Quality Management Plan

APPROVAL

The Quality Management Plan for Gulf Bend Center was reviewed and approved on

September 26, 2023.

Signature on File

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Steve Hipes,
Gulf Bend Center Board of Trustees Chair

Signature on File

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Jeffrey Tunnell, Executive Director
Gulf Bend Center

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Julia Galvan, Director of Quality and Compliance
Gulf Bend Center

Quality Management Plan

PURPOSE

Gulf Bend Center's (GBC) Quality Management program is to assure ongoing excellence in the quality and safety of the care and services provided by Gulf Bend Center. GBC's Board of Directors and staff are committed to improving the overall health of individuals within our service area. GBC accomplishes this by continually monitoring, measuring, assessing, and improving the excellence of all customer care services provided by or contracted by GBC and organizational operations. Our goal is for each program to provide care that is safe, effective, customer- oriented, timely, efficient, and equitable. Ensuing that individuals who are receiving assistance through Gulf Bend, are receiving quality services provided by culturally competent and adequately trained staff in a manner that is financially viable, focused on recovery and is person and family centered.

The Quality Management (QM) Program is comprehensive; quality and safety must extend to all facets of the organization - clinical and administrative. The plan outlines the principles of Gulf Bend Centers quality management plan. It provides a systematic approach to measure, assess, and improve the quality and appropriateness of the internal delivery system. Quality improvement is considered an ongoing structure of quality management plan.

OUR MISSION, OUR CULTURE & OUR VISION

Our mission statement and core values are key elements to planning and implementing our quality program for continuous improvements for services. We strive to enhance the behavioral and developmental health and wellness of our community by helping people live their best lives in an environment that is linguistically and culturally appropriate and focusing on person and family centered services that meet the needs of our individuals. We assist individuals to receive supportive nurturing care appropriate to their needs in the least restrictive enforcement possible.

Quality Management Plan

OUR CORE VALUES

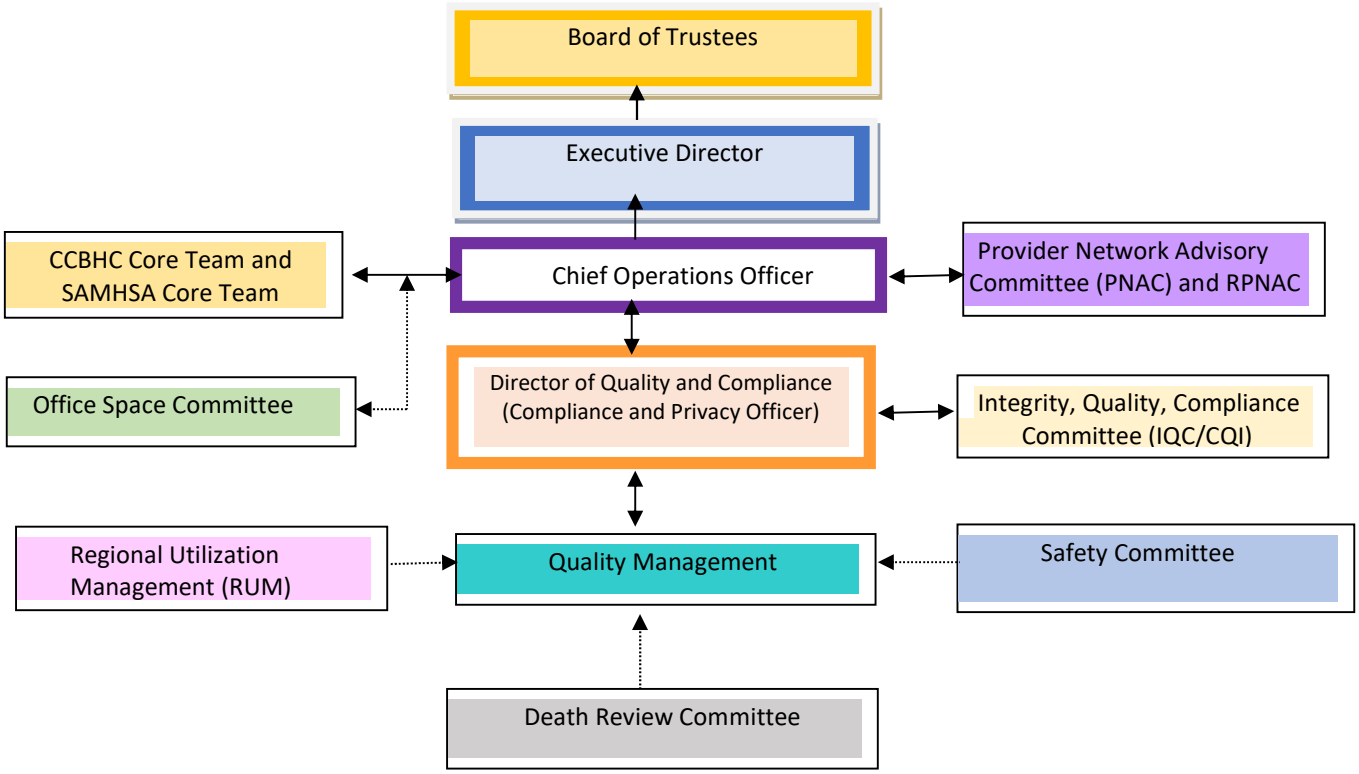
CHAPTER 1
STRUCTURE OF THE QUALITY MANAGEMENT PROGRAM

The structure of the Quality Management (QM) program flows from the following principles:

- The Quality Management program must ensure accountability at all levels within all programs.
- All staff play a key role in quality management, and this role should be made as efficient and effective as possible.
- Use QM findings to develop current and future strategies for quality service delivery.
- Engage stakeholders for input and ongoing assessment of services provided.
- Continuously evaluate the Center's progress toward our mission and values.

