Quality Management Plan
FY 2026-2027

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Quality Management Plan

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PURPOSE, MISSION STATEMENT AND CORE VALUES

PURPOSE

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

The Quality Management (QM) Program is comprehensive, with quality and safety extending to all facets of the organization, both clinical and administrative. This plan outlines the principles of Gulf Bend Center's quality management efforts and provides a systematic approach to measure, assess, and improve the quality and appropriateness of the internal delivery system. Quality improvement is not a one-time initiative but an ongoing and integral component of the quality management framework.

OUR MISSION, OUR CULTURE & OUR VISION

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

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OUR CORE VALUES

QUALITY MANAGEMENT PROGRAM OVERVIEW

STRUCTURE OF THE QUALITY MANAGEMENT PROGRAM

The structure of the QM program flows from the following principles:

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

This Quality Management Plan provides a framework for evaluating all programs under both the LMHA and the LIDDA to ensure compliance with contractual obligations and the delivery of exceptional services. Accordingly, this document functions as both the Behavioral Health Quality Management Plan and the LIDDA Quality Management Plan. The Quality Management Plan is presented to the Gulf Bend Center Board of Trustees for approval. The plan is reviewed annually by the QM and Compliance Department and updated at least every two years with the approval of the board. The Board receives and acts upon periodic reports developed through the QM and CQI program, and it ensures the availability of resources and systems necessary to support all QM activities. The Board holds Gulf Bend Center's Executive Director and Executive Management Team accountable for the development, implementation, monitoring, and evaluation of the Quality Management Plan and continuous improvement of services. Gulf Bend Center's Director of Quality Management and Compliance holds operational responsibility for the QM program.

QUALITY MANAGEMENT DEPARTMENT

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

The Quality Management Department is responsible for the following:

- Reviewing the QM Plan annually, update as needed, soliciting input from Integrity Quality and Compliance (IQC) and other stakeholders
- Conduct planning activities
- Aiding with plans for improvement to meet the HHSC Performance Contracts for Behavioral Health and Intellectual Developmental Disability services
- Ensuring implementation of the Quality Management Plan
- Performing and ensuring compliance with Internal/External review activities
- Provide oversight of all services, contracts, and subcontractors regardless of the amount of funding
- Measure, assess, and improve consumer satisfaction
- Measure, assess, improved quality management activities, administrative services, consumer services, and outcome for individuals
- Ensure compliance with all laws, rules, policies, and procedures for service implementation and billing.
- Monitor any new initiatives
- Review and analyze grievances, appeals, fair hearings, expedited hearings, mortality, and incident/accident data
- Ensuring QM training is provided to new and tenured employees
- Providing technical assistance to other departments related to quality oversight necessary to improve the quality and accountability of services
- Provide oversight to ensure compliance with required management practices, including the monitoring of fidelity to service models defined by HHSC (minimum once per year for CCBHC)
- Improve the consumer rights protection process, including review of rights restrictions
- Reporting and trending data collection related to reported incidents, medication errors, abuse, complaints and neglect, privacy/security incidents
- Assisting with the development/revision of center procedures and plans, making that information available to all staff
- Assisting in the development, facilitation and ensuring the implementation of Certified Community Behavioral Health Clinics (CCBHC) requirements for compliance
- Facilitating the IQC Meetings
- Reviewing, trending and summarizing program performance indicator data for review by the IQC
- Measure, assess, and improve the local authority functions
- Conduct self-assessment activities
- Respond to mandates by HHSC or any other oversight entity, including self-monitoring activities.

Within each program, departmental leadership**,** including Directors, Managers, and Team Leads, holds primary responsibility for the development, support, and operation of activities that promote the effectiveness of the QM Program. Leaders are expected to integrate quality principles into daily operations, foster a culture of

accountability and improvement, and ensure that departmental activities align with organizational quality goals. Working collaboratively with the IQC Committee, departmental leadership helps implement and sustain quality initiatives by accomplishing the following:

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

QUALITY MANAGEMENT PLAN

PURPOSE

The QM Plan provides a structured and coordinated framework for planning, performance improvement, and system enhancements. It outlines the full scope of QM activities, with the Director of Quality Management and Compliance responsible for oversight and coordination. This plan is reviewed annually or more frequently, as needed. The Board of Trustees must approve any revisions and re-approve the QM Plan during the first quarter of each biennium. The QM Plan is located in the GBC Local Plans manual within the Quality Management and Compliance department and on our website for reference and transparency.

SCOPE

This plan applies to all adult and children's behavioral health services and IDD services, including but not limited to:

- Behavioral health services
- Crisis services
- Substance Use Disorder (SUD) services
- Intellectual and Developmental Disability (IDD) services
- Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) services
- Veteran's services

QUALITY MANAGEMENT ACTIVITIES

GOALS OF THE QUALITY MANAGEMENT PROGRAM AND PLAN

The goals of the Quality Management and Compliance department are designed to ensure that Gulf Bend Center's activities effectively measure, assess, and improve the key elements of service delivery across all programs. These goals serve as the foundation for the efforts of the QM and Compliance department, providing direction and focus for continuous quality improvement initiatives. However, they are not intended to represent the full scope of the department's responsibilities.

