Quality Management Plan
FY 2015-2016

I. Overview

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

Mission Statement

Working together to improve lives

Vision Statement

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

Goals

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

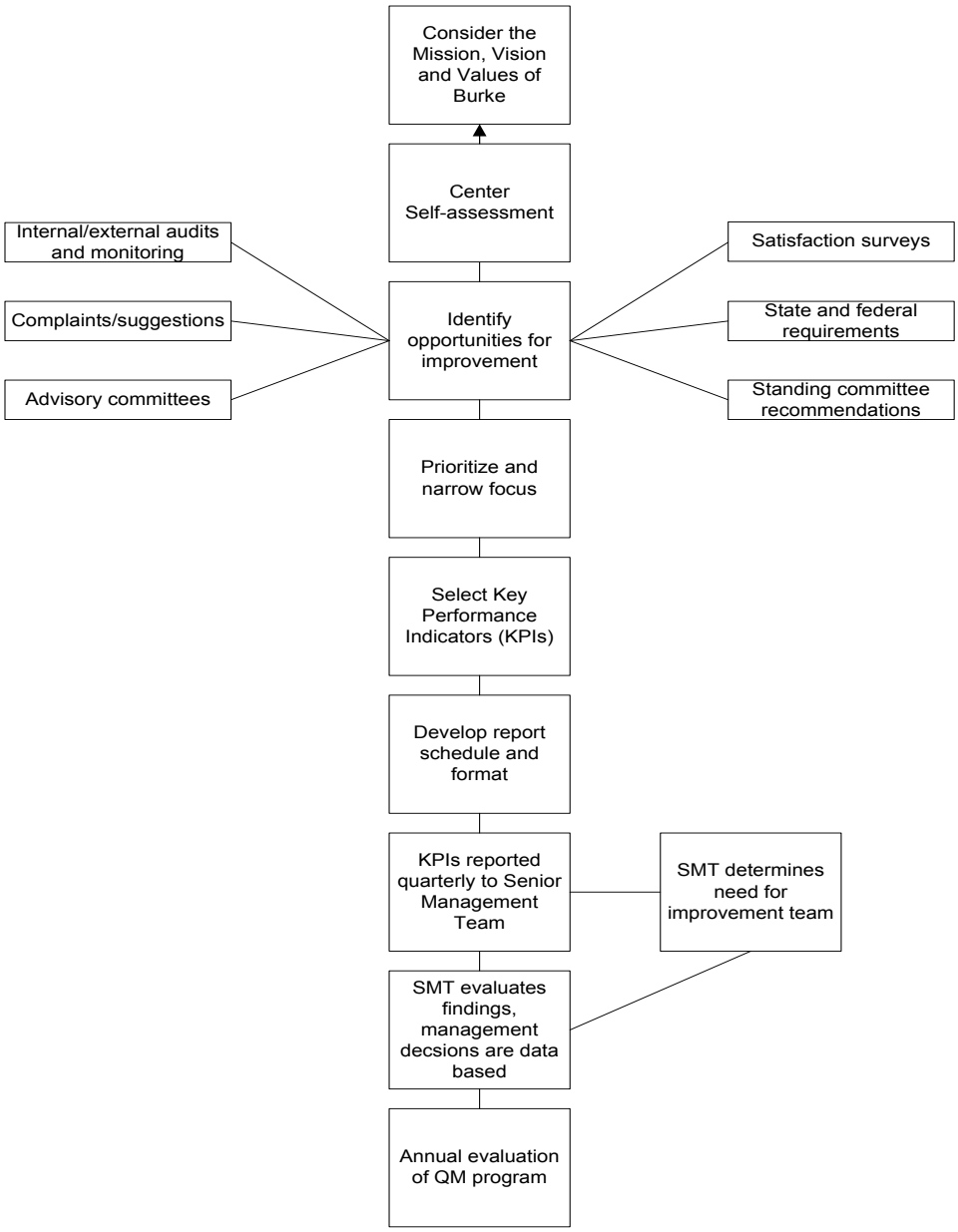
Values

1. We affirm the dignity, rights, and strengths of the people and families we serve.
2. We are committed to excellence in everything we do.
3. We continually seek better and innovative ways to provide and improve services.

