QUALITY MANAGEMENT PLAN

FY 2010 / 2011

1. Introduction

The Alamo Local Authority (ALA) is committed to continuous quality monitoring and improvement in the overall performance of the organization through an ongoing, comprehensive performance measurement program. This effort requires ongoing communication with consumers, employees, stakeholders, board directors, Planning and Network Advisory Committee (PNAC), clinical providers and all levels of management. Furthermore, ALA supports an effective Quality Management Program consistent with ALA'S mission, values and goals. The Quality Management Plan (QM Plan) is developed and implemented as approved by ALA's Management Team (MT). Decisions concerning program-wide operations are made by the MT, the ALA Director and the Executive Director of the Alamo Area Council of Governments (AACOG). Information sharing occurs at bi-weekly Management Team (MT) meetings and monthly at Full Staff (FS) meetings. The Plan strives for quality data collection which will assist ALA's administration and its providers in making judgments relating to policy issues, delivery of care, work load measures, funding and growth; supporting information for insurance and benefits claims; aiding in defending consumers and providers in legal affairs; promoting cultural competence and educating providers. The implementation and oversight of the Quality Management Plan is delegated to ALA's Quality Improvement Services Department (QIS). The PNAC receives quarterly status reports on overall achievement of ALA goals and objectives as well as specific reports that are requested concerning QM and oversight audit findings.

1.1 Purpose

The purpose of the Quality Management Plan (QMP) is to identify the ALA's quality related objectives, to describe how achievement of these objectives are measured, and to describe the quality related process that is used to assure that the objectives are met.

1.2 Scope

The scope of the objectives, measures and processes described in this plan apply to the entire fiscal year. Results are given on a quarterly basis. Data, trend, and cost analysis are the basis of ALA's efforts to profile performance at the individual, unit, program and provider network levels. Data and trend analysis focuses on root problem identification, correction and follow-up to problem resolution. The QM effort is a continuous process, which will improve and inform the delivery system of outcome results. It demonstrates a commitment to provide quality services for all individuals served within ALA's provider network.

1.3 Background

The Quality Management Plan (QMP) is developed and implemented as approved by ALA's Management Team (MT). The QMP must have all objectives in place necessary for ALA to stay in Performance Contract compliance and ensure quality outcomes to the people served.

1.4 References

ALA's QMP follows all applicable rules including but not limited to the Texas Administrative Code, Health and Safety Code and DADS Performance Contract.

1.5 Quality Checkpoints

This section describes in detail the quality assurance (QA) processes used and when they are used. For each checkpoint, a detailed overview of who is involved, the criteria used for evaluation, and what the quarterly results yield is given.

➢ Internal Quality Management Plans

This plan requires the ALA and its provider network to develop Internal Quality Management Plans (IQMP's) specific to their functions. IQMP's are the foundation of the Quality Management Plan. Each department or service whether a provider of services or an authority or administrative support department develops its own IQMP that is coordinated and approved through the QIS Manager followed by the Management Team (MT).

ALA establishes benchmarks for excellence, internal and external accountability and ongoing quality improvement efforts by implementation of IQMP's at all administrative and provider sites, through the appropriate agency committees and administrative departments. This plan requires contracts with private local providers and internal units (Service Coordination, Eligibility and Enrollment, Continuity of Services, CLOIP, Texas Home Living, HCS Enrollments and In Home Family Support) to stipulate quantifiable performance measures for contract evaluation through completion of quarterly Provider Profiles.

For FY 2010 ALA has adopted the indicators from statewide initiatives for use as Quality Management Plan Indicators. One set of variables we will monitor and assess are derived from the Department of Aging and Disability Services Data Verification Review (DVR) Process and Quality Assurance Authority Review Protocol.

ALA will monitor services for all eligible consumers (MR and related conditions) as these applicable services are described in the FY 2010-11 Department of Aging and Disability Services (DADS) Performance Contract. These services include:

1. Screening
2. Eligibility Determination
3. Consumer Benefits

4. Service Coordination
    Basic Service Coordination

    Continuity of Care / Permanency Planning

    - Continuity of Care System for Offenders with Mental Impairments (46 B Criminal Cases)

    Service Authorization and Monitoring

    Texas Home Living

    Home and Community Services

    Community Living Options Information Process (CLOIP)

    Omnibus Budget Reconciliation Act (OBRA)

5. Support Services
    Community Support

    Respite

    Supported Employment-Employment Assistance

    Supported Employment-Individualized Competitive Employment

    Nursing

    Behavioral Support

    Applied Behavior Analysis Therapy

    Specialized Therapies

6. Day Training Services
    Vocational Training**

    Day Habilitation

7. Residential Services
    Residential-Family Living**

    Residential Living **

    Contracted Specialized Residences***

8. In-Home and Family Support (IHFS) services

** Currently only provided by ALA and its provider network to eligible OBRA clients

*** Crisis Respite / Safety Net Services only

All service providers and ALA staff (internal and external) will complete monthly peer reviews to ensure compliance with the Performance Contract, and billing requirements with QUALITY IMPROVEMENT SERVICES DEPARTMENT (QIS) validating these findings. QUALITY IMPROVEMENT SERVICES DEPARTMENT will provide the protocols used for these reviews. QIS Dept. makes quarterly reports to the Management Team (MT).

The second set of ALA quality indicators is derived from the protocols used by the Department of Aging and Disability Services (DADS) to assess risk in the operations and management of the ALA. The Department will provide individual MRA's with their own risk assessment reports. The QIS Department will collaborate with all Departments to monitor, analyze and report the findings for the following risk assessment indicators (organized by domain):

- **Financial**

- Current Ratio
- Unreserved fund balance to total expenditures
- Long term debt to total fund balance

- **Provider Network/ALA Internal Departments Performance**

- Time and financial Information, Medicaid and CAM – Mental Retardation
- Rights, Abuse & Neglect – Mental Retardation
- Health & Safety – Mental Retardation
- Admission, Tracking and Placement – Mental Retardation
- Admission (Personnel & Caseload) – Mental Retardation
- Continuity of Services – Mental Retardation
- Waiting List Management – Mental Retardation

- **External Environment**

The third set of indicators is from the **Internal Services Quality Initiative (ISQI)** which focuses on organizational systems. An organization achieves quality in its services through the cooperation of its employees and contracted service providers. Many departments or units must work together toward common goals. This plan recognizes that it is not just some of the organization's parts but the sum of its parts that are responsible for reaching its goals. Although those departments that provide a direct service (i.e. Service Coordination, Intake Workers, etc.) fulfill our essential mission of providing appropriate, quality care to our consumers, they depend on the assistance and cooperation of many administrative and support units and departments. Additionally, recognition must be given to the importance of cooperation among provider units and among administrative and support units. The ISQI may be revised with approval from the ALA Director and the Management Team as implementation efforts are evaluated.

The QIS department collects data through on-going monitoring. Each indicator is summarized and reported by QIS Management staff during regular program reviews. These findings are presented to the provider/unit reviewed. Providers/Units prepare plans of correction and QIS staff returns for follow-up reviews. In addition, contracted and internal (service coordination) service providers, QIS staff, program directors and department directors are responsible for recording their actual figures for each peer review and monthly performance profile and comparing those figures to the established threshold. For each indicator whose actual measure does not meet the threshold or benchmark requirement, they will develop a plan of correction to meet the established criteria.

2. Staffing

2.1 Roles and Responsibilities

This section identifies the general responsibilities of the QIS team, the program management, ALA staff and those of the private providers and their staff.

All ALA employees and AACOG central administration are responsible for implementing the ALA's **Quality Management Plan**. All staff levels must commit to providing quality services.

The DEPUTY DIRECTOR, ALA DIRECTOR, MRA MANAGEMENT TEAM (MT) and QIS TEAM form the structure through which the entire organization participates in continuous quality improvement and the effort to meet quality goals. The quality management effort becomes part of normal business activity and is incorporated into ALA's routine activities. QIS works directly with providers and units, presenting reports and operational concerns to ALA DIRECTOR and MT for final action. The Client Rights Officer, as an advocate for consumers, will be part of the MT and attend meetings as requested/scheduled.

Critical or unusual incidents involving consumers may be reviewed by an ad hoc Committee for Category I incidents such as physical restraint and seclusion, breaches of confidentiality, quality of client care related to diagnosis and treatment, elopements, exposure to hazardous substances/infectious diseases, medication errors, serious injuries to clients or staff, serious property damage involving client or staff, and Category II incidents such as incidents of sexual contact between clients and staff, and major safety violations. Category II incidents (deaths) are reviewed by the QIS staff. All proceedings and records of the above shall be privileged.