The QM and Compliance department will emphasize the following ongoing initiatives to support excellence in service provision, compliance, and organizational performance:

- Deliver high-quality, person-centered services that meet the highest standards of care and are tailored to the unique needs of each individual
- Ensure access to the full continuum of care necessary to support recovery, stability, and well-being
- Monitor and evaluate programs through internal reviews and organizational self-assessment activities to ensure effective and efficient service delivery
- Identify and implement quality improvement initiatives based on data analysis, evaluation findings, and identified needs
- Promote regulatory compliance by ensuring adherence to contracts, licensing standards, and applicable laws
- Provide staff with the training, tools, and support needed to perform effectively and deliver quality services
- Ensure that individuals served are treated with dignity and respect in all aspects of service delivery
- Facilitate regular IQC meetings (at least quarterly) to review data, discuss performance trends, and communicate key findings and decisions to staff and leadership
- Integrate quality management principles across all Center committees to promote coordination, shared accountability, and system-wide improvement

MEASURING, ASSESSING AND IMPROVING SERVICES AND OUTCOMES

GBC delivers a wide range of services across all age groups through behavioral health, substance use, and Intellectual and Developmental Disabilities (IDD) services. A full listing of services and detailed descriptions is available on the GBC website at https://www.gulfbend.org/.

The performance of key organizational functions directly impacts consumer care outcomes. This drives the quality management program to focus on ensuring that services are delivered efficiently and effectively, meet the highest quality standards, and remain in full compliance with laws, regulations, standards, and HHSC service contracts. This is achieved through a structured approach that includes defining desired outcomes, measuring and assessing progress toward those outcomes, and implementing target improvements.

Data collection and analysis are central to the continuous quality improvement process. Making decisions driven by data allows the organization to accurately identify problems, develop and plan appropriate improvements, and evaluate the strengths and weaknesses of any changes implemented.

METHODOLOGIES AND MEASURABLE ACTIVITIES

GBC uses a variety of tools to solve problems, monitor services, evaluate performance, and ensure compliance with applicable standards. Those tools may include, but are not limited to:

- Performance Indicator Analysis and PDSA Action Plan form
- Plan, Do, Study, Act (PDSA)
- Audit tools customized to specific reviews
- External audits from regulatory agencies, payors, financial, etc.
- SmartCare generated reports
- Encounter data from MBOW
- Performance contracts and other data reporting activities
- Stakeholder collaboration
- Core team collaborations

PERFORMANCE METRICS AND REGULATORY COMPLIANCE REVIEWS

Quality Management Plan

The Director of Behavioral Health Services, or their designee, will be responsible for providing services to adults, children and adolescents in compliance with Texas Administrative Codes (TAC), Texas Health & Safety Code, and other relevant standards. QM and Compliance staff are responsible for collaborating with appropriate personnel to monitor behavioral health and IDD performance measures and other regulatory compliance metrics, including Texas Certified Community Behavioral Health Clinics (T-CCBHC) measures and HHSC Directed Payment Program for Behavioral Health Services (DPP) measures. SmartCare generated reports and MBOW reports are used to monitor measures to monitor compliance with the performance contracts and regulatory standards. Data on outcomes and contractual requirements is reviewed and reported to the CCBHC Core Team, IQC, or other appropriate committees. The committee members will determine who is responsible for addressing any necessary corrective actions identified during these reviews.

Programs that may be reviewed for compliance may include, but are not limited to:

- Crisis Intervention Services
- Mobile Crisis Outreach (MCOT)
- Screening
- Routine Case Management
- Counseling
- Peer Support
- Nursing Services
- Care Coordination and Continuity of Care Services and Supports
- Pharmacological Management
- Medication Training and Support
- Psychosocial Rehabilitative Services
- Skills Training and Development Services
- Substance Use Disorders (SUD)
- Jail Diversion Services
- IDD Services
- MH-Preadmission Screening and Resident Review (PASRR)

CONTRACT MONITORING

The Quality Management and Compliance department collaborates with the Accounting Manager to ensure that all contracts include the necessary elements to maintain compliance with all applicable regulations, laws, and standards. The Program Director/Manager responsible for the contracted service is accountable for monitoring compliance with the identified fiscal and qualitative indicators. Collected data is evaluated to guide informed decisions regarding the renewal or re-contracting of service providers. The qualitative indicators must be tailored to the specific service provided to ensure achievement of the desired outcomes and full compliance with all relevant rules, laws, and contractual standards. Results from contract monitoring activities must be reported to the IQC at least quarterly, or more frequently if circumstances warrant.

CORPORATE COMPLIANCE REVIEWS

All new staff receive training in the GBC's Corporate Compliance and Standards of Conduct plan during New Employee Orientation (NEO). QM and Compliance staff conduct routine reviews of assessments, progress notes, recovery plans, and other relevant documentation to ensure that practices meet all compliance requirements. If serious compliance infractions are identified, internal investigations may be initiated by QM and Compliance staff. Findings from these reviews or investigations are communicated with the appropriate personnel responsible for addressing and resolving non-compliance issues in order to meet required standards. All results are compiled and

reported to the IQC on a quarterly basis for oversight and accountability.

CRISIS RESPONSE REVIEWS

The Crisis Program Manager is responsible for the oversight of the crisis response system, which involves a comprehensive review process to ensure timely, appropriate, and effective care for individuals experiencing a behavioral health crisis. Data is collected and analyzed to provide detailed information on the timeliness of crisis responses, the appropriateness of interventions provided, and the continuum of care following each crisis event. Psychiatric Emergency Service Center (PESC) and Private Psychiatric Bed (PPB) reports are utilized to monitor admission patterns, identify trends, and assess whether individuals are being diverted to the least restrictive and most appropriate level of care whenever possible.

Performance metrics are regularly reviewed to evaluate the efficiency and effectiveness of the crisis system. Findings are presented to the CCBHC Core Team, IQC, or any other appropriate committee to ensure that appropriate steps taken to correct any issues are data driven.