4. We use our resources in a careful, efficient, and well-planned manner.

The leadership of Burke is entrusted with the implementation of the quality management plan. Planning involves taking into account the population served, the organization's mission, the scope of services and care, and needs identified by all stakeholders. The purpose of the Burke Quality Management Plan is to establish the process by which an objective means of evaluating performance is achieved, allowing management decisions to be data driven, assuring that processes are designed well, and that the organization continually assesses, monitors and improves its performance in priority areas of clinical outcome, financial stability and organizational efficiency.

Annual Process for Quality Management and Performance Improvement



II. Quality Management Program Structure

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

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

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

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

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

III: Determining Improvement Priorities

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

- Issues related to safety and level of risk to consumers served, particularly adverse occurrences affecting individuals served
- Issues related to state or federal mandates
- Issues identified through stakeholder surveys or advisory committees which impact critical functions or outcomes
- Problem prone processes
- New processes adopted such as Targeted Case Management, Jail Diversion or Crisis Redesign

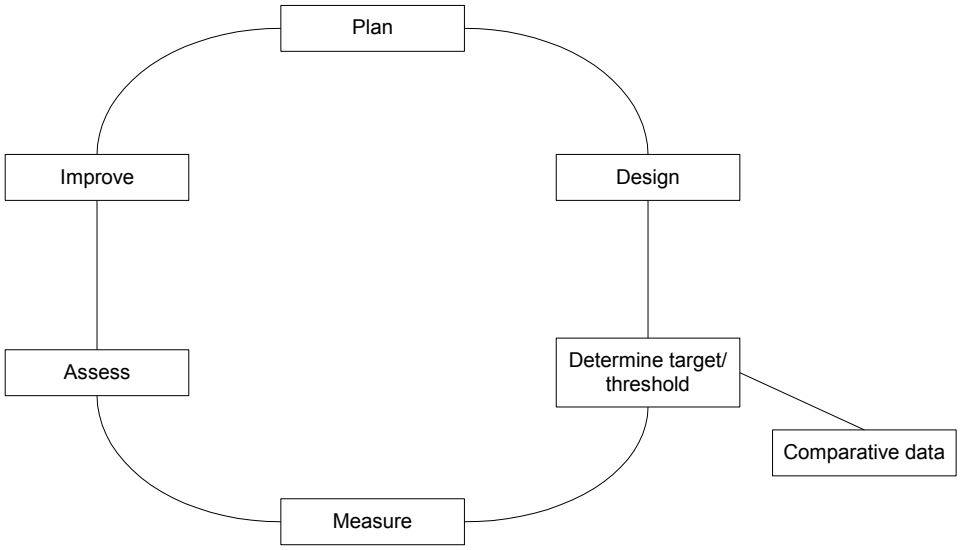
Priorities are adjusted in response to unusual or urgent events, as determined by the Senior Management Team.

IV. Key Performance Indicators

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

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

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



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

- **Findings**: Data is reported is relative to the performance target and in the manner described in the indicator (i.e. rate based vs. incident based. The use of charts and/or tables, including bar graphs, run charts, histograms, pie charts or any other appropriate visual technique is encouraged. Data is reported in a manner determined by the process or outcome measured, to allow identification of unacceptable variations in performance, and focus correction efforts.

- **Analysis/Evaluation**: This section is for discussion of the data, with evaluation of the impact of the findings, turning data into information. The report describes if

the process or outcome is assessing, monitoring, improving or maintaining performance.

- **Corrective actions taken/planned**: Actions planned or taken to address unacceptable or unexpected variations are described. Timelines and remedies are determined by the program with input from SMT.

- **Results of corrective actions**: Results of actions taken or planned are addressed. If a specific service area cannot correct the unacceptable performance by itself, a process improvement team may be suggested.

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

V. Other Quality Management Activities

1. Stakeholder Involvement:

A. Customer Satisfaction and Perception of Care

Burke utilizes several different means to gather information regarding stakeholder's perception of care and services. Consumer satisfaction is assessed with evidence based tools and comparative benchmarks are employed when available. Client satisfaction with video conferencing processes is assessed no less than annually. Other program specific survey tools are utilized as appropriate. Findings of all of these surveys are reported to the Senior Management Team and are used to identify areas of exceptional service and opportunities for improvement.

B. Employee Satisfaction

Biannually and as needed, Burke conducts an employee satisfaction survey. Results of the survey are discussed at Senior Management Team and with employees, and improvement activities are identified. Periodic meetings by Human Resource staff with employees at their job sites also allow input.

