QUALITY MANAGEMENT PLAN
FY 2018

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I

AUTHORITY

The Quality Management Plan of Metrocare is authorized by Section 534 of the Texas Health and Safety Code, and:

1. The Chief Executive Officer of Metrocare has the authority and responsibility to establish an integrated quality management program within the Center.

2. The Board of Trustees mandates the implementation of an effective quality management program through actions taken by the Chief Executive Officer.

3. The Chief Executive Officer of Metrocare has designated the responsibility for coordinating all quality management activities within the Center to the Director of Quality Management.

4. The Quality Improvement Council, with support from the Quality Improvement Group, serves as a mechanism for a data-based system review in order to identify needs and make recommendations to the Chief Executive Officer in areas of administrative policy and procedure. The Group offers technical assistance regarding standards compliance to the Center units; monitors individual unit and departmental performance on adherence to applicable standards, policies, procedures, laws, rules and regulations; and coordinates the monitoring and evaluation of the Center's service delivery system, including its service network, through the use of quality committees. While the department carries the title "quality management" the performance improvement function is the shared responsibility of all Center staff and network providers.

5. The Quality Management Plan is developed with input from Center clinical and support staff, and with input from the Mental Health Advisory Committee and the Intellectual and Developmental Disability Network and Planning Advisory Committee.

6. The Quality Management Plan is applicable to all Center staff activities, and to contractors and network providers.

7. The Quality Management Plan reflects the Mission and Value Statements of the Board of Trustees of the Metrocare (see Section II).

8. The activity of the Quality Improvement Council and its affiliated committees, as outlined in this document, are considered Medical Peer Review Committees and Professional Review Bodies as that term is recognized and defined under Texas and federal law, including Tex. Rev. Civ. Stat. Art. 4495b. and the Health Care Quality Improvement Act, 1986, 42 USC Section 10 111.

II

MISSION STATEMENT

"Our mission is to serve our neighbors with developmental or mental health challenges by helping them find lives that are meaningful and satisfying.

VALUES

Integrity

We are accountable to those we serve, and to those from whom we receive support.

Quality

We pursue quality of life for those we serve, and therefore require quality of services from our staff.

Diversity

We seek a diverse and inclusive workplace in which to fulfill our mission.

Perseverance

As advocates, when we lose, we don't give up; and when we win, we raise the bar.

All activities of Center employees, as well as the work of the committees described in this Plan, are conducted with the Mission and Value Statements as guiding principles. These Statements have been developed with input from stakeholders and are amended from time to time by the Board of Trustees as appropriate to the needs of the residents of Dallas County and the available resources of Metrocare.

III

PURPOSE

The Center is committed to providing professional, comprehensive, quality care to people with mental illness, substance abuse disorders and/or developmental disabilities through Center-provided services and through a network of other community-based services. The obligation to implement this initiative is shared by all providers within the Center and within it is service network. The Quality Council, with support form the Quality Improvement Group, has been designated to establish an interactive, Center-wide Quality Management Plan to ensure systematic and objective planning, monitoring and ongoing improvement of the quality and appropriateness of services provided to service recipients. As such, this Quality Management Plan is intended to serve as a guideline for these activities by providing the following:

1) Identifying Center-wide quality measures and desired outcomes;

2) Providing the Center with a structure for an active, systematic, objective, and continuous process for monitoring, evaluating, and improving the quality and appropriateness of service recipients;

3) Outlining the performance improvement activity to which the Center has committed itself, as part of its service to individuals who are members of the Health and Human Services Commission (HHSC) - defined priority population, or who are receiving services from the Center's provider network. The quality process involves all employees and network providers of the Center. It is measured through the satisfaction of the service recipient and the staff, and through the outcomes of services for those served through the Center.

