accuracy of data through the UM Committee
 - Evaluate and monitor data gathering activities
 - Summarize results of data gathering for reporting to appropriate internal bodies
 - Provide internal consultation and technical assistance to program units
 - Integrate quality principles in daily work activities and monitor indicators for program units
 - Coordinate the development of relevant and appropriate outcomes
 - Monitor death review and reporting process, consumer incident reporting, and trends analysis process
 - Manage the consumer rights investigation process
 - Coordinate review and analysis of reported incidents and recommend changes to prevent recurrence of incidents
- Liaison with the Texas Department of Family and Protective Services (DFPS) regarding alleged incidents of abuse, neglect, and exploitation
- Liaison to the Medical Council
 - Provide support of peer review monitoring and reporting of data collection
- Utilization management and review activities
 - Provide summary reports, documents, and recommendations to managers, committees, and the Board of Trustees
 - Maintain confidential and secure files of information, including performance related matters
- Collect and maintain a centralized documentation repository to contain at least the following:
 - Evidence of successful transmission of contract reporting to HHSC
 - Evidence of annual facilities reviews, reports, corrective actions and follow-up activities by QA staff
 - Evidence of annual subcontracted service reviews, reports, corrective actions and follow-up activities by QA staff
 - Evidence of annual fidelity reviews of evidence-based and best-practice programs and services, reports, corrective actions and follow-up activities by QA staff
 - Minutes of UM Committee meetings including reports
 - Evidence of internal chart reviews, reports, corrective actions and follow-up activities

- Evidence of external audits, reviews, surveys and corresponding reports, corrective actions and follow-up communications
- Documentation from performance improvement workgroups and activities
- Documentation of other activities of the quality management process

Medical Council – led by the Chief Medical Officer or designee; the council provides leadership and oversight within the Center for the delivery of medical services to consumers. The council also reviews medication resource allocations, medication errors, technology utilization, infection control and other reports of interest to the medical providers.

Utilization Management Committee – The Center’s Utilization Management (UM) program is responsible for the authorization and/or denial of services based on protocols developed by funding entities and applicable legal and regulatory requirements. UM protocols are reflective of Performance Contract requirements, all relevant UM guidelines including SUD and TRR, and associated evidence-based practice fidelity requirements. The UM Committee meets at least quarterly and currently analyzes more than thirty data elements related to service access and delivery and utilization of resources. The data are tracked and trended for performance improvement as indicated. As positive and negative trends are identified, service and administrative departments are identified for commendation or advised of the need for corrective actions and performance improvement activities, respectively.

Client Rights, Abuse, Neglect and Exploitation - Abuse and complaint tracking is monitored by the Rights Protection Officer (RPO) and is trended by the Utilization Management Committee. Rights restrictions are reviewed by the service planning team before any restrictions are imposed. In the event of a disagreement among the service planning team, members will consult with the RPO and QM department. The Rights Protection Officer develops an annual plan to reduce abuse and complaint allegations and to improve the rights protection process. The RPO also measures, assesses, and recommends actions to reduce critical incidents and incidents of consumer abuse, neglect and exploitation. All new employees receive training pertaining to Client Rights and the Prevention of Abuse, Neglect and Exploitation within the first two weeks of employment and are required to pass a related competency exam. All current employees, contractors, volunteers and interns receive refresher trainings annually, or more frequently if needed, including a competency exam. The Center’s Client Rights staff also document and track all allegations of abuse, neglect and exploitation, report related concerns or trends to various committees and EMT for appropriate action and implement additional or more frequent employee training as indicated.

Planning Advisory Committees – The PACs advise the Board of Trustees and Center staff on matters related to the planning and administration of mental health and intellectual and developmental disability services. These committees present an annual report to the Board and participate in surveys to assist Center staff in responding to consumer needs. QA staff attend all PAC meetings to report on quality management and performance improvement activities as well as gather feedback from the committee on needs of the community and persons served.

