ANDREWS BEHAVIORAL HEALTH
QUALITY AND UTILIZATION MANAGEMENT (QMUM) PLAN
FISCAL YEARS 2026 AND 2027

APPROVAL SIGNATURES

Name / Title	Signature	Date
Chief Executive Officer	Becky Mangum	12/02/2025
Chief Operations Officer	Becky Mangum	12/02/2025

REVISION INFORMATION

Revision Date	Summary of Revisions	Approved By
November 2025	Initial Draft for FY 2026–2027	

Introduction

At Andrews Behavioral Health (formerly Andrews Center), the Quality and Utilization Management (QMUM) Plan serves as a foundational framework for delivering safe, effective, and person-centered services. The plan guides ongoing efforts to enhance treatment outcomes, promote client safety, and strengthen organizational efficiency. *Through structured monitoring of performance indicators, data-driven analysis, and adherence to evidence-based best practices,* Andrews Behavioral Health maintains a continuous cycle of quality improvement. This approach ensures that services not only meet regulatory and accreditation standards but also reflect the Center's commitment to *excellence, accountability, and the well-being of every individual served*.

I. Strategic Planning

Strategic planning identifies key areas to measure and assess, with a focus on high-volume, high-risk services. Andrews Behavioral Health uses annual summaries from local and regional sources to set priority functions for evaluation and improvement.

Strategic planning draws upon:

- Mission, Vision, and Values statements
- Most updated community needs assessment
- Self-assessment results
- Leadership initiatives
- Feedback from stakeholders and community partners

Stakeholder engagement helps ensure that Andrews Center's priorities align with community needs and system goals.

A. Stakeholder Involvement

Andrews Behavioral Health solicits input from stakeholder groups, each of which plays a distinct role. Clients and families provide insights into care experiences, while advocacy and client organizations represent client interests and voices. Referral sources and

network providers share information on service needs and coordination, while state facilities and local community members contribute perspectives on system impact and community priorities.

Input is collected through surveys, public hearings, community forums, and Citizen Planning and Advisory Committees (CPACs).

Contracts with HHSC and DADS require Andrews Behavioral Health to establish at least one CPAC for each population served.

The Center works with the East Texas Behavioral HealthCare Network (ETBHN) to maintain a Regional Planning and Network Advisory Committee (PNAC).

Two Board-appointed members, one representing mental health consumers and one representing intellectual and developmental disability consumers or their family members, serve on the Regional PNAC to present consumer perspectives and ensure their active involvement in planning and evaluation.

The Board of Trustees incorporates stakeholder feedback in strategic planning and policy. Local MH and IDD Planning Advisory Committees have at least nine members, with at least half being clients or family members. Appointees from these groups participate in Regional PNAC meetings to support communication and continuity.

II. Leadership

Andrews Center's Executive Leadership Team sets strategic direction. It ensures that quality and utilization management align with organizational goals.

Members include:

- Chief Executive Officer (CEO)
- Chief Operations Officer (COO)
- Chief Financial Officer (CFO)
- Chief Sequential Intercept Mapping (SIM) Officer
- Director of Human Resources
- Director of Management Information Services (MIS)
- Director of Intellectual and Developmental Disabilities (IDD) Services
- Director of Behavioral Health Intensive Community Services
- Director of Clinical Services
- Director of Compliance and Clinical Outcomes

- Representative from Supporting, Healing, Innovative, Family, Teamwork, Steadfast (SHIFTS) Team

The Leadership Team:

• Sets annual goals and priorities to advance client outcomes.

• Provides resources and support for continuous improvement initiatives.

• Ensures staff are trained to assess, measure, and improve process performance.

• Promotes open communication between clients and staff to enhance service coordination and quality.

The Executive Leadership Team reviews performance data weekly. It monitors HHSC Contract Outcomes and Performance Measures.

– Regulatory Agency Reviews

– Utilization Management Data

– Stakeholder Satisfaction Data

Directors share findings and recommendations with Leadership each month. These are also shared with the Board of Trustees in CEO reports and presentations.