The following describes quality indicators for inter-organizational service/staff:

a. Data Management:

- ALA's Data Management system and staff will be available for use during normal working hours (8:00 AM to 5:00 PM, Monday – Friday).

b. Information Systems:

- The Help Desk staff will acknowledge receipts of service requests and provide an estimation of when the problem will be resolved.
- The Help Desk staff will resolve most services requests within three working days of submission.

c. Fiscal Services:

- Approval will be obtained before any purchase is charged to a unit's accounts.
- Monthly revenue and expense reports will be submitted to the ALA Director within ten working days of end of month.
- Financial reports will be accurate. Unit financials will contain no more than one error per month.
- Fiscal services staff will correct errors and respond within ten working days of receipt of error tracking form.

d. Payroll:

- The names of employees no longer employed by the unit are removed from the payroll schedule within five working days of request. The unit receives corrected payroll schedule in time for the next unit payroll calculation.

e. Human Resources:

- Personnel revisions are processed within three working days and a copy of the completed paperwork given to the MRA Director by the end of the third day.

f. Purchasing:

- Purchase orders will be filled within two weeks. If a vendor is unable to meet this requirement, purchasing will locate another vendor who is able to deliver the order within two weeks.

g. Staff Development:

- Training changes are communicated to the affected units within five days of the change.
- Training schedules will be published at least monthly to ensure that staff can schedule required training
- Staff is informed of their training needs status by the training department.
- In order to assure compliance QIS staff will work collaboratively with the AACOG training department.
- QIS will use and create a tickler file to ensure compliance.

h. Maintenance:

- Work Orders will be addressed within three working days, including notifying requesting party of the status of the work order.

i. Credentialing:

- Staff licensing status is kept current and available to managers every month.

j. Medical/Clinical Records:

- The forms committee will review proposed new forms, and a response regarding their acceptance is provided to the submitting party within one month.
- Approved forms are presented at the program management meetings.
- Medical/Clinical Records Manager will establish and enforce appropriate policies and procedures for the handling of consumer records.

k. Quality Improvement Support Services:

- Audit procedure changes are communicated to affected providers/units within five working days of approval.
- Under normal circumstances, units will receive three days notice of audit or review.
- All external invoices will be reconciled prior to payment.

l. Consumer Relations:

- ALA Director, QIS Manager and Client Rights Officer will meet with AACOG's Public Relations Manager and program management at least quarterly to provide information regarding on-going activities.

m. Resource Development:

- ALA Director and MT will conduct and periodically update a gaps/needs assessment across all direct service programs and discuss Resource Development.
- ALA will ensure that resource efforts directed at funding opportunities are distributed equally among all programs as applicable.
- ALA will actively involve the PNAC for community gap analysis.
- ALA will continue to actively recruit new providers and expand the network of choice.

n. Legal Services:

- Legal Services will provide timely information, advice and work product regarding proposed contractual or other proposed actions by ALA, having a legal element.

o. Contract Administration:

- QIS will track and follow the suspense of all reports due to funding agencies, and will report their status to the MRA Director for action as required.
- QIS will develop all Contracts and Amendments, RFPs and RFAs.
- QIS will provide an annual Provider Manual as well as intermittent updates.

p. Clinical Services

- Providers/Units will conduct peer reviews to assess the quality of services provided on a monthly basis
- Units will participate in quarterly DADS Data Verification audits.

q. Client Rights

- The Client Rights Officer (CRO) will investigate reports of alleged abuse, neglect and exploitation upon receipt of same. CRO also functions as liaison between ALA and the Department of Family Protective Services.

2.2 Required Skills

All QIS staff is required to, at a minimum, have a Bachelors degree from an accredited University in a behavioral science, or related field, in order to be eligible to work in the QA department. Each staff must be knowledgeable and able to interpret rules, regulations and the DADS Performance Contract.

3. Audit & Reviews

3.1 Methodologies and Standards

- As a standard, Internal Quality Management Plans (IQMP's) are the foundation for ALA's Quality Improvement efforts. Each IQMP is tailored to the services, processes, requirements, needs and goals of a specific unit, program, division or department.
- Internal Quality Management Plans (IQMP's) are submitted to QUALITY IMPROVEMENT SERVICES DEPARTMENT for review, and then submitted to the Management Team for approval. New Contract Providers must make their IQMP available for review by QIS within 90 days from contract start, and annually (whether revised or not) by September 30 thereafter. The QIS Manager and staff

review all internal annual plans for approval in November of each year. Results are reported to the ALA Director.

- Provider, Unit or Program, Division or Department Quality Management Reports are standard format performance reports of quality indicators with an attached Plan of Correction if any of the indicators do not meet the required threshold or benchmark. Reports are submitted to QIS monthly via an email attachment. QIS staff prepares summary reports that are presented by QIS manager for review by the ALA Director and the MT.
- The MT meets monthly to review assigned indicators based on their areas of concern. Monitoring and evaluation processes allow collection of data and monitoring of important aspects of care or service. The monitoring process consists of the reporting of these assigned quality indicators and consideration of implications of the reports and taking action to correct/identify causes and/or investigate solutions regarding report results.
- The ALA Director and the Management Team consider the implications of the reports and direct action as deemed necessary. Findings are also reported to the Board of Directors, The Executive Director of AACOG and the MR PNAC.
- The focus of our quality efforts is to achieve outcome excellence through analysis of processes and variables that effect desired quality goals. ALA Director, QIS and MT will define quality goals based on analysis of their customers/stakeholders' expectations. Then, using the JCAHO ten steps CQI Process, prioritize important aspects of quality service of care and initiate improvement efforts. Through ongoing measurement, either by the clinical monitoring and evaluation process or other collection method, Service Providers and ALA Managers will monitor their progress toward meeting Service quality goals.

Clinical and administrative audits/reviews:

- For the clinical audits/reviews, the sample will be developed by randomly selecting at least one (1) chart per service code at the identified provider's/unit for a pre-determined time period.

- Although the sample is drawn from a specific time period, the complete chart will be subject to audit/review to ensure all supporting documents (i.e., Diagnosis, PDP, IPC, service reviews) are in place, are current and meet funding source requirements, TAC, and other requirements for each service in the audit sample. Additionally, other issues discovered in the process of auditing the identified services may expand the scope of the audit.

- All programs are expected to attain a score of 90% or higher on billable services. This score measures compliance with funding sources and is determined by the audit of progress notes and supporting documents for the selected service. Non-billable services are also expected to reach a target of 90% compliance.

- On the final day of the audit/review, the audit/review team and the provider will meet for a preliminary review of results. This preliminary report will consist of an overview of the current findings, detailing the process that will be taken once the final results are established.

- Within ten (10) working days of the completion of the audit, the written report of audit findings will be forwarded and distributed to the provider. An Audit/Review Exit meeting may be held between QIS and the provider. QIS will review the audit findings and questions can be addressed at this time.

- All programs/units that score under 90% will be required to complete a Corrective Action Plan (CAP). This plan will specifically outline how the provider will correct deficiencies and is due to the QUALITY IMPROVEMENT SERVICES DEPARTMENT within ten (10) working days from the date of the Audit Exit meeting and/or written notification of audit/review findings by the Contract department staff.

- Individual providers' scores/deficiencies are reported to the QIS Manager. If an individual provider's service verification is not accepted, the program's CAP must specify retraining of the provider. Additionally, that provider's services may be suspended from billing until such time as the Provider/Manager has attested that the staff has been retrained and demonstrated the ability to adequately document services.

- Administrative audits/reviews will identify items that are not in compliance with acceptable standards. 100% compliance is expected.

- Technical Assistance from the QUALITY IMPROVEMENT SERVICES DEPARTMENT may be requested to assist with the formulation of the CAP.

- A quality score of less than 90% on clinical audits/reviews and less than 100% on administrative audits/reviews will require a response from the provider. The QIS staff will work with the provider to identify and correct sources of quality problems. Remedial training or technical assistance may be required, depending on the nature of the concern.

3.2 Quality Assessments and Reviews

This section describes the review procedures, criterion and processes, as well as tools used to verify quality. It includes details on assessments and reviews; when they are conducted; who will conduct them; success criteria; QMP reporting formats and monitoring processes.

Monitoring involves the collection of data for the purpose of evaluation. In this plan the data are the performance measures designated by the quality indicators. Actual performance measures are compared to quality indicator benchmark or threshold levels.