The Quality Management Plan is presented to the Gulf Bend Center Board of Trustees for approval. The plan is reviewed annually by the QM Department and updated at least every two years by the board or more often if substantial changes are made in the Quality Management program for continuous improvement. The Board receives and acts upon periodic reports developed through the QM and CQI program, and it ensures the availability of resources and systems necessary to support all QM activities. The Board holds Gulf Bend Center's Executive Director and Executive Management Team accountable for the development, implementation, monitoring, and evaluation of the Quality Management Plan and continuous improvement of services. Gulf Bend Center's Director of Quality and Compliance has operational responsibly for the QM program.

Quality Management Organizational Structure



The Quality Management Department performs functions which support and facilitate the development, implementation, monitoring, and evaluation of the Quality Management Plan. The plan is designed to ensure conformance with all applicable federal and state laws and regulations, including the regulation and guidance promulgated by the Health and Human Services Commission (HHSC), and other regulatory bodies with oversight responsibility. In addition, the QM plan complies with all quality performance requirements as presented in funding contracts with federal, state, and local entities. The Quality Management Department is not to be the sole or primary source of performance improvement activities. Rather, its objective is to involve and provide support, expertise and guidance to administrative, executive management and all staff in performance improvement activities.

The Quality Management Department is responsible for the following:

- Reviewing the QM Plan annually, update as needed, soliciting input from Integrity Quality and Compliance (IQC) and other stakeholders;
- Conduct planning activities
- Aiding with plans of improvement to meet the HHSC Performance Contracts for Behavioral Health and Intellectual Developmental Disability services;
- Ensuring implementation of the Quality Management Plan;
- Performing and ensuring compliance with Internal/External review activities;
- Provide oversight of all services, contracts, and subcontractors regardless of the amount of funding;
- Measure, assess, and improve client satisfaction;
- Measure, assess, improved quality management activities, administrative services, client services, and outcome for individuals;

- Ensure compliance with all laws, rules, policies, and procedures for service implementation and billing.
- Monitor any new initiatives;
- Review and analyze grievances, appeals, fair hearings, expedited hearings, mortality, and incident/accident data;
- Ensuring QM training is provided to new and tenured employees;
- Providing technical assistance to other departments related to quality oversight necessary to improve the quality and accountability of services;
- Provide oversight to ensure compliance with required management practices, including the monitoring of fidelity to service models defined by HHSC (minimum once per year for CCBHC)
- Improve the client rights protection process, including review of rights restrictions;
- Reporting and trending data collection related to reported incidents, medication errors, abuse, complaints and neglect, privacy/security incidents;
- Assisting with the development/revision of center procedures and plans, making that information available to all staff;
- Assisting in the development, facilitation and ensuring the implementation of Certified Community Behavioral Health Clinics (CCBHC) requirements for compliance;
- Facilitating the Integrity and Quality Committee (IQC)Meetings;
- Reviewing, trending and summarizing program performance indicator data for review by the IQC
- Measure, assess, and improve the local authority functions;
- Conduct self-assessment activities;
- Respond to mandates by HHSC or any other oversight entity, including self-monitoring activities.

Within each Program Administrator the effectiveness of the QM program is the direct responsibility of the departmental leadership (e.g., Directors, Managers, and Leads). It is the leaders' responsibility to develop, support, and operate the Quality Management program. The leaders, with the support and assistance of the Integrity and Quality Committee (IQC) accomplish the following:

- Select and prioritize metrics (performance indicators) to monitor, with a performance goal for each;
- Determine acceptable performance thresholds (quality action points) for selected metric(s);
- Ensure that all necessary data related to each metric are submitted to the IQC and QM Department on a quarterly basis;
- Manage ongoing improvement activity, through records reviews, provision of programmatic trainings, staff supervision, performance reviews, etc.;
- Assume ultimate responsibility for resolving identified quality and safety problems, as well as taking advantage of any other opportunities to systematically evaluate service delivery and monitor quality; and
- Communicating outcomes of quality improvement activities to the QM Department on a quarterly basis.

1 The QM Plan is not intended to set forth all of the programs and practices of GBC that are designed to evaluate and address quality improvement activities. In addition to this plan, GBC has developed and implemented a Local Provider Network Development (LPND) Plan, Consolidated Local Service Plan (CLSP), ADA Self-Evaluation, Infection Control Plan, Compliance Program, Emergency Preparedness Plan, IDD Local Plan, and Utilization Plan establishing guidelines and defining parameters of the Center's compliance efforts. The compliance practices included in each of these plans are coordinated to direct the Center's overall compliance efforts.

Quality Management Plan

GOALS for FY-24

- Gulf Bend Center will establish an effective means of collecting meaningful feedback from stakeholders, individuals receiving services, families, visitors, and staff.
    - Progress will be determined by implementing a system for collecting responses related to satisfaction, quality of care, etc.
- Gulf Bend Center will develop and maintain an internal resource center to assist all staff with related forms, training, procedures, and additional resources.
    - Promoting ongoing awareness of the resource center and requesting staff feedback on additional items needed.
- Gulf Bend Center will receive a comprehensive score of 85% or higher on all audits conducted by an external review.
    - Progress will be determined by documenting results for each external audit.