Compliance Program – The Center’s Compliance Program outlines measures to detect and prevent non-compliance that could cause adverse corrective actions. The seven basic elements of the Compliance Program are:

1. Written program and Code of Conduct with approved policies
 2. A designated Compliance Officer and a Compliance Committee.
 3. A training and education program for employees, contractors, and agents on Compliance.
 4. An internal audit program to ensure Center services comply with federal funding rules.
 5. Lines of communication with access to the Compliance Officer.
 6. Enforcement of disciplinary policies for existing service providers and screening of applicants with histories of non-compliance.
 7. Response to detected offenses and development of corrective action initiatives.
- See also Deficit Reduction Act below.

Safety and Infection Control Committee – The Safety and Infection Control Committee is led by the Safety Officer. The committee reviews safety and infection control systems of the Center and all required documentation. Minutes of each meeting and specific recommendations are transmitted to the Chief Executive Officer, program directors and administrators for their review and follow-up within their respective program areas. Basic responsibilities of the Committee are to develop and disseminate an acceptable Fire and Disaster Plan and an Infection Control Plan for each Center facility, make recommendations regarding staff training, receive, review, and act in a timely fashion on all injury and infection control reports on consumers, staff, or guests which require medical response, and analyze and make recommendations to keep the Center in compliance with prevailing safety and infection control laws, regulations, and external agency requirements and standards. The work of the Safety/Infection Control Committee is further described in the Center Safety and Infection Control Manual.

Consolidated Local Provider Network Development Plan – developed to assemble and manage a network of providers who are qualified to provide services for consumers who will have a choice of providers. This plan has consumer, stakeholder, and provider input to determine the community needs and priorities. The plan identifies strategies to maximize dollars available to provide services and describes the Center’s service capacity, and the number of adults and children / adolescents in each level of care. This process determines the services that can be contracted to other providers, determines the prioritization for contracting out other services in the future, and ensures that the Center is capable of serving as the “safety net” if contracted service providers terminate a contract. The process of network development is intended to be gradual over time. The plan is reviewed and approved by the RPNAC, the IDDPAC, and the Board of Trustees prior to submission to HHSC in accordance with Information Item S. This plan is available for review through the Center website.

VI. COLLECTION AND MEASUREMENT OF DATA

The Center is dedicated to the continuous quality improvement of the services it provides and will periodically evaluate the effectiveness and efficiency of, access to, and satisfaction with those services, and modify service delivery and administrative processes as appropriate based on the evaluation of review findings. Clinical outcomes and business performance indicators will be evaluated based on benchmarks and targets set forth in the performance contracts with Texas Health and Human Services Commission, applicable accreditation standards and the Center’s internal performance standards.

Data pertaining to the efficiency and effectiveness of services and access to services are obtained from reports available in the MBOW, CMBHS, as well as internally developed performance and productivity reports.

Service access, efficiency, effectiveness and related satisfaction indicators apply to all clients served. Efficiency indicators apply to the Center only, and measure the agency's productivity and the extent to which available resources are used to achieve the greatest effect.

Client and family satisfaction are evaluated using a satisfaction survey instrument, administered annually by the agency. The Center's Customer Satisfaction and Compliance Surveys also provide data related to client's perception of their access to services and their satisfaction with services. These are administered to clients periodically during, and in some cases after, their treatment.

The Center has been an active participant in the Centers for Medicare and Medicaid Services (CMS)/Texas Health and Human Services (HHSC) Healthcare Transformation and Quality Improvement Program 1115 demonstration waiver (aka Delivery System Reform Incentive Payment or DSRIP). The waiver has transformed the health care delivery system for low income Texans, increasing access to quality preventative primary and behavioral health care services as a means to improve both individual and system level outcomes while containing cost growth. The Center monitors and reports on all DSRIP measures to HHSC.

The Center has applied to seek certification from HHSC as a Certified Community Behavioral Health Clinic which will signal to the community the Center's achievement of excellence providing integrated mental health and substance use disorder services in a person-centered, culturally sensitive, flexible and accessible manner. The Center will collect, track and report data and quality metrics required for CCBHC certification and annually submit supporting data within six months after the end of each demonstration year to the state. These metrics will be reported and performance monitored as part of the QMUM committee meetings on at least a quarterly basis. See also Data Measure Reporting Policy No. 810.05.

