HEART OF TEXAS
Behavioral Health Network

Quality Management Plan
Utilization Management Plan

Fiscal Year 2024

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HOTBHN

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HOTBHN QM Plan

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MISSION STATEMENT AND GUIDING PRINCIPLES

Mission Statement

The Heart of Texas Behavioral Health Network strives to deliver accessible, caring, and responsive support services to individuals and families coping with mental illness, substance use, intellectual disabilities, developmental delays and emotional conflict.

Guiding Principles

- The Heart of Texas Behavioral Health Network is committed to providing quality services in partnership with the individual, the family and the community.
- The Heart of Texas Behavioral Health Network strives to empower the individual and family by respecting their right to make choices about their lives.
- The Heart of Texas Behavioral Health Network is actively involved with community initiatives that will improve quality of life.
- The Heart of Texas Behavioral Health Network believes that it is through commitment to the individual's personal and professional development that you build an organization that strives for excellence.

The Center holds the position that the mission statement is applicable to every service provided and applicable for every individual and family receiving services. New staff are introduced to the mission statement and the Guiding Principles as a part of new staff orientation. The mission statement is displayed in public areas of Center facilities.

QUALITY MANAGEMENT PROGRAM OVERVIEW

The Heart of Texas Behavioral Health Network has long held the philosophy that quality is the responsibility of all personnel and has engaged in practices that assessed the adequacy of services provided and compliance with applicable laws, regulations, and standards. The true achievement of "quality" lies in meeting the highest expectations of the individuals served. Continuous quality improvement (CQI) requires an ongoing collaborative effort with internal customers, external customers and other stakeholders. The expectation of quality permeates all areas of the Center and has a direct impact on all stakeholders.

Quality Management Structure

The ultimate responsibility for quality lies with the Board of Trustees who delegates the authority and responsibility for the overall management of the agency to the CEO in accordance with Board policies. The CEO is mandated to establish and maintain processes and training to ensure the Center's goal of meeting the highest possible quality of care and maintaining compliance with applicable laws, regulations, and standards. The CEO has designated the responsibility for coordinating quality management activities to the Quality Management Director (QM Director), who reports to the Director of Regulatory and Support Services and operates independently of other programs. Due to

significant overlap of activities with Corporate Compliance, the QM Director has also been appointed Corporate Compliance Officer. The Quality Management Program is responsible for oversight of administrative, authority, and provider functions and services.

It is the view of the Center that the responsibility for achievement of quality, including implementation of practices, procedures, and monitoring, is the shared responsibility of senior management, unit supervisors, and all front-line staff members. To that end, all employees will have job descriptions and job duties that clearly delineate responsibilities with performance expectations clearly communicated. Supervisors are responsible for supporting staff in their job performance, providing performance feedback, and addressing any issues in a timely manner. In addition, there are a number of committees that share responsibility for oversight of Center functions and services.

The Quality Management Plan

Purpose: The QM Plan is the broad outline for a systematic and coordinated approach to planning and performance or system improvement. It encompasses many activities with the QM Director responsible for oversight and coordination of the plan. Quality Management activities are summarized in this plan. The QM Plan is reviewed annually or as needed and revisions approved by the Board of Trustees. Due to Substance Use contract requirements, it will be re-approved by the Board in the first quarter of the biennium and as needed. The QM Plan is located in the Administrative Manual and on our website.

Scope: This plan applies to all Adult and Children's Behavioral Health services including crisis services, PASRR, PATH, Substance Use Disorder Services, COPSD Services, Intellectual and Developmental Disability Services (IDD), Children's Autism Program, Veterans services, Outpatient Competency Restoration, and TCOOMMI. YES waiver is included in this plan, though it is also mandated to have its own plan. Early Childhood Intervention (ECI) services are not included in this plan as they fall outside of LMHA or LIDDA authority or provider services.

Goals of the QM Program:

- The Center will provide person centered services that meet the highest standards of care.
- The Center will provide a highly responsive system of crisis services and safety net services.
- The Center will maintain business operations to maximize revenue collection, operate efficiently in accordance with all contracts and regulations, and to support staff in service provision.
- As the Local Authority, the Center will collaborate and coordinate with other community providers to maximize community resources.
- The Center will develop and maintain a workforce that is stable, well trained, and responsive to the needs of the consumer.

- The Center will provide community awareness for public information for other providers to promote access and appropriate use of resources.

QUALITY MANAGEMENT ACTIVITIES

Measuring, Assessing and Improving Services and Outcomes:

As a provider, the Center provides a wide variety of services to all age groups through our Early Childhood Intervention (ECI) program, behavioral health, substance use, and IDD services. Services offered and their descriptions can be found on the Center's website at www.hotbhn.org. Since performance of important organizational functions significantly affects outcomes of care and customer satisfaction, the QM program's primary focus is to ensure efficient, quality services are provided that are in compliance with laws, regulations, standards, and the HHSC Community Services contracts. This is accomplished by identifying desired outcomes, measuring and assessing progress towards outcomes, and implementing improvements in authority, provider, and administrative functions.

Data collection and review are of utmost importance throughout continuous quality improvement processes. Data based decision making provides the basis for identifying problems, recommending and planning improvements, and in analyzing the strengths and/or weaknesses of such improvements.

Methodologies/Measurable Activities:

A variety of tools may be used to problem solve, monitor services, performance, and/or compliance with standards including, but not limited to:

- flowcharts
- Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis
- project planning
- Plan, Do, Study, Act (PDSA)
- review tools tailored to the particular item, service, or program under review
- checklists
- satisfaction surveys
- computer reports and encounter data from state and internal systems
- contract reporting processes
- external audits by government agencies
- collaboration with stakeholders
- staff meetings
- trainings

Goal 1: Support full implementation of Certified Community Behavioral Health Clinic (CCBHC) services on or before September 2025 as evidenced by completion of the following objectives:

Objectives to help accomplish and/or support CCBHC implementation:

- Continue to build out the SmartCare Electronic Health Record as evidenced by the ability to pull numerous data points for reporting and service monitoring for CQI purposes
- Fully integrate physical health services into the Center regional areas so that integrated health services are available to our customers in our rural service areas
- Procedure management software will be fully implemented to allow for efficient storage, revision, authentication, and distribution of Center policies and procedures
- Incident reporting software will be obtained and implemented to aid in efficient reporting and tracking of routine incidents, critical incidents, medication errors, consumer deaths, etc.
- Audit management software will be obtained and implemented to aid in efficient implementation and monitoring of quality management activities/projects
- Explore potential benefits and cost of CARF accreditation to determine feasibility as evidenced by a decision on whether or not to pursue.
- Develop a dynamic training department in order to support the training requirements and needs of our agency, consumers, and communities as evidenced by formation of a dynamic training department
- Full implementation of trauma-informed care throughout the Center to support our consumers in their recovery goals is an active ongoing effort as evidenced by completion of committee goals
- Review of current and future space needs to develop a master plan for future space needs and to identify the best possible use of current space as evidenced by completion of master plan
- Develop new books of business to lessen dependence on state and federal revenue and grants to ensure financial viability, stability, and sustainability of services which is an active and ongoing goal as evidenced by a greater variety of services and increase in income