Directors meet monthly—both individually and in groups—to review performance, discuss improvement opportunities, and share ideas with Leadership. All recommendations are tracked to ensure follow-up and resolution.

III. The Quality Management Program

The Quality Management Program provides the structure and methodology for evaluating and improving service quality across Andrews Behavioral Health programs.

The Quality Management (QM) team coordinates quality and utilization management activities to ensure compliance with Texas Resiliency and Recovery (TRR) principles and evidence-based care.

A. Quality Management Team Members

- Quality Assurance Reviewer
- Utilization Reviewer
- Ancillary Support Service Coordinator
- MIS Senior Programmer
- Clinical Outcomes Data Analyst
- Director of Compliance and Clinical Outcomes

B. Quality Management Functions

The Quality Management Program enables Andrews Behavioral Health to:

- Evaluate organizational efficiency and performance.
- Review and improve services provided through the provider network and the Local Authority.
- Establish measurable goals and objectives that promote service and billing accuracy.
- Conduct self-assessments and planning activities.
- Ensure services are person-centered, recovery-oriented, and aligned with TRR philosophy.
- Continuous quality improvement initiatives and planning.

IV. Procedures

Major activities of the Quality Management Team include:

Core Activities

• Development, assessment, and monitoring of the QMUM Plan.

• Regional and internal Utilization/Quality Management Committee meetings.

• Coordination of data collection, analysis, and corrective action plans.

• Development of Executive Leadership Reports.

• Coordination of internal review/auditing of programs, contractors, billing, and client care.

• Facilitation of TRR assessment authorizations.

• Oversight of utilization management activities.

• Use of fidelity instruments to ensure adherence to TRR principles.

V. Performance Contract Measures

Andrews Behavioral Health uses data from the Mental and Behavioral Health Outpatient Warehouse (MBOW) to ensure compliance with HHSC Performance Contract requirements.

A. Data Monitoring and Review

- Data are reviewed regularly to identify trends and errors, to guide compliance and/or outcome-based recommendations.
- Staff document results in a spreadsheet and then share with the Leadership staff.
- Performance measures are reviewed twice monthly during Executive Sessions.

B. Reporting

- Findings are communicated through performance spreadsheets, Director meetings, and Executive Leadership reviews.
- Corrective actions and training needs are documented, assigned, and tracked until resolved.

VI. QA Unit Chart Audits

Each month, the Quality Assurance Unit randomly selects a cross-program sample (MH and IDD) of at minimum sixty services for review.

Audits evaluate documentation quality, funding compliance, and treatment accuracy.

A. Supervisor Feedback

Results are distributed to program supervisors to:

- Identify staff training needs.
- Ensure corrective documentation.
- Track recurring errors or compliance gaps.

B. Continuous Improvement

Audit findings inform agency-wide quality initiatives and individual staff performance monitoring.

Use of the Plan-Do-Study-Act (PDSA) model for testing and improvement of the change process.

Results are presented monthly to the Executive Leadership Team for review and action.

Community needs assessments are conducted every three years to identify challenges and concerns from community members, stakeholders, and clients engaged in services.

VII. Quality Monitoring of Screening, Access to Services, and Statewide Recovery Plan Review

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A. Screening and Access to Services

Random clinical chart reviews are conducted to ensure compliance with screening, crisis, and discharge procedures.

The sample, which contains individuals screened in the previous month, is reviewed for:

• Proper client-number assignment and entry in the electronic health record (EHR)

• Documentation completeness and accuracy

• Compliance with screening protocols and timelines

Discharge-chart reviews and audit-team feedback are incorporated into system-improvement planning.

Client appeals related to service denials or reductions are reviewed quarterly and reported to the Regional Utilization Management (UM) Committee.

VIII. Supervisory and Peer Review

Supervisors review assigned records for:

• Service quality and clinical appropriateness

• Documentation accuracy and timeliness

• Compliance with funding and treatment standards

A. Scoring and Corrective Action

Staff members must meet established target scores for three consecutive months to be exempted from review for the next quarter.

Those who do not meet targets receive retraining on documentation standards or face progressive personnel action.

X. Unit Accountability and Productivity Targets

Each organizational unit establishes monthly accountability and productivity benchmarks.