REGISTRATION AND INTAKE SERVICES REVIEW

The Registration and Intake Services Review ensures that all aspects of the intake process meet regulatory, contractual, and organizational standards for quality and compliance. This review includes a thorough examination of consent forms to verify that they are complete, accurate, and signed appropriately before the initiation of services. In addition, administrative processes are evaluated to confirm that all required information is collected efficiently, and that intake procedures are performed in a consistent, timely, and professional manner. Findings from these reviews are used to identify training needs, streamline processes, and implement improvements in registration and intake practices. Results are reported to the IQC on at least a quarterly basis or more frequently if concerns are identified.

YOUTH EMPOWERMENT SERVICES (YES) WAIVER REVIEWS

The Director of Behavioral Health Services, or their designee, will be responsible for the monitoring of services provided through GBC's YES Waiver program and ensuring compliance with policies and procedures outlined in the YES Waiver Policy Manual. The QM and Compliance Department will collaborate with the Director of Behavioral Health Services, or their designee, to conduct quality management reviews, provide oversight, and ensure adherence to regulatory and contractual requirements.

If any corrective actions are identified during these reviews, the Director of Behavioral Health Services, or their designee, will collaborate with the QM and Compliance department to develop, implement, and monitor corrective action plans to ensure timely resolution of identified deficiencies and ongoing compliance.

Identified outcomes to monitor include:

- Waiver participants have timely access to services.
- Waiver participants are enrolled in a timely manner.
- Plans of Care and Services are based on underlying needs and outcome statements.
- Services are provided according to the Waiver participant’s approved Individual Plan of Care.
- Child and family team meetings include provider participation.
- IPCs are developed and revised according to HHSC policy.
- Health and Safety risk factors are identified and updated.
- Providers are credentialed and trained.
- There is adherence to established policies and procedures.

- There is continuity of care for waiver participants.
- Medicaid, demographic, and clinical eligibility criteria are met.
- Any applicable Waiver service associated cost limitations are not exceeded.

FIDELITY REVIEWS

Evidence-based practices (EBP's) will be reviewed collaboratively by the applicable program directors, managers, and supervisors in partnership with QM and Compliance staff. Appropriate fidelity tools for each practice will be utilized to ensure compliance with established standards and best practices. EPBs to be reviewed include, but are not limited to, the following:

Adult

- Assertive Community Treatment (ACT)
- Illness Management and Recovery (IMR)
- Cognitive Behavioral Therapy (CBT)
- Motivational Interviewing (MI)
- Safety Planning Intervention
- Suicide Screenings
- Person-Centered Planning (PCP)

Children's

- Skill Streaming and Aggression Replacement Techniques (ST-ART)
- Preparing Adolescents for Young Adulthood (PAYA)
- Seeking Safety
- Nurturing Parenting Program
- Wraparound Implementation
- Safety Planning Intervention
- Suicide Screenings
- Person-Centered Planning (PCP)

LOCAL INTELLECTUAL & DEVELOPMENTAL DISABILITY AUTHORITY (LIDDA) REVIEWS

The Director of Intellectual and Developmental Disability (IDD) Services, or their designee, will be responsible for the monitoring of IDD Service Coordination program and compliance with Texas Administrative Codes (TAC) that apply to Home and Community Based Services (HSC), Texas Home Living (TxHmL), Community First Choice (CFC), and Preadmission Screening Resident Review (PASRR). The Director of Intellectual Development Disabilities program is responsible for addressing any necessary corrective actions identified during the external HHSC Review and the internal Quality Management Reviews. EHR data is used to assess timely data entry and service delivery.

Services that may be reviewed for compliance may include, but are not limited to:

- Screening gathering information to determine the need for services.
- Eligibility Determination
- Service Coordination
- Development and Monitoring of Person Directed Plan (PDP)
- Community Support

- General Revenue and Crisis Respite
- Crisis Intervention Specialist Services
    - Behavioral Support
    - Specialized Services
- Community First Choice Services
- IDD-Preadmission Screening and Resident Review (PASRR)
- Assistance locating Intermediate Care Facilities for Individual with an Intellectual Disability or Related Conditions (ICF/ID)
- Assistance in completing application for admission to State Supported Living Centers (SSLC's)

Additionally, the LIDDA measures, assesses, and improves both its authority functions and the services delivered directly or through contracted providers. Key performance indicators and internal audits are used to evaluate compliance with contractual requirements, timeliness of service coordination, and overall effectiveness of core functions. Service quality is further assessed through individual and family satisfaction surveys, monitoring of service utilization and outcomes, and provider performance reviews. Findings are analyzed to identify trends, gaps, and opportunities for improvement, and corrective action plans are implemented as needed to strengthen both internal operations and the quality of services available to individuals and families.

QM INTERNAL AUDIT REVIEWS

The quality management internal audit process begins with quality assurance at the service provider level. GBC service providers in all programs are monitored for contract compliance and productivity by Program Directors and/or Managers. These quality assurance activities are reported during regular team meetings and/or various management and committee meetings. Additionally, the QM department conducts regular contract compliance audits/reviews for all center programs.

When a program is selected for review, the QM reviewer will have a pre-audit discussion and share the audit tool that will be used during the audit with the Program Director and/or Program Manager. The audit tool is reviewed, discussed, and modified until both teams agree on the direction of the audit. Once the audit tool is finalized, QM staff can begin the audit.