4) Ensuring that Metrocare achieves the goals outlined by the Board of Trustees' Mission and Value Statements with efficiency, quality and minimum risk;

5) Assisting the Center in monitoring its adherence to the goals and objectives outlined in the Center's Local Plan and it's contract with the Local Mental Health Authority;

6) Ensuring that services are provided based upon assessed need, according to prescribed plans of care, and according to established standards of care determined by the clinical staff;

7) Ensuring a process for service recipients rights protection;

8) Ensuring that the Center maintains compliance with HHSC/IDD Authority Certification requirements;

9) Ensuring a system for measuring, assessing and reducing incidents of service recipients abuse, neglect and exploitation;

10) Integrating the monitoring of compliance with the Department of Health and Human Services, Office of Inspector General (OIG) guidelines into the provider network review process;

11) Assisting in program planning and development through the collection and analysis of performance outcome and improvement data;

12) Integrating findings of quality improvement activities into quarterly/annual program evaluation and profiling of unit performance.

The Quality Management Plan is to be revised annually by the Quality Improvement Group, in consultation with Center clinical and support staff, and input from the Mental Health Advisory Committee and the Intellectual and Developmental Disability Network and Planning Advisory Committee, and then submitted for approval to the Chief Executive Officer of the Center.

IV
QUALITY IMPROVEMENT COUNCIL

The Quality Improvement Council serves in an advisory capacity to the Chief Executive Officer and, as such, may not act independently nor determine Center-wide policy. The Council functions as an oversight committee in tracking outcomes of internal and network service programs, and of internal support units. It identifies duplication of services, assures compliance with Center policy and procedures, reviews clinical staff, support staff and network resources for over/under utilization, and oversees goals and quality measures of both clinical and non-clinical areas.

The chairperson of the Council is designated by its membership. The Director of Quality Management will provide administrative support to the council.

Council membership shall include:

- One representative from the Local Authority Division, appointed by the Director.
- One representative from the Developmental Disability Provider Division, appointed by the Director.
- One representative from the Mental Health And Substance Abuse Disorder Division, appointed by the Executive Medical Director
- Chief Medical Officer
- Compliance/Risk Manager
- One active service recipient from the mental health and/or substance ABUSE disorder services, appointed by the Mental Health Advisory Committee
- One active service recipient or family member from the Center's developmental disability services, appointed by the Intellectual and Developmental Disability Planning and Network Advisory Committee
- Director of Quality Management, Ex Officio

Meetings shall be conducted at least quarterly, but may occur more frequently if deemed necessary by the Chair.

The Quality Improvement Council shall review summaries of monitoring and evaluation activities ("QI minutes") provided from all Departments and network providers represented by its membership. The data set required from each Department, from the Quality Management Department, and from the Center's Quality Committees shall be recommended to the Chief Executive Officer by the Council, but shall at least include information related to the goals described by the quality indicators below. The Quality Improvement Council should review QI minutes from each Department and each network provider at least quarterly.

The results of Council reviews and subsequent performance improvement recommendations shall be forwarded to the Chief Executive Officer. The Chief Executive Officer or designee shall forward all or parts of the materials to the Senior

Management Staff, the Mental Health Advisory Committee, the Intellectual and Developmental Disability Planning and Network Advisory Committee and the Board of Trustees, as he/she deems appropriate.

V

CENTER-WIDE OUTCOMES
FOR PEOPLE AND FOR THE ORGANIZATION

The Center's Quality Management Plan identifies and focuses on specific indicators of desired outcomes. These indicators reflect state and national quality standards, and are monitored throughout the year on a scheduled basis. Results are reviewed, trended and used by the Center's Board, its Planning Advisory Committees, and its administrative staff for quality improvement and management purposes.