COMMITTEES

Gulf Bend Center has established standing committees to conduct Quality Management functions. These committees address issues which have center- wide implications and cross program and departments:

Integrity, Quality and Compliance Committee (IQC)

The IQC is comprised of directors from Intellectual Developmental Disability Services, Behavioral Health Services, Administration, QM, Information Technology, Nursing, Utilization Management, Medical, Human Resources, and Finance and is facilitated by Director of Quality and Compliance. The IQC reviews and monitors the assessment of data for trends and patterns that affect the outcomes for services provided by GBC. IQC will make appropriate recommendations for performance review activities or project management initiatives.

Death Review Committee

The Death Review committee is comprised of the Director of Nursing, Chief of Clinical Services, Quality Management Department, and a Provider. The Death review committee is notified by staff of any deaths. that involves an individual that receives our services. The committee is tasked with completing the required documentation, conducting the appropriate Administrative or Clinical review depending on the circumstances and making recommendations for improvements. Any Administrative death review recommendations will be reported to HHSC, IQC, and to the Board

Office Space Committee

The Office Space Committee is comprised of the Chief Operating Officer, Director of Human Resources, Director of Quality and Compliance, Chief Business Services Officer, Director of Program Operations, Chief Financial Officer, and the Executive Administrative Assistant. The committee is tasked with making sure the staff and customers have an environment that is linguistically and culturally welcoming and functional to their needs so they can strive to feel safe and improve their likelihood of recovery and a positive work environment.

CCBHC Core Team

The CCBHC Core Committee members include the Chief Operating Officer, Director of Program Operations, Director of Behavioral Health, Director of Nursing, Chief Business Services Officer, Director of Human Resources, Chief Financial Officer, and the Quality Management Department. This group of individuals are tasked with ensuring the compliance of the CCBHC model within GBC services by reviewing protocols, stakeholder input, outcomes, collecting data, and making the needed changes to ensure improvement. This committee plans needed trainings to staff and help develop the actions for the Trauma Informed Care/Time for Change (TIC/TOC) group to do ongoing trainings for staff throughout the year and

independent surveys and self-assessments to measure our improvement and understanding of TIC/TOC.

Utilization Management

Gulf Bend Center employs a utilization management system to ensure customers receive the right services, in the right amount, at the right time; timely and meaningful assessments; accurate assignments of level of care; determination of medical necessity, focused treatment/recovery plan development and active monitoring of progress towards outcomes. Gulf Bend Center participates in a Regional UM (RUM) Committee for Behavioral and IDD service, both of which meet no less than quarterly. Established as a regional committee within the East Texas Behavioral Health Network (ETBHN), the primary function of the UM Committee is to monitor utilization of Gulf Bend Center's clinical resources to assist the promotion, maintenance, and availability of high-quality care in conjunction with effective and efficient utilization of resources. See Gulf Bend Center's Utilization Management Plan.

Safety Committee

The Safety Committee includes the Chief Operating Officer, Quality Management Department, Maintenance Supervisor, Director of Human Resources, Chief Financial Officer, and the Building Manager if needed. The function of the safety committee is to continuously monitor, assessing, prevention, and response to ongoing changes to safety within all facilities and vehicles are maintained to provide a safe environment for all individuals. The safety program ensures compliance with all applicable federal, state, and local guidelines, including but not limited to codes for buildings, health, and fire safety. Additionally, TCRMF assist with periodic on-site visits or webinars for providing safety recommendations and trainings to staff.

SAMHSA Core Team

The SAMHSA Core Team is comprised of Chief Operating Officer, Director of Program Operations, Chief Financial Officer, Director of Behavioral Health, Director of Nursing, CCBHC Project Director, Wellness Community Manager, Specialty Clinical Services Manager, Program Evaluator, Data Support Specialist. This group of diverse individuals is tasked with ensuring that the measures for SAMHSA grants are being accurately measured and documented for reporting purposes. Additionally, sharing this data with the IQC committee for further evaluation and possible implementation changes for better outcomes.

PNAC

The Planning Network Advisory Committee (PNAC) is comprised of community members appointed by the Board of Trustees to advise them on planning, budget, and contract issues as well as needs and priorities for the service area. The PNAC board represents persons with mental illness, substance use disorders, and other populations served (i.e., Veterans). This committee is tasked with reviewing and providing input on the Local Provider Network Development (LPND), the Consolidated Local Service Plan (CLSP) and obtaining stakeholder input on service needs and delivery to present information to the Board of Trustees and the Executive Director. GBC also participates in the Regional PNAC through East Texas Behavioral Health Network (ETBHN) for additional regional stakeholder input and review of our LPND and CLSP.

GBC Regional Collaborative

The Regional Collaborative is a diverse group of community members within our 7-county community. They represent different agencies, community partners, or stakeholders that share their input on the needs of our community and how to provide those services. This group has successfully worked with our local senate and house of representatives to advocate for funding and awareness for needed services for our rural area to improve our service delivery.

CHAPTER 2
QUALITY MANAGEMENT ACTIVITIES

Youth Empowerment Services (YES) Waiver Services

The Director of Behavioral Health Services, or their designee will be responsible for the monitoring of services provided through GBC's YES Waiver program and compliance with YES Waiver policies and procedures addressed in the YES Waiver Policy Manual. The Director of Behavioral Health Services is responsible for addressing any necessary corrective actions identified during Quality Management Reviews.