When targets are not met, supervisory staff are responsible for corrective training or personnel action.

XI. Safety, Risk Management, And Infection Control

Staff responsible for safety, risk management, or infection control will engage in surveillance, documentation, and reporting activities and will store data in a centralized, secure location accessible to QMUM.

Aggregate data are submitted to the Executive Leadership Team for analysis and corrective action.

Consultation with the Texas Council Risk Management Fund supports prioritization of identified risks and safety planning.

XII. Corporate Compliance

Corporate compliance activities are implemented in accordance with Andrews Behavioral Health's Business Code of Conduct.

All staff participate in annual training on HIPAA, fraud prevention, waste, abuse prevention, and ethical standards.

Compliance data and findings are reviewed quarterly by the Corporate Compliance Committee and reported to the Executive Leadership Team.

XIII. Utilization Management Committee Purpose

The Utilization Management Committee ensures that Andrews Behavioral Health's clinical resources are used effectively and efficiently, in alignment with HHSC Utilization Management Guidelines.

A. Committee Structure and Frequency

• Regional UM Committee – Meets quarterly under the East Texas Behavioral HealthCare Network (ETBHN).

• Internal UM Committees – Meet monthly to review local issues and report quarterly to the Regional UM Committee.

B. Performance Measure Integration

Quarterly UM meetings review Performance Measure data from Business Objects to promote staff awareness of utilization trends and to align service delivery with contractual benchmarks.

XIV. Client Rights Protection Process

A. Overview

Protecting client rights is fundamental to Andrews Center's mission of delivering safe, ethical, and high-quality care.

All employees, contractors, and volunteers receive training in client rights and abuse/neglect/exploitation before client contact and annually thereafter.

B. Client Orientation

At screening and intake, clients are verbally informed of their rights and receive a Client Rights Handbook that includes complaint procedures and contact information.

During annual registration updates, staff re-review rights information with each client.

C. Rights Officer Role

The Client Rights Officer investigates complaints alleging violations of client rights.

If a violation is confirmed, corrective actions may include policy revision, training, or other remedies to restore rights.

When no violation is found, the individual is notified in writing and provided external appeal options (DSHS, HHSC, and Disability Rights Texas).

D. Reporting and Analysis

Quarterly, as part of the Safety and Risk Assessment Committee, the Client Rights Officer submits aggregate complaint data to the Executive Leadership Team to identify trends and opportunities for improvement.

XV. Youth Empowerment Services (YES) Waiver Quality Management Plan

A. Purpose

The YES Waiver program prevents or reduces institutionalization for children and adolescents aged 3 – 18 with serious emotional disturbance (SED) by enhancing access to community-based services and family support.

Andrews Behavioral Health adheres to the HHSC YES Waiver Policy and Procedure Manual.

B. Policy Highlights

YES Waiver operations include:

• Maintaining an Inquiry List for children seeking waiver services.

• Operating an interest-list phone line with voice messaging capability.

• Returning calls within one business day and registering clients in order received.

• Verifying demographic eligibility by phone and completing a face-to-face clinical eligibility assessment within seven business days (extensions documented at client or LAR request).

• Completing an Initial Service Authorization Request and Individual Plan of Care (IPC) within ten business days of HHSC authorization.

• Submitting completed IPCs to CMBHS for approval within five business days.

• Providing Intensive Case Management through the Wraparound Planning Process per 25 TAC § 412 Subchapter I.

• Initiating transition planning at least six months before the participant's 19th birthday.

• Monitoring service delivery to ensure compliance with the approved IPC and engagement in all authorized services.

C. YES Waiver Quality Management Activities

Monthly monitoring includes data collection and analysis to improve the following performance dimensions:

- Timely access to services and enrollment.
- Alignment of plans of care with underlying needs and outcome statements.
- Service delivery consistent with each participant's approved IPC.
- Provider participation in child and family team meetings.
- Ongoing assessment and revision of IPCs based on changing needs.
- Health and safety risk factors monitoring and updates.
- Critical-incident data collection and trend analysis.
- Verification of provider credentialing and training.
- Adherence to approved policies and procedures.
- Continuity of care and cross-system coordination.

