Quality Management Plan

Plan Year: FY26-28
Board approval: 10/28/2025
Review/Revision: 10/22/2025

Standards References:26 TAC §301.333; 26 TAC §301.335; CARF Behavioral Health Standards; 26 TAC §330.17; State Contracts

I. OVERVIEW

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

Mission Statement

WORKING TOGETHER TO IMPROVE LIVES.

Vision Statements

1. Burke is the provider of choice for individuals in the region.
2. Our customers benefit from the services they receive.
3. Services are collaborative, person centered and trauma-informed.
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.

Center Goals

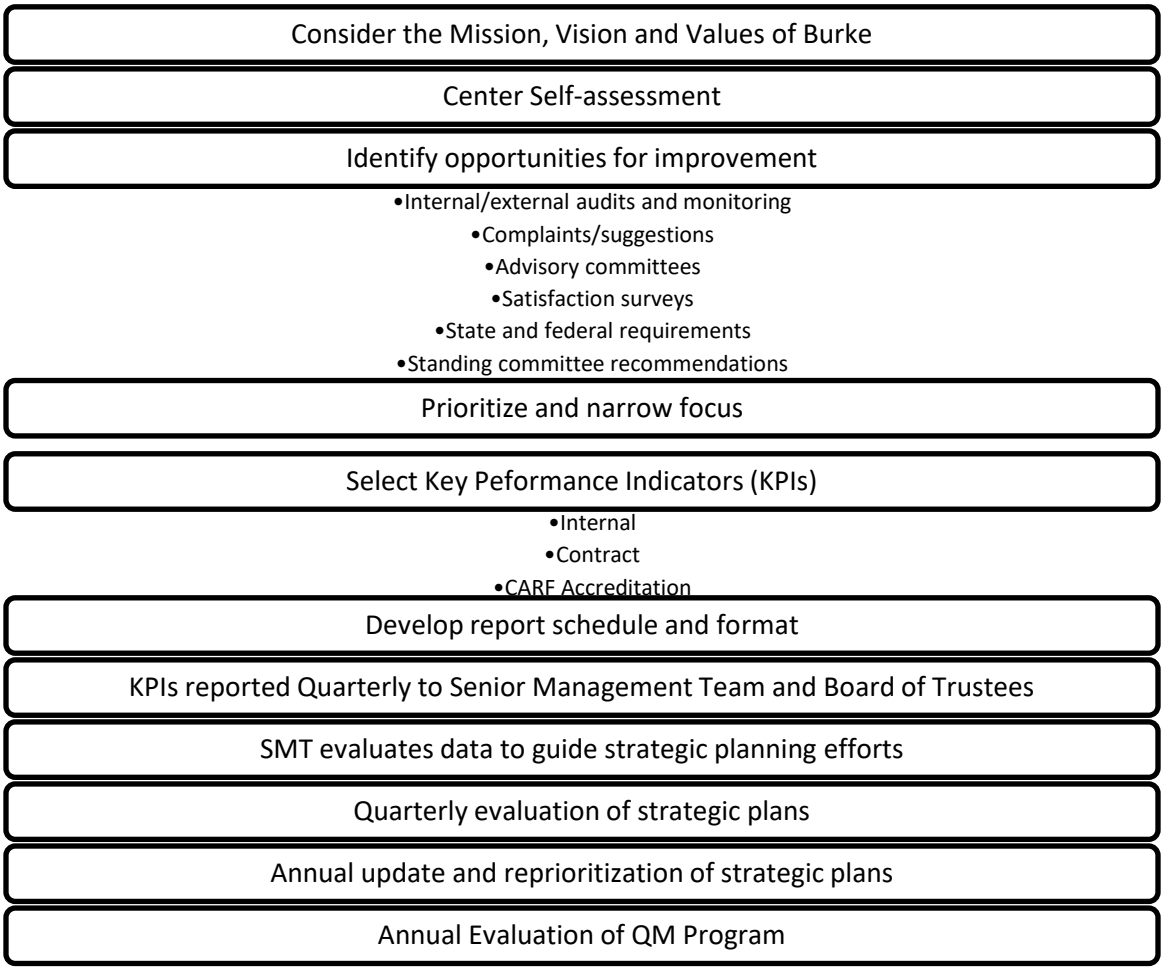
1. To continually improve the quality of services
2. To improve access and efficiency of services
3. To provide effective resource management
4. To promote a positive work environment
5. To improve public understanding
6. To continually assess and address the safety of service delivery
7. To be a respected community partner

Center 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 Center's mission, the scope of services and care, and needs identified by all stakeholders. The purpose of Burke's Quality Management Plan is to provide an objective, data-driven framework for evaluating performance. It guides management decisions, ensures effective process design, and supports continuous improvement in clinical outcomes, financial stability, and organizational efficiency through the Center's strategic planning efforts.