Identified outcomes to monitor include:

1. Waiver participants have timely access to services.
2. Waiver participants are enrolled in a timely manner.
3. Plans of Care and Services are based on underlying needs and outcome statements.
4. Services are provided according to the Waiver participant's approved Individual Plan of Care.
5. Child and family team meetings include provider participation.
6. IPCs are developed and revised according to HHSC policy.
7. Health and Safety risk factors are identified and updated.
8. Providers are credentialed and trained.
9. There is adherence to established policies and procedures.
10. There is continuity of care for waiver participants.
11. Medicaid, demographic, and clinical eligibility criteria are met.
12. Any applicable Waiver service associated cost limitations are not exceeded.

Fidelity Reviews

Adult and Children evidence-based practices will be reviewed by applicable Program/Department Directors/Managers/Supervisors and QM staff utilizing appropriate fidelity tools for each practice. Fidelity reviews will be completed at least annually with reports submitted to IQC. Evidence based practices to be reviewed include:

Adult

- Assertive Community Treatment (ACT)
- Supported Employment (SE)
- Permanent Supportive Housing (PSH)
- Illness Management and Recovery (IMR)

Children's

- Social Skills and Aggression Replacement Techniques (START)
- Preparing Adolescents for Young Adulthood (PAYA)
- Seeking Safety
- Nurturing Parenting Program
- Wraparound Planning Process.

Local Intellectual & Developmental Disability Authority (LIDDA) Services

The Director of Intellectual and Developmental Disability (IDD) Services, or their designee will be responsible for the monitoring of IDD Service Coordination program and compliance with Texas Administrative Codes (TAC) that apply to Home and Community Based Services (HSC), Texas Home Living (TxHmL), Community First Choice (CFC), and Preadmission Screening Resident Review (PASRR). The Director of Intellectual Development Disabilities program is responsible for addressing any necessary

corrective actions identified during the external HHSC Review and the internal Quality Management Reviews.

- Screening gathering information to determine need for services.
- Eligibility Determination
- Service Coordination
- Development and Monitoring of Person Directed Plan (PDP)
- Community Support
- Respite
- Behavioral Support
- Specialized Services
- Community First Choice Services
- Preadmission Screening and Resident Review (PASRR)
- Assistance locating Intermediate Care Facilities for Individual with an Intellectual Disability or Related Conditions (ICF/ID)
- Assistance in completing application for admission to State Supported Living Centers (SSLC's)

Behavioral Health Services

The Director of Behavioral Health Services, or their designee will be responsible for providing Behavioral Health Services in compliance with Texas Administrative Codes (TAC) and Texas Health & Safety Code. Services are provided to Adult, Children and Adolescents. The Director of Behavior Health Services is responsible for addressing any necessary corrective actions identified during the external HHSC Review and the internal Quality Management Reviews.

- Crisis Intervention Services
- Mobile Crisis Outreach (MCOT)
- Screening
- Routine Case Management
- Counseling
- Peer Support
- Nursing Services
- Care Coordination and Continuity of Care Services and Supports
- Pharmacological Management
- Medication Training and Support
- Psychosocial Rehabilitative Services
- Skills Training and Development Services
- Supported Employment and Supported Housing Assistance
- Substance Use Disorders (SUD)
- Jail Diversion Services

Crisis, Registration, and Intake Services

Appropriate Program/Department Director/Manager will complete reviews and collect data related to timeliness of response and appropriateness of care. QM will provide necessary audit and data collection tools with expected outcomes and the sample cases to be reviewed. QM will review results to identify compliance issues. The results will be reported to the IQC and used to identify performance improvement activities.

OTHER QM ACTIVITIES

Internal Compliance Reviews

The QM Department, Directors, Managers and Leads conduct routine reviews of assessment, progress note, and treatment/recovery plan or person-directed plan to determine whether treatment is consistent with department approved evidenced-based practices throughout the fiscal year. QM will provide necessary audit tools with expected outcomes and the sample cases to be reviewed. QM reviewers collaborate with the appropriate program management members to address instances of non-compliance by providing technical assistance and follow-up to remedy any concerns or deficiencies identified and to determine the need for further reviews. The results will be reported to the IQC and used to identify performance improvement activities.

Contract Monitoring

Contract monitoring is a function of gathering and evaluating fiscal and qualitative indicators specific to a contracted service to determine whether the service provider is following the contract. The appropriate Program/Department Director/Manager, for which the contracted service is being provided to, is responsible for monitoring compliance with identified fiscal and qualitative indicators. Data is evaluated to make informed decisions regarding re-contracting with service providers. The qualitative indicators should be tailored to the service provided and ensure achievement of desired outcomes, compliance with applicable rules, laws, and standards which relate to the contracted service. Reports of monitoring should be reported to the IQC at least quarterly, or more often as needed.

External Audits from State Contract and Other Oversight Entities

Each department is subject to and participates in onsite or desk reviews from HHSC and other regulatory agencies. Reviews range from those related to implemented programs, services provided, and/or funds awarded. Reviews may assess compliance with contractual obligations, billing accuracy, personnel competency, facility requirements, or quality service provision.

The QM department facilitates the majority of all external audits conducted by funding sources and regulatory authorities. The appropriate department and QM will collect and submit required documentation and information as requested. The QM department and appropriate department Director will communicate with whomever is conducting the audit to answer questions throughout the audit process. Additionally, developing and responding to any required corrective actions plans as needed.

Reports, data, and results from onsite reviews or desk reviews from HHSC, TCOOMMI, Managed Care Organizations and other review agencies are used to identify performance improvement activities and to assess unmet needs of individuals served and service delivery problems.

