

Burke Center Quality Management Plan

I. OVERVIEW

The Burke Center Quality Management Plan is based on the mission, vision, values, and goals of the center, which are approved by leadership and communicated center wide.

Mission Statement

WORKING TOGETHER TO IMPROVE LIVES.

Vision Statements

1. The Burke Center is the provider of choice for citizens in the region.
2. Our customers (internal, external, and ultimate) are delighted with the services they receive.
3. Our customers are actively involved in their care and in the development of their services.
4. Our staff feel valued and challenged and are proud of their association with our Center.
5. The general public knows who we are and values what we do.
6. Our internal and external communications are clear and consistent. We function as an integrated and supportive network.

Centerwide Goals

1. To continually improve the quality of services
2. To expand services to meet the ever-growing need
3. To provide effective resource management
4. To promote a positive work environment
5. To improve public understanding
6. To ensure the safety of customers

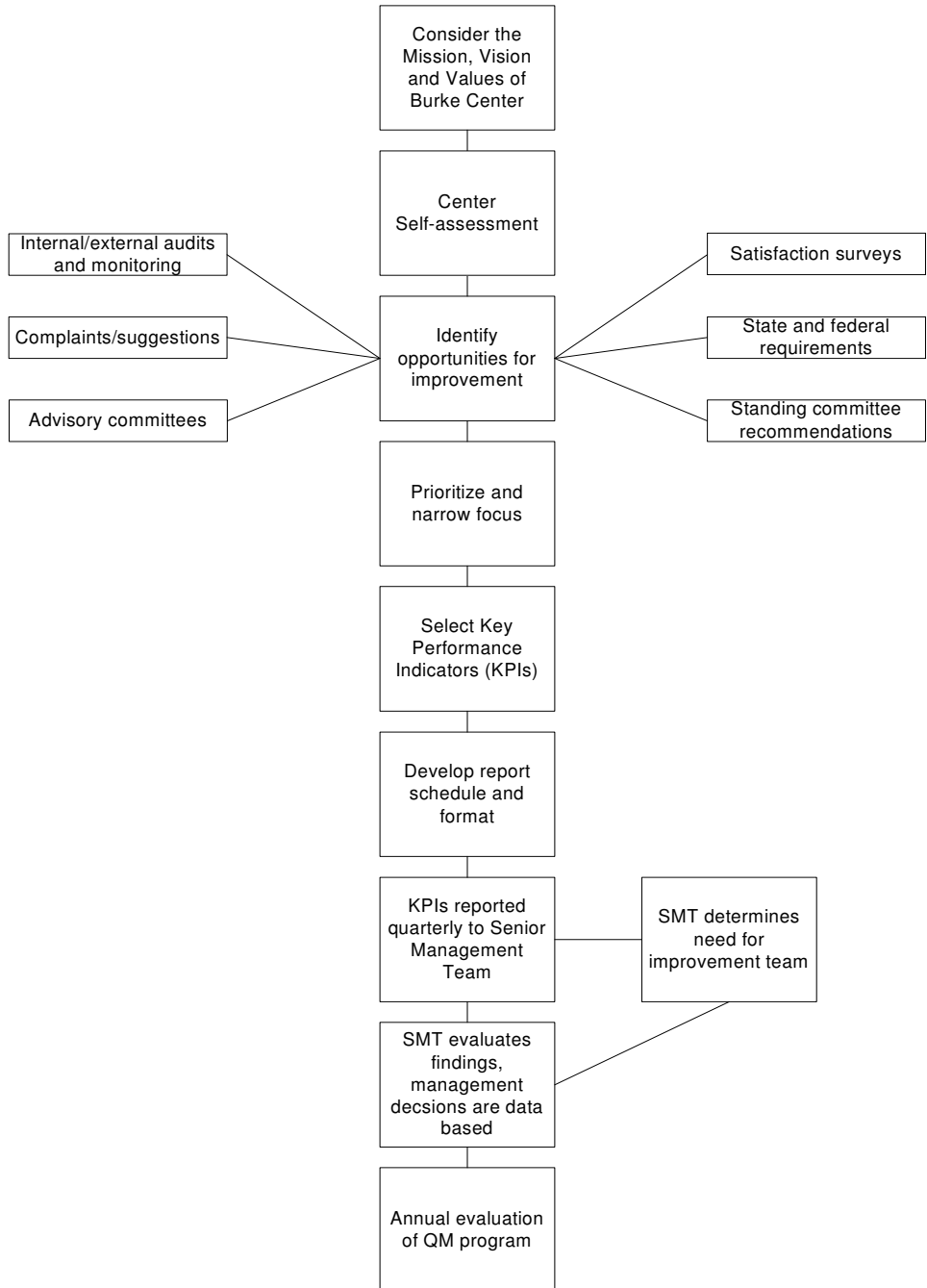
Centerwide Values

1. We affirm the dignity, rights, and strengths of the people and families we serve.
2. We are committed to excellence in everything we do.
3. We continually seek better and innovative ways to provide and improve services.
4. We use our resources in a careful, efficient, and well-planned manner.