Additionally, the data from the following areas are collected and reported to monitor performance:

- Financial Data
- Internal and External program reviews
- Interest Lists
- CMBHS reports of aggregate client and service data
- CARE reports
- Cerner Client Data System
- Performance Contract and MBOW reports
- Management Reports
- Strategic Plan
- Corporate Compliance
- Provider Profiling Reports
- Staff Training Curriculum and Performance Evaluation Data
- Key Performance Indicators
- Satisfaction Surveys
- Risk Indicators-Critical Incident Reporting System

VII. ASSESSMENT OF DATA

The processes described above allow for comparative analysis of clinical outcomes and satisfaction for individual clients, specific clinic sites and overall business performance over time. The data are used to assess the Center's performance and determine strengths, weaknesses, and opportunities for improvement. At least annually, the Quality Assurance department provides a summary analysis of the outcomes management data to the Center's Executive Management Team to recommend necessary administrative and/or service delivery improvements.

Monitoring

All of the services provided by the Center are monitored at least annually.

The following services will be monitored at least quarterly due to critical importance:

- Continuity of Care
- Medicaid Billing
- Utilization Review
- Crisis services

Additionally, activities intended to monitor compliance with all YES Waiver policies and procedures (as outlined in the YES Waiver Policy Manual) will be implemented and any necessary corrective actions identified during Quality Management reviews will be executed.

Trending and Reporting Findings:

The results of the analyses including any identified trends will ultimately be sent to the EMT and Board of Trustees for recommended action. Reports will also be sent to service area director, managers, the Rights Protection Officer, and other program directors, managers and supervisors as indicated. Corrective measures and improvements are monitored through follow-up reviews tracked by the QA Department. The timeframe for all corrective actions and follow-up reviews will be determined by the severity of the findings. Adverse events determined to present imminent and/or high risk will be escalated for immediate action and resolution. All other adverse findings or trends will be addressed within a reasonable amount of time as determined by the Director of Quality Assurance. Corrective action plans to address adverse findings and trends must be submitted to QA within 10 business days of request and all plans must be approved by the Director of QA prior to implementation.

Performance Improvement:

Data collected will be analyzed at least quarterly to determine trends. The collected data will guide the development of plans for improvement. Data indicating negative outliers will be addressed through targeted workgroups and/or brought to the attention of the EMT for recommended action. Positive outliers will become best practices, serving as benchmarks for the Center's continuous quality improvement processes. Upon discovery, remedial action will be taken to address unacceptable levels of performance outcomes. Submission of plans of improvement to the QA Department will be required to address negative outliers. Such plans for improvement will include responsible person, actions to correct or improve, activities to monitor continued improvement, follow-up activities to ensure compliance, and a proposed timeline for successful completion. Plans for improvement including proposed timeline for completion must

be submitted to QA within 10 business days of request and all plans must be approved by the Director of QA prior to implementation. Subsequent performance will be evaluated to determine the effectiveness of each plan of improvement. All targeted performance improvement workgroups will have at a minimum one staff person from QA as a member, and all workgroup activities will be documented and stored by QA.

VIII. ADDITIONAL QUALITY MANAGEMENT ACTIVITIES

Accreditation: The Center has achieved successful 3-year accreditation by the Center for Accreditation of Rehabilitation Facilities (CARF) for the following program/treatment areas:

- Assertive Community Treatment (ACT)
- Supported Housing: Mental Health
- The Hope Center (consumer-run day treatment)
- Crisis Intervention Services (adults and children)
- Case Management/Service Coordination (adults and children)
- Outpatient Treatment: Mental Health (adults and children)
- Outpatient Treatment: Substance Use Disorders (adults)

This accreditation will extend through March 31, 2024. The Center will annually submit a signed Annual Conformance to Quality Report (ACQR) to CARF on accreditation anniversary reaffirming ongoing conformance to CARF standards. Every three years, the Center will be resurveyed by CARF.