Monitoring methods include:

- Unit and Department Reports
- Network Oversight
- Employee Job Performance Evaluations
- Clinical Service Reviews and Audits
- On-Site Programmatic Reviews
- On-Site Administrative Reviews
- Business Objects Reports on Performance Indicators
- CARE Reports
- Q-Continuum Reports
- DADS Data Verification Reports

ALA furthermore follows the JCAHO Ten Step Continued Quality Improvement (CQI) process which is applicable to both Administrative Services including Service Coordination processes. The QIS staff is available to assist the Contracted Service Providers (Provider Network) in implementing the CQI processes in their programs and will support Service Providers with developing methods of determining and prioritizing critical administrative and direct service aspects affecting their components as needed. In addition, the QIS staff will facilitate training for process evaluation teams as they start to work through the improvement process.

The Ten Step Process

1.	Assign responsibility for monitoring and evaluation activities.
2.	Delineate scope of service or care provided in the department.
3.	Identify the most important aspects of care or service.
4.	Identify indicators for monitoring the most important aspects of care/service.
5.	Establish thresholds (control limits) for the indicators.
6.	Collect and organize data.
7.	Evaluate results of data.
8.	Take action to improve care.
9.	Assess effectiveness of the actions taken.
10.	Communicate the results.

3.3 Development and Implementation of Internal Quality Management Plans (IQMP) – The Quality Evaluation Process

a. All local area network services (Local Authority, AACOG's Central Administration contracted private providers) are required to develop, implement and actively monitor an Internal Quality Management Plan (IQMP) specific to their functions. IQMP are designed to provide a means of evaluating service delivery or in the words of the JCAHO "Doing the right thing and doing it the right way."

b. The development, implementation and monitoring of Internal Quality Management Plans for Network Providers and their corresponding quality indicators are the responsibility of the Contract Provider, or designee. Plans will be revised annually, or as needed, to reflect the needs of the customers as well as the service.

c. All revised plans by providers are to be completed and available to the QIS department for review. Proposed Internal IQMP are to be submitted to the QIS staff by September 30 of each year and need subsequent approval by the MT prior to implementation.

QMP includes the following:

- A plan to administer and evaluate consumer/customer satisfaction including the survey instrument(s).

- Key Quality of Care and/or Service indicators (based on consumer/customer expectations, key aspects of clinical care, DADS or Medicaid Standards, etc.) It is understood that each department or service has customers. Clinical programs have consumers who receive clinical treatment and administrative services or departments have customers who need and use their services. While the clinical services consumers have been recognized as ALA's traditional customers, the latter must also be recognized as customers. Without the services of the administrative departments the clinical services units could not perform their functions.

- A plan to complete Internal Service Reviews using applicable licensing, regulatory, contract and/or other standards.

Quality Management Indicators (QMI's) for Monitoring and Evaluation

- All IQMP will include a documented and monitored QMI section addressing the following plan requirements:

REQUIREMENT	EXPLANATION
Quality Indicators	Measurable objectives identifying acceptable performance
Monitoring Rationale	Reason the indicator was chosen
Monitoring Methodology	The process of evaluating the units performance levels
Monitoring Frequency	How often performance will be measured
Person(s) Responsible	The person(s) responsible for implementing the evaluation
Optimal/Minimal Range	Acceptable performance level range

To ensure compliance with DADS, Medicaid, and other required standards, the IQMP must effectively measure performance against the Quality Indicators.

- Performance Profiling reviews critical performance variables monthly and/or quarterly on individual, Unit, and ALA levels. Results provide an overview of ALA performance.

- Although ALA QMI must be monitored (as they pertain to a given department, program, unit or service), IQMP may incorporate additional indicators for monitoring and evaluation relevant to their services.

All providers of consumer services will have their own IQMP, available to the ALA QUALITY IMPROVEMENT SERVICES DEPARTMENT upon request. The Plan will include outcome measures, based on department and other contract requirements. Provider IQMP's will be reviewed by QIS staff. The IQMP will include specific quality indicators, which measure, at a minimum, contract targets, over- and under- utilization of services, consumer access, quality of service delivery and consumer satisfaction.

All Program services provided by or through ALA are required to develop and submit/have an IQMP.

3.4 Oversight Audits/Reviews and Provider Network Reviews (Clinical & Administrative); Initial; Follow-up & Final audits/reviews

This section describes the Provider Network review process and procedures.

Purpose:

To ensure consumers receive services that are appropriate and documented in compliance with all ALA, DADS and other applicable regulatory requirements.

Procedures:

- All programs will be audited/reviewed by Contracts/QM within 45 days of their opening and as scheduling permits. Audit/review protocols are developed from standards set forth by regulatory agencies using the strictest standards as the audit benchmarks.

- Notification of audit/review is made prior to the appearance of the QIS audit/review team. All providers will receive written notice of the audit/review, the sample list of client case numbers (if applicable), the time period from which the sample was selected (if applicable), copies of the audit/review protocols, and the date and time the audit/review will begin.

- The QIS audit/review team will meet with the provider at the beginning of the audit/review to explain the procedure and answer questions regarding the audit/review procedures and the parameters of the audit/review. It is requested Providers have knowledgeable staff present during the audit/review to resolve any questions during the documentation review.

- For audits/reviews that could result in revenue payback, two categories will be identified; one for billable services (based on funding source requirements) and one for quality of the documentation and provider practices (based on quality standards of the mental retardation professions, best practice guidelines, etc.). ALA shall recoup from the provider funds paid for all services determined to be inappropriate for billing.

- The quality component reflects ALA's efforts to monitor and improve the quality of services. This may result in required remedial training in the areas identified.

- Written reports are organized to separate "billable" services from quality components.

Follow-up audits & reviews

Clinical and administrative audits/reviews:

QUALITY IMPROVEMENT SERVICES DEPARTMENT will review the Corrective Action Plan (CAP) and notify the Provider by letter regarding acceptance within ten (10) working days of receipt.

- A follow-up Audit is conducted within thirty (30) days from the date that the QIS department accepts the CAP. If the Provider fails to submit a CAP, the follow-up audit may be conducted at any time after the deadline for the CAP has passed.

- Individual providers' scores/deficiencies are reported. If an individual provider's service verification is not accepted, the provider's CAP must specify retraining of the staff. Additionally, that provider's services may be suspended from billing until such time as the Contract Provider's Director/ Manager has attested that the staff has been retrained and has demonstrated the ability to adequately document services.

- Administrative audits/reviews will identify items not in compliance with acceptable standards. 100% compliance is expected.

- Technical Assistance from the QIS Department to assist with the formulation of the CAP can be requested.

- A quality score of less than 90% on clinical audits/reviews and less than 100% on administrative audits/reviews will require a response from the provider. The QUALITY IMPROVEMENT SERVICES DEPARTMENT will work with the program to help identify and correct sources of quality problems. Remedial training or technical assistance may be required, depending on the nature of the concern.

- All programs scoring below 90% on clinical audits/reviews can be placed on vendor hold. The effective date of vendor hold will be the date of the Follow-up Audit/Review Exit meeting.

- A provider will not be able to bill for services lacking appropriate authority documentation.

- Individual provider's staff scores are reported also. If one of the provider's individual staff scores below 90% on billable services, the provider's billing may be suspended, regardless of whether the company/provider as a whole passed the audit/review, until retraining is documented and accepted by the QIS Department.

- All requests for technical assistance from QIS staff must be requested in writing.

Final Audits/Reviews

Clinical and administrative audits/reviews:

The Provider's CAP outlines how the provider plans to correct deficiencies and is due to the QIS DEPARTMENT within ten (10) working days from the date of the Follow-up Audit Exit meeting.

QIS DEPARTMENT will review the CAP and notify the Provider by letter once the plan is accepted

- A Final Audit/review is conducted 30 days from the date that the QIS DEPARTMENT accepts the CAP.

- For the clinical audits/reviews, the sample will be developed by randomly selecting from the Q Continium Data System (Q) at least one (1) chart per service code, depending on sample size.

- Although the sample is drawn from a specific time period, the complete chart will be subject to audit/review to ensure that all supporting documents (i.e., Diagnosis, PDP, service reviews) are in place, are current and meet funding source, TAC, and other requirements for each service in the audit sample. Additionally, other issues discovered in the process of auditing the identified services may expand the scope of the audit.

- All programs are expected to attain a score of 90% or higher on billable services. This score measures compliance with funding sources and is determined by the audit of progress notes and supporting documents for the selected service.

- On the final day of the audit/review, the audit/review team and the provider will meet for a preliminary review of results. This preliminary report will consist of an overview of the current findings, detailing the process that will be taken once the final results are established.

- Within ten (10) working days of the completion of the audit, the written report of audit findings is forwarded to the QIS Manager who will authorize distribution of the report to the provider.