The leadership of Burke Center is entrusted with the implementation of the quality management plan. Planning involves taking into account the population served, the center's mission, the scope of services and care, and needs identified by all stakeholders. The

purpose of the Burke Center Quality Management Plan is to establish the process by which an objective means of evaluating performance is achieved, allowing management decisions to be data driven, assuring that processes are designed well, and that the center continually assesses, monitors and improves its performance in priority areas of clinical outcome, financial stability and organizational efficiency.

Annual Process for Quality Management and Performance Improvement



II. QUALITY MANAGEMENT PROGRAM STRUCTURE

Governance and leadership retain ultimate responsibility for the Quality Management Plan. The Board of Trustees approves the Quality Management Plan and other documents that provide guidelines for management of the center and its network, and entrusts the Senior Management Team (SMT) with its implementation.

Leadership of the Burke Center conducts the Center's self-assessment, oversees the collection and evaluation of data from stakeholders (including consumers and families), including gathering assessing and approving action on information related to stakeholder's satisfaction with treatment, care and services provided. Leaders evaluate results of performance indicators, use data to drive decisions regarding clinical outcomes, financial stability and organizational efficiency, and identify training programs as needed. Leaders also appoint improvement teams when a multidisciplinary approach is required to address an opportunity for improvement. The leaders ensure that the processes and activities most important to treatment, care and service outcomes are continuously and systematically measured, assessed and improved throughout the center.

The leaders entrust the responsibility for oversight of the Quality Management Plan to the Director of Quality Management (who is a member of the Senior Management Team) and assure that sufficient resources are allocated to make improvements necessary throughout the center. The leaders and the Director of Quality Management assure that a planned, systematic, centerwide approach to process design and performance measurement, analysis and improvement is achieved. The Director of Quality Management reviews the plan annually, and updates as needed, soliciting input from Senior Management Team and other staff and stakeholders.

The leaders entrust operational directors with assuring that all staff participate in the Quality Management Plan by being aware of the outcomes of quality management activities in their service areas and are given opportunities to suggest improvement activities.

The Burke Center endorses the involvement of consumers, family members and advocates in the design, delivery, implementation and evaluation of services. Advisory committees such as the Regional Planning and Network Advisory Committee (RPNAC), internal and external satisfaction surveys and a centerwide self-assessment process contribute to the identification of opportunities for improvement as well the effectiveness of actions taken to make improvements.

III: DETERMINING IMPROVEMENT PRIORITIES

In determining prioritization of improvement opportunities, the following hierarchy will be followed, with declining level of emphasis:

- Issues related to safety and level of risk to consumers served, particularly adverse occurrences affecting individuals served
- Issues related to state or federal mandates

- Issues identified through stakeholder surveys or advisory committees which impact critical functions or outcomes
- Problem prone processes
- New processes adopted such as Jail Diversion or Crisis Redesign

Priorities are adjusted in response to unusual or urgent events, as determined by the Senior Management Team.

Examples of recent improvement team efforts are:

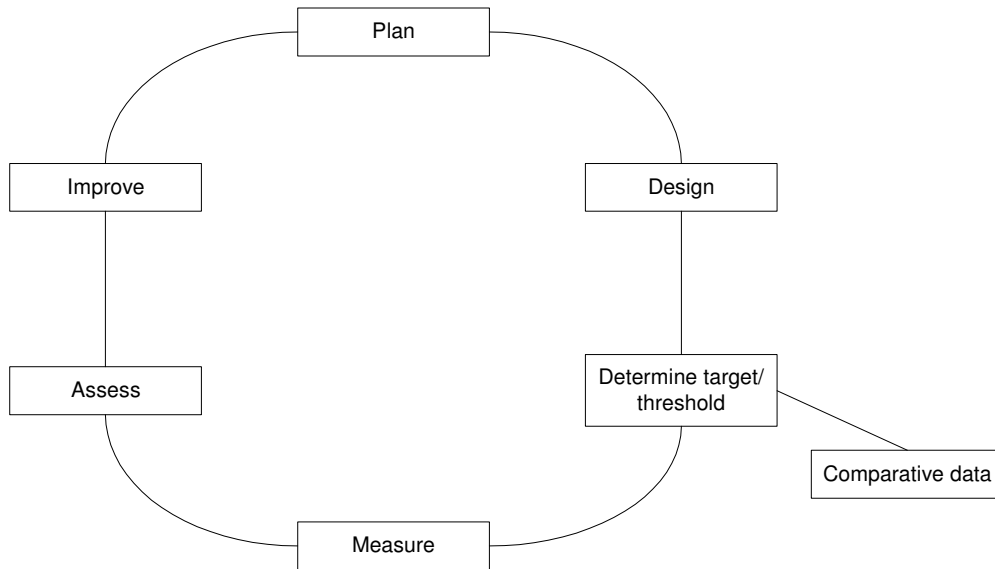
- Improved water safety procedures with program specific assessment process.
- A protocol for handling serious infections was developed.
- Continuity of care among mental health clients was improved.

