"Tropical Texas Behavioral Health improves the lives of people with behavioral health needs through the efficient and effective provision of quality services delivered with respect, dignity, cultural sensitivity, and a focus on recovery."

STRATEGIC PLAN
FY2026
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I. EXECUTIVE SUMMARY

During Fiscal Year (FY) 2025 two new programs commenced. The building that houses Milestone, transitional housing in McAllen, was completed in the Fall of 2024 and started serving clients in April of 2025. Milestone provides temporary, stable housing, as well as support services to individuals experiencing homelessness or who are marginally homeless. The goal is to assist individuals in achieving self-sufficiency and secure safe, affordable, and permanent housing options.

State funding was available to address the need for a mental health diversion program. The Diversion Center in Edinburg construction was completed at the end of May,2025 and the program started serving people in June, 2025. Tropical is proud of the broad array of services offered to the Rio Grande Valley community. TTBH continues to grow the relationship with all stakeholders, especially the schools, law enforcement agencies and hospital systems.

During the Texas Legislative Session that ended in the summer of 2025, funding for certain opportunities in the Rio Grande Valley were discussed such as: Youth Crisis Outreach Team (YCOT); youth intensive services; and the local 100 bed mental health inpatient facility.

Tropical purchased 6.5 acres of land across the street from their current Outpatient and Plaza facilities. The community, Board and Board subcommittees have created a list of top priority programs for this future project. The Health and Human Services Commission awarded Tropical with a grant for constructing certain parts of the facilities that meet crisis, diversion, and other criteria.

TTBH is meeting the challenges of staffing shortages in specific areas with a "grow our own" licensed master's level program, a pipeline that has yielded great results. TTBH is continuing the popular Alternative Work Schedule (AWS) so employees can work different hours or days of the week or certain days remotely. Additional retention incentives and the separate sick leave bank have continued and remain popular with TTBH employees.

TTBH successfully expanded Integrated Care with the addition of a Registered Dietician and continues to offer additional funds to cover more specialty services for clients in need of colonoscopies, mammograms, and other more advanced testing and treatment.

TTBH continues to adjust to the ever-changing world of the Directed Payment Program (DPP) and Charity Care Program (CCP) that took the place of the CMS/HHSC Healthcare Transformation and Quality Improvement waiver. The State continues to change the formula for how it is calculated and dispersed remains challenging and ever changing.

TTBH remains the Regional Suicide Care Support Center and expands and improves the Suicide Care Initiative (SCI) with suicide care pathways. TTBH continues the AS+K and CALM training, as well as expanding the Multi Systemic Therapy (MST) program.

TTBH was successfully re-certified as a Certified Community Behavioral Health Center (CCBHC) and the State continues to support the movement to CCBHC models of care.

Tropical Texas Behavioral Health is a leader in the innovative management and provision of healthcare for our local communities. The Center follows its Mission Statement of "improving the lives of people with behavioral health needs through the efficient and effective provision of quality services delivered with respect, dignity, cultural sensitivity, and a focus on recovery." This mission is indicative of the Center's total commitment to providing healthcare services that will improve the quality of life for individuals served.

The Center establishes annual goals and objectives to act as a guide in achieving our mission. Information is collected through the analysis of the internal/external environments and organizations, as well as consulting groups. This Strategic Plan provides guidance for promoting linkage and cohesion among the various functional components of outcome-based quality management, business and utilization management plans. TTBH is proud of the accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) which commenced in August of 2008. The following programs are accredited: Assertive Community Treatment-Mental Health Adults; Outpatient Treatment-Mental Health Adults; Outpatient Treatment-Mental Health Children and Adolescents; Governance: Crisis Services; MH Case Management; Integrated BH/Primary Care, Supported Living (Supportive Housing), Alcohol and Other Drugs (substance use disorders), and Consumer-Run (Drop-In Centers). TTBH received CARF re-accreditation in February of 2024 and extends to February 28, 2027.

The goals and objectives for the operational strategies fall under the following categories:

- Management of Human Resources
- Management of Fiscal Resources
- Management of Service Delivery
- Directed Payment Program (DPP) and Crisis Services
- Standards Compliance

These goals are continuously reassessed due to the constant change in the healthcare system throughout the state and across the nation. Progress on goals and objectives will be published for review by, and celebrated with, agency employees and stakeholders. Progress is presented and reviewed by the Board of Trustees on a regular and on-going basis. Many improvements have been realized by Tropical Texas Behavioral Health during the preceding twelve months, and many more opportunities for improvement exist. Undertaking the activities outlined in this strategic plan will result in the achievement and accomplishment of the goals/objectives and, ultimately, lead to fulfillment of the Center Vision Statement - "Tropical Texas Behavioral Health continues its commitment to excellence and will be an innovative provider of comprehensive and compassionate recovery-oriented services to individuals with behavioral health needs. We will treat all stakeholders with honesty, fairness and respect."