The domains under which these indicators fall are:

MENTAL HEALTH SERVICES

- Service Delivery
- Performance Improvement
- Service Utilization
- Individual Rights and Responsibilities
- Personal Health, Safety and Welfare Goals
- Abuse, Neglect and Exploitation

SUBSTANCE ABUSE DISORDER SERVICES

- Service Delivery
- Performance Improvement
- Service Utilization
- Individual Rights and Responsibilities
- Personal Health, Safety and Welfare Goals
- Abuse, Neglect and Exploitation

INTELLECTUAL AND DEVELOPMENTAL DISABILITY SERVICES

- Service Delivery
- Performance Improvement
- Service Utilization
- Individual Rights and Responsibilities
- Personal Health, Safety and Welfare Goals
- Abuse, Neglect and Exploitation

Organization

- Leadership and Vision
- Human Resources
- Organizational Learning
- Organizational Foundation
- Organizational Stewardship
- Financial Planning and Management

Service Recipient and Financial Accounting
Management of Information
Marketing and Public Relations

Goals for FY 2018

- Ensure the organization provides person-centered and recovery oriented services to individuals enrolled in center programs.
- Provide a responsive system of crisis services and effective safety net services.
- Develop and maintain a stable workforce which is well trained and responsive to the needs of individuals seeking services.
- Maintain compliance with all federally funded program requirements and the performance contract with the Health and Human Services Commission, North Texas Behavioral Health Authority and managed care organizations.
- Maintain customer satisfaction rate >4.0
- Review and update center procedures as appropriate.
- Maintain Center accreditation through the Accreditation Commission for Health Care (ACHC) and pursue CARF accreditation for the Cohen Veterans Clinic.

VI

QUALITY IMPROVEMENT SYSTEMS

Guiding Principles

- Drives quality improvement deeper into the organization
- Promotes departmental and individual accountability.
- Collaborative in nature
- Supports effective organization-wide communication.
- Linked to organizational planning (mission, vision, values, and goals).
- Measures and assesses performance data.
- Anchored in improving clinical care and organizational performance.
- Based on the principles of continuous quality improvement.

Purpose

The Center's Quality Improvement System (QIS) provides the framework within which quality improvement activities are conducted. The QIS is constructed to provide knowledge and information to people nearest to the source of activity that will facilitate an understanding of what our performance priorities are, what individual roles and expectations are, and how we aggregate data to determine the center's overall performance. The QIS requires that processes be designed to reflect the center's mission, vision, and goals, the needs of service recipients, families, staff and community, current knowledge-based information and information regarding the center's performance, measured both internally and externally. The overall purpose of the QIS is to establish a systematic process for collecting and analyzing data in order for center leadership to determine:

- The level of performance and the stability of existing process which support the identified goals of the operational divisions.
- Priorities for improving existing processes or outcomes,
- The design and implementation of actions needed to improve performance or outcomes,
- The effectiveness of actions taken to improve performance or outcomes, and
- When new processes are needed.

Organizational Self-Assessment

The center conducts assessment activities through the year in order to measure progress and identify areas for improvement. Results of these assessments are analyzed and reviewed by the Quality Council, Planning Advisory Committees and the Board of Trustees.

Implementation of QIS

The QIS integrates design, measurement, assessment, and improvement functions within all levels of the organization into a single system of quality improvement. The four major quality improvement functions are discussed in more detail in the following section.

DESIGN:
Improving organizational performance begins with good planning. Integral to this process is the requirement that all organizational stakeholders address quality improvement initiatives related to the center's goals and objectives. The planning function is a QIS activity occurring with the support and leadership of the Chief Executive Officer. The QIS structure provides the framework within which quality improvement activities are conducted. The Quality Council is responsible for reviewing the plan as well as the initiatives identified by the administrative and service divisions.

MEASUREMENT:
The second function of improving organizational performance following the design function is performance measurement. The goal of performance measurement is to obtain information for decision-making and improvement purposes. Measuring performance involves not only setting expectations, but also collecting data and assessing how well expectations are met. Measurement is the foundation of quality improvement activities. Once current performance is known, informed decisions can be made about process stability, opportunities for improvement can be identified and processes in need of design or re-design can be targeted.