After the completion of the audit, the results are shared with the Program Directors and Program Managers during a post-audit discussion. This discussion allows the directors/managers to discuss any inconsistencies or provide additional information that may have been unknown or missed by the auditor. Any differences in opinion between the reviewer and the program being audited will be decided by the Director of Program Operations. The QM auditor may use an additional five business days to look over any new information based on the discussion. If no additional material needs to be reviewed, the results will be submitted to the Program Directors and Managers for final review.

EXTERNAL REVIEWS AND AUDITS

All departments are subject to, and actively participate in, onsite or desk reviews from HHSC and other regulatory agencies. These reviews may address a wide range of areas, including, but not limited to, program implementation, services provided, and funds awarded. Specific areas of assessment may include compliance with contractual obligations, billing accuracy, staff competency, facility requirements, and curriculum requirements.

The QM and Compliance department will be responsible for facilitating the majority of external audits conducted by funding sources and regulatory authorities. QM and Compliance staff will collaborate with the appropriate departments to collect and submit all requested documentation and information. Appropriate QM and

compliance staff will maintain communication with the appropriate Program Director, and/or designee(s) along with designated auditors to respond to questions and provide clarification throughout the audit process. When corrective action plans are required, QM and Compliance staff will collaborate with the appropriate department to develop, implement, and monitor the necessary steps to ensure compliance.

Reports, data, and results from onsite reviews or desk reviews from HHSC, Managed Care Organizations (MCOs) and other oversight bodies are systematically analyzed. These results are used to identify performance improvement opportunities, address service delivery challenges, and evaluate unmet needs of the individuals served.

ASSESSING

Data collected from audits and reviews is carefully reviewed in relation to the specific methodology, process, or activity being evaluated. The process involves a structured analysis that is designed to identify errors, root causes, ineffective processes, and negative trends that may impact service delivery or compliance. Identified issues are evaluated to determine if they are isolated incidents or systemic concerns, which allows leadership and staff the opportunity to take a proactive approach to resolving identified issues. Corrective Action Plans (CAPs) are developed and implemented, as needed, to strengthen processes, prevent recurrence, and promote ongoing quality improvement.

REPORTING QUALITY MEASUREMENT ACTIVITIES

Program Directors, in collaboration with QM and Compliance staff, are responsible for monitoring established quality measures across all programs. Findings are communicated to the appropriate committees, stakeholders, and consumers as needed to ensure transparency, accountability, and shared understanding of performance outcomes. Benchmarks that are not met are reviewed during relevant committee meetings to allow members to work together to identify contributing factors, discuss potential barriers, and determine the most effective course of action to achieve improvement.

CORRECTIVE ACTION PLANS (CAPS)

Corrective actions are implemented after problems are identified, evaluated, and confirmed through internal or external reviews. CAPs may include, but are not limited to, policy and procedural changes, staff education and training, documentation corrections, or process improvements.

INTERNAL AUDIT CAPS

The decision to require a CAP may be based on several factors including, but not limited to:

- The severity of non-compliance
- The potential for risk
- Change in regulatory standards
- An overall audit score of <85%
- An audit with substantial findings

When a CAP is required, QM and Compliance staff will allow program directors, or their designees, 15 business days to submit a CAP, using the CAP tool that is built in as a component of the audit tool. Once the CAP is agreed upon, the CAP should be addressed in a timely manner to meet the deadlines set in the CAP. All evidence of corrections should be submitted to the QM and Compliance department by the due dates on the CAP. The auditor

will monitor implementation of the plan and conduct focused follow-up activities as needed.

EXTERNAL AUDIT CAPS

When an external audit requires a CAP, the QM and Compliance Department will coordinate with all relevant staff to ensure the CAP is addressed in a coordinated and effective manner. QM and Compliance staff will review the plan's content to ensure that all deficiencies are adequately addressed. Additionally, QM and Compliance will monitor timely submission of CAPs along with any additional documentation required by the auditor.

MEASURING, ASSESSING, AND IMPROVING DATA INTEGRITY

Gulf Bend Center uses multiple oversight methods and reporting systems that monitor billing, encounter data, and program performance while also maintaining the integrity of the data. The processes work together to identify errors, highlight trends, and guide continuous quality improvement processes.

CLAIMS OVERSIGHT

The Billing Department, along with Program Directors and QM and Compliance staff in unique circumstances, routinely monitor billing activities for inaccuracies or missed claims. The focus of this monitoring process is to verify correct service codes that are used, search for denied claims, or find unauthorized services. Additionally, this provides valuable information that is used to refine the billing system and improve data reporting practices. When issues are identified, modifications to reporting and billing processes are implemented.

MBOW DATA WAREHOUSE, CMBHS AND ELECTRONIC HEALTH RECORD (EHR) SYSTEM

Reports generated from state databases, like the Mental Health and Behavioral Health Outpatient Warehouse (MBOW) and Clinical Management for Behavioral Health Sciences (CMBHS), are routinely reviewed by leadership to monitor GBC's performance across a wide range of indicators. These reports are used to validate the accuracy of data collection and to evaluate the organization's progress on key outcome measures. The EHR system provides additional support to data integrity by producing a variety of reports used for collecting, analyzing, and reporting information related to outcomes, service delivery, and performance measures. The EHR is continuously updated to improve reporting functionality, allow for better trend identification, and support the creation of new reporting requirements.