Process for Quality Management and Performance Improvement



II. QUALITY MANAGEMENT PROGRAM STRUCTURE

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

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

The leaders entrust the responsibility for oversight of the Quality Management Plan to the Director of Quality Management (who is a member of the Senior Management Team) and assure that sufficient resources are allocated to make improvements necessary throughout the center. The leaders and the Director of Quality Management ensure that a planned, systematic, center 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 a center 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 PRIORITES

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 - Any identification of significant, imminent risk to consumer or staff safety will be corrected or mitigated as soon as is feasible but in no case longer than 7 days.
- Issues related to state or federal mandates - Preparation for such changes will begin before the requirement takes effect, to be implemented upon the date the requirement takes effect.

- Issues identified through stakeholder surveys or advisory committees which impact critical functions or outcomes - An action plan to address such issues will be developed within 90 days of the recommendation.
- Problem prone processes – Management of the relevant programs will determine the priority and timeliness dependent on the process in question.

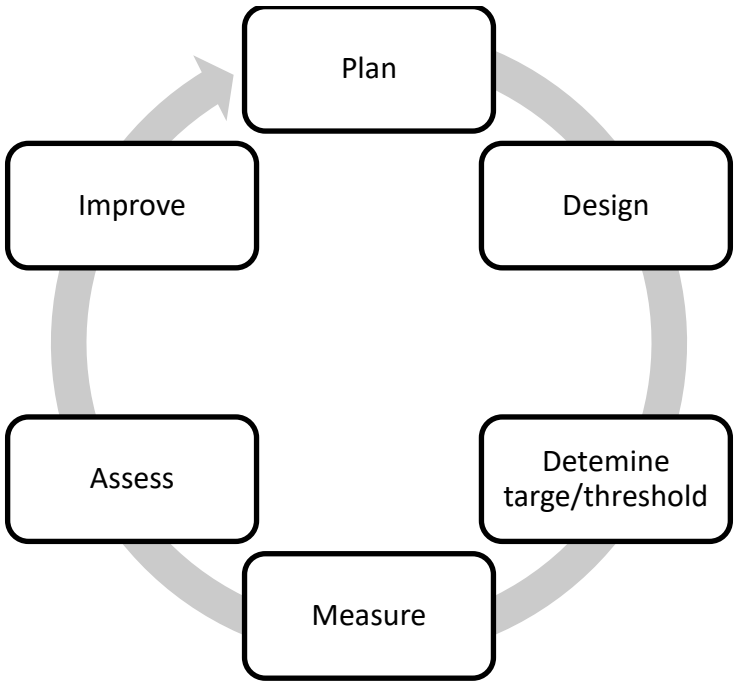
Priorities are adjusted in response to unusual or urgent events, as determined by the Senior Management Team.

IV. PEFORMANCE MEASUREMENT AND MANAGEMENT

Key Performance Indicators (KPIs) are measurable, specific monitors of processes or outcomes that are collected in a uniform, systemic manner and reported quarterly to Burke's SMT and Board of Trustees. 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 SMT and the Board of Trustees but is also reported through the Burke intranet.



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

- **Findings**: Data 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, and are monitored quarterly.

- **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 as an evaluation of the Quality Management program. This is reviewed by the Board of Trustees as well as by SMT.

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. Other program specific survey tools are utilized as appropriate. Findings of all of these surveys are reported to SMT and are used to identify areas of exceptional service and opportunities for improvement.

B. Employee Engagement: Employee engagement is assessed through surveys on topics such as culture of safety, health and security, and other issues related to employee satisfaction. Results of surveys are discussed with SMT 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 reviews from various oversite divisions of Texas Health and Human Services are used to identify performance improvement activities and to assess unmet needs of consumers, service delivery problems and effectiveness of system interventions.

B. Compliance Audit Calendar: The Compliance Audit Calendar, as determined by the Compliance Committee, sets out a schedule of routine and focus audits, 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 SMT as appropriate. Results of the audit are used to identify staff training needs as well opportunities to improve patient care and organizational efficiency.

Medical services are monitored quarterly in a peer review process as directed by the Burke Medical Director. Medical staff billing is audited quarterly to assure that documentation required to support E&M code usage. 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. All critical incidents are referred to the Director of Quality Management, with subsequent investigation and corrective actions as needed. Data from critical incident reports are also entered into the database, maintained by Quality Management, to allow for aggregation and analysis of trends. The database is

used to identify unacceptable variation in performance, to monitor the effects of actions taken, to identify areas in need of staff training and to evaluate the effectiveness of the Risk Management Program. The Committee makes recommendations to the Senior Management Team on the performance of the Center based on this data. Facilities are inspected quarterly by the Facility Safety Officer and annually by the Center Safety officer and Facility Director. Other safety inspections include Fire Marshal inspection, Fire Alarm Inspection, Sanitation Inspection by local health authority, Fire Extinguisher Inspections, and routine fire and emergency drills. All reports are submitted to Burke's Safety Officer. Deficiencies are noted and corrected. The Risk Management process also includes the review and analysis of deaths of person served in accordance with State and contract requirements.