IV. KEY PERFORMANCE INDICATORS

Key performance indicators are measurable, specific monitors of processes or outcomes that are collected in a uniform, systemic manner and reported quarterly to SMT. Each indicator is developed in accordance with consideration of the following information:

- The performance standard it addresses
- The comparative sate used to assess performance
- The purpose of the data collection
- How data will be reported
- Data source
- Collection schedule
- Reporting schedule

The diagram below describes the process utilized in performance improvement activities. Processes are planned well and the design of both gathering and measuring data are based on statistically sound premises. Tools such as flow charts, histograms, run charts, Pareto charts and other visual representations of data are used when they facilitate understanding of data. Analysis involves an evaluative process in which data is turned into information. Improvement activities are enacted when substandard performance is identified, or a negative trend identified, and continued data collection and analysis is made. Processes are modified based on data, with appropriate timelines for improvement determined by SMT. Information is shared not only with the Senior Management Team and Board of trustees but is also reported center-wide when the Senior Management Team minutes are distributed.



All data is analyzed quarterly, and reported with the following elements:

- **Findings:** Data is reported is relative to the performance target and in the manner described in the indicator (i.e. rate based vs. incident based. The use of charts and/or tables, including Pareto charts, bar graphs, run charts, histograms, pie charts or any other appropriate visual technique is encouraged. Data is reported in a manner determined by the process or outcome measured, to allow identification of unacceptable variations in performance, and focus correction efforts.
- **Analysis/Evaluation:** This section is for discussion of the data, with evaluation of the impact of the findings, turning data into information. The report describes if the process or outcome is assessing, monitoring, improving or maintaining performance.
- **Corrective actions taken/planned:** Actions planned or taken to address unacceptable or unexpected variations are described.
- **Results of corrective actions:** Results of actions taken or planned are addressed. If a specific service area cannot correct the unacceptable performance by itself, a team may be suggested.
- **Anticipated changes to indicator:** Indicators may be modified if necessary, or discontinue if improvement has been sustained.

An annual summary of the results of each KPI is completed at the end of the fiscal year, and compiled into an evaluation of the Quality Management program. This evaluation is reviewed by the Board of Trustees as well as the Senior Management Team.

Appendix A lists current KPIs.

V. OTHER QUALITY MANAGEMENT ACTIVITIES

1. Stakeholder Involvement:

- A. **Customer Satisfaction and Perception of Care:** Burke Center utilizes several different means to gather information regarding stakeholder's perception of care and services. Burke Center participates in surveys offered through the Mental Health Corporations of America, utilizing the Mental Health Corporations of America, Inc. (MHCA) to survey consumers, employees and referral sources. MHCA surveys are done approximately every 2 years. Client satisfaction with telehealth processes is assessed no less than annually. Through the Regional Planning and Network Advisory Committee (RPNAC), a regional assessment of community stakeholders was used to identify local perceptions and needs and to offer regional comparisons. Burke Center's Director of Community Relations surveys stakeholders (including consumers, advocates, law enforcement, hospitals and referral sources) annually. Findings of all of these surveys are reported to the Senior Management Team and are used to identify areas of exceptional service and opportunities for improvement.
- B. **Employee Satisfaction:** Biannually and as needed, Burke Center conducts an employee satisfaction survey. Results of the survey are discussed at Senior Management Team and with employees, and improvement activities are identified. Annual meetings by Human Resource staff with employees at their job sites also allow input.