- All programs scoring below 90% are required to complete a CAP. This plan will specifically outline how the provider will correct deficiencies. The report is due to the QIS DEPARTMENT within ten (10) working days from the date of the written notification of audit/review findings.

- Individual provider staff scores/deficiencies are reported. If a provider's individual staff member's verification is not accepted, the Provider's CAP must specify retraining of the individual staff member. Additionally, that staff member's services may be suspended from billing until the Provider Director/Manager has attested that the provider has been retrained and has demonstrated the ability to adequately document services.

- Administrative audits/reviews will identify items not in compliance with acceptable standards. 100% compliance is expected.

- Technical Assistance from the QIS DEPARTMENT with the formulation of the CAP must be requested in writing.

- A quality score of less than 90% on clinical audits/reviews and less than 100% on administrative audits/reviews requires a response from the provider. The QIS DEPARTMENT staff will assist the program with identifying sources of quality problems. Remedial training or technical assistance may be required, depending on the nature of the concern.

- Once 90% compliance for billable services is achieved, the vendor hold will be removed (if applicable).

- If the provider is unable to obtain 90%, compliance for billable services the audit results are sent to the MRA Director for review and action as appropriate.

Random/Focus Audits/Reviews

Random, focused audits may occur at any time without notice. These audits will be triggered if other administrative audits, billing concerns, or documentation concerns identify a need for the collection of additional data of a particular nature or required by a funding source.

- Audit protocols specific to the request are developed by the QIS DEPARTMENT. These audits/reviews are accomplished by QIS staff who can be available for consultation and data analysis.

- The Administrative Audits conducted by the QIS DEPARTMENT look for deficiencies concerning informing consumers of their rights, i.e. information concerning rights and crisis access is prominently displayed in areas frequented by consumers. In addition, random, focused audits concerning the documentation of the distribution of rights information to individual consumers are conducted.

Administrative audit results can trigger random/focused audits to ensure that corrective action has been sustained.

Provider Peer Review

- QUALITY IMPROVEMENT SERVICES DEPARTMENT distributes a random sample to each external provider as well as all internal units (obtained from Data Management) of reported services that are to be reviewed each month. One service per Service Coordinator is identified for review. For external providers the sample size each month is not greater than 10% of the total number of consumers served.
- Results of these reviews are reported to QIS DEPARTMENT and subsequently to the ALA Director. QIS staff conducts desk reviews on a monthly basis, to verify the findings of unit peer reviews. Each unit is asked to submit documentation for review on a rotating basis. QIS DEPARTMENT-QM reports on the results of the desk reviews to Program/Unit administration monthly, and MT quarterly. A CAP from the provider/unit is required if QIS DEPARTMENT fails to validate their finding.
- Program/Unit administration may request technical assistance from the QIS DEPARTMENT as the need arises.

SURVEYS

- QIS DEPARTMENT coordinates the survey process as determined by DADS and reports results to MRA Director and management.
- Employee Satisfaction surveys for [internal] MRA staff is conducted bi-annually.
- QIS DEPARTMENT is available to provide technical assistance to all internal and external providers/units on the development of survey instruments, and plans for implementation as the need arises.

Contract Obligations

QUALITY IMPROVEMENT SERVICES DEPARTMENT conducts and/or participates in all required audits/reviews as required and/or conducted by funding agencies. Among these are:

- DADS Data Verification audits
- TX Home Living audits/reviews
- IHFS audits
- State Auditor's Office
- QA Authority Reviews

Utilization Review

Formal reviews of consumer utilization and appropriateness of services on a prospective, concurrent and retrospective basis is performed by Utilization Management Committee and QIS staff.

Special Note:

Audits, Reviews and Surveys, and Studies are formal activities that result in a written report and may have consequences for the provider/unit or service being audited or reviewed.

In contrast, Technical Assistance is an informal process when initiated by the provider or unit. It is an effort on the part of the provider or unit to monitor and improve the quality of services or procedures. This QM service is not intended to put the provider at risk for negative consequences. The exception is when fraud or other illegality is found or suspected. In that case, technical assistance will trigger a full audit.

4. Quality Assurance Milestones

This section identifies the QMP deliverables and the timelines associated with the deliverables. Information like frequency of due dates for each measured item is included.

During the first quarter of each fiscal year, all service providers will review ALA standards and regulations and develop methodologies to ensure that they (local area network contract service providers) satisfy those standards and service contract requirements.

Administrative Reviews:

QIS staff conducts audits/reviews and re-audits/reviews until all identified deficiencies have been corrected. Corrections not made after two re-audit/reviews are forwarded to the MRA Director for appropriate action.

5. Resource Estimates

This section shows an estimate of resources required to perform QMP activities, such as number of staff, hours of effort, direct expenses, etc.

At this time the QM department is staffed with 1 Contract and Quality Coordinator who also functions in the role of Client Rights Officer, UM Coordinator and Credentialing Staff plus 2 Contract/Quality Monitors. The staffing pattern will be increased by 1 Quality Improvement Services Manager, 1 full time Client Rights Officer and 1 additional Contract/Quality Monitor by 1 June 2010.

It is estimated that all monitors utilize 70 % of their staff time on internal & external reviews and the remaining 30% with development of continuing improvement plans.

6. Provider Network Controls

This section gives an overview of the ALA QM controls and processes in place for efficiently monitoring providers work products against their contract requirements.

ALA's QIS department utilizes the following QM controls to efficiently monitor quality and quantity of provider work product:

1. Monthly peer reviews
2. Annual on-site clinical and administrative review
3. Focus reviews to check:
   i. Data Verification Compliance
   ii. Billing accuracy
   iii. Utilization review
4. Bi-annual Provider Profiles

7. Corrective Actions

7.1 Processes

This section provides a description of the planned tracking and resolution procedures for identified issues or problems detected during QMP reviews.

External:

- QIS staff will receive a Plan of Correction from Provider within 30 days of audit report.
- QIS Manager notifies the Provider by letter regarding acceptance or denial of their proposed CAP within ten (10) working days of receipt.
- A follow-up Audit is conducted within thirty (30) days from the date that the QIS DEPARTMENT accepts the CAP. If the Provider fails to submit a CAP, the follow-up audit may be conducted at any time after the deadline for the CAP has passed.

Internal:

- QIS staff will receive a CAP from internal Program Manager within 30 days of audit report.
- QIS Manager notifies the Program Manager by letter regarding acceptance or denial of their proposed CAP within ten (10) working days of receipt.
- A follow-up Audit is conducted within thirty (30) days from the date that the QIS DEPARTMENT accepts the CAP. If the Program Manager fails to submit a CAP, the follow-up audit may be conducted at any time after the deadline for the Plan of Correction has passed.

7.2 Products

This section identifies the tools used in the planned tracking and resolution of identified problems.

Incident Reports	Quality Assurance Check List
Q Reports	Excel Reports
Surveys	Provider Profiles
Peer Reviews	DVR audit reports

(See Attachments for samples)

7.3 Quality Assurance Checklists

Quality Assurance Management Plan Checklist

YES	NO	Check List Description
		Are QA tracking activities evident?
		Are QA reviews being conducted?
		Are all reviews conducted within prescribed timeframes?
		Are all issues arising from peer reviews addressed and closed?
		Are QA status review meetings conducted and attended as scheduled?
		Are changes made in accordance with QA findings?
		Are all QA project roles assigned and responsibilities defined?

Configuration Management Plan Checklist (CMP)

YES	NO	Check List Description
		Does a CMP exist?
		Is the CMP being followed?
		Does the CMP identify the person or group who has the authority to approve changes to the CMP?
		Does the CMP outline remediation's for identified problems?

Attachments

A. Plan to Reduce the Number of Cases of Abuse and Neglect
B. DADS Quality Assurance Authority Review – Report of Findings 2010
C. Consumer Quality of Life Survey
D. General Revenue Site Assessment Survey Tool
E. Peer review forms
F. Provider Profile – General Revenue
G. Staff Survey
H. Consumer Satisfaction Surveys
I. Quarterly QIS Department Summary's available upon request
Please contact – QIS Manager at (210) 832-5020

ALAMO LOCAL AUTHORITY

PLAN TO REDUCE THE NUMBER OF CASES

ABUSE AND NEGLECT

INTRODUCTION:

ALAMO LOCAL AUTHORITY (ALA) strives to deliver quality services to consumers with mental retardation and related conditions throughout Bexar County. Basic to this service delivery is the guarantee that individuals served are not abused, neglected, or exploited. To aid in this effort ALA has developed, published, and internalized policies and procedures, which prohibits abusive conduct by its employees, agents, or affiliates. In achieving a safe environment for consumers, ALA has implemented practices, which recognizes the importance of identifying, hiring, and training a qualified, consumer conscious staff. ALA has also implemented procedures in contracting with providers whereby these same tenants are put in place and has developed a detailed, system of checks and balance reviews to identify potential problem areas to preclude adverse situations for our clientele.