OTHER QUALITY MANAGEMENT AND COMPLIANCE ACTIVITIES

GBC POLICY AND LOCAL CENTER PLAN DEVELOPMENT AND MANAGEMENT

QM and Compliance collaborate with appropriate Program Directors to review and update all policies and local plans. Any modifications, deletions, or additions to GBC policies or local plans must be approved by the Executive Director (ED) prior to being sent out to all GBC staff. The Medical Director must review all modifications made to policies related to clinical processes carried out by nursing staff or psychiatric providers, and crisis procedures prior to the ED reviewing and finalizing modifications to policies or plans. Gulf Bend Center policies, procedures, and plans are distributed to all staff whenever they are developed or updated. Notifications are sent by email and include instructions on where the documents can be accessed on the Group H drive, as well as contact information for staff who can provide clarification or guidance. It is the responsibility of all staff to review these email notifications and remain familiar with current policies and procedures to ensure ongoing compliance with agency standards, contractual requirements, and regulatory expectations. Staff are expected to stay informed of updates

and incorporate any new or revised procedures into their daily practices. Updating policies, procedures, and plans is an ongoing process designed to ensure that services remain responsive to the evolving needs of the community. All updates are made with a focus on providing care that is person- and family-centered, while maintaining alignment with best practices and regulatory requirements.

COMMITTEES

Gulf Bend Center has established a series of standing committees to carry out essential quality management functions. These committees provide structured oversight, review key performance data, and address issues that may have a center-wide impact.

INTEGRITY, QUALITY AND COMPLIANCE COMMITTEE

The IQC committee is comprised of staff from Utilization Management, Quality Management and Compliance, Human Resources, Intellectual Developmental Disability Services, Finance, Information Technology, Nursing and Clinic Services, Community Development, and Behavioral Health Services. This committee is facilitated by Director of Quality Management and Compliance. The IQC committee is responsible for reviewing and monitoring data assessments to identify trends and patterns that affect the quality and outcomes for services provided by GBC. IQC committee will make appropriate recommendations for performance review activities, quality improvement activities, and project management efforts to ensure continuous improvement and accountability across the organization. Other staff may be called to serve on the committee depending on the specific initiatives of the committee.

DEATH REVIEW COMMITTEES

Upon notification of a consumer death, the investigating officer (Director of Nursing) is responsible for completing a preliminary death review along with the required documentation and initiating either an Administrative or Clinical review, depending on the circumstances. Gulf Bend Center maintains two committees responsible for reviewing the deaths of individuals served- the Clinical Death Review committee and the Administrative Death Review committee. The Clinical Death Review Committee is comprised of the Investigating Officer and at least two additional medical or nursing professionals, one of whom is not an employee of GBC and was not the attending physician of the deceased. This committee is convened when clinical circumstances, treatment factors, or potential care issues require additional medical evaluation and analysis. The Administrative Death Review committee is comprised of the Investigating Officer, the appropriate Program Director or Manager, Director of Quality Management and Compliance, Director of Program Operations, Chief of Clinical Services, and a representative of the public who will not be related to GBC, HHSC, or the deceased individual, unrelated to the Center. The Administrative Death Review committee is notified by staff of any deaths, regardless of the reason for death. The committees also make recommendations for process improvements to strengthen care processes and reduce future risks. Findings and recommendations of death reviews will be reported to HHSC, IQC, and to the Board of Directors for oversight and accountability.

OFFICE SPACE COMMITTEE

The Office Space Committee is comprised of the Executive Management Team (EMT). Additional staff may be invited to help carry out initiatives set by the Office Space Committee. The committee is tasked with ensuring that office environments are functional, safe, and supportive of staff and consumer needs. This included creating spaces that are linguistically and culturally welcoming, conducive to recovery, and aligned with a positive and professional work environment. By maintaining appropriate facilities, the committee supports both the well-being of the consumers and the effectiveness of staff performance.

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CCBHC CORE TEAM

The CCBHC Core Committee members include the Chief Operating Officer, Director of Program Operations, Director of Behavioral Health, Director of Nursing, Chief Business Services Officer, Director of Human Resources, Chief Financial Officer, and the Director of Quality Management and Compliance. Additional staff may be invited to help carry out initiatives set by the CCBHC Core Team. This team is responsible for ensuring that Gulf Bend Center maintains full compliance with the Certified Community Behavioral Health Clinics (CCBHC) model. Responsibilities include, but are not limited to, reviewing policies and procedures, incorporating stakeholder feedback, monitoring outcomes, collecting and analyzing data, and implementing changes necessary to drive continuous improvement.

SAFETY COMMITTEE

The Safety Committee is overseen by the Chief Finance Officer (CFO) and the Director of Human Resources, who provide guidance and accountability for all safety-related activities. The Safety Committee is comprised of the CFO, Director of Human Resources, and five additional representatives, as needed. The primary function of the Safety Committee is to continuously monitor, assess, prevent, and respond to safety concerns across all facilities and vehicles in order to maintain a safe environment for staff, consumers, and visitors. The committee ensures compliance with all applicable federal, state, and local guidelines, including, but not limited to, building, health, and fire safety codes. In addition, the Texas Council Risk Management Fund (TCRMF) provides support through periodic on-site visits and webinars, offering safety recommendations and staff training to strengthen the overall safety program.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA) CORE TEAM

The SAMHSA Core Team is comprised of Chief Operating Officer, Director of Program Operations, Chief Financial Officer, Director of Behavioral Health, Director of Nursing, CCBHC Project Director, Specialty Clinical Services Manager, Program Evaluator, Data Support Specialist. This multidisciplinary team is responsible for ensuring that all SAMHSA grant measures and objectives are accurately collected, analyzed, and documented for required reporting purposes. In addition, the team share these data findings with the IQC Committee for further evaluation. Based on this review, recommendations may be made to adjust or implement new practices that improve outcomes and strengthen service delivery.