D. **Accreditation by The Commission on Accreditation of Rehabilitation Facilities (CARF):** Burke maintains accreditation by CARF, requiring adherence to internationally recognized standards related to the provision of care. Attachment #1 outlines key measures for monitoring and evaluating effectiveness, efficiency, experience, and access of CARF-accredited programs. Ongoing self-assessment of services and compliance with CARF standards ensures continuous quality improvement and accountability in service delivery.

E. **Specialty Programs:** Programs and Processes such as Co-Occurring Psychiatric and Substance Use Disorders (COPSD), Youth Enrichment Services (YES), Specialized Treatment of Early Psychosis (STEP), and IDD Crisis Services are audited per contract requirements and no less than annually. Records are assessed for adequacy of assessment, service 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 as opportunities to improve consumer care.

F. **Crisis Response**: Oversight of the response system includes data collection on hospitalizations, safety planning interventions, and appropriateness of care. Results of this monitoring are used to assess the effectiveness of the system and identify training needs.

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 is part of their regularly scheduled performance evaluation, reported quarterly to SMT.

H. **Certified Community Behavioral Health Clinic (CCBHC):** In addition to routine monitoring of clinical outcomes and organizational indicators, continuous quality improvement is monitored relative to ongoing compliance with CCBHC certification. Individual provider adherence to evidence-based provider protocols is monitored annually, and overall adherence to CCBHC criteria is formally assessed no less than annually. Consumer input is gathered

using satisfaction and outcome of care surveys, discussion with clients, and informal means.

3. Measuring, Assessing and Improving Data Integrity:

A. Claims Oversight: Ongoing validation audits of 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. IDD Targeted Case Management (TCM) Encounters: IDD Authority Services audits TCM encounters to assure data quality and accuracy. Type A and B claims are monitored quarterly. 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 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. Please see Appendix A for Burke's UM Plan.

B. Request for Services: Burke monitors access to services by monitoring appeals of termination, reduction and denial of services.

C. Intellectual and Developmental Disabilities Key Performance Indicators: Tracking is completed on a monthly basis to assess the referral and admission process to ensure that consumers are enrolled into services in a timely manner. This data assists managers in assessing intake and referral procedures and the accessibility of Intellectual and Developmental Disabilities Services provided by Burke. Findings are reported to SMT and the Board of Trustees quarterly. Additionally, productivity of individual staff is monitored to maximize caseload capacity.

5. Rights Protection Process

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

6. Reduction in Abuse, Neglect and Exploitation

Please see Appendix C 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 consumer 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 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 process coordinates procurement of services in compliance with 26 TAC Chapter 301A. Community services contracts 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. Additionally, subcontractors are subject to monthly monitoring to assure compliance with contract requirements.

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 consumers 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 individual outcomes. This includes assessing the consistency of practices with approved evidence-based approaches, the accuracy of assessments, and the quality of treatment planning. The monitoring process includes the following components:

A. **Self-Assessment:** Self-assessment tools from the TRR fidelity toolkits 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.

APPENDIX A

UTILIZATION MANAGEMENT PLAN

This Utilization Management Plan (UM Plan) describes the Utilization Management (UM) program of Burke, hereafter "the Center", and is written to be consistent with the Center's policies and procedures and applicable regulatory and contractual requirements. The Center's Utilization Manager, under the direction of a UM psychiatrist and in consultation with the UM Committee, assumes the responsibility for execution of this UM Plan.

A. Psychiatrist Oversight of UM Program

The psychiatrist who provides oversight of the responsibilities of the UM Program and Committee, through both the local UM committee and the East Texas Behavioral Healthcare Network (ETBHN), is Mark Janes, M.D, Burke Medical Director.

B. Utilization Manager Designation

The Center Utilization Management Director, , oversees all aspects of the Center's Utilization management division. The Center Utilization Director has designated the Center Utilization Manager, to assist with utilization management, utilization review, authorizations for services as per HHSC TRR UM Guidelines, and oversight of delegated utilization management functions. Qualifications for both the Center Director and Manager are met as detailed in the performance contract statement of work Sections I(A)(5)(c-e).

C. Utilization Review Activities

1. **Procedure for Eligibility Determination: The** Center conducts screenings of each individual to determine whether the requirements are met for admission to services and initial Level of Care assignment using Texas Health and Human Services Commission (HHSC) criteria. Determinations are conducted to ensure the Center's practice guidelines deliver treatment in the most effective and efficient manner.