2. Measuring, Assessing and Improving Services and Outcomes:

A. Feedback from State Contract Oversight

Reports, data and results from on site reviews from the Department of State Health Services (DSHS), Department of Aging and Disability Services (DADS), and Department of Assistive and Regulatory Services (DARS) are used to identify performance improvement activities and to assess unmet needs of individual served, service delivery problems and effectiveness of system interventions.

B. Compliance Billing Audit

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

Medical staff billing is audited quarterly to assure that documentation required to support E&M code usage, and results are shared with the medical and program staff as well as the Compliance Committee.

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

C. Safety, Risk Management and Infection Control Committee

Along with other duties, this committee review all incident reports and results of hazard surveillance. Data is aggregated, and summarized and evaluated quarterly, with an annual evaluation of the program completed at the end of the fiscal year. Results are reported to the Senior Management Team, and are used to assess the safety of services and the environment, staff training needs and other opportunities for improvement. Vehicles and Facilities are inspected quarterly by the safety officer. Other safety inspections include Annual Fire Marshal inspection,

Annual Fire Alarm Inspection, Annual Kitchen Inspection by local health authority (Angelina Counties Health District), Annual Fire Extinguisher Inspection by a certified business and monthly by maintenance foreman, and monthly fire drills. All reports are submitted to Burke's safety officer. Deficiencies are noted and corrected. Additionally, an annually proactive risk reduction project is completed to increase the safety and quality of services provided. This project is determined through internal data collection and identified needs of improvement. The Risk Management process also includes the manner in which deaths of person served are recorded, reported and analyzed, in accordance with state and contract requirements.

D. Accreditation by The Joint Commission

Burke maintains accreditation by the Joint Commission, requiring adherence to nationally recognized standards related to the provision of care. Through ongoing self-assessment of compliance with standards, this accreditation assures a constant process of improvement of services.

E. Co-occurring Psychiatric and Substance Use Disorders (COPSD) Oversight

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

F. Crisis Response

Oversight of the response system includes data collection on timeliness of response and appropriateness of care. Data on SMHF usage is aggregated and reported to the Utilization Management Committee.

G. Staff Competency Determination

Qualified and trained staff make up an important component of quality service provision. Qualifications and education are verified prior to hire and competency to perform essential direct care duties is assessed prior to staff's working unaided with consumers. All staff complete required

training and competency assessment annually and compliance with this KPI is monitored and reported quarterly to SMT.

3. Measuring, Assessing and Improving Data Integrity:

A. CA MH Claims Oversight

Ongoing validation audits of Medicaid claims are done to assure data quality and accuracy. Audits of factors such as use of incorrect service codes, denied claims, and unauthorized services, and results are used to refine Burke's billing system and data reporting. As issues are identified, modifications to the data reporting and billing system are made. Staff training needs are also identified in this process.

B. DD Targeted Case Management (TCM) Encounters:

DD Authority Services audits TCM encounters to assure data quality and accuracy. Type A and B claims are monitored monthly. Staff training needs are identified through this process.

C. Cost Accounting Methodology (CAM)

CAM data is developed annually. The process involves assessing accuracy of data collection and reporting as well as to compare Burke's costs with that of other organizations and/or centers.

D. MBOW Data Warehouse

The reports generated in the state database are constantly reviewed by management staff to assess Burke's performance on a variety of indicators, and used as a means to judge accuracy of data collection as well as to evaluate Burke's performance on outcome measures.

4. Measuring, Assessing and Improving Service Delivery, Continuity and Access to Services:

A. Utilization Management (UM)

Burke participates in both a local and regional UM Committee for mental health services, both of which meet no less than quarterly. Established as a regional committee within the East Texas Behavioral Health Network (ETBHN), the primary function of the UM Committee is to monitor utilization of Burke's clinical resources to assist the promotion, maintenance and availability of high quality care in conjunction with

effective and efficient utilization of resources. The objectives of UM Committee include processes to:

- Assure the overall integrity of the utilization management process to include timely and appropriate assignment of DSHS Mental Health levels of care based on the DSHS UM Guidelines;
- Approve and oversee the appeal system for adverse determination decisions;
- Analyze utilization patterns and trends throughout the ETBHN region, to include gaps in services, rates of no shows for appointments/services, billing issues, underdeveloped frequently requested services, existing services that are under- and over-utilized, and barriers to access; and
- Establish mechanisms to report quantitative and qualitative information on service utilization and service delivery to ETBHN Regional Oversight Committee members, Burke's management and staff, the Board, providers and other interested persons in a timely manner.
- Review data on SMHF hospital utilization, including forensic stays.