STAFFING:

ALA assures that the contracted private providers use a staffing model which ensures adequate staffing levels are maintained so that the consumer to server ratio are optimized and within standard, when such standards require specific client/server ratios. Through this process, the requisite skills, knowledge, and abilities of staff are evaluated in order to attain the appropriate mix of staff to provide a safe and secure environment. Theses traits are inculcated in the job description development process, which formalizes the abilities needed to perform specific job tasks, while setting in place a means of articulating performance expectations for consumer care and establishing accountability and responsibility.

Once ALA has a recognized staff need, we then begin the hiring process to satisfy this need. In doing so, we seek candidates who possess the skills, knowledge, and abilities needed to perform the job and begin the formal hiring process, which includes:

- The hiring process begins at the Unit Manager level, and will require on average five separate approvals before the employment offer is made. Candidates are screened to ensure they satisfy the stated requirements for the position for which they apply. When suitable candidates are identified, in person interviews are scheduled and initial hiring decisions are recommended. At this point the candidate will have their references checked and this is documented in the hiring packet.

- Candidates who are recommended for employment will have a criminal history check conducted. The Human Resources Department is responsible for requesting this check and will work through DADS and TDPS to acquire this information. When the information received shows the existence of a criminal conviction, the conviction is reviewed to determine if the information received would lead a reasonable and prudent person to believe it to be a contraindication of employment. Employees on the job are required to disclose convictions as a condition of employment and are subject to unannounced re-verification. Criminal violations subject the employee to a management review to determine if continued employment is appropriate

- ALA has developed procedures, which would verify the criminal histories of candidates. Currently, ALA utilizes background checks via the employee misconduct registry, and for those potential employee candidates who have resided outside the state of Texas over the past two years a process has been implemented with the Federal Bureau of Investigation. This process will eventually entail the fingerprinting of candidates and forwarding of prints to the FBI. Pre-clearance procedures have not yet been finalized concerning ALA's position on offering conditional employment pending final background checks. However, senior administration members are addressing what would be in the best interest of the consumers that we serve.

- The pre-employment screening of employee candidates includes Controlled Substance testing. The failure to pass this screening is a basis for employment offer withdrawal or is reviewed to determine if the employment offer is to be finalized following an acceptable explanation and re-test. ALA does not conduct random post employment sampling, however, it reserves the right to do so when specific situations warrant.

- ALA recognizes that many potential staff members working the field of mental retardation will migrate from one employer to another as they continue their career growth. When DADS determines that it is appropriate for MRA's to have access the Client Abuse and Neglect Reporting (CANRS) database, ALA will implement procedures, which will prescreen all potential employees. However, DADS has implemented the employee misconduct registry, and the ability to conduct this screen, is vital to the overall well being of the consumer because many confirmed cases of abuse are not criminal in nature and would not be reported out on the TDPS check.

- In order for consumers and non-MRA employees to recognize and feel confident of the identity of the staff providing services, ALA issues picture identification cards to all employees. This identification is worn by staff while on duty and is returned to the Human Resources Department during employment out-processing.

TRAINING:

ALA believes that the hiring of qualified, dependable, and competent, caring staff is not the end of the process for ensuring that our consumers are safe and are treated with respect. ALA believes that training and communication is an essential component for ensuring the safety, well-being, and respect that our consumers deserve and need. While many employees receive training, via their formal educational backgrounds, we require ALA specific training in compliance with the DADS Community Services Standards for MR. We require all employees, agents, and affiliates to comply with our training requirements or, to demonstrate competency in the subject matter. Our training program consists of a New Employee Orientation and Refresher Training, which is either annual, bi-annual, or is required every third year. We offer training classes every month to satisfy the recurring/refresher training requirements of ALA and conduct a New Employee Orientation at least once each month.

New Employee Orientation is required of all employees prior to their reporting to work within ALA. Exceptions are allowed, but only rarely granted and only by the Executive Director, to satisfy a critical MRA need. New employees attend approximately 64 hours of training of which 46 hours are critical in the 1) prevention, detection, and reporting of abuse, neglect, and exploitation 2) ensuring of consumer safety and 3) understanding of our consumers and their needs. This training is given in order to prevent situations of abuse or neglect and to ensure quality services to help staff and the public, to see consumers first as people and then as people with disabilities.

The majority of training, which DADS has designed, is utilized by ALA. The courses we feel support our belief are as follows:

- Client Abuse, Neglect, and Exploitation
- The Rights of Clients
- HIPAA-Confidentiality
- Our Population
- Cultural Sensitivity
- Customer Service
- SATORI/SAMA
- Psychotropic Medications and Medication Monitoring
- Infection Control and HIV/AIDS Awareness
- First Aid/CPR (adult and children)
- Introduction to Quality Assurance/Incident Reports
- Safety and Emergency Plan Procedures

- Clinical Records Training
- Sexual Harassment and Sensitivity

Refresher Training is scheduled on a recurring basis and satisfies ALA's obligations to be in conformance with the various community and licensure standards of DADS and other agencies for which we provide services. The purpose of refresher training is to keep staff and other participating providers current with changes and to reinforce the importance we place on keeping the consumers of our service in a safe; and quality assured environment. These classes include:

ANNUAL:

- Client Abuse, Neglect, and Exploitation
- The Rights of Clients
- HIPAA-Confidentiality
- SATORI/SAMA
- Psychotropic Medications and Monitoring

BI-ANNUAL:

- CPR (adult and children)
- Infection Control- HIV/AIDS Awareness

TRI-ANNUAL:

- First Aid

DETECTION AND INVESTIGATION:

All employees, agents, and affiliates are informed that all allegations of abuse, neglect, or exploitation must be reported to the Texas Department of Protective and Regulatory Services within one hour of the event and or Texas Department of Human Services for our ICF/MR facilities. Additionally, appropriate MRA staff is notified of incidents concerning our clients. All reports of investigation conducted by DPRS concerning clients of ALA are sent to ALA's Client Rights Officer (CRO) who reviews the report for material completeness for the Quality Improvement Services (QIS) Manager. After the DPRS investigator identifies areas of concern or recommendations for care, the CRO, communicates these items, with a requirement that appropriate actions be taken to preclude recurrence.

To insure that the reporting of allegations of abuse, neglect, or exploitation are made without fear of recrimination or reprisal to the reporter, ALA has procedures which maintain the confidentiality of the reporter when needed.

PREVENTION:

ALA takes a proactive approach to the prevention of abuse, neglect, and exploitation of our consumers. Because we work in a highly demanding environment we have made available to our employees specific management training, which helps staff in coping with the pressures of the job. Additionally, we have implemented supervisory training within ALA which refines the skills of our employees, and imparts to them the skills and knowledge needed to manage increasing numbers of staff members, with and the resultant case load increases which are involved.

ALA staff actively monitors the behaviors of our clientele and, when warranted, referrals are made to the appropriate Specialized Therapy for individual evaluations of consumers to determine the appropriateness of a Behavior Therapy/Modification Plan. Service Coordinators and private provider staff are responsible to monitor the level of change and or modification, based on consumer response and input accordingly.

Staff is required to interact with consumers in the least restrictive manner. Whenever a volatile situation arise, staff utilize there training in the **S**atori **A**lternatives to **M**anaging **A**ggression (**SAMA)** to resolve the conflict. On those occasions when a consumer must be restrained, the staff involved must complete an incident report. This report is reviewed by the CRO and QIS Manager, and by the Provider of the Behavioral Services when applicable.

CONTRACTED SERVICES:

ALA is not a provider of services. Our service array is expanded through contractual commitments. In meeting our commitment to quality service ALA takes a proactive approach to the prevention of abuse, neglect, and exploitation of our consumers. ALA has implemented a positive and proactive contract monitoring program. The basis of our monitoring is to ensure that the service that ALA provides through external agencies meets the same standard of care and safety that we provide internally. Each contract with a service provider requires that they screen their employees for criminal violations, and that after employment certain criminal violations are reported to ALA. The list of violations is the same as for DADS and ALA employees to self report. Within each contract, the provider is accountable to ALA to maintain a safe and secure environment and to provide services, which are appropriate to the consumer. The contract provider policies covering the rights and abuse of consumers which are provided to ALA for review to ensure that they adequately protect consumers, and provide the information on the proper reporting of suspected violations.

Lastly, to ensure quality of service delivery, ALA uses announced and unannounced visits to providers as a means of assuring quality and appropriateness of service provision.