2. **Procedure for Level of Care Assignment:** The Center assigns each individual to the appropriate Level of Care according to HHSC UM guidelines and conducts retrospective oversight of initial and subsequent level of care assignments to ensure consistent application of HHSC UM guidelines. These processes ensure sufficient utilization and resource allocation determinations based on clinical data, practice guidelines, and information regarding the individual's needs with consideration of the individual's (and LAR's on the individual's behalf) treatment preferences and objections.

   Medical necessity is assessed with every individual and admission to medically necessary services is jointly determined by the individual and the Center. Documentation of medical necessity is made in the individual's medical record.

   In addition to the verbal discussions that occur regarding authorizations, providers document importation information relative to requests for deviations, overrides and add-ons in the notes section of the Uniform Assessment (UA).

   The Center ensures that the UM system facilitates timely access to services, and as such the safety of individuals requesting or receiving services is not

compromised. The flow of information between the crisis response system, entry into routine services and the UM system is monitored.

Providers have direct access to UM staff from 8 AM to 5 PM each business day to afford discussion of relevant clinical information. After hours, back up is available by secure email and voice mail to ensure timely authorizations. After hour messages' date and time data are available.

Psychiatric consultation is available 24 hours a day for the crisis response system, including discussion of potential adverse determination decisions.

3. **Procedure for Authorizations and Reauthorizations:** The Center has a timely authorization system in place to ensure medically necessary services are delivered without delay and with prior authorization, except that the delivery of crisis services does not require prior authorization but rather must be authorized subsequent to delivery. The center reviews requests for authorization of services, determine if services should be authorized and if so which services to authorize based on TRR UM Guidelines, UA, Diagnosis, additional clinical information, and clinical judgement. The determination and documentation of services to be authorized shall occur according to these timeframes:

   a) Crisis intervention services: within two business days of the date of service:

   b) Inpatient services: within sufficient time to ensure medically necessary services are delivered without delay;

   c) All other mental health community services, including outpatient and add-on services upon receipt but no later than three business days and prior to service delivery; and

   d) Reauthorization for continuing services according to established timeframes in the utilization management guidelines, as updated and amended.

   The Center conducts oversight of initial and subsequent level of care assignments to ensure consistent application of HHSC Utilization Management guidelines as follows:

   a) ***Prospective Review:*** Pre-admission review for appropriateness of admission to services prior to receiving services. The determination for authorization must be made within two days. The provider is notified via telephone within one business day, when necessary, and electronic notification is made within three business days.

   b) ***Concurrent Review:*** A routine review conducted to establish need for continued services or review of automatic authorizations. The determination for authorization must be made within one day. The provider is notified via telephone, when necessary, and electronic notification within one business day.

   c) ***Retrospective Review:*** A review following service provision to assess the appropriateness, necessity, quality and reasonableness of services provided. The determination is made within 30 calendar days. The provider is notified in writing of denial within 5 business days.

   The Center is able to grant an automatic authorization without UM staff review when there is a written agreement, Level of Care- Recommended (LOC-R)

equals Level of Care-Authorized (LOC-A), and staff have demonstrated competence in the UA.

4. **Procedure for Outlier Review:** The Center and ETBHN, as designated by the Center, by and through its Utilization Management Committee, will conduct Outlier Review. This process will consist of a review of data to identify outliers and to determine any need for change in level of care assignment processes, service intensity or other Utilization Management activities. These reviews are conducted to ensure provider treatment is consistent with practice guidelines as is the process for making utilization/resource allocation determinations.

5. **Procedure for Inpatient Admissions, including State Hospitals and Discharge:** The Center conducts reviews of inpatient admissions to ensure the most clinically effective and efficient length of stay at an inpatient facility and reviews discharge plans to ensure timely and appropriate treatment following an inpatient stay. These reviews are conducted to ensure continuity of services for coordinating the delivery of mental health community services by multiple providers. Authorization for hospitalization and continued stay are made through the Center's UM staff and/or designee.

   Authorization for continued hospitalization or services includes the number of extended days or units of services, the next anticipated review point, the new total number of days or services approved and the date of admission or onset of services.

6. **Procedure for Administrative Review:** The Center may conduct a review of clinical administrative documentation for timeliness and adequacy of UM processes to include reimbursement, corporate and contract compliance, data verification and rehabilitation plan oversight.

D. UM activities Fulfilled by persons other than Utilization Manager

The following person conducts UM activities and is not the qualified Utilization Manager: Melissa Simmons, MA LPC. At a minimum, staff is a QMHP-CS with 3 years' experience in direct care for adults with serious mental illness or children and adolescents with serious emotional disturbances and have all UM activities directly supervised by the qualified Utilization Manager. The UM activity conducted by this person is: Authorization for hospitalization and continued stay.

E. Conflict of Interest

It is the policy of the Center that providers of mental health services may conduct screening and eligibility determination functions on behalf of the Center, as well as other business functions. However, providers of mental health services may not grant authorizations.