B. Request for Services

Burke monitors access to services by monitoring appeals of termination, reduction and denial of services.

C. Developmental Disabilities Key Performance Indicators

Tracking is completed on a monthly basis to assess the referral and admission process to ensure that individuals are enrolled into services in a timely manner. This data assist managers in assessing intake and referral procedures and the accessibility of Developmental Disabilities Services provided by Burke. Additionally productivity of individual staff is monitored to maximize caseload capacity. Findings are reported to SMT quarterly.

5. Rights Protection Process

Please see Appendix A for Burke's Rights Protection Process.

6. Reduction in Abuse, Neglect and Exploitation

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

VI. Authority Function

1. Regional Planning and Network Advisory Committee (RPNAC)

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

2. Contract and Network Management

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

3. Criminal and Juvenile Justice Diversion

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

4. Quality Management oversight of Texas Resilience and Recovery (TRR)

Ongoing monitoring of TRR processes is conducted to systematically monitor, analyze and improve performance of provider services and outcomes for individuals and to review whether practices are consistent with approved evidence based practices, accuracy of assessment and treatment planning and include the following:

A. Self Assessment
Self-assessment tools from the TRR fidelity toolkit are used to identify degree of compliance with TRR processes and documentation.

B. Outcome Measures
Burke's performance on state contract TRR outcome measures are monitored monthly and reported quarterly, assessed against both state averages and targets.

C. Fidelity Measures
Burke's performance on state contract TRR fidelity measures are monitored and reported quarterly. Technical assistance to providers is provided as necessary to improve fidelity and accountability.

D. Utilization Management Processes
Deviations and appeals are monitored to assess for consistency, appropriateness and clinical necessity. Additionally, the UM program is evaluated by the Regional UM committee. Further information regarding UM processes may be found in the Burke Utilization Management Plan.

Appendix A
Rights Protection Procedure

Communication of Consumer Rights

The Department of Aging and Disability Services **(**DADS), the Department of State Health Services (DSHS), and the Department of Assistive and Rehabilitative Services (DARS) offices of Consumer Services and Rights Protection publishes rights handbooks written in simple and non-technical language that contains interpretations of the various rights afforded consumers receiving services in mental health, early childhood intervention, and intellectual and developmental disabilities programs. Any Rights Handbooks designed by Burke must be approved by DADS, DARS, or DSHS before use.

Copies of Rights Handbooks shall be displayed prominently at all times in all areas frequented by consumers. A sufficient number of copies shall be kept on hand in each of these areas in order that a copy may be readily available to anyone requesting one. In addition, all staff members who perform intake and screening functions for admission to Burke services shall also maintain a supply.

Upon admission into Burke services, each individual and their legally authorized representative (LAR), if applicable, shall be given a copy of the appropriate Rights Handbook by intake staff. Rights shall be reviewed orally using simple language and terms and explained in the primary language of the individual. The explanation includes a description of the circumstances under which those rights may be limited and an explanation of how a compliant may be filed.

Accommodations will be made for hearing or visual impairment or language barriers.

When an individual receiving services is unable or unwilling to sign a document confirming that rights have been explained, a brief explanation of the reason shall be entered into the client record along with the names of the staff member who explained the rights and a third-party witness.

If the individual does not appear to understand the rights explanation, staff will attempt to provide another explanation periodically until understanding is reached, or until discharge. The necessity for repeating the communication of rights is documented, signed, and dated by the staff member.

Staff will document each attempt to explain the individual their rights and may, if applicable, develop a goal on the individual's treatment plan to address the continuing need of the individual to be informed and understand their rights.

Oral communication of rights shall be documented on a form bearing the date and signature of the individual; and their LAR and the staff member who explained the rights. Initial and annual notification of rights shall be documented.

Changes in federal or state statues regarding rights will be communicated promptly to each clients and their LAR. Documentation of notification of any changes in client rights will be obtained.

Communication of Pain Management: Individuals served have the right to appropriate screening or assessment and referral for or provision of management of pain. Should individuals indicate that they are experiencing pain and/or have experienced pain in the recent past, the individual will be referred to a physician for evaluation and pain management. Individuals will receive education regarding their roles in managing pain and what to do should they experience pain.