Surveys

Feedback from individuals receiving services and GBC staff is vital to gauging the overall quality of services provided at GBC. The QM department and Trauma Informed Care/Time for Change (TIC/TOC) group will coordinate and develop various surveys across the Center to evaluate the needs and elements of quality specific to particular programs or departments.

The QM department will evaluate the results of the surveys conducted including, response rate and responses provided. The QM department will evaluate the effectiveness of the surveys being conducted and make recommendations for improvement as needed.

Quality Management Plan

Safety and Risk Management

- The QM will review all submitted incident reports and medication errors to identify trends and patterns related to safety or health risks and reports the data to the IQC.
- Building inspections are completed by QM/Maintenance staff for and reported to the IQC on a quarterly basis to identify health and safety hazards and ADA compliance.
- All deaths are reviewed by the Death Review Committee to determine if the death was incidental to the care of the individual on the part of Gulf Bend Center or natural causes, and results are reported to the IQC.
- Workers' Compensation/Employee incidents will be reviewed by Human Resources and reported to the IQC.

Staff Development and Competency

Qualified and trained staff make up an important component of quality service provision. Qualifications and education are verified prior to hire and competency to perform essential direct care duties is assessed prior to staff working unaided with consumers. All staff complete required training and competency assessment annually and compliance with this performance indicator is monitored by the Human Resource Team and reported to the IQC on a quarterly basis.

GBC also partners with the Texas Council Risk Management Fund to offer training specific to leadership and to all workforce members to encourage growth and development as a part of providing high quality services to individuals.

Policies and Center Plans

The Gulf Bend Center procedures and Center Plans are sent out to all staff as they are updated or developed. The email also contains instructions of where to find all center procedures on the Group H drive and who to contact for clarification or guidance. The updating of procedures and center plans is an on-going project to accommodate the needs and services of our community, ensuring that services are person and family oriented.

MBOW Data Warehouse, CMBHS and Electronic Health Record (EHR) system

The reports generated in the state database are constantly reviewed by appropriate Program/Department Directors/Managers to monitor GBC's performance on a variety of indicators. The reports are used to judge accuracy of data collection as well as to evaluate Gulf Bend Center's performance on outcome measures.

The Electronic Health Record (EHR) system provides a variety of reports for the purpose of collecting, reporting, and analyzing data for improvement of outcomes, service delivery and performance measures. The EHR system is evolving with continuous upgrades which helps to identify trends, create new reports, and improve our services.

Reduction in Abuse, Neglect and Exploitation

Gulf Bend Center (GBC) has adopted policies and procedures that prohibit the abuse, neglect and/or exploitation of individuals served by GBC employees, volunteers, consultants, and contract providers. Supports have been designed and implemented to ensure that all risks to individuals have been minimized.

They include staff screening, staff education and training for individuals served in recognizing and reporting all forms of abuse and neglect. The Rights Officer continuously monitors information relevant to abuse and neglect of persons served, and reviews relevant data quarterly or more frequently as needed.

This analyzed data is shared with IQC/ CQI committee members for trends and patterns involving Particular programs, certain staff, or people served.

Pre-Employment Screening Procedures:
To minimize unnecessary or unreasonable risk, GBC mandates the following:

- All individuals considered for employment will have background checks completed to determine the existence of a criminal history with the Texas Department of Public Safety or other suitable sources; and a check made to determine the existence of an abuse/neglect confirmation through HHSC, the Employee Misconduct Registry, and the Nurse Aid Registry. This also applies to volunteers. If the applicant has lived outside of Texas within the past two years preceding the application for employment/volunteer status, GBC will obtain criminal history information through the FBI. These screenings will also be conducted before employment for all staff and annually thereafter.

- Human Resources will review all pre-employment background checks that reflect convictions of other types of criminal offenses that may be considered a contraindication to employment or volunteer status and make the decision relative to the employment (of the applicant or conditional new hire) or continued employment (of an existing employee). Such decisions may be made in consultation with legal counsel. The following will be considered when making decisions:
  1. The nature and elements of the offense, including the circumstances surrounding the offense.
  2. The nature of the job and the job responsibilities for which the individual is being considered (or for the position which is occupied by existing employees).
  3. The remoteness in time of the offense or offenses.
  4. The number and frequency of offenses, and the age of the individual at the time of the offense.
  5. Texas Administrative Codes that relate to the above background checks.

All employees will receive pre-service training (New Employee Orientation) and annul training through face-to-face and/or computer competency-based training. The material covered includes an explanation of the acts and signs of possible abuse/neglect/exploitation; procedures for reporting incidents; methods of intervention; disciplinary consequences of abuse/neglect/exploitation.

Information on reporting abuse/neglect/exploitation (phone numbers, who to call) is given to customers and/or legally authorized representatives upon admission and annually. Gulf Bend Center contact information for Rights officers, Compliance, and Complaints is located on the GBC website with a toll-free number to contact us at any time although after hours contact will be sent to a voicemail. Additionally, out Crisis hotline is also available for a live caller 24 hours a day, 365 days a year. Emails can be sent to compliance@gulfbend.org

Rights Protection Process

The QM Department establishes procedures regarding customer education, the protection and advocacy of rights of customers, as well as methods of reporting and investigating suspected violations to those rights in accordance with the applicable laws and regulations. The QM Department staff serve as Customer Rights Protection Officers and are standing members of the Integrity, Quality and Compliance Committee which is designed to:

1. Review any use of physical restraints as this is not allowed.
2. Review reported allegations of Abuse, Neglect and Exploitation.