F. UM Documentation of Training and Supervision

It is the policy of the Center that UM staff are properly trained and supervised as required by HHSC or by other policy, law or regulation. It is the responsibility of the Center's Utilization Manager, in consultation with the UM psychiatrist and the Human Resources department, as necessary, to ensure documentation and supervision are properly maintained.

Inter-rater reliability is monitored for all UM staff and physicians, with a benchmark of no lower than 80%.

G. Utilization Management Committee

The Center maintains a Utilization Management Committee through ETBHN, as well as a center UM sub-committee. Each member of the UM Committee shall receive appropriate training and the necessary materials to fulfill the responsibilities of the committee

The primary function of the UM Committee is to assist the promotion, maintenance and availability of high quality care in conjunction with effective and efficient utilization of resources. ETBHN facilitates a UM Committee to ensure compliance with applicable contractual and regulatory UM requirements. UM Committee meetings are held quarterly or more frequently as needed at a designated time and include a physician, UM staff, Quality Management staff, and fiscal/financial services staff. The UM Committee will maintain representation from all Member Centers of ETBHN. UM Committee members are appointed by each ETBHN Member Center's respective Executive Director/CEO. ETBHN is responsible for taking, distributing, and storing minutes of every UM Committee meeting.

The Center sub-committee is responsible for monitoring the Center's UM data and performance contract requirements, including hospitalization access and utilization, waiting list, appeals, provider profiles and other data relative to the Center UM plan goals. Relevant information on service utilization is reported to the board, management staff, providers and other interested parties.

The role and responsibilities of the Center sub-committee are as follows:

1. Identify and analyze current service, provider, and individual outlier use patterns.
2. Recommend methods to minimize inappropriate or outlier practices.
3. Develop and distribute basic provider profiles to providers and managers.
4. Develop and deploy methods to educate clinical decision-makers regarding practice improvement and over- and under-use of service.
5. Review reports from MBOW to monitor appropriateness of eligibility determinations, the use of exceptions and overrides, over- and under- utilization of services, appeal and denials, fairness and equity, the cost- effectiveness of services provided, and authorizations prior to services being provided.
6. Review recommendations from other existing review mechanisms regarding individual practitioner activity.
7. Analyze utilization patterns and trends to include gaps in services, rates of no show for appointments, as well as service and billing issues.
8. Monitor clinical outcomes and analyze barriers to access.
9. Review state hospitalization bed day trust fund use.

The Utilization Manager acts as chairperson for the Center sub-committee and is responsible for all administrative tasks related to the actions of the sub-committee.

H. Exception/Clinical Override Process

The Center will maintain a system to override the UA when there is the need and to make exceptions to and manage the number of units of service authorized for an individual. The Center will report on exceptions and overrides as required by HHSC.

I. Right to Make a Complaint or Appeal and Adverse Determination Decision

1. **Procedure for Appeals:** Pursuant to 25 TAC 401.464, the Center is dedicated to providing mental health services which are viewed as satisfactory by individuals receiving those services and their legally authorized representatives. The purpose of this procedure is to assure that these individuals have a method to express their concerns or dissatisfaction, are assisted to do so in a constructive way, and have their concerns or dissatisfaction addressed through a review process.

   A request to review decisions described in this section may be made by the individual requesting or receiving services, the individual's legal representative, or any other person with the individual's consent.

   At the time of admission into services and on an annual basis thereafter, the Center shall provide to individuals who receive services and their legally authorized representatives written notification in a language and method understood by the individual of the Center's policy for addressing concerns or dissatisfaction with services. The notification shall explain an easily understood process for individuals and legally authorized representatives to request a review of their concerns or dissatisfaction by the Center or make a complaint to HHSC, inform the individual of their right to receive assistance in requesting the review, outline the timeframes for the review, and the method by which the individual is informed of the outcome of that review.

   The Center shall notify individuals and legally authorized representatives in writing in a language and/or method understood by the individual of the following decisions and of the process to appeal by requesting a review of those decisions:

   a) a decision to deny the individual services at the conclusion of the Center's intake procedure which determines whether the individual meets the criteria for the priority population;

   b) a decision to terminate services and follow-along from the Center or its contractor, if appropriate; and,

   c) a decision to reduce services during the course of treatment,

   d) A denial of access to requested services or support based on clinical determination

   e) an involuntary reduction or termination of services due to non-payment if the Center is not responsible for court-ordered outpatient services and the proposed action does not oppose an imminent risk to the persons mental or physical health, and;

   f) referrals to third part coverage under 26 TAC, Subchapter C, Section 301.111.

   The denial of services based on Administrative Determination is made by the Utilization Manager, Director or the UM physician. Only the UM Manager, licensed Director, or Physician can reduce or terminate services based on clinical determination excluding court ordered outpatient treatment.