TREND ANALYSIS AND REPORTING:

ALA has implemented several reporting and review procedures to identify potential areas of high risk to clientele and to ALA staff.

√ On a daily basis, or as they occur, informational reports are reviewed and analyzed to determine if ALA has systemic issues which need resolutions or if this is a one time occurrence. When indicators are found that lead us to conclude that there is a systems issue, a plan of action is developed to redress the situation prior to it developing into a problem which impacts on the care and safety of consumers, visitors, or staff. The types of reports that are reviewed include:

- ❖ Incident Reports occurring within or involving consumers of ALA
- ❖ Reports of Restraint
- ❖ DPRS reports of investigation
- ❖ Monitoring reports of contract providers

√ On a monthly basis several Contract/QM department staff review the various reports, which have been rendered during the month. These reports include those identified above, with specifics to types of occurrences, locations, staff involvement, and consumer involvement. These reports are reviewed by:

- ❖ CRO
- ❖ QIS Manager
- ❖ MRA Director

Quarterly and upon request, the ALA Director is provided information which includes the data gathered from the listed reports and trends that are being observed, what actions have been initiated, and where ALA's staff thinks improvement is needed. These reports are available to program staff members during in-service training.

EXTERNAL OVERSIGHT:

ALA's Public Network Advisory Committee (PNAC) has developed into a proactive, independent overseer. The PNAC is informed if completed reports of investigation show a high frequency.

This provides them with information specific to the allegation of abuse, neglect and exploitation. In addition, ALA is involved with various stakeholder groups (i.e.a group called "SALSA" (San Antonio League for Self Advocacy), Parent Groups and the Downs Syndrome Association, which are advocates for themselves and/or their family members receiving MR services). This provides ALA with an independent evaluation of corrective actions and provides feedback on additional actions need, to preclude similar problems.

CONCLUSION:

ALA is committed to our consumers. We strive to provide the highest quality service by employing the best possible staff available and by providing them with the skills, knowledge, and environment to perform their jobs. This same philosophy is incorporated in our contractual links to service providers and we require them to meet the same standard we set for ourselves. We have in place numerous mechanisms to monitor how well we are doing and to identify areas for improvement. When we encounter a situation of abuse of our clients, we ensure it is thoroughly investigated, and if confirmed, remedies are immediately set in place.

Insert DADS QM Protocol here

ATTACHMENT H

Alamo Local Authority

Quality Improvement Services Department

Provider Profile – General Revenue Services

Provider Name	**Address**	**Phone Number**
54XX		
Contact Person		**Fax Number**
Fiscal Year 2010		

Contract Service Description

Alamo Local Authority General Revenue and/or Crisis Respite Services provided in an outpatient setting which include one or more of the following services: Day Habilitation, Community Supports, Daily Respite, Hourly Respite, Crisis Respite, Behavioral Supports, Employment Assistance, Supported Employment, and Specialized Therapies Services.

Indicators

Access	**1st Qtr**	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	**YTD**
# of authorized consumers					
# of consumers discharged					
$ amount of services billed					
Capacity					
Staff to Consumer ratio					
Day Habilitation					
All other services					

Staff turn-over rate					
Outcomes					
# of on-site reviews					
# of utilization reviews					
# of internal documentation reviews					
# of peer reviews					
# of Critical Incident Reports submitted					
# of APS/CPS investigations					
# of complaints submitted					

The following forms are utilized for ALA Intake; DMR Process; Consumer Benefits; In-Home Family Support and HCS Enrollment:

Quality Improvement Services Department

Satisfaction Survey

Please indicate whether you agree with the following statements by circling the number that reflects your answer to each question. Thank you.

1 = Strongly Disagree 2 = Disagree 3 = Undecided 4 = Agree 5 = Strongly Agree

		Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
	ALA INTAKE SERVICES					
1	**My intake appointment started on time.**	**1**	**2**	**3**	**4**	**5**
2	**I was treated with respect by ALA staff.**	**1**	**2**	**3**	**4**	**5**
3	**Staff explained all forms during the intake process.**	**1**	**2**	**3**	**4**	**5**
4	**Staff answered all my questions.**	**1**	**2**	**3**	**4**	**5**
5	**I understand all services available to me at this time.**	**1**	**2**	**3**	**4**	**5**
6	**I received contact information for ALA staff.**	**1**	**2**	**3**	**4**	**5**

Additional Comments:

The following is optional:

Name:_____

Phone:_____

May we contact you?

○ **Yes** ○ **No**

Quality Improvement Services Department

Satisfaction Survey

Please indicate whether you agree with the following statements by circling the number that reflects your answer to each question. Thank you.

1 = Strongly Disagree 2 = Disagree 3 = Undecided 4 = Agree 5 = Strongly Agree

		Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
	ALA DETERMINATION OF MENTAL RETARDATION SERVICES					
1	My testing appointment started on time.	1	2	3	4	5
2	I was treated with respect by ALA staff.	1	2	3	4	5
3	Staff explained all forms & tests during the process.	1	2	3	4	5
4	Staff answered all my questions.	1	2	3	4	5
5	I understand the interpretation of my testing.	1	2	3	4	5
6	I received contact information for ALA staff.	1	2	3	4	5

Additional Comments:

The following is optional:

Name:_____

Phone:_____

May we contact you?

○ **Yes** ○ **No**

Quality Improvement Services Department

Satisfaction Survey

Please indicate whether you agree with the following statements by circling the number that reflects your answer to each question. Thank you.

1 = Strongly Disagree 2 = Disagree 3 = Undecided 4 = Agree 5 = Strongly Agree

		Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
	ALA CONSUMER BENEFITS SERVICES					
1	My appointment started on time.	1	2	3	4	5
2	I was treated with respect by ALA staff.	1	2	3	4	5
3	Staff explained all forms and application information during the process.	1	2	3	4	5
4	Staff answered all my questions.	1	2	3	4	5
5	I understand what is expected of me during the benefits process.	1	2	3	4	5
6	I received contact information for ALA staff.	1	2	3	4	5

Additional Comments:

The following is optional:

Name:_____

Phone:_____

May we contact you?

○ **Yes** ○ **No**

Quality Improvement Services Department

Satisfaction Survey

Please indicate whether you agree with the following statements by circling the number that reflects your answer to each question. Thank you.

1 = Strongly Disagree 2 = Disagree 3 = Undecided 4 = Agree 5 = Strongly Agree

		Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
	ALA IN HOME AND FAMILY SUPPORT SERVICES					
1	My appointment started on time.	1	2	3	4	5
2	I was treated with respect by ALA staff.	1	2	3	4	5
3	Staff explained all forms and application information during the process.	1	2	3	4	5
4	Staff answered all my questions.	1	2	3	4	5
5	I understand what is expected of me while receiving in home services.	1	2	3	4	5
6	I received contact information for ALA staff.	1	2	3	4	5

Additional Comments:

The following is optional:

Name:_____

Phone:_____

May we contact you?

○ **Yes** ○ **No**

Quality Improvement Services Department

Satisfaction Survey

Please indicate whether you agree with the following statements by circling the number that reflects your answer to each question. Thank you.

1 = Strongly Disagree 2 = Disagree 3 = Undecided 4 = Agree 5 = Strongly Agree

		Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
	ALA HCS ENROLLMENT SERVICES					
1	My appointment started on time.	1	2	3	4	5
2	I was treated with respect by ALA staff.	1	2	3	4	5
3	Staff explained all forms during the process.	1	2	3	4	5
4	Staff answered all my questions.	1	2	3	4	5
5	I understand the HCS services available to me.	1	2	3	4	5
6	I received contact information for ALA staff.	1	2	3	4	5

Additional Comments:

The following is optional:

Name:_____

Phone:_____

May we contact you?

○ **Yes** ○ **No**

Quality Improvement Services Department

Staff Satisfaction Survey

May 26, 2010

Dear Staff Member:

ALA is committed to continuous quality monitoring and improvement in the overall performance of the organization. The ALA FY 2010 Quality Management Plan describes this process under section 3.4 Oversight Audits/Reviews and Provider Network Reviews for reporting employee satisfaction surveys as determined by DADS. The quality management plan identifies an ongoing, comprehensive performance measurement documenting the results for ALA Management review. We invite you to take this brief survey to determine our staff's level of satisfaction.

Your participation is voluntary, and your answers will be anonymous; do not write your name on the questionnaire. All answers are analyzed by group, not individually. Your answers are kept confidential.

Please answer the questions for yourself and not as a group. This survey will take approximately 10 (ten) minutes. Direct questions about the survey to: Sonja Baggett, Quality Improvement Services Manager.