3. Review quarterly YES Waiver CIRS data.
4. Review, monitor and make suggestions to the Center about its practices and programs as they relate to drug usage, physical restraints, control of inappropriate behavior, protection of customer rights and funds, outcomes, and any other area the committee believes need to be addressed.

All Gulf Bend Center staff receive initial training on the content of the Customer Rights policy, and annually thereafter. New employees may not assume job responsibilities prior to Customer Rights Training. All suspected violations of Customer Rights are reported to the Customer Rights Officers immediately either through internal GBC email, compliance email, GBC website, or local 1-800-421-8825 number. Any allegation or suspicion of Abuse, Neglect, or Exploitation involving customer of Gulf Bend Center is reported to the Texas Department of Family and Protective Services by contacting the hotline number **1-800-252-5400** or **web-based portal www.txabusehotline.org/Login/Default.aspx** immediately to initiate an investigation. The Rights Protection Officer works closely with the Office of the Ombudsman, HHSC Provider Investigations, and DFPS to address concerns as they are identified.

CHAPTER 3
CONTINUOUS QUALITY IMPROVEMENT

The QM Department will work in conjunction with the appropriate Director/Managers to maintain continuous quality improvement (CQI) for clinical services and clinical management for CCBHC population annually. Evaluation of improved behavioral and physical health outcomes and actions taken for compliance will be tracked for CCBHC performance. The IQC will review reports of CCBHC quality measures on a quarterly basis. Measures that do not meet target expectations will be monitored through the Performance Measure process. In addition, Quality Management will conduct reviews of these measures on an annual basis. In addition to reviewing/monitoring the CCBHC Quality measures, the IQC will review reports related to special events such as (1) CCBHC consumer suicide deaths or suicide attempts;(2) CCBHC consumer 30-day hospital readmissions for psychiatric or substance use reasons; and (3) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation.

Gulf Bend Center has adopted a continuous improvement model for producing improvement in key services and clinical areas. This model encompasses a systematic series of activities, organization-wide, which focus on improving the quality of key systems, service, and administrative functions.

The overall objective of the quality improvement process is to ensure that quality is built, measured consistently, interpreted, and articulated into the performance of Gulf Bend functions. The CQI projects will include documented reasons for the CQI project and measurable progress achieved by the project. The quality improvement process is incorporated internally into all service areas of Gulf Bend and the Quality Management Plan for the Center.

A CQI Data monitoring spread sheet was developed to help with tracking data for different CCBHC and SAMHSA measures. This tool enables GBC to effectively review, monitor, and evaluate Clinical quality measures for improvement of service delivery. This is updated regularly and shared in an open folder available to committees such as: IQC, CCBHC Core Team, SAMHSA Core Team, Executive Management and QM Department.

Quality Management Plan

Goals of Quality Improvement (QI):

1. Identify important practices and processes where improvement is needed to achieve excellence and conformance to standards.
2. Monitor these functions accurately.
3. Draw meaningful conclusions from the data collected using valid and reliable methods.
4. Implement useful changes to improve quality.
5. Evaluate the effectiveness of changes.
6. Communicate findings to the appropriate people/departments.
7. Document the outcomes.

Identifying Quality Improvement Projects:

Gulf Bend Center utilizes the following potential topics for quality improvement projects:

1. Client -centered services: Review of client complaints/grievances, requests for appeals and State Fair Hearings.
2. Safety – reducing serious incidents: Review of incident report data, safety inspections, and any ADA reviews.
3. Effective services – continuity of care, performance outcome measures.
4. Efficient and accessible services
5. Equitable services – access to services in clients' preferred language
6. Timely services – timely access to services

Quality Management and IQC reviews the following data at Quarterly meetings to identify quality improvement projects:

1. Incident reports – number and type of reports submitted (to include HIPAA compliance violations)
2. Safety inspections
3. Client complaints and grievances
4. QM Medical Record review findings related to provision of consents/rights, completion of assessments and recovery plans, documentation of service provision and progress made toward documented recovery plan, discharge (planning and referrals), utilization of translation/interpreter services as it relates to language preferences, etc.
5. State and payor review findings
6. CCBHC and applicable extension grant outcome measure data to include mental and physical health
7. SUDS outcome measure data
8. HHSC Performance measure data from MBOW
9. Internal data reports related to service provision and billing (denials, claims, etc.)
10. Death reports and suicide attempts
11. Hospitalization readmission rates and timely follow-up related to hospital discharges
12. Satisfaction surveys
13. Utilization Management
14. Referral reports (external and internal)
15. Staff training
16. New Hires and Terminations
17. Demographic and population management data from the EHR system

Quality Management Plan

Quality Improvement Work Plan (QIWP) - FY 2024

The QIWP for Gulf Bend Center defines the specific areas of quality of services, both clinical and administrative, that GBC will evaluate for FY 2024. The QIWP includes plans for monitoring previously identified issues, sustaining improvement from previous years, and tracking issues over time.

Quality Management and the IQC will monitor the QIWP and revise on an ongoing basis. Additional QI activities may be added during the year based on requirements from the State, recommendations by the IQC or other stakeholder group, or may be based on observed patterns, trends, or single occurrences. *See Attachment A.*

Annual Evaluation of the QIWP

The IQC will evaluate the QIWP annually in order to ensure that it is effective and remains current with overall goals and objectives. This evaluation will be the Annual QIWP Evaluation. The assessment will include a summary of completed and in-process quality improvement activities, the impact of these processes, and the identified need for process revisions and modifications. The QIWP is reviewed and approved by the IQC on an annual basis.