Goal 2: Develop an ambitious program for quality management of IDD programs by September 2025

- Create an IDD quality management team with working knowledge of IDD contract requirements, person-centered services, the HHSC monitoring tool used during annual program reviews, and MBOW reports so that IDD CQI is supported
- Develop a survey tool to gauge satisfaction with current services and at the same time to identify problem areas or gaps in service provision to inform the quality management team on how to best move forward based on the information gleaned from the survey tool
- Assist in developing a robust community network to focus on IDD resource and service development, especially as it relates to transition planning for school-aged children, and integrated employment for those pursuing that goal
- Develop an ongoing process to measure, analyze and improve service capacity and access to services to better serve our consumers

Corporate Compliance Reviews: All new staff receive training in the Center's Code of Conduct and Corporate Compliance/DFRA (Deficit Reduction Act) during orientation. QM staff perform routine record reviews and conduct investigations at the request and direction of the CEO. Billing reviews compare progress notes or other program documentation with the billed services, billing codes, and/or billed amounts to ensure documentation compliance. A routine record review may consist of consumer record and billing report reviews or simple spot checks of staff documentation. Investigation reports are maintained in the QM Director's files.

Performance Measure Reviews: QM staff are responsible for monitoring behavioral health and substance use disorder contract performance measures as well as the outcomes of adults and children who have received a Texas Resilience and Recovery (TRR) Level of Care. The CMBHS system and MBOW reports are used to monitor measures to ensure they are in accordance with the performance contracts and current state utilization requirements. Data on outcomes and contractual requirements is distributed monthly to management staff and the QM/UM Committee. These behavioral health and IDD measures are reported quarterly to the Board. The CCBHC quality measures are monitored and reported by management staff.

IDD Internal Reviews: The current QM plan includes goals to improve the quality management function for IDD services, by developing a dedicated team to serve in the QM role to create a more robust system of record reviews, and a more meaningful satisfaction survey process. Currently, the IDD Services division conducts periodic internal reviews that utilize chart reviews to assess the Center's efforts with person directed planning and quality of services. Upon request, the Center Quality Management department assists the IDD services with these reviews. Rights, abuse, safety and health data will continue to be collected per the performance contract. This data contributes to the self-assessment and quality improvement process. Other Utilization processes for the IDD programs are described in the IDD Utilization Management Plan (AM 7.5).

Satisfaction Surveys: Internally, various IDD programs assess consumer satisfaction by using satisfaction surveys completed by consumers when they come in for services or through mail outs. Participation in these informal surveys is voluntary and the responses are intended to be anonymous. Some respondents identify themselves because they have specific issues they want addressed.

Clinical Record/Continuity Review: A record review is a clinical review of the quality, outcomes, and continuity of services from the initial assessment and discovery to recovery or person-directed planning, progress notes, and routine review/re-assessment. In addition, the records review assesses the presence or absence of required documentation at this Center. QM may also conduct "spot reviews" in conjunction with other reviews. In these spot reviews, a single data requirement (such as crisis assessments) is reviewed in addition to the information required for other reviews.

External Reviews: QM coordinates external reviews, audits, and surveys that may be mandated by state or federal entities. QM staff are integral to on-site reviews by

providing information on internal monitoring activities of records, rights issues, or incident reporting. All necessary staff are required to participate in on-site reviews as applicable. In a typical desk review, QM staff notify program directors, service coordinators and/or other responsible staff of the review once the protocols are received from the state. Clinical records are pulled or brought in from the regional counties if necessary to complete a review. Once the review is completed, the data and any supporting documentation required are delivered to the state as requested. Any problems noted in the review are communicated to the program director or supervisor and plans for remediation are developed. Overall results of the reviews are communicated to the QMC.

Internal Program Reviews: Internal Program Reviews will be conducted at the request of the CEO or a Division Director. Elements of review could include Rights Review, Procedure Review, Medication Procedure and Practices Review, Facility Review, or any other review requested.

Fidelity Reviews: Fidelity reviews for TRR, ACT using the Dartmouth Assertive Community Treatment Scale (DACTS), Supported Employment, Supported Housing, Seeking Safety, Aggression Replacement Therapy, and other evidence-based practice fidelity reviews will be conducted by QM, supervisors, or designee as recommended by the practice and/or as outlined in the QM department work plan. Providers are required to participate in this oversight.

Medication Protocol Reviews: Medical staff will conduct a review of persons served as directed by the Performance Contract or DSHS in accordance with current recommended guidelines. In the past, the focus of the reviews shifted from year to year in order to meet the survey needs of the Psychiatric Services Department.

Specialty Programs: Programs and processes such as Co-Occurring Psychiatric and Substance Use Disorders (COPSD), Youth Empowerment Services (YES), TCOOMMI, Outpatient Competency Restoration (OCR), PATH, Veterans services, and Crisis Services are audited per contract requirements or according to the QM work plan. Records are assessed for adequacy of assessment, service planning, education and documentation. Results are shared with staff and managers. Results of these audits are used to identify staff training needs as well opportunities to improve client care.

Crisis Response Monitoring: Oversight of the response system includes data collection on timeliness of response and appropriateness of care. Data on SMHF usage is aggregated and reported to the Utilization Management Committee.

Assessing

Data is analyzed relative to the methodology, process, or activity. Once data is gathered, it is analyzed to identify errors, root causes, faulty practices, negative trends, the scope, and corrective action.

Reporting Quality Management Activities:

Communication of the progress or results of any quality management activity is critical if organizational improvements are to occur. Communication is planned to flow along the lines of the Center's organizational chart and chains of command, although it is not restricted to those lines. QM and management staff provide feedback through meetings, emails, and phone calls in order to communicate a unit or department's performance or needs. Specific information is communicated to units or departments, while aggregate information is reported to the Quality Management Committee. The Center's board and PNAC receives reports of program activities throughout the year. (At times, the potentially sensitive nature of the information could possibly preclude releasing unnecessary or confidential details.)