Please return the survey in a sealed envelope to: **Eva Mata, ALA Receptionist** by close of business on Wednesday, June 02, 2010.

The ALA management team will convene to review and discuss the results, identify opportunities for improvement, plan the improvement(s) and implement a plan. Afterwards, the results will be discussed with staff members during one of the monthly staff meetings.

Thank you for your feedback.

Anthony Jalomo, B.A.

ALA Director

Staff Satisfaction Survey

Please indicate whether you agree with the following statements by circling the number that reflects your answer to each question. Thank you.

1 = Strongly Disagree 2 = Disagree 3 = Undecided 4 = Agree 5 = Strongly Agree

		Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
	WORK ENVIRONMENT					
1	**I have a good understanding of the mission and the goals of ALA.**	**1**	**2**	**3**	**4**	**5**
2	**I have the resources I need to do my job well**	**1**	**2**	**3**	**4**	**5**
3	**I have all the information I need to do my job effectively.**	**1**	**2**	**3**	**4**	**5**
4	**Communication is encouraged with Senior Managers, Supervisors and Peers of the ALA.**	**1**	**2**	**3**	**4**	**5**
5	**Relevant information and knowledge are shared openly within the ALA.**	**1**	**2**	**3**	**4**	**5**
	MANAGEMENT					
6	**The ALA senior managers demonstrate strong leadership skills.**	**1**	**2**	**3**	**4**	**5**
7	**There is a strong feeling of teamwork and cooperation within senior management.**	**1**	**2**	**3**	**4**	**5**
	SUPERVISION					
8	**The Supervisors demonstrate strong leadership skills.**	**1**	**2**	**3**	**4**	**5**
9	**The Supervisors know what they are doing.**	**1**	**2**	**3**	**4**	**5**
10	**My Supervisor is always consistent when**	**1**	**2**	**3**	**4**	**5**

	administering policies and procedures.					
11	**My Supervisor encourages and supports my development.**	**1**	**2**	**3**	**4**	**5**
12	**My Supervisor values my talents and the contribution I make.**	**1**	**2**	**3**	**4**	**5**
	TRAINING					
13	**I receive the training I need to do my job well.**	**1**	**2**	**3**	**4**	**5**
14	**The necessary information systems are in place and accessible for me to get my job done.**	**1**	**2**	**3**	**4**	**5**
15	**I have received the training I need to do my job efficiently and effectively.**	**1**	**2**	**3**	**4**	**5**
16	**I have received support from my Supervisor when working with challenging consumers/families.**	**1**	**2**	**3**	**4**	**5**
	IN GENERAL					
17	**There is a strong feeling of teamwork and cooperation within the ALA.**	**1**	**2**	**3**	**4**	**5**
18	**I am encouraged to develop new and more efficient ways to do my work.**	**1**	**2**	**3**	**4**	**5**
19	**Employees work well together to solve problems and get the job done.**	**1**	**2**	**3**	**4**	**5**
20	**The pace of the work enables me to do a good job.**	**1**	**2**	**3**	**4**	**5**

Comments:

In your opinion, what is the one thing you would change to improve the ALA?

Tell us what you like best about working for the ALA?

1st Quarter QIS Department Summary

Summary of results:

- Allocated dollars spent during 1st Quarter are below target. Utilization of services remains below expectation/projections, indicating that there is potential risk utilizing all dollars budgeted for FY 2010 service delivery.
  Remediation: Drafted letter for consumers/LAR's regarding under- utilizationof services. Action plan: re-allocate unspend dollars to consumers awaiting services. Continue monitoring utilization collabaratively with MR GR Services Manager.

- Consumer Survey had a 13% return rate of the 590 surveys provided to consumers. The highest range 3.7 to 3.8 had 4 indicators; the medium range 3.6 to 3.7 had 4 indicators and the lowest range 3.4 to 3.5 had 3 indicators. Most noted is consumers lack of community integration opportunities.

  Remediation: Discussed with Manager the need to increase SC's awareness and knowledge of community opportunities, consumer safety and consumer decision making. In-service on quarterly basis.

- Critical incidents reports: It is apparent that we have a system wide issue with under reporting of incidents involving ALA consumers. This is especially noticable when comparing "like" providers.
  Remediation: QIS dept. will schedule and require participation in a provider refresher training for incident reporting. Providers will also submit copies of their "Rights, Abuse & Neglect" training materials for QIS dept. to determine adequacy.

- DVR Results:Results from Data Verification (DV) reviews serve to inform all involved divisions within DADS and activate mechanisms to ensure and improve data accuracy as needed (e.g., comnets, training, on-site reviews, technical supports, etc.). As a measure of the validity, verifiability, reliability, and accuracy of performance contract data, data verification review results are also used in assessing overall risk, as well as performance for MRA's.

  Samples are drawn from clients who had one valid CARE assignment during the three months prior to the sample month, and from whom one encounter for an assignment service was reported to the Health and Human Services Commission Mental Retardation and Behaviral Health Outpatient Warehouse (HHSC MBOW) during the sample month of September 2009.

ALA self audit scores:

Expected Matches – 180

Observed Matches – 170

Observed/Expected – 94.4%

CAO Scores

Expected Matches – 88

Observed Matches – 88

Observed/Expected – **100.00%**

Statewide Average Scores

Expected Matches – 2230

Observed Matches – 2033

Observed/Expected – 91.17%

Difference from Statewide – ALA **exceeded** Statewide average by – **8.83%**

Remediation: None needed at this time. Continue to achieve 90+% in all future audits.

- Number of completed ALA Provider Annual Audits
  - √ 16 - 1st Quarter Audits completed
  - √ 03 -1st Quarter Audits moved into 2nd Quarter due to no consumers (new providers)

- Number of Corrective Action Plans (CAP) submitted/accepted
  - √ 04 – Providers did not require CAP
  - √ 08 – Provider CAP's were submitted within 30 days
    Explanation: Areas of concern are Environmental Hazards (electrical outlets, bathrooms, building maintenance), Consumer Rights (HIPAA compliance), Staff training, Vehicles (wheel chair lifts, invalid

insurance, spare tire missing) and Infection Control (staff training and first aid kits not fully equipped)

- √ 03 – Provider CAP's due in the 2nd quarter
- √ 01 – Provider placed on 60 day Probation for no CAP & billing issues (as of Dec. 16, 2009; to be reviewed Feb. 16, 2010.)

- Recoupement Requested/Pending
  - √ One recoupment has been requested for FY09. Audit revealed services provided were not in compliance with DVM standards.
  - √ No Safety Net Provider recoupment requested during 1st Quarter FY 2010.

  Remediation: None at this time

- Results of Provider Peer Reviews

  Providers are turning in all peer review forms on time with the exception of one Provider (who is currently on Probation). Overall scores are in compliance with the 90% or greater requirement.

ALA Score (Internal Programs)

Expected Matches – 240

Observed Matches – 240

Observed/Expected – 100%

Provider Score (External Provider Services)

Expected Matches – 1596

Observed Matches – 1581

Observed/Expected – 99.06%

Identified areas for concern:

1. Strategies & Methodologies – Providers are not receiving updated services into PDP in a timely manner. SC's fail to respond to provider inquires when emailed.
2. IPC authorizations – Unit allocations are not re-authorized quickly enough by SC's (quarterly allocations) and client services are interrupted/stopped.

Remediation 1: Requested that Manager in-service all SC staff on their responsibilities regarding responsiveness and acceptance/rejection of Strategies/ Methodologies.
Remediation 2: Look at viable options regarding which services can be exempt from quarterly allocations. Doing so will alleviate the interruption of services significantly.

- Results of Internal CAP/Peer Reviews
  - √ **General Revenue** – All peer reviews comply with a score of 90% or greater. The Service Plan Management Review form and Direct Service Encounter Review form are not submitted as required; the forms are currently being revised. The General Revenue team meets minimally twice a month, a copy of the sign-in sheets and agenda's are available for review (This fulfills part of our CAP for DADS). The caseload reports are discussed and corrected (if applicable) with responsible staff on a weekly basis.

    1st quarter review shows the following areas of concern:

    1. DMR and PDP Diagnosis information do not mirror each other
    2. Strategies and Methodologies are not updated and provided by the Provider and documented in the current PDP
    3. Service Coordinators are not signing consumers out when visiting at a Day Habilitation site.

Remediation 1: Manager/Team Leaders continue to in-service staff. QIS staff increases the frequency of random reviews for identical dx in charts.

Remediation 2: Manager have individual employee discussion regarding non-compliance issues.

Remediation 3: **P**roviders inform Contract Monitor of each incident, QIS staff forwards information to responsible manager for in-service & further action when applicable. Include these requirements as performance indicators for subsequent quarters.