To measure performance, the center collects data on processes and outcomes through a comprehensive set of performance measures. These include those that focus on high-risk, high-volume, and problem-prone processes, as well as other sensors of performance. Some processes are measured on a periodic, ongoing basis while others are measured more intensively for a shorter duration. Some of the measurement tools and processes used include Cost of Services Reports, Encounter Data, CARE Reports, Intellectual and Developmental Disabilities and Behavioral Health Outpatient Warehouse Reports (MBOW), PsychConsult clinical software management reports, critical incident data reports. Center integrated QIS measures include, but are not limited to the following:

System Measures:

- Environment of Care
- Consumer Rights
- Staff Turnover
- Training Compliance
- Corporate Compliance Audit
- Contract Performance Measures
- Utilization Management
- Fidelity Reviews

Outcome Measures**:**

- Satisfaction
- Functioning
- Personal Outcomes
- Symptomology

Financial Measures:

- Revenues
- Expenses
- Denial/Appeals
- Billing Goals
- Claims Collections

Service Measures:

- Encounters
- No-Show Rates
- Documentation Standards
- Contract Compliance
- Engagement of Service Recipients
- 7 day Follow-up After Inpatient Stay
- Service utilization

ASSESSMENT:

Assessing performance over time is an integral component of improving organization performance. This involves assessing patterns and trends and comparing recent performance with past performance and with that of other organizations. Data collected through measurement activities substantiate acceptable levels of performance, identify areas of excellence in comparison to internal expectations or external best practices, and are the starting point for assessment of opportunities for improvement.

IMPROVEMENT:

The final component is quality improvement. The goal of the quality improvement phase is to continuously improve outcomes for service recipients. Performance data, when assessed, provide information on which improvements can be planned. The major improvement phase includes the following steps:

- Identification of opportunities for improvement.
- Study of quality improvement opportunities.
- Determination of the underlying factors associated with the improvement opportunity.
- Selection and testing of improvement intervention.
- Observation of the effects of the intervention.
- Analysis of the effects of the intervention.
- Communication of intervention results
- Formal implementation of intervention or re-design of intervention.
- Periodic monitoring of intervention.

The above described nine-step quality improvement process provides a conceptual model for implementing quality initiatives at different levels within the organization.

The Quality Improvement Group is responsible for monitoring and evaluating the quality of services provided by the organization. Their focus includes:

- Reviewing internal and external programs to ensure their compliance with state and federal rules, along with contracts.
- Reviewing and analyzing data for both internal and external programs.
- Compiling results and producing reports of findings.
- Requesting corrective action plans, as appropriate.
- Monitoring process changes initiated as a result of corrective action plans.

Utilization Management:
The Utilization Management Program (UM) and Quality Improvement Group 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 internal computer system, 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 historically has issued routine reports from the internal computer system. These reports are readily available to division directors and managers 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 Quality Council discusses trends and patterns as well as procedural revisions or training needs to modify inefficient utilization practices.

VII

QUALITY COMMITTEES

Implementation of Quality Management activities is completed, in part, through a number of committees. This section discusses the committees designated as quality committees.
Behavior Therapy Committee
Clinical Care & Oversight Committee
Environment of Care Committee
Human Rights Committee
Professional Review Committee
Site-based Performance Improvement Teams

Each committee will maintain and distribute minutes in accordance with the Health Care Quality Improvement Act and other applicable state and federal statutes. Minutes will be submitted to the Director of Quality Management, for review by the Quality Council, at least quarterly.

The minutes shall reflect committee activities consistent with this quality improvement plan. Goals should be set and thresholds determined. If not met, these thresholds will require action planning for issue resolution, system review, or administrative action.

Any issue identified by any committee as requiring resolution will be made know to the appropriate unit director for immediate action. The unit director may be asked to submit a report stating actions taken to resolve the issue, and the request may require that the report be delivered to the chairperson of the committee prior to its next meeting. Issues will continue to be reviewed until the committee determines and documents an adequate resolution.

It shall be the responsibility of the Quality Improvement Council, assisted by the Quality Improvement Group, to assure that the goals and activities of the individual committees are consistent with this Plan, and that there is no duplication of committee reviews or other activities, and that committee activities are integrated with one another. If deemed appropriate, joint meetings of certain committees may be conducted.