HHSC Community Services or other governmental reports, surveys, and feedback are considered most seriously. Often the reports and feedback are shared with staff, the PNAC, and with consumer and stakeholder representatives. In every case, all of the information gathered from consumers and stakeholders is reviewed by the CEO and is often incorporated into the quality improvement process.

Corrective Actions:

Corrective actions are taken after problems are identified and evaluated. Corrective actions take a variety of forms such as procedural changes, staff education and training, documentation corrections, or process changes. For internal reviews, QM typically requires written plans of correction due within ten working days from supervisory staff for any internal reviews that are substandard or score below 80% or as required by a particular tool or the parameters of state reviews. The plans of correction may address training needs, technical assistance, and recommended follow up to correct current problems/deficits and prevent any future problems or deficits. If an external review requires a plan of correction, QM will review the plan's content to ensure all deficient areas are addressed adequately. QM monitors timely submission of all plans of correction and will submit any behavioral health plans of correction to the state. QM will verify corrections have occurred by doing a focused review of deficient areas. Also, before and after data can be compared to see how well corrections worked.

Measuring, Assessing and Improving Data Integrity:

Claims Oversight: Managers routinely receive reports to monitor billing for inaccuracies or failures to bill. This ongoing validation of claims is done to assure data quality and accuracy. Audits of factors such as use of incorrect service codes, denied claims, and unauthorized services, and results are used to refine the billing system and data reporting. As issues are identified, modifications to the data reporting and billing system are made. Staff training needs are also identified in this process.

Encounter Data: Service reports and encounter data reports are used to ensure data quality and accuracy. Data corrections and staff training needs are identified through this process.

Cost Accounting Methodology (CAM): CAM data is developed annually. The process involves assessing accuracy of data collection and reporting as well as to compare costs with that of other centers.

MBOW Data Warehouse: The reports generated in the state database are constantly reviewed by management staff to assess performance on a variety of indicators and used to judge accuracy of data collection as well as to evaluate performance on outcome measures.

OTHER QUALITY RELATED ACTIVITIES:

Quality Management Committee (QMC) has been a body in place for many years. It meets regularly and disseminates its information on a Center wide basis. The QMC functions within the membership of the Management Team that is selected by the CEO. It consists of staff from Behavioral Health Services, Substance Use Disorder Services, Administration, Quality Management, Information Services, Intellectual & Developmental Disability Services, and Finance. Additional members are added to the committee as needed. This ensures not only a balanced representation, but also investment by all factors. Developing any plans for improvement cannot take place unilaterally. Decisions to implement changes will not happen without support from the clinical arena and administration. QM staff interact with all other departments in the agency in order to improve the quality of services delivered by the Center.

This body has historically analyzed data from a variety of sources including quality management activities, self-assessments, and external assessments. The committee is charged with conducting analyses and developing strategies for improvement. It has typically defined its parameters, including establishing benchmarks, and has set priorities for quality improvement efforts at the Center. When quality management issues are brought before the Management Team, the CEO appoints a work group as needed to address the issue. Work groups are charged with examining relevant data, creating solutions to problems, and overseeing the implementation of the solution.

HOTBHN has several sub-committees:

The Quality Management/Utilization Management Committee is composed of a psychiatrist who is the chair of the QM/UM Committee, the UM Manager, the Quality Management/UM Director, supervisors, and ad hoc representatives from finance and IT. It meets at least quarterly to review QM activities including internal and external reviews, CQI projects, complaints and appeals, review performance data, analyze service trends and patterns, in order to provide direction and feedback to staff and to identify and correct inefficiencies. (See Attachment 1 for the UM Plan)

Nursing Peer Review Committee provides guidance to nurses and others in determining whether a nurse has engaged in unprofessional conduct that indicates that the nurse's continued practice would pose a risk of harm to patients, consumers, or others and should be reported to The Texas Board of Nursing. The NPRC also provides guidance when a nurse refuses to engage in a requested assignment that the nurse believes in good faith will result or

impose patient harm. The CEO appoints an RN or APN to serve as Chair and to oversee all aspects of the NPRC. Requests for review are submitted to the Chair verbally, by voice mail, or by email within four hours of the incident followed by a formal written report. Composition of the NPRC is determined according to the licensure of the nurse under review. All proceedings of the NPRC Committee are confidential and all communications made to the committee are privileged.

Administrative Safety Committee is composed of representatives from the different departments and meets at least quarterly. It monitors any environmental issues, staff or consumer safety issues, and incident reports involving other safety issues such as accidents, infection control, medication errors, etc. Committee members also conduct periodic environmental reviews. Incident reports are routinely reviewed by QM and staff follow-up is documented on the incident report. Incidents are tracked by QM and reported to the Safety Committee.

The Infection Control Committee meets as needed. Infection Control has been a cooperative effort between the medical units, safety committees, the human resources/training unit, and the quality management staff. Incident Reports are reviewed by the Infection Control Officer to detect any trends or patterns in consumer care, observance of universal precautions, etc. Should any negative trends be discovered, the Infection Control Officer or committee assigns staff to address and correct the problems. The Infection Control Officer and/or committee reviews incidences of consumer and staff illness/infections and makes recommendations if needed. The Infection Control Officer is responsible for reviewing the Center's infection control plan for any necessary revisions.

IDD Safety Committee meets regularly, with participation from Quality Management staff, to consider rights, abuse, safety, health data, critical incidents, and other issues identified in the quality management process. Areas reviewed and tracked include a review of physical injuries, restraints, or other incidents reported on the Center's Incident Reports, infection control trends, medication errors, fire drill reports, and any other safety issues that arise. Based on these reviews, recommendations for improvement through staff training or changes in procedure are made directly to program supervisors from this committee if improvements have not already been made and reported to the committee.

RISK MANAGEMENT

The Center monitors attempts to mitigate and prevent risk situations in a number of ways. Data obtained through these processes and activities can be used to identify a problem and the degree of the problem. Corrective actions can be identified as well.

Incident Reports are routinely reviewed. The QM Director, Nurse Manager, and HR Director review each Incident Report and conduct follow up as needed; however, it is expected that most follow-up activities should be conducted at the division and/or unit level due to proximity. Incidents are monitored and tracked to identify trends and necessary corrective actions.

Administrative Death Review Committee reviews consumer deaths to formulate recommendations for policy and procedures based on its review. An Administrative Review Committee consists of a minimum of three senior administrative and medical personnel and a representative of the public as an external member. The external member may not be related to or associated with the deceased. The CEO may appoint other staff members to the committee as deemed appropriate. The CEO will designate one of the staff committee members to chair the committee. Relevant information is submitted to the state after the review.