2. Measuring, Assessing and Improving Services and Outcomes:

- A. **Feedback from state contract oversight:** Reports and data from the Department of State Health Services (DSHS), Department of Aging and Disability Services (DADS), Department of Assistive and Regulatory Services (DARS) and Southeast Texas Management Network (SETMN) are used to identify performance improvement activities and to assess unmet needs of individual served, service delivery problems and effectiveness of system interventions.
- B. **Texas Implementation of Medication Algorithms (TIMA):** Burke Center's Medical Director and Director of Quality Management monitor compliance with TIMA requirements biannually to assure the process is implemented appropriately and continually improved. TIMA studies include a peer review process, chart audits, and medical staff meetings, and assess for utilization of patient education materials, proper algorithm staging, and assessment and follow up to the potential for metabolic syndrome. Results of this study are used to identify opportunities for improvement in patient care. TIMA studies

are inclusive of studies of Metabolic Syndrome and the Patient and Family Education Program.

- B. Compliance Billing Audit:** Through the Compliance Committee, the billing audit includes a comprehensive audit of all notes written by new employees during their first 30 days of work, as well an audit of an ongoing sample of notes of all direct care staff. This process reviews all program areas on a monthly basis, assessing quality of services, treatment and care, timeliness and completeness of documentation and outcome of staff training. Results are shared with staff and managers, aggregated quarterly and reported to the Senior Management Team. Results of the audit are used to identify staff training needs as well opportunities to improve patient care and organizational efficiency.

Burke Center is in full compliance with the Federal Deficit Reduction Act (DRA) of 2005, as described in the Burke Center Code of Conduct and compliance plan, as well as the procedure supporting these processes.

- C. Safety, Risk Management and Infection Control Committee:** Along with other duties, this committee review all incident reports and results of hazard surveillance. Data is aggregated, and summarized and evaluated quarterly, with an annual evaluation of the program completed at the end of the fiscal year. Results are reported to the Senior Management Team, and are used to assess the safety of services and the environment, staff training needs and other opportunities for improvement. Vehicles and Facilities are inspected quarterly by the safety officer. Other safety inspections include Annual Fire Marshal inspection, Annual Fire Alarm Inspection, Annual Kitchen Inspection by local health authority (Angelina Counties Health District), Annual Fire Extinguisher Inspection by a certified business and monthly by maintenance foreman, and monthly fire drills. All reports are submitted to Burke Center's safety officer. Deficiencies are noted and corrected. Additionally, an annually proactive risk reduction project is completed to increase the safety and quality of services provided. This project is determined through internal data collection and identified needs of improvement. The Risk Management process also includes the manner in which deaths of person serviced are recorded, reported and analyzed, in accordance with state and contract requirements.
- D. Accreditation by The Joint Commission:** Burke Center maintains accreditation by the Joint Commission, requiring adherence to nationally recognized standards related to the provision of care. Through ongoing self-assessment of compliance with standards, this accreditation assures a constant process of improvement of services.
- E. Co-occurring Psychiatric and Substance Use Disorders (COPSD) Oversight:** Audits of medical records of clients identified as requiring

participation in the COPSD process are completed biannually. Charts are assessed for adequacy of assessment, treatment planning, education and documentation. Results are shared with staff and managers, aggregated and reported to the Compliance Committee. Results of these audits are used to identify staff training needs as well opportunities to improve patient care.

- F. Crisis Response:** Oversight of the response system includes data collection on timeliness of response and appropriateness of care. Data is aggregated and reported to the Utilization Management Committee.
- G. Substance Abuse Services Self-evaluation:** All Substance Abuse programs submit a biannual and annual self-evaluation plan to SETMN. The prevention programs completes an evaluation specific to the education material they are using. Key Performance Measures are produced quarterly and submitted and analyzed by SETMN biannually and annually.
- H. 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 and compliance with this KPI is monitored and reported quarterly to SMT.

3. Measuring, Assessing and Improving Data Integrity:

- A. CA MH Claims Oversight:** Ongoing validation audits of Medicaid claims are done to assure data quality and accuracy. Audits of factors such as use of invalid service codes, invalid claims, unauthorized services, and translator bypass are done routinely, and results are used to refine Burke Center's 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. The Burke Center Director of Quality Management attests to the accuracy of the validation.
- B. Cost Accounting Methodology (CAM):** CAM data is developed biannually. The process involves assessing accuracy of data collection and reporting as well as to compare Burke Center's costs with that of other centers.
- C. Mental retardation and Behavioral health Outpatient Warehouse (MBOW):** The reports generated in the state database are constantly reviewed by management staff to assess Burke Center's performance on a variety of indicators, and used as a means to judge accuracy of data collection as well as to evaluate Burke Center's performance on outcome measures. This information is also used in preparation for a fee for service environment.