II. OVERVIEW

A. STRENGTHS, WEAKNESSES, OPPORTUNITIES, THREATS (SWOT analysis)

Strengths

1. Dedication to clients
2. Quality of service provision
3. Financial position
4. Solid relationships with local stakeholders
5. Lean organization – administrative overhead costs remain low
6. Adaptable/flexible staff
7. Change oriented
8. High level of client and staff satisfaction
9. Understanding numerous external requirements
10. Advocate on behalf of clients at the local, state and national level
11. Involvement in the Community Center system, viewed as leaders and a valuable resource, statewide
12. Integrity
13. Strong productivity of staff
14. New/renovated facilities
15. CARF accreditation of key programs
16. Expanded crisis services
17. Expanded funding for local in-patient psychiatric care
18. Innovative and extensive use of technology
19. Fully electronic health record (EHR)
20. Involvement in State and National improvement projects (Wraparound, ASIST, COPSD, CCBHC, CSC, MST, etc.)
21. Suicide Care Initiative (Certified ASIST training site, AS+K, CALM). First certified Suicide Safe Care Center in the state of Texas.
22. Continued improvement in compensation package
23. Commitment and hard work of our improvement teams
24. Over 55 years of services to the Rio Grande Valley
25. Leader in Mental Health First Aid
26. Tenured Staff
27. Community Involvement (presentations, booths, media posts)
28. Awareness of the needs of the area
29. Strength in leadership as evidenced by the requests for speaking at local, state and national meetings and conferences
30. Innovative and cutting edge in numerous areas
31. Supportive and engaged Board of Trustees
32. Great reputation throughout the State of Texas
33. Highly supportive community partnerships (hospitals, law enforcement, educational systems, etc.)
34. Highly regarded by local funding entities. TTBH is often requested by local, state and federal agencies with funding opportunities.

Weaknesses/Barriers

1. Under served area/recruitment challenges.
2. Bureaucracy (reporting requirements, external audits, etc.)
3. Border Issues/Poverty
4. Transportation
5. Continual increasing demand for services
6. Turnover
7. Development of technology and its usability
8. Complicated processes
9. Lack of clear, consistent directives from funding sources
10. Complex regulatory environment
11. Individualized requirements for a large number of grants
12. Funding for access to care limited by "qualifiers" and therefore lacks flexibility for local need.
13. Intermittent capacity issues.
14. Lack of community infrastructure for behavioral health services.
15. Increased number of grants not covering indirect costs.
16. Board turnover.

Opportunities

1. Strong financial position
2. Improvement in service delivery
3. Leadership development (Staff strengthening, mentorship)
4. Skill Building
5. Employee engagement
6. Improve use of information systems to support and track performance improvement (analyze data more effectively)
7. Improve employee satisfaction
8. Community partnerships and support of other local community providers in their development of behavioral health resources
9. Strengthen supervisory training
10. Expansion Substance Use Disorder Services
11. Succession Planning/Building the Bench
12. MCOs funding what TTBH is doing
13. CCBHC
14. Submitting for larger grants/right grants, improved vetting process
15. Emergence of artificial/augmented intelligence (AI) creates opportunities that remain difficult to gauge.
16. Often requested to respond to needs and capacity assessments (NCAs) from local, state and national funders.

Threats

1. Directed Payment Program (DPP) and Charity Care Program (CCP) requirements
2. Economic Issues
3. Increased demands of regulatory environment (targets, PASRR, etc.)

4. Political environment
5. State budget concerns
6. Statewide forensic bed demand/civil bed capacity
7. Challenge to identify funding sources, or alternative funding, to sustain innovative programs.
8. Emergence of artificial/augmented intelligence (AI) may create risks that remain difficult to gauge.
9. Emerging resources may not be perfectly aligned with Tropical's mission and/or needs

B. VISION STATEMENT

Tropical Texas Behavioral Health continues its commitment to excellence and will be an innovative provider of comprehensive and compassionate recovery-oriented services to individuals with behavioral health needs. We will treat all stakeholders with honesty, fairness and respect.

C. MISSION STATEMENT

Tropical Texas Behavioral Health improves the lives of people with behavioral health needs through the efficient and effective provision of quality services delivered with respect, dignity, cultural sensitivity, and a focus on recovery.

D. PHILOSOPHY/CORE VALUES:

Ethical Tropical Texas Behavioral Health (TTBH) is committed to abide by all honest, legal and moral principles in its operations.

Competent TTBH is committed to providing efficient and quality services through qualified, trained and credentialed professional staff.

Trustworthy TTBH is committed to responsibly provide an organized system of care through the careful and planned expenditure of all available resources.

Dedicated TTBH is committed to the caring support of the individuals it is privileged to serve.