Behavior Therapy Committee

This committee functions as an oversight committee that approves behavior intervention programs. It makes recommendations for approval to the Chief Executive Officer and to the Human Rights Committee when behavior programs include aversive or restrictive procedures.

The committee designates the chairperson. Committee membership minimally is comprised of:

- A senior psychologist from the Developmentally Disabilities Division;
- At least one other Center clinical staff member who is qualified to evaluate behavior management plans; and
- Other staff members as recommended by the committee and appointed by the Clinical Services Division Director.

Meetings are conducted at least quarterly, or as needed, as determined by the chairperson.

Clinical Care & Oversight Committee

This committee monitors and evaluates the overall clinical care offered by the Center. This includes policy development related to guidelines of care, ensuring that pharmacy and therapeutics are compliant with applicable HHSC (Mental Health, Substance Abuse Disorder and IDD), state and federal laws, oversight of credentialing and privileging of clinical staff, and peer review.

The Chief Medical Officer serves as chairperson. Site Medical Directors make up the balance of the committee. The Director of Pharmacy also participates when issues concerning pharmacy and therapeutics are addressed. Other members are designated as required to meet the committee's mandate.

Environment of Care Committee

This committee ensures that all facilities occupied or maintained by Center personnel are kept free of recognizable safety and environmental hazards. This committee also reviews reported accidents and employee injuries, develops and maintains safety manuals, monitors the safety inspection program, provides preventative materials and training to staff, and maintains an accident inspection program.

As part of its responsibilities, this committee also develops and monitors the implementation of a Center-wide Exposure Control Plan and related Center policies and procedures, monitors and evaluates communicable disease data from the Center, and ensures compliance with applicable HHSC standards, as well as with State and federal laws.

The chairperson is the Safety Officer. The committee membership is comprised of:

- Safety Officer
- Chief Medical Officer
- Risk Manager/Compliance Manager
- Legal Counsel, as needed
- Human Resources Director or his/her designee
- A support staff employee representing the Developmental Disability Division, appointed by the Division Director
- A support staff employee representing the Mental Health/Substance Abuse Disorder Division, appointed by the Division Director

Meetings are conducted quarterly, or as determined by the chairperson.

The committee oversees safety reviews to be conducted at each program site on at least an annual basis. Results of reviews are forwarded to the unit director for plan of correction. Copies of safety surveys and plans of correction are to be maintained by the Safety Officer.

Human Rights Committee

This committee reviews all program rules related to service recipient conduct, all Center policies and procedures related to the service recipient's rights protection, and all behavior programs that contain aversive or restrictive procedures. The committee makes recommendations to executive staff, as appropriate, regarding rights advocacy.

The committee designates its chairperson. Committee membership is comprised of:

- A representative from the Developmental Disability Provider Division
- One person from the developmental disability advocacy community, recommended by the Intellectual and Developmental Disability Planning and Network Advisory Committee, and who is not a Center employee.
- Rights Protection Officer
- A Center physician qualified to evaluate proposals that use medications to manage behavior

Meetings are conducted quarterly, or as needed, as determined by the chairperson.

Professional Review Committee

This committee reviews all deaths of individuals served to determine the quality and appropriateness of care given prior to the person's death, and makes recommendations that may improve the quality of future services.

The Chief Medical Officer serves as chair. Committee membership is comprised of:

- Chief Medical Officer, or designee

- Director of Quality Management, or designee
- Legal counsel, as needed
- One additional professional member, at the discretion of the committee when deemed appropriate.

Meetings are conducted as needed, as determined by the Director of Quality Management.

Issues identified as requiring medical or administrative review will be forwarded to the site Medial Director or Division Director for action. The committee may request written follow-up within thirty days. Cases in which clinical peer review appears to be indicated are immediately referred by the committee to an independent peer review committee, as required by administrative code. All proceedings of the committee will be conducted in compliance with the rules and regulations protecting committee privilege, as outlined in State and federal statute.