Texas Resilience and Recovery (TRR): Spindletop Center implements TRR as mandated by HHSC to determine the consumer's eligibility and assignment to a level of care using the appropriate Uniform Assessment tool. The consumers are assigned to the appropriate level of care, limited or denied services, or placed on the waiting list when services are not available. The program is evaluated at least annually through review of the HHSC Business Objects data system and through internal fidelity measurements to determine its effectiveness in facilitating access, managing care, improving outcomes, and providing useful data for resource allocation, quality improvement, and other management decisions.

Utilization Management (UM) is a functional component of the Center Quality Management Plan that reviews accuracy of data sent to HHSC. The Utilization Management program reviews the Center's effectiveness in facilitating access, managing care, improving outcomes, providing useful data for resource allocation, quality improvement, and other management decisions. The UM Committee evaluates the effectiveness of meeting goals by collecting and analyzing data such as eligibility appropriateness, exceptions and overrides to services, appeals and denials, fairness and equity and cost effectiveness of all services provided. (See Appendix A: Utilization Management Plan.)

Written Policies and Procedures: Each program unit has department specific written policies and procedures. These unit-specific manuals are reviewed annually and revised when necessary. The policies and procedures are readily accessible to all employees. Variations from written policies or procedures are documented and submitted to Quality Assurance. Center-wide policies and procedures are available to all staff via the intranet. See also Policy Writing and Approval Process No. 400.00.

Incident Reports: The established incident report procedure is included in Center Policies and Procedures available via the intranet and is included in the New Employee Orientation Program. Incident reports are forwarded to the Rights Protection Division according to the procedures described in the policy on Incident Reporting. The Rights Protection Division is responsible for categorizing and developing a summary trend analysis for review by appropriate internal committees. Incidents are reported to the QM department for oversight and reporting into CARE. See also Incident Reporting Policy No. 400.05.

Record Reviews – Quality record reviews are conducted Center-wide in accordance with policy at the program unit level by qualified supervisory staff. These record reviews are submitted to QA for additional analysis and trending. Quality Assurance staff identify specific areas of weakness concerning accuracy, quality and completeness of service documentation, assessments, and person-centered recovery plans that may necessitate further staff training. QA staff review the following:

1. Reviews the level of consumer record compliance for each Center program unit
2. Evaluates the quality of consumer care via monitoring of aggregate chart deficiencies and makes recommendations for change when necessary to comply with procedure
3. Conducts random clinical record reviews of a representative sample of records quarterly
4. Supervises and receives corrective action plans from Center service programs
5. Monitors aggregate chart deficiencies and makes recommendations for necessary changes to written or actual procedures
6. Reviews records responsive to external requests for completeness prior to submission by Central Records Department.

See also Quality Records Review and Compliance Call Policy No. 400.51.

Facility Reviews – All Center owned/operated facilities are reviewed annually by QA staff for compliance with relevant ADA, National Safety, regulatory, licensing, state, federal, and accrediting standards and rules. Reviews are unannounced and result in a report of findings, corrective action plan to address findings, and follow-up to ensure corrective actions implemented were successful in addressing the finding. All documentation related to facility reviews is stored by the QA department.

Subcontractor Reviews – All non-residential subcontracted services are reviewed annually by QA staff for compliance with contract terms and conditions as well as any relevant state, federal, regulatory, licensing and accrediting standards and rules. Reviews of subcontracted services result in a report of findings, corrective action plan to address findings, and follow-up to ensure corrective actions implemented were successful in addressing the finding. All documentation related to subcontractor reviews is stored by the QA department. See also Quality Management Contract Review Policy No. 400.82.