Restrictions of Consumer Rights

Client rights are guaranteed under this provision of the Texas Administrative Code, although under special circumstances, certain rights can be limited. For an individual's personal safety, certain rights for persons with IDD may be limited. In these cases, it is mandatory to obtain informed consent when the limitation of rights is contemplated, as well as afford the individual due process.

The Human Rights Committee (HRC) meets monthly to consider rights restrictions for IDD consumers. All restrictions in IDD programs are enacted only with due process and approval of the HRC. Rights restrictions are forwarded to the Rights Protection Officer and aggregated to identify trends in use.

Rights for children or adults in outpatient mental illness shall not be restricted under any circumstances. Rights for individuals in residential crisis services are restricted only by physician's order and in accordance with state law and Joint Commission standards.

Informed Consent

All individuals have the right to make informed decisions and to give informed consent regarding treatment. Informed consent is a process involving mutual understanding

between the individual/LAR and the service provider. To be able to make informed decisions individuals should be given a clear, concise explanation of:

- their situation;
- proposed interventions, treatment, care, or services, or medications;
- potential benefits, risks or side effects;
- any limitations or confidentiality;
- the likelihood of success;
- any significant alternatives or interventions; and
- their right, to the extent permitted by law, to refuse interventions/treatment.

When asking individuals to give their informed consent staff should present the information to the individual in a manner in which they can understand and allow them the opportunity to seek more information prior to making an informed decision. Informed consent will be documented in the individual's record.

Options for Reporting Suspected Violations of Consumer Rights

A consumer, family members of a consumer, a staff member, or other interested party have choices when reporting suspected violations of individual rights. Allegations may be reported to:

A. Burke Rights Protection Officer:

The Burke Chief Executive Officer shall appoint a Rights Protection Officer. Individuals desiring to contact the RPO shall be allowed access to a Burke telephone to do so. Duties of the RPO are specified by the CEO, and must include at least the following:

1. Receive complaints of violations of rights, allegations, of inadequate provision of services, and requests for advocacy from service recipients, their families, their friends, service providers, other Burke staff, other agencies, the general public, and the DADS and DSHS Office of Consumer Services and Rights Protection.
2. The thorough investigation of each complaint.
3. Representing the expressed desires of the complainant and advocating for the resolution of their grievance.

4. Reporting the results of investigations to the complainants, consistent with the protection of the service recipient's right to have any identifying information remain confidential.
5. Ensuring that consumer rights have been thoroughly explained to Burke staff through periodic training.
6. Reviewing all policies, procedures, and rules that affect the rights of consumers.

B. Office of Consumer Services and Rights Protection:

In addition to the Rights Protection Officer, complaints may be made to DADS and DSHS:

DADS: 800/458-9858
DSHS: 800/252-8154
DARS: 800/628-5115

C. Disability Rights Texas

Disability Rights Texas (formerly Advocacy, Inc.) is a nonprofit corporation funded by the United States Congress to protect and advocate for the legal rights of people with disabilities in Texas:

Disability Rights Texas
1500 McGowen Suite 100
Houston, Texas 77004
(800) 252-9108
V/TDD (866) 252-9108

D. The Joint Commission

The Joint Commission
One Renaissance Plaza
Oakbrook Terrace, Illinois 60181
Fax: 630-792-5636
E-mail: complaint@jointcommission.org

Procedures for Reporting and Investigating Allegations of Consumer Rights Violations to the Burke Rights Protection Officer

Suspected violations of consumer rights will be reported to the Rights Protection Officer within 24 hours of the event. Individuals reporting rights violations will provide, at minimum, their name and phone number. Anonymous complaints will be investigated to the extent possible given limited information.

Rights investigations will begin within ten working days of receipt of the request for review and be completed within ten working days of the time it begins unless an extension is granted by the CEO or their designee. The investigation will begin immediately and be completed within 5 working days if the decision is related to a

crisis service. Investigations are conducted by the RPO or their designee, but may not be conducted by a person involved in the complaint. The investigation will include a review of the original action or decision that led to a person's dissatisfaction, and result in a decision to uphold, reverse or modify the original decision. The individual will be provided opportunity to express their concern directly, if appropriate, and may appoint a representative to act in their behalf. Following investigation, the RPO will explain to the individual the action taken, or, if no action will be taken, why the original decision will not be changed.