UTILIZATION MANAGEMENT

The Director of Program Operations, Director of Behavioral Health and the Director of Quality Management and Compliance are GBC UM designees who oversee the UM process at the local level. GBC employs a utilization management system to ensure consumers receive the right services, in the right amount, at the right time. This system supports timely and meaningful assessments, accurate of level of care assignments, determination of medical necessity, focused treatment and recovery plan development, and active monitoring of progress towards desired outcomes. Gulf Bend Center also participates in a Regional Utilization Management (RUM) Committee for Behavioral Health and IDD services, which meet at least quarterly. Established as a regional committee within the East Texas Behavioral Health Network (ETBHN), the RUM Committee's primary function of the is to monitor utilization of Gulf Bend Center's clinical resources and to support the promotion, maintenance, and availability of high-quality care while ensuring the effective and efficient utilization of resources. UM reports are discussed during with the IQC committee members by the UM manager. For additional details, refer to Gulf Bend Center's Utilization Management Plan.

GBC REGIONAL COLLABORATIVE

Quality Management Plan

The Regional Collaborative is a diverse group of community members representing Gulf Bend Center's seven-county catchment area. Participants include agencies, community partners, and other stakeholders who provide valuable input on community needs and strategies for delivering effective services. This group plays an important role in advocacy, having successfully collaborated with local Senate and House of Representatives to raise awareness and secure funding for essential services in rural areas. Service delivery and equitable access to care across the region is strengthened through the efforts of the Regional Collaborative

SURVEYS

Feedback from individuals receiving services and GBC staff is essential for evaluating the overall quality of services provided at GBC. To support this, the QM and Compliance department, CCBHC committee, and the Marketing Specialist coordinates and develops a variety of surveys across the Center. These surveys evaluate the needs and capture program and department-specific elements of quality.

The Marketing Specialist reviews and analyzes the survey results, including response rates and the content of the responses and reports this to the appropriate personnel. Findings are used to identify strengths, highlight opportunities for improvement, and evaluate the effectiveness of the survey tools themselves. Based on the findings, recommendations for improvements are made to enhance survey design, increase participation, and ensure that feedback continues to inform quality improvement efforts across the organization.

RISK MANAGMENT

Gulf Bend Center implements a comprehensive risk management program designed to identify, mitigate, and prevent potential risks to consumers, staff, and the organization. Data obtained through these activities are analyzed to determine the scope of identified problems, recognize trends, and develop corrective actions as needed.

The QM and Compliance Department plays a central role in this process by reviewing all submitted incident reports, including medication errors, to identify trends and patterns related to safety or health risks. These findings are reported to the IQC Committee for further review and oversight. In addition, building inspections are conducted by the maintenance staff along with QM and Compliance staff to identify potential health and safety hazards and to ensure Americans with Disabilities Act (ADA) compliance. Results are reported to the IQC Committee.

Additionally, the Death Review Committee reviews all consumer deaths to determine whether the death was incidental to care provided by Gulf Bend Center or the result of causes unrelated to care provided by GBC. This review process is critical to risk management, as it helps identify potential gaps in care, system failures, or safety concerns. *See above in Committees section for additional details.*

Employee-related incidents, including those involving staff injuries, are sent to the Human Resources Department for review and determination of eligibility for Workers' Compensation. This process helps identify workplace safety concerns, reduce the likelihood of recurrence, and ensure corrective measures are implemented to protect the staff and the organization.

STAFF DEVELOPMENT AND COMPETENCY

Qualified and trained staff are critical to the delivery of high-quality services. Staff qualifications and education are verified prior to hire, and competency to perform essential direct care duties is assessed before an employee may work independently with consumers. To ensure ongoing proficiency, all staff are required to complete annual training and competency assessments. Compliance with this performance requirement is monitored by the Human Resources Team and reported to the IQC on a quarterly basis.

Gulf Bend Center also partners with the TCRMF to provide targeted training opportunities for both leadership and the broader workforce. These trainings support professional growth and development, reinforce best practices, and enhance the Center's ability to provide safe, effective, and person-centered services.

REDUCTION IN ABUSE, NEGLECT, AND EXPLOITATION (ANE)

Gulf Bend Center maintains strict policies and procedures that prohibit abuse, neglect and exploitation of individuals served by GBC employees, volunteers, consultants, and contract providers. GBC has implemented preventative support and safeguards to minimize all potential risks to individuals served. These safeguards include comprehensive staff screening, ongoing staff education and training, and training for individuals served and their legally authorized representatives (LARs) to help them recognize and report all forms of ANE. The Rights Officer continuously monitors information relevant to ANE of persons served, and reviews relevant data quarterly or more frequently as needed. The data analyzed is shared with IQC committee members for trends and patterns involving specific programs, staff, or individuals served to guide system improvements

PRE-EMPLOYMENT SCREENING PROCEDURES

To minimize unnecessary or unreasonable risk, GBC mandates the following pre-employment and ongoing screening procedures:

- All individuals considered for employment or volunteer status must undergo a criminal background check through the Texas Department of Public Safety (DPS) or other suitable sources, as well as checks made for ANE confirmations through HHSC, the Client Abuse and Neglect Reporting System, the Employee Misconduct Registry, and the Nurse Aid Registry. These screenings are performed pre-employment, pre-assignment, and annually thereafter.
- All individuals undergo pre-assignment screening through the state and Federal Office of the Inspector General to identify exclusion from participation in healthcare programs. These screenings are performed pre-assignment, pre-employment and monthly thereafter.
- If the applicant has lived outside of Texas within the past two years preceding the application for employment or volunteer status, GBC will obtain criminal history information through the FBI