Staff Competency Determination: 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's working unaided with consumers. All staff complete required training and competency assessment annually

CONSUMER RIGHTS PROTECTION

Methods to Prevent Abuse, Neglect, and Exploitation: Applicants are screened via misconduct registries and criminal history checks. Staff receive training on the Center's Code of Conduct, confidentiality, and rights training upon hire and annually thereafter. This training includes abuse, neglect, and exploitation reporting and procedures. Upon admission to services, consumers receive a copy of the rights handbook particular to their services. The Rights Officer provides additional training as requested.

Rights Protection Process: The Rights Officer, who reports directly to the QM Director, is responsible for providing guidance and oversight in the area of consumer rights, including review of restrictions, investigation of internal rights complaints, responses to complaints lodged with the Office of the Ombudsman, HIPAA complaints, individual advocacy as requested by the consumer, case consultation with staff members, coordinating the behavioral health appeals process, and ongoing training as requested for identified needs in the area of consumer rights. The Rights Officer also receives the initial and final allegation reports of abuse, neglect, and/or exploitation from DFPS and forwards these to the CEO and QM Director. The QM department maintains these files on the QM file share which is only accessible by QM staff. Personnel action is taken in any confirmed case. The HR Director maintains documentation of personnel action taken as a result of the findings of the investigation.

Notices informing the consumer of the right to file a complaint are posted at each service location along with the Rights Officer's contact information. In addition, each reception area has complaint forms available. Consumers are notified of their right to appeal an involuntary reduction or denial of services via letter as outlined in Center policy and procedures. Complaints and appeals are taken orally, in writing, or in person. Typically complaints and appeal requests are made by phone. Switchboard staff route client complaints or rights calls to the Rights Officer or designee. A staff member is always designated to take complaints, appeals, or receive allegations of abuse/neglect/exploitation should the Rights Officer be out of the office. Complaints and appeals are processed according to current procedure located in the Administrative Manual. All complaints and appeals are tracked using a spreadsheet so

that trends and opportunities for improvement can be identified. Rights complaints are reported to HHSC monthly as directed by the performance contract. Aggregated complaint and appeal data is reviewed in the QM/UM Committee meetings.

Human Rights Committee: The committee reviews requests for rights restrictions, behavior therapy plans, or any other rights issues in need of review and approval for our ICF/IID consumers. Quality Management staff participate in the Human Rights Committee chaired by the Rights Officer. The HRC is composed of at least four members, of which one-third are not affiliated with the Center. The committee meets to review requests generally on a quarterly basis. Restrictions for psychoactive medication additions/changes can be reviewed immediately as they are submitted. A licensed medical staff and at least two other HRC members review all interim and routine rights restrictions for psychoactive medication for ICF/IID consumers prior to the full HRC review. Interim medication approvals are delivered immediately so that medication administration can begin without undue delay.

Reduction of Critical Incidents and Incidents of Abuse, Neglect, or Exploitation: In addition to pre-employment screening and routine staff training, incidents of abuse, neglect and /or exploitation (A/N/E) are tracked to identify any trends requiring intervention and according to departmental regulations. QM staff report aggregated allegations to the safety committees. The Rights Officer may make unannounced visits to service locations and tracks complaints by keeping a log which is kept privileged. The IDD Safety Committee reviews and tracks IDD incident reports as well as critical incident data according to HHSC requirements. The IDD safety committee makes recommendations for improvement in staff training or procedure.

AUTHORITY FUNCTIONS

Measuring, Assessing, and Improving Authority and Administrative Functions

As the Local Authority (LA) for behavioral health and intellectual and developmental disability (IDD) services, the Center is the single point of responsibility for planning, policy development; resource development, allocation, and management; and oversight of authority and provider functions. Data collection and review also occur during the course of authority functions and is of utmost importance throughout quality improvement processes. Data based decision making provides the basis for identifying problems, recommending and planning improvements, and in analyzing the strengths and/or weaknesses of such improvements to the service system and overall organization.

Local Planning

Stakeholder Involvement is achieved in a number of ways and is an area that continues to be of importance and continues to be developed at the agency.

The Planning and Network Advisory Committee (PNAC) meets at least quarterly and is a combined committee composed of equal numbers of behavioral health and IDD services clients or family members that are appointed by the Board of Trustees.

The PNAC will continue to impact Center services when it considers Center data and reports submitted for consideration. The PNAC reports to the Board of Trustees quarterly.

The Home and Community-Based Services (HCS) and Texas Home Living (TxHmL) programs hold at least quarterly combined **Advisory Committee** meetings. The committee is composed of individuals, Legally Authorized Representatives (LARs), community representatives, and family members. The committee, at least annually, reviews satisfaction of individuals and LARs with services, information regarding complaints, restraints, incidents of confirmed abuse, neglect, and exploitation and unusual incidents, information regarding termination of HCS or TxHmL Program services, and makes recommendations for improvements to processes and operations.

Additional input from stakeholders comes from local law enforcement and jails, local courts, probation/parole departments, the area Outreach Screening Assessment and Referral organization (OSAR), the City of Waco, Prosper Waco, the Waco Mayor's Committee for People with Disabilities, local hospitals and public health care entities, sister agencies, Homeless Coalition, Veterans' Coalition, Behavioral Health Justice Involved Group, Behavioral Health Leadership Team, NAMI, DePaul, Caritas, Friends For Life, Region 12 Education Service Center, ARC of McLennan County, Communities in Schools, Heart of Texas Human Trafficking Coalition, Heart of Texas Autism Network, Heart of Texas Down Syndrome Network, the VA, Mission Waco and My Brother's Keeper, The Family Health Center (FQHC), Waco Housing Authority, Baylor University, McLennan Community College, local school districts, and Cenikor.

The Consolidated Local Service Plan (CLSP) incorporates community participation efforts, general system-wide priorities, and specific system-wide priorities to address Local Services and Needs, the Psychiatric Emergency Plan, and Plans and Priorities for System Development into one comprehensive plan that is completed in compliance with the Performance Contract. The PNAC participates in the development of this plan.