   The UM staff shall verbally notify the individual or their LAR and provider of the proposed action, and then the individual is mailed or given written notification. The process does not continue for administrative determinations; however, an individual can appeal clinical determinations.

The written notification referred to above must:

a) be given or mailed to the individual and the legally authorized representative within 3 working days, but not later than 10 working days of the date the decision was made;

b) state the reason for the decision;

c) explain that the individual who has Medicaid may contact HHSC with a request for a Fair Hearing within ninety days if dissatisfied with the decision; and/or

d) explain that the individual and legally authorized representative may contact the Center if dissatisfied with the decision and request that the decision be reviewed in accordance with this procedure; and

e) include name(s), phone number(s) and address(es) of one or more accessible staff to contact during office hours.

2. **Appeal by Client:** Pursuant to 26 TAC Section 301.155 (Notification and Appeals Process), the Center must offer people an opportunity to challenge UM or resource allocation decisions with which they disagree. If an individual or legally authorized representative believes that the Center has made a decision to involuntarily reduce services by changing the amount, duration, or scope of services provided and is dissatisfied with that decision, then the individual may request that the decision be reviewed in accordance with this procedure.

   Appeals logs are maintained by the Quality Management Director and Utilization Manager and shared with other appropriate management staff. The appeals log is categorized by cause and disposition, including the length of time for resolution of each appeal. The record shall be maintained for a minimum of six years.

   The request must be made within 30 calendar days after receiving the written notification of an adverse determination to initiate a request for appeal. It may be written or made verbally. If the individual requests assistance in completing a written appeal, the Center will provide assistance.

   The review process:

   a) Shall be completed within 20 business days, unless the CEO or Director grants an extension of the timeframe.

   b) If the decision is related to a crisis service, the review will begin immediately upon receipt of the request and be completed within 5 business days.

   c) The representative reviewing the appeal must be an individual who was not involved in the initial decision.

   d) Include a review of the original decision which led to the individual's dissatisfaction

   e) Following the decision, within one business day, verbally notify the individual, or designee, and the provider of the individual, the decision to uphold, reverse, or modify the original decision.

   f) Provide the individual with an opportunity to express his or her concerns in person or by telephone. The review shall also allow the individual to have a

representative talk with the reviewer or submit his or her concern in writing, or in some other fashion.

Within three business days of the decision, but not more than 10 business days, the Center shall explain to the individual and legally authorized representative in writing and also if requested in person or by telephone, the action it will take or, if no action will be taken, the reason it will not change the decision or believes such action would not be in the individual's best interest. This is the final step in the review process.

The notification and review process described in this procedure is applicable only to services funded by HHSC and provided or contracted for by its local authorities and does not preclude an individual's or legally authorized representative's right to reviews, appeals, or other actions that accompany other funds administered through the Center or its contractors, or to other appeals processes provided for by other state and federal laws, e.g., Texas Health and Safety Code, Title 7, Chapter 593 (Persons with Mental Retardation Act); 42 USC §1396 (Medicaid statute); Texas Human Resources Code, Chapter 73 (Chapter 350 of this title (relating to Early Childhood Intervention)), Early Childhood Intervention programs as funded by the Texas Interagency Council for Early Childhood Intervention.

Additionally, the Center will give Medicaid-eligible individuals notice of their right to request a fair hearing prior to denial, reduction, or termination of services, in accordance with 25 TAC §419.301.

3. Appeal by Provider:

In addition to the appeals an individual may request, service providers may appeal UM decisions. The provider has the right to appeal if, in his or her clinical judgment, the services approved are not sufficient to meet the needs of the individual. Such reviews will be handled by the Medical Director, unless the Medical Director is the provider, in which case the review will be made by another member of the center medical staff.

Such reviews must begin within ten working days of receipt of the request for a review and be completed within ten working days of the time it begins, will include a review of the original decision, and will result in a decision to uphold, reverse or modify the original decision. In such appeals, the decision of the Medial Director is final.

Providers are informed of this right to appeal, including their obligation to assist an individual in filling an appeal. Contractual providers are educated on this expectation via the Request for Proposal (RFP) process and at the time of contracting. Allegations that a provider, whether Center staff or contractual, failed to assist a consumer in the appeals process shall be referred to the Center's Right's Protection Officer for investigation.

J. HHSC UM Oversight Activities

The Center will participate in UM oversight activities, including submitting the requisite Appeal Reports, as defined and scheduled by HHSC.

K. Quality Management and Utilization Management

The Center Quality Management (QM) staff provides oversight to ensure compliance with and the quality of the implementation of Texas Resiliency and Recovery (TRR) practices, monitor

fidelity to service models, monitor performance in relation to HHSC-defined performance measures, and coordinate activities with the UM program.