The HR department will review all pre-employment background checks that reveal criminal convictions or other findings that may contraindicate employment or volunteer service. Decisions regarding employment, conditional hiring, or continued employment are made by Human Resources and may include consultation with legal counsel. When making such determinations, the following factors are considered:

- The nature and elements of the offense, including the circumstance
- The nature of the job responsibilities for which the individual is being considered (or currently holds)
- The remoteness in time of the offense or offenses
- The number and frequency of offenses, and the age of the individual at the time of the offense
- Relevant TAC that relates to the above background checks

STAFF TRAINING

All employees will receive pre-service training during NEO and refresher training through face-to-face sessions and/or computer competency-based modules. Training materials include information on:

- The acts and signs of possible ANE
- Procedures for reporting incidents

- Intervention methods, and
- The disciplinary consequences for act, failure to report, or prevent ANE.

CONSUMER AND LEGALLY AUTHORIZED REPRESENTATIVE EDUCATION

Information on how to report ANE, including contact names, phone numbers, and reporting instructions, is provided to all consumers and/or LARs upon admission and annually thereafter. The Gulf Bend Center website also lists contact information for:

- The Texas Department of Family Protection Services toll-free ANE hotline
- The Rights Protection Officer
- The GBC Compliance Hotline
- A toll-free number to contact GBC at any time

Calls received after business hours are directed to a voicemail system, and consumers will be contacted the following business day. Additionally, the 24-hour crisis hotline is available for a live caller 24 hours a day, 365 days a year. Reports of concerns may also be submitted via email to compliance@gulfbend.org.

RIGHTS PROTECTION PROCESS

The QM and Compliance Department is responsible for establishing and maintaining procedures that ensure consumer education, protection, and advocacy of rights, as well as reporting and investigation of suspected violations in accordance with applicable laws and regulations. The Director of Quality Management and Compliance serves as the Rights Protection Officer and is a standing member of the IQC Committee. The IQC committee is responsible for:

- Reviewing any use of physical restraints, which is not allowed
- Reviewing all reported allegations of ANE
- Reviewing quarterly YES Waiver CIRS data
- Monitoring and providing recommendations to the Center regarding practices and programs related to drug usage, behavioral interventions, protection of consumer rights and funds, service outcomes, and any other area deemed necessary for review or improvement.

All Gulf Bend Center staff receive initial training on the Consumer Rights Policy and annually training thereafter. New employees are not permitted to assume job responsibilities until they have successfully completed Customer Rights training. Any suspected violations of consumer rights are immediately reported to the Rights Protection Officer via internal GBC email, the compliance email, the GBC website, or local 1-800-421-8825 number. Allegations or suspicions of ANE involving any consumer of Gulf Bend Center must be reported to the Texas Department of Family and Protective Services by contacting the toll-free hotline 1-800-252-5400 or the web-based portal at *www.txabusehotline.org/Login/Default.aspx* to initiate an investigation. The Rights Protection Officer collaborates closely with the Office of the Ombudsman, HHSC Provider Investigations, and DFPS to address concerns as they arise and ensure that appropriate corrective and preventive actions are implemented.

AUTHORITY FUNCTIONS

AUTHORITY

GBC is structured into multiple authorities, including the Local Mental Health Authority (LMHA) and Local Intellectual Developmental Disability Authority (LIDDA). As the local authority for mental health and IDD services, GBC serves as the single point of responsibility for planning, policy development, coordinating with the community

to align and coordinate services, and resource allocation and management. Additionally, GBC ensures that consumers receive services they need through a network of internal and external providers and engages in ongoing efforts to expand and strengthen this network, so consumers have a variety of providers to choose from. Within these authority roles, data collection, review and analysis are fundamental components of GBC's operations and quality improvement processes.

LOCAL PLANNING

STAKEHOLDER INVOLVEMENT

Gulf Bend Center is committed to creating and maintaining strong partnerships with the local community stakeholders for both LMHA and LIDDA programs to enhance the coordination and quality of care for the individuals and families we serve. Stakeholders involved in LMHA and LIDDA strategic planning include individuals receiving services, their families, LARs, and/or guardians, advocacy groups, community partners, service providers, and direct support staff. GBC actively works to develop and maintain relationships with local independent school districts, hospitals, emergency departments, law enforcement agencies, the criminal justice system, and other organizations essential to supporting the delivery of quality services to all consumers. Stakeholder input from these organizations assists GBC in improving the delivery of quality services that honor consumer choice, account for cultural diversity, and prioritize community needs.

Organizations in which GBC participates in include, but are not limited to:

- Homeless Coalition of the Golden Crescent
- United Way of the Crossroads
- Planning Network Advisory Committee (PNAC)
- Regional Planning Network Advisory Committee (RPNAC)
- Victoria Chamber of Commerce
- Community Resource Coordinating Groups (CRCG)

PLANNING NETWORK ADVISORY COMMITTEE

The PNAC is comprised of community members appointed by the Board of Trustees to provide guidance on planning, budgeting, and contracting issues, as well as identifying needs and priorities for the service area. The PNAC board is comprised of persons with lived experience with or families of persons with mental illness, substance use disorders, and other populations served. This committee is responsible for reviewing and providing input on the Local Provider Network Development (LPND) and the Consolidated Local Service Plan (CLSP). In addition, PNAC gathers and incorporates stakeholders input on service needs and delivery to present this information to the Board of Trustees and the Executive Director. Additionally, GBC participates in the Regional PNAC through ETBHN for additional regional stakeholder input and supports the review of the LPND and CLSP at a broader, collaborative level.