The Local Provider Network Development Plan (LPND) exists for both Behavioral Health and IDD services and is designed to develop a network of behavioral health and IDD service providers that will meet local needs and priorities, allow for more consumer choice, improve access to services, and make the best use of available funds, and promote consumer, provider, and stakeholder partnerships. The PNAC participates in the development of these plans. The LPNDs are completed in compliance with the Performance Contracts for LMHA and LIDDA services.
Though the Center employs full-time psychiatry staff, we also contract with a Medical Director and outside providers of psychiatry services via telemedicine. The Center has a number of additional contracts in place with a variety of providers, some of which include:

- Crisis Hotline services
- Pharmacy services

- Nursing Services
- BH Crisis Respite Services
- Lab services
- Alternative therapy providers

Procedure Development and Management

The Administrative Manual outlines the procedures which have applicability on a Center-wide basis. Any modifications, deletions, or additions to Administrative Procedures are issued only by the CEO or designee. The official copy is maintained and accessible to staff via the procedure management software program. Procedures will be reviewed and updated on an ongoing basis. Periodically, the CEO will ensure that a review of the Administrative Procedures Manual is conducted. Changes in the Administrative Procedures Manual are communicated by electronic notifications generated by the software and distributed to all staff.

Program Level Procedures define operations which are specific to that program unit. Each Program Director must approve procedures for his/her program. Program directors periodically complete a comprehensive review of operational procedures within their program area.

All procedures, either Center-wide or at the program level, which affect client rights will be reviewed by the Client Rights Officer or QM Director. Any utilization management or crisis procedures are reviewed and approved by the Medical Director prior to final approval by the CEO or designee.

Rule Review is completed by QM staff as departmental rules and related rules are proposed and adopted. Relevant sections of the Texas Register are disseminated to appropriate staff. Copies of the rules are readily available to all units via the internet.

Coordination of the Service System with the Community and HHSC Community Services

Coordination with Community: The Center coordinates with many local organizations, outside providers, county and local governments to improve coordination of services and communication. This involvement fosters open communication and education which aids in problem solving and coordination of consumer care. The formal collaborative efforts are evidenced by sign-in sheets or minutes from meetings, memoranda of agreement, or memoranda of understanding. Some of the organizations the Center coordinates with include the area Community Resource Coordination Groups (CRCGs), local law enforcement and jails, local courts, probation/parole departments, the area Outreach Screening Assessment and Referral organization (OSAR), the City of Waco, the Heart of Texas Council of Governments Prosper Waco, the Mayor's Committee for People with Disabilities, local hospitals and public health care entities, sister agencies, Homeless Coalition, Veterans' Coalition, Behavioral Health Justice Involved Group, Behavioral Health

Leadership Team, NAMI, DePaul, Caritas, Friends For Life, Region 12 Education Service Center, ARC of McLennan County, Communities in Schools, Heart of Texas Human Trafficking Coalition, Heart of Texas Autism Network, Heart of Texas Down Syndrome Network, the VA, Mission Waco and My Brother's Keeper, The Family Health Center (FQHC), Waco Housing Authority, Baylor University, McLennan Community College, local school districts, and Cenikor.

In the event of a local, state, or federal emergency, a criminal incident, a public health emergency, or a natural or human-caused disaster as declared by the Governor, the Center assist HHSC's Disaster Behavioral Health Services program in providing **disaster behavioral health services**.

Continuity of Care: Frequent interaction and collaboration with law enforcement, local jails, and the judicial system is a necessity due to the Center's operation of a continuity of care program for offenders with mental impairments. The goal of the program is to divert persons with mental illness away from jail when intensified treatment would be able to resolve the issue. In a separate contract with the state, the **Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI)** program serves behavioral health consumers who are also engaged in the legal system. The unit provides screening and assessment of youth and adults referred from the probation and parole departments to determine if the individuals meet admission criteria. Case managers coordinate ongoing services and supervision in collaboration with a designated behavioral health probation or parole officer. The overall goal of the TCOOMMI program is to provide comprehensive services to reduce recidivism.

Home and Community-Based Services- AMH (HCBS-AMH): The Center coordinates the HCBS-AMH referral process for individuals residing in the community or transitioning out of the state hospital or with law enforcement or emergency department staff for individuals referred to the program. The Center assists the individual with the enrollment process including reviewing MBOW 1915i report for evidence/supporting documentation of eligibility and by completing the HCBS-AMH Uniform Assessment and Clinical Eligibility Screen and Medicaid Eligibility Verification submission in CMBHS. The Center assists with provider transfers, and conducts initial/annual assessments, reassessments, and participates in recovery planning to ensure the individual's needs are addressed.

In addition, the Center has procedures in place regarding continuity of care for individuals transitioning to or from Center services and psychiatric hospitalization, State Supported Living Centers (SSLCs), nursing facilities, assisted living, jails, or between divisions of the Center (e.g. ECI to CMH or IDD, CMH to AMH).

Permanency Planning: The LIDDA is aware when people with IDD under the age of 22 are admitted to HCS Waiver Provider or ICF group homes, LTC institutions, and nursing facilities in the HOTBHN catchment area. Authority staff will maintain regular contact with the individual's parent or guardian to ensure that the

parent/guardian is aware of community-based services and supports that could provide alternatives to the institution or group home and allow the individual to move back home. This regular contact is formalized in a Permanency Plan, created to plan for the eventual return to the family. (Permanency Planning for children in nursing facilities is completed by EveryChild, Inc). When an individual is participating in residential services provided by this Center, the Center will contract with another Local Intellectual and Developmental Disability Authority (LIDDA) to complete the required Permanency Plan and avoid conflict of interest.

PASRR Evaluations: The Center is mandated by the Texas Administrative Code and State Performance Contracts to complete Level 2 Preadmission Screening and Resident Review (PASRR) Evaluations for individuals seeing admission to and residing in Nursing Facilities who are identified as possibly eligible for specialized behavioral health or IDD services. The intent of this requirement is to identify those individuals in Nursing Facilities that need additional advocacy and support to ensure they receive the services they need and to possibly transition from the nursing facility to a community setting.

Benefits Eligibility: As mandated by the performance contract and in accordance with the Center's Client Benefits Plan (A.M. 7.13), the Center provides consumers with assistance in completing applications for Medicaid, Medicare, Medicare Part D, and other third-party assistance. The initial and annual fee assessment identifies consumers who may be eligible for benefits, but who are not currently receiving benefits. Identified consumers are referred to the Benefits Eligibility unit and staff work through the entire process of application, approval, and when necessary, appeal.

Coordination with other Community Centers: To ensure statewide quality improvements, Center management staff participate with other centers in consortia meetings, webinars, and workgroups.