Performance Improvement Teams

These local teams function as an oversight committee to review the results of random samples of active cases from the site. The Committee is interdisciplinary and composed of site's clinicians and leadership. Meetings are conducted monthly, or as needed, as determined by the local chairperson.

The proceedings of the committee meetings shall be documented and collated for review by the Director of Quality Management and the Chief Medical Officer. The proceeding shall include plans of action.

Committee Minutes

All quality committees maintain minutes that include date and place of meeting, committee members present, review findings, summary of discussions of agenda items, recommendations, and actions taken. Unfinished agenda items are revisited in subsequent meetings until resolved. All meetings are to be conducted by agenda.

Meeting minutes are to be structured and formatted so that the discussion of agenda items is clear, and so those follow-ups on recommendations from previous meetings are documented. Supporting documentation of issue resolution may be attached to minutes, but references to other sources should be avoided.

The distribution of minutes shall occur in compliance with State and federal guidelines on privileging.

VIII

IMPLEMENTATION OF THE QUALITY MANAGEMENT PLAN WITHIN THE DEVELOPMENTAL DISABILITIES NETWORK

Each contracted service program in the Metrocare Services developmental disability provider network shall implement a structured, ongoing process for the monitoring and improvement of services. The Quality Improvement Council determines the adequacy of these processes, with advice from the Quality Improvement Group and the Senior Management Staff.

Through the Network Provider Relations Specialist and the Director of Quality Management, network providers will submit quality management reports for review by the Quality Improvement Council at least quarterly. The council shall ensure that these reports reflect that the provider network programs maintain compliance with state and federal regulations, and with contract stipulations required in the Metrocare Performance Contract with HHSC.

IX

PROCESS MANAGEMENT

The methods for measuring, assessing and reducing incidents of service recipient abuse, neglect and exploitation:

a. All suspected incidents of abuse, neglect and/or exploitation are reported to the Texas Department of Family and Protective Services (TDFPS).
b. Incidents are then investigated by TDFPS with facilitation by the Rights Protection Officer.
c. Staff involved in the allegation is placed on administrative leave or resigned until there is a resolution to the allegation.
d. Case not accepted for investigation by TDFPS are investigated by the Rights Protection Officer
e. The Rights Protection Officer tracks all allegations until there is a resolution for each case.
f. Information on each allegation is compiled, analyzed and presented to the IDD Planning Advisory Committee, MH Advisory Committee and the Metrocare Board of Trustees monthly.
g. The Quality Improvement Workgroup and the local Performance Improvement Teams as appropriate address systemic issues identified.
h. Personnel issues when identified are addressed by the Service Area Director and Human Resources Department.
i. Annual training is provided to all staff regarding abuse, neglect and exploitation.

Rights Protection Process

- Metrocare has a complaint line to receive concerns regarding rights violations.
- Complaint specific concerns are referred to the Service Area Director for investigation and resolution.
- Concerns dealing with potential abuse or neglect issues are referred to TDFPS for investigation
- The Rights Protection Officer investigates concerns involving the Service Area Director.
- The Human Rights Committee reviews issues dealing with Behavior Plans, Medication Plans and/or Rights Restrictions.
- Data from the complaints line and HRC Committee are tracked, compiled and analyzed monthly.
- Information is then submitted to the Metrocare Quality Council for review and recommendations.
- All Metrocare employees and contractors receive annual training regarding Service Recipient Rights Protection.

Local Authority Functions

The method for measuring, assessing and improving Metrocare authority functions include:

- Each function within the local authority has identified goals and established performance standards.
- Performance standards are reviewed monthly using reports developed to determine if established targets have been met for each identified area.
- Data captured in the organizations internal systems is analyzed and compared to information maintained in the CARE system.
- Monthly reports are developed and distributed to each area for review by the Program Manger or Director.
- The Program Manager and/or Director are responsible for developing a plan of improvement if the expected performance standards are below target.
- Random reviews are conducted to assure the implementation of improvement plans.
- Review data is compiled, analyzed and reported to the Service Area Directors and Quality Improvement workgroup for recommendations.
- Satisfaction surveys are conducted quarterly for consumers and annually for providers within the network.
- Data obtained from the surveys is compiled, analyzed and trended after each survey period.
- Review and survey information is then distributed to the Quality Council, Board of Trustees and Advocacy groups for review and recommendations.
- Goals and performance standards are modified based on feedback and recommendations from each group.