<u>GOALS for FY-24</u>

- SUD Service records reviewed have a completed ASAM and Recovery Plan that addresses SUD goals and objectives.
    - 90% of records reviewed will have a documented ASAM and Recovery Plan in the EHR as required by SUD standards/criteria.
- Implement Method to collect and report data related to suicide attempts and suicide and reduce by 10%.
    - Progress will be determined by comparing FY-23 data on suicide attempts and suicide to FY-24 data.
- Decrease the number of occurrences of known rehospitalizations within 30 days.
    - Progress will be determined by comparing FY-23 data on rehospitalization for a reduction of 2 in FY-24.
- Implement method to collect and report timeframe of initial contact to evaluation within 10 days.
    - 90% of records reviewed will have met the required timeframe of initial contact to evaluation within 10 days.
- Implement a process to share data reports related to all CCBHC outcome measures and performance contract measures with IQC utilizing a central repository.
    - Data will be reviewed and analyzed quarterly as evidenced by the IQC agenda minutes.
- The Center will reduce the number of no-show percentage by 3% in FY-24 for at least one clinic location or overall center average.
    - Progress will be determined by comparing FY-23 no show information to FY-24.

Continuous Quality Improvement: Performance Indicators

Each Program Administrator is charged with monitoring predetermined performance indicators (metrics) of quality outcomes, as selected by the Directors/Managers of each Program/Department in conjunction with Gulf Bend Center's IQC. At least two indicators will be selected/developed each fiscal year for each Program/Department. These indicators will be based on internal/external reviews, satisfaction surveys, incident reporting, grant/contract requirements, new service initiatives, etc. Throughout the year additional metrics (indicators) may be added for monitoring.

Quality Management Plan

A performance indicator is a quantitative tool that provides information about the performance of the center's process, services, functions, or outcomes. Selection of a Performance Indicator is based on the following considerations:

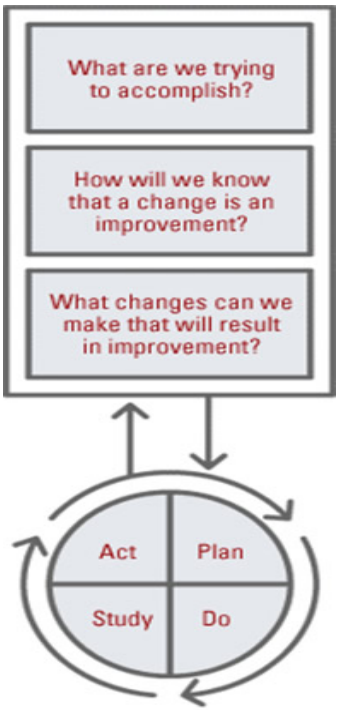
- Relevance to the Center's mission, values, and strategic initiatives; and
- Importance - whether it addresses an important process that is:
  - high volume
  - problem prone or
  - high risk.

For the purposes of this plan, an indicator(s) comprises five key elements: name, definition, performance threshold, data to be collected, the frequency of analysis or assessment, and preliminary ideas for improvement. The following Table will be used for each performance indicator chosen by the IQC and appropriate department program leadership.

Name	***Usually a brief two- or three-word title.***
Performance Standard	*Identify what you will review TAC if possible*
Comparative Data Used to Assess Performance	*Why is this performance standard being assessed*
Performance Threshold	*What are the specific performance expectations (list percentages)*
Data Collection	*How data will be collected and reported; frequency of collection and reporting; (who will collect the data)*
Outcomes/ Corrections	*Spreadsheet/tool submitted to QM? Yes ___ No___* *Outcomes submitted to Program Manager/Director? Yes No*

Once the performance indicator has been developed, data is collected and reported to the IQC, or to the Quality Management Team, using charts and graphs whenever helpful. Data will be analyzed to identify trends, patterns, and performance levels that suggest opportunities for improvement. Analysis is based on predetermined benchmarks, quality action points or thresholds.

Quality Improvement Initiative



After the selected process has been measured, assessed, and analyzed, the information gathered for the above performance indicator(s) is used to identify a continuous quality improvement initiative that may need to be undertaken. The decision to undertake the initiative is based upon Center priorities. The purpose of an initiative is to improve the performance of existing services or to design new ones. The model utilized at Gulf Bend Center is called Plan-Do-Study-Act (PDSA)

The IQC will track reports on progress until improvement has been fully realized. When improvement activity is complete, the IQC will periodically re-analyze related performance and/or outcomes data to ensure that improvement is sustained. An annual summary of the results of each performance indicator will be completed at the end of the fiscal year and will be reported to the board of trustees.

Quality Management Plan

The Plan Do Study Act is an iterative, four-stage problem-solving model used for improving a process or conducting a change. It is important to include internal and external customers; they can provide feedback about what works and what does not. The customer defines quality, so it would make sense to also involve them in the process when appropriate or feasible, to increase acceptance of the end result. In applying PDSA, ask yourself three questions:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in an improvement?

Stage 1: Plan

1. Recruit Team - Assemble a team that has knowledge of the problem or opportunity for improvement. Consider the strengths each team member brings-look for engaged, forward-thinking staff. Then identify roles, and responsibilities, set timelines, and a meeting schedule.
2. Draft an aim statement - Describe what you want to accomplish in an aim statement. Try to answer three fundamental questions:
    a. What are we trying to accomplish?
    b. How will we know that a change is an improvement?
    c. What change can we make that will result in improvement?
3. Describe current context and process (Brainstorm) – Start by asking the team these basic questions:
    a. What are we doing now? And how do we do it?
    b. What are the major steps in the process?
    c. Who is involved? And What do they do?
    d. What is done well?
    e. What can be done better?
4. Describe the problem – using the aim statement, state your desired accomplishments, and use data and information to measure how your organization meets/does not meet those accomplishments. Write a problem statement to clearly summarize your team's consensus on the problem.
5. Identify causes and alternative – analyze causes for the problem in your problem statement, work to identify causes of the problem using tools. Examine your process, and ask:
    a. Is this process efficient? What is the cost (including money, time, or other resources)?
    b. Are we doing the right steps in the right way?
    c. Does someone else do this same process in a different way?