D. Reporting

Findings from YES Waiver monitoring are reviewed monthly by the internal Utilization Management Committee and Executive Leadership Team to identify trends and assign corrective actions.

XVI. IDD Quality Management

A. Stakeholder Involvement

Stakeholders participate in Andrews Center's quality management programs through multiple avenues, including:

- Client satisfaction surveys
- Client house councils
- HCS and TxHmL Advisory Councils
- Citizens Planning and Network Advisory Committees (CPACs)
- Northeast Texas Regional Interagency Council

B. Client Surveys and Perception of Care

Each year, individuals in HCS, TxHmL, ICF/IDD, and Day Habilitation programs complete satisfaction surveys.

Survey results are reviewed by Program Managers, Directors, and the Advisory Council.

Unresolved concerns are escalated to the Chief Operations Officer and, if necessary, to the Executive Leadership Team for action.

C. Client House Councils

Residents of Andrews Center-supported ICF/IDD facilities meet monthly to discuss safety, satisfaction, and service quality.

Feedback is shared with the Interdisciplinary Team (IDT) to guide programming adjustments.

D. HCS/TXHML Advisory Council

This council meets quarterly to review:

• Critical incidents (e.g., medication errors, PMAB use, injuries)

• Abuse, neglect, and exploitation reports

• Client complaints and incident/accident reports

Providers collaborate with Andrews Behavioral Health staff to develop corrective strategies and streamline processes.

Recommendations are reported to the Chief Operations Officer.

E. Regional Collaboration

Agencies providing HCS/ICF-IDD/TxHmL services are invited to regional provider meetings to discuss program updates, identify issues, and exchange best practices.

The Chief Operations Officer communicates key findings to the Executive Leadership Team for planning purposes.

F. IDD Consortium Participation

IDD staff participate in two major consortia:

• The IDD Directors Consortium, sponsored by the Texas Council of Community Centers, meets quarterly in Austin.

• The ETBHN IDD Committee meets monthly via video conference.

These forums promote training, networking, and problem-solving across regional partners.

G. Roundtable and Community Collaboration

Andrews Behavioral Health collaborates with ACCESS, Area Agencies on Aging, Community Healthcore, and other partners under a shared Memorandum of Understanding (MOU) to improve access and streamline referrals across DADS programs.

Outcomes include a shared referral form, interagency training, and ongoing evaluation to strengthen access systems.

XVII. MH Quality Management

A. Client Surveys and Perception of Care

Client-satisfaction surveys are conducted biennially to assess satisfaction with mental health services.

Survey findings guide service improvements, staff training, and program modifications.

B. Oversight and Coordination

Findings from MH and IDD quality initiatives are integrated into a combined QM report, which Leadership reviews.

Action items, timelines, and responsible parties are tracked through Director meetings to ensure accountability.

XVIII. Strategic Plan, Measurement, And Improvement

A. Measurement and Assessment

Measurement is the foundation for all performance improvement activities. Reliable data allows Andrews Behavioral Health to:

- Identify process stability and opportunities for improvement.
- Evaluate outcomes and resource efficiency.
- Confirm that redesigned processes achieve desired objectives.

B. Data Sources

- Organizational goals, workload, budget, and strategic plan achievements
- Risk-management data
- Clinical monitoring results
- Customer satisfaction studies
- State hospital utilization rates
- Self-assessment and provider complaint data

C. Benchmarking and Normative Data

Andrews Behavioral Health establishes baseline performance data and uses:

- Internal comparisons over time
- Regional ETBHN data
- Published national standards and evidence-based guidelines

D. Improvement Methods

Improvement efforts focus on redesigning or refining existing processes to:

- Reduce risk to clients
- Enhance core service performance
- Address high-frequency or high-volume concerns
- Meet external and internal review findings

E. Example: Monitoring of Abuse, Neglect, and Exploitation

Human Resources, Operations, Quality Management, and Utilization Management review data on abuse, neglect, and exploitation quarterly.

Trends are analyzed, and corrective plans are implemented when needed.

Results are reviewed during the following quarterly review to verify improvement.