Staff Training

All new employees shall receive training on client rights during their orientation training and prior to beginning work.

Within 60 days of the effective date of new rights directives from DADS, DARS, or DSHS, the RPO shall brief all employees of updates or changes.

In any program having special requirements related to consumer rights, training in those requirements is provided by the Service Director or designee within the first five working days of a new employee's employment. This training shall also be documented on the Staff Education and Training Record.

Quarterly Review

All rights violation allegations are logged into a database by date, complainant, alleged perpetrator, program, type of complaint, and outcome of the investigation. Allegations are aggregated and complied quarterly, and reviewed by the Compliance Committee to assess for training needs, trends, and/or situation that requires broader attention. Rights restrictions are also logged into a database by date, consumer, type of restriction and length of restriction. Allegations and rights restrictions are aggregated and complied quarterly, and reviewed by the Compliance Committee to assess for training needs, trends, and/or situation that requires broader attention. An annual report of rights allegations and restrictions is also compiled. The Compliance Committee reports to the Senior Management Team and to the Board of Trustees.

Appendix B
Plan for Reducing the Number of Confirmed Incidents of Abuse, Neglect & Exploitation

The Burke Board of Trustees has adopted a policy that prohibits the abuse, neglect, and/or exploitation of individuals served by Burke employees, volunteers, consultants, and contract providers. Supports have been designed and implemented to ensure that all risks to individuals have been minimized. They include staff screening, staff education and training for individuals served in recognizing and reporting all forms of abuse and neglect.

Pre-Employment Screening Procedures

To minimize unnecessary or unreasonable risk, Burke mandates the following:

A. All individuals considered for employment, as well as direct care contractors, interns and volunteers, will have an investigation made to determine the existence of a criminal history with the Texas Department of Public Safety or other suitable sources; a driver's record check; and an investigation made to determine the existence of an abuse, exploitation or neglect confirmation through the Texas Department of Aging and Disability Services, the Employee Misconduct Registry, and the Nurse Aid Registry. This also applies to volunteers. If the applicant has lived outside of Texas within the past two years preceding the application for employment/volunteer status, Burke will obtain criminal history information through the FBI. These screenings are done monthly for any individual providing direct care.

B. Human Resources, will review all pre-employment checks that reflect convictions of other types of criminal offenses that may be considered a contraindication to employment or volunteer status and make the decision relative to the employment (of the applicant or conditional new hire) or continued employment (of an existing employee).

1) The nature and elements of the offense, including the circumstances surrounding the offense.
2) The nature of the job and the job responsibilities for which the individual is being
Considered (or for the position which is occupied for existing employees).
3) The remoteness in time of the offense or offenses.

4) The number and frequency of offenses, and the age of the individual at the time of the offense.
5) Texas Administrative Codes that relate to the above screenings.

If an applicant is denied employment because of information obtained through the Texas Department of Public Safety, Nurses Aid Registry or Employee Misconduct Registry, they will be notified in writing by the Human Resource Department. As required by Texas Government Code 411.115, Burke must destroy conviction information that relates to an applicant/volunteer immediately after making an employment decision or taking personnel action to determine employment status.

C. All abuse and neglect data and arrest and conviction data received is intended for the exclusive use of the Burke and is to be treated as privileged information. As such, this information will not be disclosed to any other person or agency except on court order, or, as authorized by the employee in writing, or as required by contracts for services to which Burke is a party.

D. All individuals considered for employment will have an initial driving record check and the same driving check will be conducted annually for all staff to verify valid Texas driver's licenses and to determine whether or not the driving record is insurable by our insurance carrier. This also applies to volunteers. This will be done by the Human Resource Office, and appropriate supervisors will be notified by Human Resources if anyone's driver's license has been revoked or driving record is uninsurable. An employee without a valid Texas driver's license will not be eligible to drive Burke vehicles, transport consumers in any vehicle, or drive any vehicle on Burke business. (See the Burke Human Resources Administrative Guide for definition of uninsurable driving record.)

E. In case of existing Burke employees, it is the responsibility of the employee to notify the Director of Human Resources in the following situations:

1) The employee is convicted of any offense listed on the Pre-employment Screening Information form.
2) The employee gets cited for DWI/DUI or gets a restriction placed on their license to drive (as a result of a driving infraction) and has a job that requires driving for the Burke.

3) The employee gets a substantiated charge of client abuse or neglect against them from another employer.