Goals of Burke's UM plan include the following:

1. Assure and improve accessibility by monitoring timely authorization of UAs and average hour requirements.
2. Assure and improve availability of services by monitoring the time to the first service and proper use of the wait list set forth in TAC 412.314 (d)(2) Access to Mental Health Community Services, the performance contract and TRR UM Guidelines.
3. Improve quality of services by monitoring outcomes.

L. Provider Profiling

The Center will utilize provider profiling to review, identify, and analyze current mental health community services, providers, and utilization patterns in order to educate clinicians and facilitate practice improvement. Provider profiles may include assessment of caseload size, UA competency, number of consumers on caseload served but not assessed, percent of consumers not meeting their recommended average hours, and total hours by level of care.

M. Provider Manual

Providers are knowledgeable of relevant aspects of the UM Program Plan and provided a provider manual prior to providing services to individuals at the Center. See "Mental Health Manual".

N. Delegated Utilization Management Activities and Oversight

Pursuant to a written agreement, certain Utilization Management Activities have been designated by the Center to East Texas Behavioral Healthcare Network (ETBHN), as have been described in this Utilization Management Plan. It is the responsibility of the Center's Utilization Manager to ensure oversight of these delegated activities. To that end, ETBHN will provide all Utilization Management reports, results, and analysis, of the above-mentioned Delegated Activities to the ETBHN Regional Oversight Committee, as well as to the Center's Utilization Manager.

O. Utilization Management Program Evaluation

The UM program of the Center is evaluated at least annually to determine its effectiveness in facilitating access, managing care, improving outcomes, and providing useful data for resource allocation, quality improvement, and other management decisions, as well as identifying improvements that can be made. Any Utilization Plan Evaluation conducted by the Center will include an evaluation of the Center's Performance Contract measures. UM Program Evaluation activities will be reflected in the UM Committee meeting minutes.

APPENDIX B
RIGHTS PROTECTION PROCEDURE

1. COMMUNICATION OF CONSUMER RIGHTS

The Texas Health and Human Services office of Consumer Rights and Services publishes rights handbooks written in simple and non-technical language that contain 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 HHSC.

Rights shall be posted in common areas of programs and copies of rights handbooks shall be available 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.

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.

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 or 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 consumer rights will be obtained.

RESTRICTION 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.

All restrictions in IDD programs are enacted only with due process. Additionally, in some circumstances, restrictions are reviewed by the Human Rights Committee (HRC). Rights restrictions are reviewed by 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 CARF standards.

INFORMED CONSENT

All individuals have the right to make informed decisions and to give informed consent regarding medical treatment and therapy. 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 rights violations. Allegations may be reported to:

A. Burke Rights Protection Officer:

The Chief Executive Officer shall appoint a Rights Protection Officer (RPO). 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 staff, other agencies, the general public, and the HHSC Office of Ombudsman.
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 staff through periodic training.
6. Reviewing all policies, procedures, and rules that affect the rights of consumers.

B. Office of Consumer Rights and Services:

In addition to the Rights Protection Officer, complaints may be made to HHSC:

IDD: 800/458-9858
MH: 800/252-8154
ECI: 877/787-8999

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
2222 West Braker Lane
Austin, Texas 78758
(800) 252-9108
V/TDD (866) 362-2851

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 be completed within ten working days of the time it begins unless an extension is granted by the CEO or their designee. 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 consumer rights during their orientation training and prior to beginning work.

Within 60 days of the effective date of new rights directives from HHSC, 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 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 compiled quarterly, and reviewed by the Compliance Committee to assess for training needs, trends, or situation that requires broader attention. An annual report of rights violation allegations is also compiled. The Compliance Committee reports to the Senior Management Team and to the Board of Trustees.

APPENDIX C
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 Health and Human Services Commission, 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).

   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 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.

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 IDD 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 that are not emergent may also be reported online at: www.txabusehotline.org.**

B. In addition to notifying TDFPS, programs surveyed by Long Term Care/ICF must also report allegations of abuse to HHSC immediately, but in no case more than one hour after suspicion or knowledge of the abuse, online through TULIP portal, by phone at 1-800-458-9858, by email at ciicomplaints@hhs.texas.gov, or by mail to the Complaint and Incident Intake department. Within five (5) days of the initial notification, Burke must send a "Status of Investigation" report to HHSC online through TULIP Portal, by email at ciiprovider@hhs.texas.gov, by fax at 1-877-438-5827, or by mail. When the investigation is complete, the Director of IDD Provider 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 Long Term Care/ICF in Austin.

   When an investigation is completed on an individual receiving Home Community-based Services, the Director of IDD Provider Services will submit an 8494 within 14 days to Waiver Survey Certification Risk Assessment Coordinators.

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.). Consumers 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 IDD Provider Services will ensure that the contractor receives any required documentation 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 the allegation of abuse, neglect or exploitation identifies Burke Mental Health Staff as a perpetrators, an email regarding the incident must be sent to the HHSC contract manager with 48 hours.