Systemic Solution: Increase staff awareness of DADS prescribed requirements by incorporating into "general training curriculum".

- √ **HCS and TxHmL**

  Peer review forms are reviewed; however, scoring is not determined at this time for pass/fail compliance. Supervisor has developed her own forms. Unit trainings occur monthly. No other areas of concern for 1st quarter.

Remediation: QIS staff convert peer review into scorable form in order for QIS dept. to measure 90% performance. (done)

√ **In Home and Family Support/GR**
Peer reviews are completed with a score of 90% or greater. Trainings are completed monthly with IHFS and GR team. No areas of concern for 1st quarter.
Remediation: None needed

√ **Permanency Plan** – Training and Peer reviews being completed.
1st Quarter reviews show only one area of concern regarding notification letters sent out 21 days in advance of planning meeting. During each monthly review, at least 2 of the six charts indicated a "No" response with having the notification present in the chart. Supervisor addressed staff issues and training session to correct.

Remediation: Continue to monitor

√ **Continuity of Care System for Offenders with Mental Impairments (46 B Criminal Cases)** - These cases are closely followed and monitored by supervisor assures staff attendance at all required meetings and court appearances.
Remediation: None needed

√ **CLOIP** – Training and Peer reviews are being completed. 1st Quarter reviews show no areas of concern and all documentation is present.
Remediation: None needed

√ **Intake & Eligibility** – Staff training is being completed.
- Intake & Eligibility – No peer review form has been created at this time. No review has been completed.
- R005/DMR – Previous supervisor indicated reviews were completed, but no records were turned in or reviewed. No peer review forms have been turned in or reviewed.

Remediation: Forms have been developed by QIS dept. and will be implemented Feb. 2010.

Area of concern and needed Remediation:

- 1st quarter report shows a total of 106 Information & Referral; average of 35 per month; 8.5 per staff per month
- 1st quarter report shows a total of 61 Intake Interviews; average of 20 per month; 5 per staff per month

The above is a snapshot of the extremely low numbers recorded in the Q data system. It is my **assumption** that the appropriate documentation is not completed by Intake staff, therefore **data** is **skewed**.

- 18 ICAP Services done by departed staff continue to show **active** in Q.
- Ran 3 reports - billed services Sep - Nov; active & closed assignments Sep - Nov; R005 active & closed. Information that should match does not. Clients show assigned & work performed by one PA on one report & another PA on the next report.
- Assignments from intake worker are still active after long period of time (up to 1 year+)

Remediation: Revamp I & E department procedures. The new P&P's include performance measures and timelines to enable the manager to effectively measure staff performance. Implement Peer review/check list by February 28. This measure will help staff to do unit QA check. QIS staff to assist manager with in-service as needed. QIS staff to prioritize & increase reviews of I & E activity and data reporting. Consult with Data Manager on options of reports to give needed info in easier format. Continue working with I & E Manager on procedures. Investigate if Data entry shows increased error rate. QIS staff requested additional training from Data Manager – response pending. Peer Review Forms have been developed by QIS and will be implemented Feb 2010.

√ **Consumer Benefits** - No peer review form has been created at this time.

- No review has been completed.
- 1st quarter report shows a total of 22 Benefit Applications; average of 7 per month between all staff

Remediation: Forms have been developed QIS dept. with implementation effective Feb 2010.

√ **Data Entry Issues** - 18 ICAP Services done by departed staff continue to show active in Q.

Remediation: Request all data entry staff receive in-service from Data Manager. QIS staff to run monthly report for inaccurate open assignments.

2nd Quarter QIS Department Summary

Summary of results:

- Allocated dollars spent during 2nd Quarter are currently pending.

- Consumer Survey had a 14% return rate of the 590 surveys provided to consumers. The highest range 3.7 to 3.8 had 4 indicators; the medium range 3.6 to 3.7 had 4 indicators and the lowest range 3.4 to 3.5 had 3 indicators. Most noted is consumers lack of community integration opportunities.
  Remediation: Discussed with Manager the need to increase SC's awareness and knowledge of community opportunities, consumer safety and consumer decision making. In-service on quarterly basis.

  Critical incidents reports: The apparent 1st quarter problem with under reporting of incidents involving ALA consumers was addressed during the 2nd quarter. Providers submitted copies of their "Rights, Abuse & Neglect" training materials for QIS dept. which were reviewed and discussed to determine appropiratness. Provider training has been scheduled for March 17, 2010, which falls during the 3rd quarter.

- DVR Results: 2nd quarter did not yield a Data Audit from the State. At the beginning of the 3rd quarter, Priority Population data verificaiton will occur along with our annaul on-site DADS audit.

- Number of Corrective Action Plans (CAP) submitted/accepted
  - √ 01 – Provider placed on 60 day Probation in the 1st quarter has met all probation requirements and was taken off at the end of the 2nd quarter.

- Recoupement Requested/Pending
  - √ No Provider recoupment requested during the 2nd Quarter FY2010.
  - √ No Safety Net Provider recoupment requested during 2nd Quarter FY 2010.

- Results of Provider Peer Reviews
  Providers are turning in all peer review forms on time with the exception of one Provider (who is currently on Probation). Overall scores are in compliance with the 90% or greater requirement.

  ALA Score (Internal Programs)

  Expected Matches – 217

  Observed Matches – 216

Observed/Expected – 99.53%

Provider Score (External Provider Services)

Expected Matches – 2409

Observed Matches – 2393

Observed/Expected – 99.33%

Identified areas for concern:

1. Strategies & Methodologies – Providers are not receiving updated services into PDP in a timely manner. SC's fail to respond to provider inquires when emailed.
2. IPC authorizations – Unit allocations are not re-authorized quickly enough by SC's (quarterly allocations) and client services are interrupted/stopped. A spreadsheet has been created to identify submission deadlines for revisions and data entry.

Remediation 1: Requested that Manager in-service all SC staff on their responsibilities regarding responsiveness and acceptance/rejection of Strategies/ Methodologies.
Remediation 2: Look at viable options regarding which services can be exempt from quarterly allocations. Doing so will alleviate the interruption of services significantly.

- Results of Internal CAP/Peer Reviews
  - √ **General Revenue** – All peer reviews comply with a score of 90% or greater. The Service Plan Management Review form and Direct Service Encounter Review form are not submitted as required; the forms are currently being revised. The General Revenue team meets minimally twice a month, a copy of the sign-in sheets and agenda's are available for review (This fulfills part of our CAP for DADS). The caseload reports are discussed and corrected (if applicable) with responsible staff on a weekly basis.

2nd quarter review shows the following areas of concern:

4. DMR, PDP and Q System Diagnosis information do not mirror each other
5. Strategies and Methodologies are not updated and provided by the Provider and documented in the current PDP

Remediation 1: Manager/Team Leaders continue to in-service staff. QIS staff increases the frequency of random reviews for identical dx in charts.

Remediation 2: Manager have individual employee discussion regarding non-compliance issues.

Remediation 3: Providers inform Contract Monitor of each incident, QIS staff forwards information to responsible manager for in-service & further action when applicable. Include these requirements as performance indicators for subsequent quarters.

Systemic Solution: Increase staff awareness of DADS prescribed requirements by incorporating into "general training curriculum".

√ **HCS and TxHmL**
Peer review forms are reviewed; all peer reviews comply with a score of 90% or greater. Trainings are completed quarterly with HCS and TxHmL. No areas of concern for 2nd quarter.

√ **In Home and Family Support/GR**
Peer reviews are completed with a score of 90% or greater. Trainings are completed monthly with IHFS and GR team. No areas of concern for 2nd quarter.

√ **Permanency Plan** – Peer review forms are reviewed; all peer reviews comply with a score of 90% or greater. Trainings are completed quarterly. No areas of concern for 2nd quarter.

√ **Continuity of Care System for Offenders with Mental Impairments (46 B Criminal Cases)** - These cases are closely followed and monitored by supervisor assures staff attendance at all required meetings and court appearances.

√ **CLOIP** – Peer review forms are reviewed; all peer reviews comply with a score of 90% or greater. Trainings are completed quarterly. No areas of concern for 2nd quarter.

√ **Intake & Eligibility** - Peer review form has been created at this time. On January 27, Peer reviews were created and provided to the Manager on February 10, 2010. Staff training was completed on February 16, 2010. Reviews will be provided for 3rd quarter.

√ **Consumer Benefits** - Peer review form has been created at this time. On January 27, Peer reviews were created and provided to the Manager on February 10, 2010. Staff training was completed on February 16, 2010. Reviews will be provided for 3rd quarter.