Accuracy of Data Submitted to NTBHA and HHSC

- The center has methods for measuring, assessing, and improving the accuracy of data reported to the state. The center has incorporated encounter field requirements and grid codes into clinical documents.
- Annual training is provided to all employees regarding program criteria and documentation requirements.
- Encounter data is submitted through a batch process, which pulls events from the PsychConsult database for the previous month.
- Criteria for encounter submission identified and written into the batch process.
- ERR Tentative Center Error Loge from the MBOW Data Warehouse reviewed prior to the final batch submission.
- Continuing issues are reviewed for resolution.
- Information is then submitted to the Quality Improvement Workgroup for review and recommendations.

Assessment of QM Plan Effectiveness

- Each committee identified in the QM Plan establishes goals and performance targets for the year.
- Each committee maintains minutes, which reflect the status of goals, performance targets and issues requiring further action.
- Committee minutes are forwarded to the Quality Improvement Workgroup for review of issues identified and actions taken to address each issue. Concerns and/or recommendations identified by the Quality Improvement Workgroup after reviewing minutes are forwarded to each committee as appropriate.
- The IDD Planning and Network Advisory Committee and the MH Planning Advisory Committee review the QM Plan annually and make recommendations regarding its content and direction
- The Metrocare Quality Council reviews the QM Plan, committee minutes and associated plans of improvements to determine its impact upon the organization and makes recommendations to the CEO regarding changes for coming year.

Critical Incidents

The method for measuring, assessing and reducing critical incidents includes:

- Critical incidents data is collected from each network provider monthly.
- Providers reporting incidents in any category must submit plans to address noted issues.
- Data received from the provider network is compiled, analyzed and trended
- Reports are developed from the data and presented to the IDD Planning Advisory Committee, MH Planning Advisory Committee and the Metrocare Board of Trustees.
- Deaths reported are referred to the Professional Review Committee for disposition
- Incidents dealing with potential abuse or neglect issues are referred to the Texas Department of Family and Protective Services (TDFPS) for investigation.
- Critical incident data reported to NTBHA and HHSC monthly.

Rights Restrictions

The method for assessing and improving the process for reviewing rights restrictions include:

- Presentation of all rights restrictions before the Human Rights Committee (HRC) prior to its implementation.
- Review and input by the Rights Protection Officer to assure due process, representation and advocacy for the identified individual and others who may be impacted by the restriction.
- Annual review of the Texas Administrative Code to assure that procedures utilized by the HRC are in compliance with regulatory authority.
- Annual review of conditional approvals granted to identify repeat issues, which prevent the full approval of rights restrictions, submitted to the HRC.

Service Delivery

The method for measuring, assessing, and improving the services provided by or through the Center's Mental Health/Substance Abuse Division and Local Authority:

- Service recipient satisfaction information is collected from individuals served on an annual basis, and used as a quality indicator to improve services.
- The data is collected, reviewed, analyzed and compiled into summary reports.
- Summary reports are distributed to the Board of Trustees, Planning and Advisory Committees, Quality Council and Division Managers.
- Division Managers are responsible for making program improvements based on information received from the surveys.
- Quality Council reviews information developed for program improvements and compares to data to the next survey results.

Service Capacity

The method for measuring, analyzing, and improving service capacity and access to services includes:

- Review of weekly metric reports, which identify number of individuals in service and the number of individuals with authorizations, but no service encounters.
- Review of authorized vs spending report weekly to identify dollars authorized, spent and percentage of utilization.
- Identify individuals from the wait list for admission into services based on available dollars.
- Monthly review of access to service and availability of clinical assessments within program sites. Information reported to the Board of Trustees.