Fidelity Reviews – Annually, QA staff will review evidence-based and best-practice programs and models of care for consistency and fidelity to the model. Such programs and models of care may include Assertive Community Treatment (ACT), Early Onset Psychosis (EOP), Youth Empowerment Services (YES) Waiver, Wraparound Implementation, Seeking Safety, Cognitive Behavior Therapy, Trauma-Focused Cognitive Behavior Therapy, Skill streaming and Aggression Replacement Techniques, Nurturing Parenting, and others as identified by HHSC. When performing fidelity reviews of evidence-based and best-practice curricula, a representative sample of service documentation will be selected for review. Reviews of evidence-based and best-practices will result in a report of findings, corrective action plan to address findings, and

follow-up to ensure corrective actions implemented were successful in addressing the finding. All documentation related to fidelity reviews is stored by the QA department.

National Culturally and Linguistically Appropriate Services (CLAS) Standards – Annually, QA staff will perform an assessment of center services for conformance to National CLAS standards in health and healthcare. This review results in a report and recommendations which are submitted to EMT for consideration. EMT also uses the information from the report to update the Cultural Competency and Diversity Plan and goals.

Accessibility Review – Annually, QA staff conduct a review of the organization for potential barriers in the areas of architecture, environment, attitudes, finances, employment, communication, technology, transportation, community integration and any other areas identified by persons served, personnel, or other stakeholders. This review results in a report and recommendations which are submitted to EMT for consideration. EMT evaluates the recommendations and approves any actions for removal of barriers. QA then monitors these approved actions and reports progress to EMT. See also Accessibility Plan Policy No. 400.50.

Community Needs Assessment – In order to ensure our services are responsive to the specific needs of our community, Spindletop Center will conduct a community needs assessment which will inform organizational decisions including strategic planning, staffing plans, cultural and linguistic needs, program services, transportation barriers, continuous quality improvement and annual budget. The community needs assessment shall be updated every three years or more frequently based on local conditions. The Community Needs Assessment is developed by the QA department for consideration and approval by the EMT.

Deficit Reduction Act: Policies and procedures are written and implemented to provide information about the False Claims Act, administrative remedies for false claims and statements, any state laws pertaining to civil or criminal penalties for false claims and whistleblower protections under such laws. The policies and procedures will also include provisions regarding detecting and preventing fraud, waste, and abuse. The Center's handbook includes information as directed by Section 6032 of the Federal Deficit Reduction Act (DRA) of 2005. All staff receive training on the Federal Deficit Reduction Act (DRA) of 2005. Procedures for minimizing the risk of fraudulent billing practices include:

- Supervisor review of progress notes.
- Monitor duplicate services report showing any duplicate or overlapping billing.
- Medical necessity is documented on the recovery plan by an LPHA before authorization can be made.
- Medicaid authorizations in place for Rehabilitative and Case management services.
- IDD billing tool is used to ensure the correct units of service are billed.
- Supervisors monitor staff by calling consumers/legal guardians and inquiring about satisfaction with services.

The Compliance Officer will maintain a log of compliance concerns that are reported. The log will record the issue, the clinical providers, units, department, and/or organizations affected the results of any investigation and whether the issue has been addressed. The log report will note any issues which remain open. The log will be treated as a confidential document, and access will be limited to those persons at the Center who have responsibility for compliance matters.

The Chief Executive Officer is notified about all investigations and signs all of the investigation reports.

IX. CONCLUSION

The Center's authority functions are monitored monthly primarily by the executive management team. Staff turnover, staff training, and staff survey results are analyzed by the chief of human resources who reports these measures and other employee improvement activities to the board, the executive management team, and the planning and advisory committees. The governing board monitors key fiscal scoreboard measures in its monthly meeting.

When programs require financial reallocations as a result of consumer needs and suggestions, the chief of financial services recommends for board approval modifications to the Center's operating budget. The information services department develops and implements software programs and reporting tools that aid program managers in evaluating the effectiveness and efficiency of services. The effectiveness of these improvements is determined by increased or improved consumer care. The goal of quality management is to develop and maintain consistent mechanisms by which consumers and employees can monitor Center operations and identify improvement opportunities. This process requires the free exchange of information between consumers, the community, staff, and executive managers.