Resource Development and Management

Staff Development: The Center will provide, encourage, and support opportunities for growth and development to all employees, both individually and collectively. Resources from within the Center, educational institutions, consultants, the community at large, and state and national resources will be utilized to enhance staff development and growth. The Center occasionally hosts regional trainings provided through the Centralized Training Infrastructure. HR provides training programs to employees, which meet training requirements for all applicable standards. QM works with HR as needed to ensure training is in compliance with all statutory, regulatory, and professional requirements. Clinical supervision procedures are also in place to assess staff performance of job duties according to credential and/or for staff pursuing licensure. Staff receive ongoing training at the unit level. The following types of training can be provided by QM or other management staff either as a result of an audit, review, or as requested:

- Documentation Training

- HHSC-approved Assessment (UA) and Utilization Management
- Policy and Procedure
- HIPAA
- Compliance
- Risk/Liability
- Other requested subjects

Maximizing Resources: Managers work closely with the CEO, Director of Human Resources, and the Chief Financial Officer to ensure that strategies are developed to optimize earned revenues and grant funding available to provide services. Collaboration with other centers is also used to assist with efficiencies. Regular program reports and data reviews occur during committee meetings and managers' meetings to assess administrative/overhead costs and plan strategies for cost-containment.

Contract Monitoring: The Center's Contract Manager is responsible for all contracted services including contracted services for consumers. Original contract documents, contract amendment documents, MOUs, and program reviews are maintained in the Contract Manager's office and on the Center file share. The Contract Manager ensures that staff responsible for state contract reporting submit the necessary reports and forms in a timely manner. Each contract specifies the staff member closest to service delivery as responsible for monitoring duties and procedures. The Contract Manager is responsible for sending out the monitoring protocol as well as reviewing the contract monitoring protocol for compliance and interviewing the staff involved. Contracts are officially monitored at least annually if contract criteria are met and maintained, more often if not. Part of the contract monitoring process includes consumer input if a consumer has made complaints. The Contract Manager works with appropriate staff to develop audit tools and plans of correction when needed. Contract monitoring software is used to monitor contracts, agreements, and contractor licensure renewals.

Utilization Management: The Utilization Management Program (UM) and QM work closely to ensure that individuals receive the services they need while maintaining equitable distribution of agency resources. Staff in all divisions rely on reports from the Center's EHR, MBOW, and CARE/CMBHS to monitor contract performance targets, utilization patterns such as level of care assignment/service capacity, authorizations, over/under-utilization, deviation reasons, hospitalizations, crisis utilization, staff productivity, billing reports, potential inaccuracies, appeals, and benefit eligibility. The Center has routine reports readily available to division directors, program directors, unit directors, and directly to staff (depending on the report) in the EHR as part of the Center's Utilization Management program. These reports are considered on both a formal and informal basis to identify trends, patterns and practices, either positive or negative. The UM Committee discusses trends and patterns as well as procedural revisions or training needs to modify inefficient utilization practices. The Center maintains UM Plans for both behavioral health and IDD services that delineate the separation between Authority and Provider functions and detail UM processes further. Both the IDD and behavioral health UM Plans are located in the Administrative Manual which is available to all. (See Attachment 1 for the behavioral health UM Plan)

Waitlist Maintenance: The Center, in compliance with Texas Resilience and Recovery Waiting List Maintenance requirements and state performance contracts, maintains waitlists for services as necessary. The Center has developed procedures to triage and prioritize service needs of individuals determined eligible for services, but for which the Center has reached or exceeded capacity to provide services.

SUBSTANCE USE DISORDER SERVICES

As a program of Heart of Texas Behavioral Health Network, Substance Use Disorder Services (SUD) are subject to the Center's Board policies and Center procedures and not just SUD program procedures. The SUD programs are not and do not function as a separate entity apart from the Center. Accordingly, SUD programs fall under the same mission statement and guiding principles as the Center. QM goals are much the same as well.

Mission Statement

The Heart of Texas Behavioral Health Network strives to deliver accessible, caring, and responsive support services to individuals and families coping with mental illness, substance use, intellectual disabilities, developmental delays, and emotional conflict.

QM Plan:

The Center's QM Plan is reviewed annually and updated as needed. Due to SUD performance contract requirements, it will be re-approved by the Board in the first quarter of the biennium and as needed (See B. The Quality Management Plan, page 2).

Goals of the SUD QM program:

- The Center SUD program will provide person centered services that meet the highest standards of care.
- The Center SUD program will develop and maintain a workforce that is stable, well trained, and responsive to the needs of the consumer.
- The Center SUD program will maintain business operations to maximize revenue collection, operate efficiently in accordance with all contracts and regulations, and to support staff in service provision.

Measuring, Assessing, and Improving Service Delivery, including but not limited to:

- implementation of evidence-based practices, programs, and research-based approaches to service delivery
- client/participant satisfaction with the services
- service capacity and access to services
- client/participant continuum of care

- accuracy of data reported to the state

Data is collected, measured, and assessed according to the method, process, or activity used. Once data is gathered, it is used (analyzed) to identify errors, root causes, faulty practices, negative trends, how big a problem is, and how we can fix a problem. As a program of Heart of Texas Behavioral Health Network, SUD uses, participates, and is subject to the ongoing, regular Quality Management Activities (see Section III. Quality Management Activities, page 3 of this plan for further explanation) of the Center including:

Assessment Methodologies/Measurable Activities:

A variety of tools may be used to problem solve, monitor services, performance, and/or compliance with standards including, but not limited to:

- flowcharts
- Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis
- project planning
- Plan, Do, Study, Act (PDSA)
- review tools tailored to the particular item, service, or program under review
- checklists
- satisfaction surveys
- computer reports and encounter data from state and internal systems
- contract reporting processes
- external audits by government agencies
- collaboration with stakeholders
- staff meetings (unit meetings, UM meetings, Infection Control meetings, Safety meetings, Administrative Death Review meetings)
- trainings
- collaborations with community partners
- Compliance Reviews
- Routine Program Review meetings
- Performance Measure Reviews
- Clinical Record/Continuity Review
- External Reviews such as state reviews
- Internal Program Reviews
- Incident Report Review
- As indicated by the practice or QM work plan, Fidelity Reviews will be conducted for evidence-based practices such as Seeking Safety, Motivational Interviewing, Anger Management for Substance Abuse and Mental Health Consumers: A Cognitive Behavioral Therapy Manual, Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders, Supported Employment for Individual Placement and Support, and any other practices used by SUD services.