XIX. Sharing Quality Management Information

A. Internal Communication

• Directors receive QM results and action plans for dissemination to their teams.

• Audit results are presented at monthly staff and committee meetings.

B. External Communication

• Advisory committees receive quarterly updates on QM outcomes.

• Contracted providers receive performance feedback related to their service areas.

• Interagency stakeholders (Smith, Henderson, Van Zandt, and Wood/Rains Counties) are briefed on QM findings during quarterly coordination meetings.

XX. Quality Management Schedule of Activities

A. Monthly QM Activities

• Training within unit meetings.

B. Bi-Weekly QM Activities

• Review of Performance Measures dashboard on the 1st and 15th of each month.

• Transfer data from the MBOW folder to the agency spreadsheet and distribute to the executive leadership team.

C. Monthly QM Activities

• MH QA Audit – 60 charts reviewed (random sampling). Results reviewed monthly by Leadership.

• IDD Chart Audit – Three charts per service coordinator reviewed using the IDD auditing tool for HCS, TxHmL, PASRR, and GR programs.

• UM Committee Meeting – Held every fourth Wednesday; findings reported to Leadership monthly.

• Corporate Compliance Committee Meeting – Follows UM Committee to address compliance and HIPAA matters.

• Monthly MBOW IDD Duplicate Errors Report.

• Monthly EHR services review to identify incomplete services.

D. Quarterly QM Activities

• YES Waiver Audit – Ten (10) charts reviewed quarterly; results reported to supervisors and Leadership.

• Regional UM Meeting – ETBHN member centers review UM contractual compliance; minutes shared with local QM/UM and Leadership teams.

• Local PNAC Meeting – Results reported to the Board of Trustees.

• Safety, Risk Management, and Infection Control Committees meet to report results of audits and identify system risks.

• Corrective Action Plan monitoring and quarterly results presentation to Directors.

• HIPAA audits and reviews conducted by Risk Management Specialists.

E. Annual QM Activities

• Comprehensive review and revision of the QMUM Plan through ongoing re-evaluation and updating as needed.

F. Biennial QM Activities

• Consolidated Local Service Plan.

• Local Provider Network Plan.

G. Routine Activities

- Routine satisfaction surveys administered to clients.

XXI. Local Planning Summary

Andrews Behavioral Health ensures all required planning functions are completed within HHSC timelines.

• The Local Plan is developed and posted in accordance with the Performance Contract's "Authority Functions."

• The Center participates in Regional PNAC through ETBHN, ensuring representation from both MH and IDD stakeholders.

• Two or more Board-appointed PNAC members serve on the Regional PNAC.

• Local MH and IDD advisory committees meet quarterly and provide an annual summary report to the Board of Trustees to guide strategic planning.

XXII. Forensic Remedies

A. Outpatient Competency Restoration

Andrews Behavioral Health's Outpatient Competency Restoration Program delivers community-based restoration, mental health and substance use treatment, and competency education for justice-involved individuals.

B. Texas Corrections Office on Offenders with Medical and Mental Impairments (TCOOMMI) Program

TCOOMMI program offers comprehensive re-entry services to reduce recidivism, improve mental health stability, and support continuity of care for individuals returning to the community.

C. Jail-Based Competency Restoration (JBCR)

JBCR provides mental health treatment to individuals found incompetent to stand trial while they are in jail.

D. Jail Continuity of Care (JCOC)

Jail Continuity of Care (JCOC) is to ensure continuity of care for justice-involved people with serious mental illness throughout their incarceration at the facility where the Jail CoC Liaison Program is operating, as well as an initial transition period while they are re-entering the community.

Andrews Behavioral Health QMUM Plan FY 2026–2027

In conclusion, the Andrews Behavioral Health QMUM Plan for Fiscal Years 2026 and 2027 ensures that our strategic actions align with our organizational mission, focusing on enhancing service quality and accessibility. Furthermore, the plan supports the Board of Trustees in their oversight responsibilities by providing detailed frameworks for regular reviews and assessments. This alignment not only reinforces accountability at all levels but also commits to continuous improvement in serving our community.