Appendix A

Spindletop Center Utilization Management Plan

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

A. Utilization Oversight

The statewide UM Committee will provide guidance to the Center's utilization management processes through making recommendations which impact policy, implementation and oversight processes.

The State will monitor the Center's data entered into CMBHS and CARE via Business Objects (MBOW) on a routine basis to determine compliance and performance, to include the outcomes of service delivery. They will review data that reflects patterns of current service utilization and the clinical/assessment decisions used by the Center to make those decisions. When outliers or trends are detected which reflect unusual or unexpected results, the State will initiate contact and the causes will be explored. The State and the Center will collaborate to ensure that necessary oversight and improvement occurs and management decisions can be made

B. UM Psychiatrist Designation

The psychiatrist who provides oversight of the responsibilities of the UM Program and Committee is the Center's Medical Director. The UM Psychiatrist must be a board eligible psychiatrist who possesses a license to practice medicine in Texas. The oversight function includes approval of all policies and procedures related to UM, to include changes based on new technology and availability of resources.

C. Utilization Manager Designation

The Center Utilization Manager is the Director of Quality Assurance and Business Development. The Center's Utilization Manager's job description includes UM responsibilities. The UM Manager, under the direction of the UM psychiatrist and in consultation with the UM Committee, assumes the responsibility for execution of the UM Plan. The UM Manager is licensed to practice in the State of Texas as a Licensed professional counselor, has a minimum of five years' experience in direct care of individuals with a serious mental illness, has a demonstrated understanding of psychopharmacology and medical/psychiatric comorbidity through training and/or experience, has at least one year of experience in program oversight of mental health care services, and has a demonstrated competence in performing UM and review activities.

D. Utilization Review Activities

1. Procedure for Eligibility Determination: The Center conducts screenings of all potential consumers to determine if requirements are met for admission and initial level of care assignment using Texas Health and Human Services Commission (HHSC) criteria. Determinations are conducted to ensure the Center's practice guidelines deliver treatment in the most effective and efficient manner.
2. Procedure for Level of Care Assignment: The Center assigns each consumer to the appropriate level of care according to HHSC UM guidelines and conducts retrospective oversight of initial and subsequent level of care assignments to ensure consistent application of those guidelines. These processes ensure sufficient utilization and resource allocation based on clinical data, practice guidelines, and information regarding the consumer's needs with consideration of the consumer's (and LAR's on the consumer's behalf) treatment preferences and objections. Medical necessity is assessed on every individual and admission to medically necessary services is jointly determined by the individual and the Center. Documentation of medical necessity is on the uniform assessment and is reviewed by the UM reviewer when the assessment is authorized.
3. Procedure for Authorizations and Reauthorizations: The Center chooses to have automatic authorization of levels of care whenever indicated and in accordance with UM Guidelines. The Center conducts retrospective oversight of initial and subsequent level of care assignments to ensure consistent application of HHSC Utilization Management guidelines.

Procedure for Outlier Review: The Center and ETBHN, as designated by the Center by and through its Utilization Management Committee, conduct outlier review. This process consists of a review of data to identify outliers and to determine any need for change in level of care assignment processes, service intensity or other Utilization Management activities. These reviews are conducted to ensure provider treatment is consistent with practice guidelines as is the process for making utilization/resource allocation determinations.

4. Procedure for Inpatient Admissions, including State Hospitals and Discharge: The Center conducts reviews of inpatient admissions to ensure the most clinically effective and efficient length of stay at an inpatient facility and reviews discharge plans to ensure timely and appropriate treatment following an inpatient stay. These reviews are conducted to ensure continuity of services for coordinating the delivery of mental health community services by multiple providers. See also Inpatient Authorization Policy No. 1400.15.