COORDINATING WITH COMMUNITY PARTNERS TO ALIGN AND COORDINATE SERVICES

GBC coordinated with various local community partners to ensure that consumers have access to continuity of care. This collaboration allows GBC and community organization to communicate needs of an individual so that services can be provided in a seamless manner. Sign-in sheets, minutes from meetings, or memoranda of understanding (MOU) are used to track collaborative inputs from the various organizations. Community partners include, but are not limited to:

- Local law enforcement agencies

- Local Jails
- Probation and parole departments
- Local hospital and emergency rooms
- Homeless coalition of the Golden Cresent

CONTINUITY OF CARE

Gulf Bend Center collaborates closely with inpatient psychiatric hospitals to ensure that consumers receive appropriate and ongoing care once they return to the Center's catchment area. These coordinated efforts follow all applicable regulatory guidelines to ensure individuals receive timely services and support necessary to maintain stabilization and recovery. In addition, GBC works with local jails, probation and parole departments to facilitate continuity of care for offenders with mental health needs, ensuring they have access to mental health treatment and services upon release.

SUMMARY AND COMMITMENT TO QUALITY AND EXCELLENCE

Through this Quality Management Plan, Gulf Bend Center ensures systematic monitoring, evaluation, and continuous improvement of all programs and services. This plan reinforces our mission to deliver safe, efficient, and person-centered care by promoting accountability, data-driven decision-making, and collaboration across departments. Additional activities coordinated by GBC can be seen in Attachment A. By integrating feedback from staff, individuals served, community partners, and regulatory entities, GBC remains committed to enhancing service quality, maintaining compliance, and achieving positive outcomes for every person we serve.

Quality Management Plan

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

ATTATCHMENT A:

Oversight Activities	Person/Entity Responsible	Timeframe
External Contracts Review/Provider Network Development	Contracts Management	On-Going
Billing/Encounter Review	Program Manager/QM	On-Going
Performance Measures	Program Manager/ UM/QM	On-Going
Safety Review	CFO/HR Director	Annually
ADA Plan Review	QM/ HR Director	Annually
Complaints/Appeals	QM/ Director of Programs	As Needed
Abuse/Neglect	QM/ Client Rights Officer	As Needed
Emergency Preparedness Plan	Executive Management	Annually
Satisfaction Surveys	QM/Community Liaison/Marketing Specialist	On-Going
Utilization Management – MBOW reports, Hospitalization Data, Appeals, Crisis	UM Director- ETBHN	On-Going
Risk Management	QM	On-Going
Death Reporting	Death Committee	On -Going
Infection Control Monitoring	Director of Nursing	On-Going
Productivity Monitoring – EHR reporting	Program Manager/IT/IS	On-Going
ANSA/CANS – Training	Program Manager / HR	Annually
Waiting List & Follow up Activities	Program Manager / QM	As-Occurs
Review of Financial Status and Budget	Executive Management	On-Going
Recovery Plan Review and Progress Notes	Program Manager /QM	On-Going
Substance Use Treatment	Program Manager /QM	Annually
Rights Review	QM	Annually
Compliance of TAC	Program Administrator/QM, UM	On-Going

	Director	
Consents Review	Program Manager/QM	Annually
Documentation of Quality Management Plan Activities	QM	Quarterly: On-Going
Incident Reporting	Staff/Program Manager/QM	As-Occurs
Workforce Competency & Credentialing	Human Resources/ Program Manager	Annually, On-Going
Quality Management Plan	QM Director	Annually and biennially
Technical Assistance Provision	QM	On-Going
Adult Services – Fidelity Review	**Person/Entity Responsible**	**Timeframe**
Assertive Community Treatment (ACT)	Program Manager/QM	Annually
Supported Employment (SE)	Program Manager	Annually
Permanent Supported Housing (PSH)	Program Manager/QM	Annually
Illness Management & Recovery	Program Manager/QM	Annually
Children & Adolescent Services – Fidelity Reviews	**Person/Entity Responsible**	**Timeframe**
Social Skills and Aggression Replacement Techniques (START)	Program Manager /QM	Annually
Preparing Adolescents for Young Adulthood (PAYA)	Program Manager /QM	Annually
Seeking Safety	Program Manager /QM	Annually
Nurturing Parenting Program	Program Manager /QM	Annually
YES Waiver – Wraparound Planning Process	Program Manager /QM	Annually
Other Programs	**Person/Entity Responsible**	**Timeframe**
COPSD	Program Manager/QM	Annually
TCOOMMI	Program Manager /QM	Annually

Jail Diversion	Program Manager /QM	Annually
Outpatient Competency Restoration	Program Manager /QM	Annually
PASRR Review	Program Manager /QM	Annually
Crisis	Program Manager /QM	Annually
Inpatient Services/ Continuity of Care	Program Manager /QM	Annually
DPP Quality Services	QM/IS	On-Going
CCBHC Services/ Metrics/Outcomes	Program Manager /QM/IS	On-Going
SAMHSA Services/Metrics/ Outcomes	Program Manager /QM/IS	On-Going

SIGNATURE PAGE

APPROVAL

The Quality Management Plan for Gulf Bend Center was reviewed and approved on 10/28/2025.

Signature on File

Steve Hipes,
Gulf Bend Center Board of Trustees Chair

Signature on File

Jeffrey Tunnell, Executive Director Gulf Bend Center

Signature on File

Sebbie Miller, Director of Quality Management and Compliance, Gulf Bend Center