    Develop alternatives – try to mitigate your root causes by completing the statement,
    "If we do _____, then _____will happen."
    Choose an alternative that you believe will best help you reach your objective and maximize your resources. Develop an action plan, including necessary staff/resources and a timeline.

Stage 2: Do

Start to implement your action plan. Be sure to collect data as you go, to help you evaluate your plan in Stage 3 Study. It may be helpful to use a check sheet to capture data occurrences as they happen over time. You will also need to document problems, unexpected effects, and general observations.

Stage 3: Study

Using the aim statement drafted in Stage 1: Plan, and the data gathered during the Stage 2: Do, determine:

1. Did your plan result in improvement? By how much/little?
2. Was the action worth the investment?
3. Do you see trends?
4. Were there unintended side effects?

You can use a number of different tools to visually review and evaluate an improvement.

Stage 4: Act

If your team determined the plan resulted in success, standardize the improvement, and begin to use it regularly. After some time, return to Stage1: Plan and re-examine the process to learn where it can be further improved.

If the team believes a different approach would be more successful, return to Stage1: Plan and develop a new and different plan that might result in success. The PDSA cycle is ongoing, and all improvements and lessons learned should be shared.

1. Communicate accomplishments.
2. Take steps to preserve your gains and sustain your accomplishments.
3. Make long-term plans for additional improvements.
4. Conduct iterative PDSA cycles when needed.

Quality Management Plan

Attachment A:

Oversight Activities	Person/Entity Responsible	Time Frame
External Contracts Review/Provider Network Development	Contracts Management/QM	On-Going
Billing/Encounter Review	Program Administrator/QM	On-Going
Performance Measures	Program Admin./ UM/QM	On-Going
Safety Review	QM/ Maintenance Dept/ Building Mgr.	Annually
ADA Plan Review	QM/ HR Director	Annually
Complaints/ Appeals	QM/ Director of Programs	As Needed
Abuse/ Neglect	QM/ Client Rights Officer	As Needed
Emergency Preparedness Plan	QM/ Executive Management	Annually
Satisfaction Surveys	QM/ TIC/TOC	On-Going
Utilization Management – MBOW reports, Hospitalization Data, Appeals, Crisis	UM Director- ETBHN	On-Going
Risk Management	QM/ Chief Business Officer	On-Going
Death Reporting	QM/ Director of Nursing	On -Going
Infection Control Monitoring	Director of Nursing	On-Going
Productivity Monitoring – EHR reporting	Program Administrator/ QM	On-Going
ANSA/CANS – Training	Program Administrator/ HR	Annually
Waiting List & Follow up Activities	Program Administrator/ QM	As-Occurs
Review of Financial Status and Budget	Executive Management	On-Going
Recovery Plan Review and Progress Notes	Program Administrator/QM	On-Going
Substance Use Treatment	Program Administrator/QM	Annually
Rights Review	QM	Annually
Compliance of TAC	Program Administrator/QM, UM Director	On-Going
Consents Review	QM	Annually
Documentation of Quality Management Plan Activities	QM	Quarterly: On-Going
Incident Reporting	Program Administrator/ QM	As-Occurs
Workforce Competency & Credentialing	Human Resources/ Program Administrator	Annually, On-Going
Quality Management Plan	Program Administrator/QM/ BH Director	Annually
Technical Assistance Provision	QM	On-Going
Adult Services – Fidelity Review	**Person/Entity Responsible**	**Time Frame**
Assertive Community Treatment (ACT)	Program Administrator/QM	Annually
Supported Employment (SE)	Program Administrator/QM	Annually
Permanent Supported Housing (PSH)	Program Administrator/QM	Annually
Illness Management & Recovery	Program Administrator/QM	Annually

Quality Management Plan

Children & Adolescent Services – Fidelity Reviews	**Person/Entity Responsible**	**Time Frame**
Social Skills and Aggression Replacement Techniques (START)	Program Administrator/QM	Annually
Preparing Adolescents for Young Adulthood (PAYA)	Program Administrator/QM	Annually
Seeking Safety	Program Administrator/QM	Annually
Nurturing Parenting Program	Program Administrator/QM	Annually
YES Waiver – Wraparound Planning Process	Program Administrator/QM	Annually
Other Programs	**Person/Entity Responsible**	**Time Frame**
COPSD	Program Administrator/QM	Annually
TCOOMMI	Program Administrator/QM	Annually
Jail Diversion	Program Administrator/QM	Annually
Outpatient Competency Restoration	Program Administrator/QM	Annually
PASRR Review	Program Administrator/QM	Annually
Crisis	Program Administrator/QM	Annually
Inpatient Services/ Continuity of Care	Program Administrator/QM	Annually
DPP Quality Services	Program Administrator/QM/IS	On-Going
CCBHC Services/ Metrics/Outcomes	Program Administrator/QM/IS	On-Going
SAMHSA Services/Metrics/ Outcomes	Program Administrator/QM/IS	On-Going