K. If an allegation of abuse, neglect or exploitation involves the clinical practice of a licensed professional, the Director of Provider 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 a consumer, 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. Confirmed allegations are also reported to the Board of Trustees quarterly.

ATTACHMENT #1
PERFORMANCE MEASURES FOR
CARF ACCREDITED PROGRAMS

I. Outpatient

Domain	Objective	Indicator	Target	Target Source	Time of Measure
Effectiveness (1.M.4)	Community Tenure	At least 98.2% of adults and children authorized in a FLOC shall avoid hospitalization in an HHSC Inpatient Bed throughout the measurement period.	98.2%	Contract	Quarterly
Consumer Satisfaction (1.M.5)	Satisfaction with services	Less than five consumer complaints made to the Burke Rights officer per quarter.	<5	Internal	Quarterly
Stakeholder Satisfaction (1.M.6)	Conformance with regulatory standards	At least 80% chart compliance with Superior Medicaid audits	80%	Medicaid	Quarterly
Efficiency (1.M.7)	Average Direct Care Service Provision	All outpatient direct care therapists and clinicians should have atleast 45% of working hours spent providing billable service (excluding and new staff in ramp up period).	45%	Internal	Monthly
Service Access (1.M.8)	CCBHC Time to services	This measure calculates the average number of days from initial request to initial evaluation.	Within 14 days	CCBHC	Quarterly

II. Case Management

Domain	Objective	Indicator	Target	Target Source	Time of Measure
Effectiveness (1.M.4)	C/A Improvement	Atleast 42.8% of all children authorized in a FLOC shall show improvement in at least one of the following CANS domains/modules: Child Risk Behaviors, Behavioral and Emotional Needs, Life	42.8%	Contract	Quarterly

		Domain Functioning, Child Strengths, Adjustment to Trauma, Substance Use.			
Consumer Satisfaction (1.M.5)	Satisfaction with services	Less than five consumer complaints made to the Burke Rights officer per quarter.	<5	Internal	Quarterly
Stakeholder Satisfaction (1.M.6)	Conformance with regulatory standards	At least 80% chart compliance with Superior Medicaid audits.	80%	Medicaid	Quarterly
Efficiency (1.M.7)	Average adult CM service provision	LOC 1S Case Managers should have atleast 45% of working hours spent providing billable service (excluding new staff in ramp up period).	45%	Internal	Monthly
Service Access (1.M.8)	CCBHC time to services	This measure calculates the average number of days from initial request to initial clinical service.	Within two days	CCBHC	Quarterly

III. Crisis Intervention

Domain	Objective	Indicator	Target	Target Source	Time of Measure
Effectiveness (1.M.4)	Effective Crisis Response	At least 78.6% of crisis episodes during the measurement period shall not be followed by admission to an HHSC Inpatient Bed within 30 days of the first day of the crisis episode.	78.6%	Contract	Quarterly
Consumer Satisfaction (1.M.5)	Satisfaction with services	Less than five consumer complaints made to the Burke Rights officer per quarter.	<5	Internal	Quarterly
Stakeholder Satisfaction (1.M.6)	Conformance with regulatory standards	Atleast every two years, State regulatory will review conformance with contract requirements for all crisis services. Burke aspires to 0 findings	0 findings	HHSC	Biennial
Efficiency (1.M.7)	CCBHC Time to services	This measures the number of hours between a crisis call and crisis service. Used in comparison to number of crisis staff to determine efficiency.	Based on level of crisis	CCBHC	Quarterly
Service Access (1.M.8)	Access to Crisis Service	At least 69.9% of crisis hotline calls shall result in in-person, synchronous audiovisual, or	69.9%	Contract	Quarterly

		synchronous audio-only encounters on the same day or within one day of a hotline call.			

IV. Crisis Program

Domain	Objective	Indicator	Target	Target Source	Time of Measure
Effectiveness (1.M.4)	Effective Crisis Stabilization	At least 75% of MHEC admits are effectively transitioned to outpatient care.	75%	Internal	Quarterly
Consumer Satisfaction (1.M.5)	Client satisfaction with MHEC	At least 85% of clients discharging from MHEC indicate they are satisfied with services received during their stay.	85%	Internal	Quarterly
Stakeholder Satisfaction (1.M.6)	Conformance with regulatory standards	At least 80% chart compliance with Superior Medicaid audits.	80%	Medicaid	Quarterly
Efficiency (1.M.7)	Reduction in length of residential stay	Average length of stay at Burke residential unit before being discharged for outpatient care.		Internal	Quarterly
Service Access (1.M.8)	CCHBC Time to services	This measures the number of hours between a crisis call and crisis services.	Based on level of crisis	CCBHC	Quarterly

V. Business Function

Objective	Indicator	Target	Target Source	Time of Measure
Improve 3rd party Client Revenue	Net days in AR	60-75 days	Internal	Monthly