Measuring, Assessing, and Improving Data Quality:

As a program of Heart of Texas Behavioral Health Network, the SUD program uses, participates, and is subject to the ongoing, regular Quality Management Activities (see Section III) of the Center including:

- computer reports and encounter data from state and internal systems to include billing
- contract reporting processes
- Compliance Reviews
- Routine Program Reviews
- Performance Measure Reviews
- Clinical Record/Continuity Review
- External Reviews such as state reviews
- Internal Program Reviews

Corrective Actions:

Things we do to improve or fix problems could be procedural changes, staff education and training, documentation corrections, or process changes. For internal reviews, QM typically has the supervisor write a plan of correction for reviews that score below 80% or are poor by the guidelines of a particular review method or tool. The plans of correction might cover training needs, technical assistance, and follow up to fix current problems/deficits and prevent any future problems or deficits. If an external review requires a plan of correction, QM will review the plan to make sure all deficient areas are addressed adequately. QM will verify by doing a spot review of problems to make sure they have been fixed. Also, before and after data can be compared to see how well corrections worked.

Job Development Component:

Job development as a component of the substance use disorder services unit will be subject to the same quality management activities and processes outlined in this SUD services QM plan and the Center QM plan as applicable. Fidelity to the Independent Placement and Support evidence-based practice model will be folded into the periodic Supported Employment fidelity review. Services will be tracked for effectiveness, efficiency, reduction in risk, and client satisfaction by monitoring of contract performance measures using the Job Development Tracking Spreadsheet. Clients with a co-occurring mental illness will be admitted to AMH services and progress monitored through Uniform Assessment results. Specific areas of the UA to be monitored include Community Data for employment type and reason for being out of the workforce. Additionally, ANSA scores in the domains for Behavioral Health Needs for Substance Abuse and Life Domain Functioning related to employment, living skills, residential stability, self-care, decision making, and involvement in recovery will be monitored.

Utilization Management:

The Utilization Management Program (UM) and QM work closely to ensure that individuals receive the services they need while maintaining equitable distribution of program resources. Staff rely on data and reports from CMBHS to monitor for errors, contract performance targets, utilization patterns such as service capacity and attendance, authorizations, over/under-utilization, staff productivity, and billing reports. These reports are considered on both a formal and informal basis to identify trends, patterns and practices, either positive or negative. The UM Committee discusses trends and patterns and recommends procedural revisions or training needed to modify inefficient utilization practices.

Attachment A

BH UTILIZATION MANAGEMENT PLAN FY 2024

INTRODUCTION:

The purpose of the Utilization Management (UM) program is to ensure that consumers receive quality, cost effective services in the most appropriate treatment setting, in a timely manner, and by appropriate staff. The UM program establishes procedure to ensure a balance between the demand for services, the availability of resources, and the needs of consumers.

GOALS OF THE MH UM PROGRAM:

- To provide behavioral health services only when medically necessary and appropriate.
- To deliver services at the appropriate level of care in a cost-effective manner.
- To meet all professionally recognized standards in the delivery of services.
- To identify opportunities to improve efficiency in the delivery of care and services by maintaining or developing appropriate programs and services.
- To measure performance in existing programs and services to identify and prioritize areas for improvement.
- To provide a due process in which appeals of adverse determinations may be objectively reviewed.

FUNCTIONS:

- To conduct **Utilization Reviews and Authorizations** of all levels of care, including inpatient admissions to private hospitals, state hospitals or HHSC-funded beds, per the Performance Contract, current UM guidelines, and payer standards. To develop and implement a process by which a request for continued stay proceeds through an authorization process.

  Authorization Procedure for Inpatient Admission may be initiated by the Center through immediate screening and assessment of any person in the local service area who is in crisis (including active and non-active clients). These services are available on a walk-in basis 24-hours a day, 7 days a week at the Crisis Treatment Center or via the Mobile Crisis Outreach Team. During business hours crisis assessments are also available at each of the HOTBHN regional offices. Hotline services are available through the toll-free number. Children in crisis that are active clients are typically assessed at the children's behavioral health office or by MCOT if they are not taken directly to the ER or to a hospital by the family/LAR. The child's case manager coordinates crisis services as appropriate.

  - Persons who present as a crisis to the Crisis Treatment Center will receive a face-to-face screening by a QMHP-CS within 15 minutes of presentation to prioritize imminently dangerous individuals for screening and intervention.

- RN will provide initial assessment to determine if individual is medically stable and consult with a psychiatrist as necessary. Medical emergencies will be directed immediately to the ER.
- Psychiatric screening will be completed by psychiatrist, if needed, and admission to appropriate treatment facility will be coordinated by triage staff.
- A fast-track option is available to individuals who present with law enforcement or through Providence ER. This allows a LPHA to admit directly to the Crisis Residential Unit or Extended Observation Unit prior to being assessed by the psychiatrist. This provides quick admission when a psychiatrist is not available within an hour of arrival to the Crisis Treatment Center; all individuals admitted under fast track must see a psychiatrist within 8 hours of admission.
- If inpatient care is indicated, triage staff attempt to place the individual in a private facility before pursuing HHSC-funded community hospital beds or state hospitalization. HOTBHN staff must authorize HHSC-funded community hospital beds or state hospitalization and authorize any continued stays in these facilities. The state hospital statewide waitlist is routinely updated and utilized as necessary.
- Individuals who are not referred by the psychiatrist for inpatient care shall receive a full crisis assessment (psychosocial, psychiatric and as ordered medical) to determine least restrictive intervention or treatment. Interventions could include the Extended Observation Unit, Crisis Residential Unit, Crisis Respite, referral to routine outpatient services, or referral to transitional services.
- Authorization of crisis services will take place within two business days of service delivery. Requests for authorization are posted to the Intranet and made available only to designated authorizing staff. Requests may be submitted at any time.

Authorization/Re-authorization Procedure for Non-MCO Consumers:

- Assessing staff will enter the Uniform Assessment (UA) data into the clinical record.
- The Utilization Manager or designated LPHA will review the assessments each business day and make a determination to authorize, deny, or modify requested service. The Utilization Managers or their designees are Licensed Professionals of the Healing Arts (LPHA) and do not function as service providers.
- Services are authorized for the length of time specified by the current UM Guidelines for each level of care.
- In the event that the requested service is at capacity, a lesser level of care may be offered or the consumer may be placed on a waiting list, unless the consumer is receiving Medicaid. Consumers with Medicaid may not be placed on a waiting list for a Medicaid service.
- With appropriate clinical justification, the Utilization Manager (LPHA) or designated LPHA may override the recommended level of care and approve an alternate level of care. Documentation of authorization will be signed by the Utilization Manager (LPHA) or designated LPHA and placed in the clinical record.
- In the event that a consumer is not authorized for a requested level of care, the Utilization Manager (LPHA) or designated LPHA will notify the responsible staff

person and will place documentation in the clinical record. UM Authorizing staff will be available throughout a routine business day.
- Requests for authorization are posted to the Intranet and made available only to designated authorizing staff. Requests may be submitted at any time.