Staff Training

All employees will receive pre-service training and annual training through written curriculum and competency-based test. The material covered includes a thorough explanation of the acts and signs of possible abuse, neglect, or exploitation, disciplinary consequences of abuse, neglect or exploitation, procedures for reporting incidents, and methods for prevention.

Consumer Training

The DD Service Division provides training to individuals who request and/or have not achieved their personal outcome of "People will be free from abuse" on the Personal Outcomes Assessment. Training provided to individuals may be provided one-on-one or in a classroom setting.

How Allegations are Addressed

A. Any employee or agent of the Burke or a contractor who suspects or has knowledge of the abuse, neglect, or exploitation of a person served, must report it immediately, but in no case more than one hour after suspicion or knowledge of the abuse, to TDFPS at **1-800-647-7418; and/or the appropriate state agency. Allegations of abuse may also be reported online at: www.txabusehotline.org.**

B. In addition to notifying TDFPS, programs surveyed by DADS Long Term Care/ICF must also report allegations of abuse to DADS immediately, but in no case more than one hour after suspicion or knowledge of the abuse, at 1-800-292-2065. Within five (5) days of the initial notification, Burke must fax a "Status of Investigation" report to DADS at 1-877-438-5827. When the investigation is complete, the Director of DD Authority Services will forward a copy of the report to the appropriate service director who will then be responsible for submitting the investigation report and description of action taken to prevent further incidents from occurring to DAD Long Term Care/ICF in Austin.

   When an investigation is completed on an individual receiving Home Community-based Services, the Director DD Authority will forward a copy of the report to the Director Provider Services who will in turn complete documentation and submit a summary of the allegation and findings to DADS Waiver Services.

C. Notify the individual's Individual Program/Service Coordinator (whether internal or external staff) of the allegation of abuse immediately, but in no case more than one hour after the allegation is made. If the alleged perpetrator is the individual's IPC, the notification must be made to that person's supervisor instead. Once a staff member of a consumer has reported allegations of abuse, neglect, or exploitation, the information concerning the allegation should be treated as privileged and confidential. *Allegations must not be discussed with other staff members*.

D. Promptly arrange for medical care or emotional support if appropriate.

E. If an employee, contractor employee, or agent of the Burke files a complaint on behalf of a consumer, the consumer shall be reassured they are protected from retaliation (harassment, disciplinary measures, discrimination, reprimand, threat, or censure).

F. If needed, take action to preserve the safety of the consumer, to include separating the individual from the alleged target until the investigation is completed. This may be done by:
   1. placing the alleged target on administrative leave;
   2. allowing the alleged target to work only when the supervisor can provide line of sight supervision, or
   3. reassigning the alleged target to a non-direct care position during the course of the investigation.

G. Preserve or protect any evidence connected with an allegation in accordance with instructions from TDFPS personnel or the Burke Rights Officer (i.e., take pictures of injuries, secure the consumer's records, etc.). Individuals suspected to have been sexually abused should not bathe prior to being examined by a physician.

H. If alleged victim is served through contract, the Director of DD Authority Services will ensure that the contractor receives any documentation pertinent to the investigation (i.e.: incident report, progress notes, TDFPS Investigative Findings) for their internal records.

I. Management staff must refrain from conducting a unit-level investigation by interviewing alleged victims and the target prior to reporting the incident to TDFPS or the appropriate party. The alleged target has the right to a fair and impartial investigation. Conducting such a preliminary investigation could bias the formal investigation and render the findings invalid.

J. If an allegation of abuse, neglect or exploitation involves the clinical practice of a licensed professional, the Director of Authority Services shall refer the allegation to the Professional Review Committee (PRC). If a Burke contractor does not have a professional review process, the allegation shall be referred to the appropriate licensing authority. The PRC shall ensure that relevant conclusions of a professional review are submitted to the appropriate licensing authority. The physician and nursing peer review process used shall be consistent with state laws.

Trending of Allegations

All allegations of abuse are trended. By trending allegations, Burke is able to identify information such as the number of times a staff member has been an alleged perpetrator, the number of allegations made on behalf of an individual, the number of allegations submitted per unit/location, action taken on confirmed allegations. Trending may be the source of further action such as employment action, training, or modifications in procedures.

The designee submits a quarterly report to the Compliance Committee of all allegations made during the quarter. This report also includes a historical report on allegations and findings.