E. UM Activities Fulfilled by Persons Other than Utilization Manager

The following persons conduct UM activities who are not the Utilization Manager: Quality Assurance Specialists. At a minimum, each of these staff is a QMHP-CS with 3 years' experience in direct care for adults with serious mental illness or children and adolescents with serious emotional disturbances and have all UM activities directly supervised by the qualified Utilization Manager. The UM activities conducted by these persons are: grant authorizations for consumers from the LPHA when the request is complete, accurate, and clearly falls within the HHSC UM guidelines, grant the initial TRR and overrides when it is a TRR error, and to gather data for the UM Committee to review outliers, trends, and performance measures.

F. Conflict of Interest

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

G. UM Documentation of Training and Supervision

It is the policy of the Center that UM staff are properly trained and supervised as required by HHSC or by other policy, law or regulation. It is the responsibility of the Center's Utilization Manager, in consultation with the UM psychiatrist and the Human Resources department, as necessary, to ensure documentation and supervision are properly maintained.

H. UM Committee

Spindletop Center has a local UM Committee which meets at least quarterly to review the clinical necessity, appropriateness, and efficiency of services provided to its consumers, the consideration of consumer preferences, consumer response to services, and the outcomes of provided services. The Center's UM committee members include Chief Executive Officer, Medical Director and other medical staff, QM Director, QM/UM staff, mental health professionals, financial and information management staff, and other staff and professionals. Participation by others may be indicated depending on the nature of issues under consideration.

The role and responsibilities of the Spindletop UM committee are as follows:

1. Identify and analyze current service, provider, and consumer outlier use patterns.
2. Recommend methods to minimize inappropriate or outlier practices.
3. Develop and distribute basic provider profiles to providers and program managers.
4. Develop and deploy methods to educate clinical decision makers regarding practice improvement and over/under use of service.
5. Review select reports from the consumer database management system.
6. Review reports from MBOW to monitor appropriateness of eligibility determinations, the use of exceptions and overrides, over and under utilization of services, appeal and denials, the cost effectiveness of services provided and authorizations prior to services being provided.
7. Review recommendations from Medical Council or other existing review

mechanisms regarding individual practitioner activity.

8. Review state and local hospitalization bed days.

The Center participates in a Regional Utilization Management (RUM) Committee through ETBHN. The primary function of the RUM Committee is to assist the promotion, maintenance and availability of high quality care in conjunction with effective and efficient utilization of resources. ETBHN facilitates a RUM Committee to ensure compliance with applicable contractual and regulatory UM requirements. RUM Committee meetings are held quarterly or more frequently as needed at a designated time and include a physician, UM staff, Quality Management staff, and fiscal/financial services staff. The RUM Committee maintains representation from all member centers of ETBHN. Each ETBHN member center's respective Executive Director/CEO appoints Committee members. ETBHN is responsible for taking, distributing, and storing minutes of every RUM Committee meeting.

I. Exception/Clinical Override Process

The Center maintains a system to override the TRR Guidelines when there is the need and to make exceptions to and manage the number of units of service authorized for a consumer and to report on exceptions and overrides as required by HHSC.

J. Adverse Determinations/Appeal Process

An adverse determination applies to a person requesting services that are denied and those persons who are receiving services, who no longer meet UM criteria for that service(s) and for whom the provider and client request additional authorization. The initial recommendations to deny authorization for continued stay is made by the Utilization Manager who then refers it to the UM Physician, who will make a decision based on all available data. The final denial of services based on failure to meet clinical criteria may only be made by a physician.

Appeal of Adverse Determinations: The Center will ensure client access to an objective appeals process when services are denied, limited or terminated. Clients funded by Medicaid are also afforded access to the Medicaid Fair Hearing Process. The Center will ensure that all providers and clients are provided information about their right to appeal and the process to do so. Pursuant to Texas Administrative Code and Information Item Q of the Performance Contract, the Center makes available a timely and objective appeal process, maintaining documentation on appeals. See also Adverse Determination Appeal Policy No. 400.01.

K. Quality Management and Utilization Management

The Center Quality Management (QM) program provides oversight to ensure compliance with and the high quality of the implementation of Texas Resiliency and Recovery practices, monitors fidelity to service models, monitors performance in relation to all contract performance measures, and coordinates activities with the UM program.

M. Provider Profiling

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