- D. Data Verification Review:** This process, done in accordance with DSHS and DADS requirements, provides a valid and reliable procedure to evaluate and promote a continuous improvement of our data and reporting of our data.

4. Measuring, Assessing and Improving Service Capacity and Access to Service:

- A. Utilization Management (UM):** Burke Center participates in both a local and regional UM Committee for mental health services, both of which meet no less than quarterly. Established as a regional committee within the East Texas Behavioral Health Network (ETBHN), the primary function of the UM Committee is to monitor utilization of Burke Center's clinical resources to assist the promotion, maintenance and availability of high quality care in conjunction with effective and efficient utilization of resources. The objectives of UM Committee include processes to:
- Assure the overall integrity of the utilization management process to include timely and appropriate assignment of DSHS Mental Health levels of care based on the DSHS UM Guidelines;
 - Approve and oversee the appeal system for adverse determination decisions;
 - Analyze utilization patterns and trends throughout the ETBHN region, to include gaps in services, rates of no shows for appointments/services, billing issues, underdeveloped frequently requested services, existing services that are under- and over-utilized, and barriers to access; and
 - Establish mechanisms to report quantitative and qualitative information on service utilization and service delivery to ETBHN Regional Oversight Committee members, Burke Center's management and staff, the Board, providers and other interested persons in a timely manner.
 - Analyze data on hospital utilization, including factors such as rates of admissions by county, diagnosis, and length of stay.
- B. Request for Services:** Additionally, Burke Center monitors access to services by monitoring appeals of termination, reduction and denial of services, including Medicaid Fair Hearings. All appeals are reported quarterly to the Compliance Committee and subsequently to the Senior Management Team.
- C. Intellectual and Developmental Disabilities Key Performance Indicators:** Tracking is completed on a monthly basis to assess the referral and admission process to ensure that individuals are enrolled into services in a timely manner. This data assist managers in assessing intake and referral procedures and the accessibility of Intellectual and Developmental Disabilities Services provided by Burke Center. Additionally productivity of individual staff is monitored to maximize caseload capacity. Findings are reported to SMT quarterly.

5. Rights Protection Process

Please see Appendix B for Burke Center's Rights Protection Process.

6. Reduction in Abuse, Neglect and Exploitation

Please see Appendix C for Burke Center's plan to reduce the incidence of abuse, neglect and exploitation.

VI. AUTHORITY FUNCTION

1. Regional Planning and Network Advisory Committee (RPNAC)

The RPNAC contributes to the development and content of the Network Plan, including the process of Local Planning and Network Development, which assures appropriate procurement of goods and services and reviews and makes recommendations that consider public input, best value and client care issues to ensure consumer choice and best use of public money in assembling a network of providers. The RPNAC also evaluates programs and services offered by the Burke Center, and compares services to that of other network centers. Outcomes of these activities form the basis for improvement activities. The RPNAC meets quarterly and through its Burke Center liaison reports to leadership.

2. Contract and Network Management

The Contract Management Committee coordinates procurement of services in compliance with 25 TAC Chapter 412B. All contracted services are evaluated annually, and community services are evaluated bi-annually on variables such as staff competency, access to services, safety of environment, continuity of care, compliance with performance expectations, consumer satisfaction, and utilization of resources.

3. Criminal and Juvenile Justice Diversion

Services and processes described in the Diversion Action Plan are monitored through quarterly county and regional stakeholder meetings, which include attendance by law enforcement, hospital staff and local judges. Additionally, the service director of the TCOOMMI (Texas Correctional Office on Offenders with Medical or Mental Impairments) program monitors referrals and services provide to clients on probation and parole.

4. Quality Management oversight of Resiliency and Disease Management

Ongoing monitoring of RDM processes is conducted to systematically monitor, analyze and improve performance of provider services and outcomes for individuals

and to review whether practices are consistent with approved evidence based practices, accuracy of assessment and treatment planning and include the following:

- A. Self Assessment:** Self-assessment tools from the RDM fidelity toolkit are used to identify degree of compliance with RDM processes and documentation.
- B. Outcome Measures:** Burke Center's performance on state contract RDM outcome measures are monitored monthly and reported quarterly, assessed against both state averages and targets.
- C. Fidelity Measures:** Burke Center's performance on state contract RDM fidelity measures are monitored and reported quarterly. Technical assistance to providers is provided as necessary to improve fidelity and accountability.
- D. UM Processes:** Deviations and appeals are monitored to assess for consistency, appropriateness and clinical necessity. Additionally, the UM program is evaluated annually by the UM committee.