Authorization/Re-authorization Procedure for MCO Consumers:

- Assessing staff will enter the Uniform Assessment (UA) data into the clinical record.
- The Utilization Manager or designated LPHA will review the assessments each business day and make a recommendation to the consumer's MCO to authorize a requested level of care according to current MCO and UM Guidelines. The Utilization Manager or their designees are Licensed Professionals of the Healing Arts (LPHA) and do not function as service providers.
- With appropriate clinical justification, the Utilization Manager (LPHA) or designated LPHA may request that the MCO override the recommended level of care into an alternate level of care.
- Final service authorizations are made by MCO UM staff in accordance with current MCO and UM Guidelines for each level of care.
- In the event that a consumer is not authorized for a requested level of care by the MCO, the Utilization Manager (LPHA) or designated LPHA will notify the responsible staff person and will place documentation in the clinical record.
- Utilization Managers will be available throughout a routine business day and serve as the primary points of contact for the MCO UM staff. Utilization Managers will have a designated staff member serving as their backup if the primary Utilization Manager is unavailable.
- Authorization of crisis services will take place when required by an MCO. Requests may be submitted at any time.

- To provide **Utilization Care Management** to accommodate unusual circumstances regarding authorization. In some unusual circumstances, when the consumer may have special needs or urgent needs, the Utilization Manager or designated LPHA may expedite the UM procedure to secure services. Special circumstances may include, but are not limited to, a physical disability, an acute health condition or illness, intellectual or developmental disability, or pregnancy.

- To confirm **adverse determinations**. Adverse Determinations are those clinical decisions that involuntarily deny, reduce, or terminate services. Recommendations based on clinical ineligibility to deny authorization for continued stay are made by the UM Manager or designated LPHA. Continued stay denials are reviewed by the UM Physician.

- To conduct the **appeal** process for adverse determination. (AM 1.4)

- Waiting list Management (See Waiting List procedure AM 5.5)

- To monitor submission of data and documentation from internal and external providers; to communicate significant or continued provider non-compliance with UM guidelines; to educate providers concerning inappropriate utilization of services identified through data analysis.

- To develop an accurate and efficient system of data submission to HHSC.
- To provide oversight to the UM activities of clinical and non-clinical staff.
- To establish a routine review process of clinical data via a **UM Committee**. The UM Committee is appointed by the CEO. The UM Committee is composed of a psychiatrist who is the chair of the UM Committee, the UM Manager, the QM/UM Director, ad hoc representatives from finance and IT, a peer provider, and other managers and supervisors. The committee meets at least quarterly to assess the UM program's effectiveness towards meeting goals by reviewing aggregated data for utilization, performance measures, and appeals. The committee monitors utilization to ensure the Center's clinical resources are being expended effectively and efficiently. The committee promotes the availability and maintenance of high-quality care through the evaluation of clinical practices, services and supports via data. When issues are found, the committee will, make recommendations and plan the implementation of recommendations and/or corrective actions.
    - Committee members will receive training to fulfill the responsibilities of the committee.
    - No committee member will participate in the review of a case in which he/she has a conflict of interest.
    - Confidentiality: All activities and deliberations which may in any way involve review or evaluation of the services received by a consumer or the services delivered by a provider are confidential and subject to applicable sections of state and federal law affecting confidentiality. Documents and other information prepared as a function of UM Activities will be released only in accordance with provisions of the UM plan. No voluntary disclosure of peer review information will be made except to persons authorized to receive such information. Data generated and utilized in accordance with the UM plan and the QM plan are maintained in a confidential manner. Only those persons who require information to recommend corrective action are permitted access to confidential information.
    - The UM Committee Physician/Chair:
        - Conducts oversight of UM processes.
        - Clinically supervises the Utilization Manager.
        - Approves all UM procedures.
        - Consults on Adverse Determinations and Appeals if requested.
        - Resolves conflicts regarding internal authorization of services for non-Medicaid consumers.
        - Provides physician –to –physician peer review as indicated.
    - The Utilization Manager (LPHA):
        - Is responsible for the authorization process (prospective and concurrent reviews), the override process, and supervises authorizing staff.
        - Assists with adverse determination decisions.
        - Is responsible for implementing the authorization process and the override process under the direction of the UM Physician and/or input from QM/UM Director.
    - The Quality Management/UM Director or QM designee:
        - Provides administrative oversight of the UM program and functions.
        - Facilitates UM Meetings.

- Monitors outcomes of UM processes
- Is responsible for oversight of utilization review and sampling processes.
- Monitors data reports for integrity.
- Monitors contract compliance reports for service providers to include a review of treatment and outcomes.
- Monitors crisis services data.
- Provides technical assistance to providers.
- Assists with implementation of plans of correction.
- Prepares retrospective data review documents and disseminates reports to the committee which may include but is not limited to summaries of:
    - Staff Productivity
    - MH/SA Performance Measures
    - LOC-A vs. LOC-R
    - High and Low Utilizer Reports
    - Hospital Utilization
    - Billing Reports
    - High/Low Utilizer or Outlier Review: Retrospective review of data to identify outliers followed by review of individual cases as necessary to determine need for change in level of care or service intensity.
    - Appeals
- Sampling: Based on the analysis of the above reports, UM Committee members may conduct individual chart review.

- Ad Hoc Members: The Financial Management Representative serves as an ad hoc member of the UM Committee and brings relevant information to the UM Committee to assist in report review. The Information System Representative serves as an ad hoc member to the UM Committee and coordinates report development.

UTILIZATION MANAGEMENT PROGRAM EVALUATION

- **Annual Evaluation:** The UM program of the Center is evaluated at least annually to determine its effectiveness in facilitating access, managing care, improving outcomes, and providing useful data for resource allocation, quality improvement, and other management decisions, as well as identifying improvements that can be made. UM Program Evaluation activities, including the UM Plan self-assessment and UM performance measures, will be reflected in the UM Committee meeting minutes.

- **Provider Profiling**: Provider profiles document compliance with Center procedure and UM Guidelines. Profiles may be used to identify areas of improvement in the effectiveness and efficiency of the delivery of services by providers. Educational or training programs for providers are implemented based on the information identified and analyzed in developing the profiles. The Center will have a formal agreement or contract with external providers (AM 3.9, 3.10, 3.11, 3.12) that specifies the method of data collection. Internal providers will submit data according to Center procedure.