Quality TTBH is committed to the provision of excellent customer service driven by the needs of all people it serves.

Advocate TTBH is committed to furthering the interests of those served and to help them lead meaningful lives as members of the community. This includes

helping them to achieve their right to belong, to be valued, to participate and to make meaningful contributions.

Resiliency & Recovery TTBH is committed to using evidence-based practices which ensures the provision of interventions with empirical support to eliminate or manage symptoms and promote recovery.

Tropical Texas Behavioral Health

Strategic Plan

Fiscal Year 2026

Board Review/Approval: October 28, 2025

1. Function and Purpose: **Management of Human Resources (HR)** **FY2026**

Evidenced by the development and maintenance of an effective management team; maintaining staffing levels that ensure appropriate quality of services and safety for consumers; providing an effective mechanism for staff orientation and ongoing training and development; and ensuring that a positive and growth-oriented system of employee performance and evaluation is developed and implemented.

		NOT MET (No score)	MEETS	score 1	EXCEEDS	score 2	COMMENDABLE	score 3
A.	Staff satisfaction survey results are positive and based on standardized rating assessments							
1	Score on Overall Satisfaction	< 70%	70 - 79.99%		80 - 89.99%		≥ 90%	
B.	Employee turnover is minimized in:							
1	Overall as compared to statewide LIDDA/LMHA average	Exceeds average	.01-.99% better than average		1-1.49% better than average		≥ 1.5% better than average	
2	Time to hire - the average amount of time from when an applicant applies to the time TTBH makes a job offer	≥ 31 days	24 - 30 Days		16 - 23 Days		≤ 15 Days	
C.	Number of adverse HR related outcomes	> 2	2		1		0	
D.	Supervisor Training: number of trainings	< 3	3		4		5+	
E.	Offer Acceptance Rate	< 70%	70 - 79.99%		80 - 89.99%		≥ 90%	
F.	Average number of candidates interviewed monthly	< 25	25 - 29		30 - 34		35+	
G.	Agency-wide Training Compliance Rate	< 82%	82 - 86.99%		87 - 92.99%		≥ 93%	
H.	Agency-wide Job Evaluation Completion Compliance Rate	< 82%	82 - 86.99%		87 - 92.99%		≥ 93%	

1. Function and Purpose: **Management of Human Resources (HR)** **FY2026**

Evidenced by the development and maintenance of an effective management team; maintaining staffing levels that ensure appropriate quality of services and safety for consumers; providing an effective mechanism for staff orientation and ongoing training and development; and ensuring that a positive and growth-oriented system of employee performance and evaluation is developed and implemented.

	NOT MET (No score)	MEETS	score 1	EXCEEDS	score 2	COMMENDABLE	score 3
Totals :			0		0		0

Total possible score for this section: 27
Sum of scores for this section: 0
Score: 0.0000

2. Function and Purpose: **Management of Fiscal Resources (Finance)** **FY2026**

Acceptable controls in place for management of Center funds with timely reporting of financial status to the Board: the development and implementation of a balanced operating budget. (Any major funding reductions outside of the Center's control will be taken into consideration if applicable.)

		NOT MET (No score)	MEETS	score 1	EXCEEDS	score 2	COMMENDABLE	score 3
A.	**Identified financial indicators (across FY):**							
1	Days of Operating Reserve	< 60	60 - 90		91 - 99		100+	
2	Acid Test Ratio	< .25	.25 - 2.0		2.1 - 2.74		2.75+	
3	Current Ratio	< 1.75	1.75 - 4.0		4.01 - 4.25		4.26+	
B.	**Medicaid and other 3rd party claims**							
1	Average days in A/R	90.1 +	90 - 75		74.99 - 60.01		≤ 60	
2	% of Medicaid/Medicare claims billed in 30 days	< 80%	80 - 84.99%		85 - 89.99%		≥ 90%	
3	Collections of Billed Claims	< 80%	80%-84.99%		85%-89.99%		≥ 90%	
C.	Administrative/indirect cost control	> 15%	14.99 - 14%		13.99 - 13.01 %		< 13%	
D.	EHR system functional (uptime in minutes/year) -based on 124,800 minutes/year, all clinics	< 98%	98 - 98.49%		98.5 - 99.49%		≥ 99.5%	
E.	Testing results ranking of the system's data security	D or Below	C Ranking		B Ranking		A Ranking	
F.	Energy consupmtion not to exceed 15kW per square foot	> 15 kW/sq ft	15 kW/sq ft		14.96 kW/sq ft		< 14.96 kW/sq ft	
G.	Average investment rate of return compared to the federal funds rate	< 3%	< 2%		< 1%		Federal Rate or Higher	

2. Function and Purpose: **Management of Fiscal Resources (Finance)** **FY2026**

Acceptable controls in place for management of Center funds with timely reporting of financial status to the Board: the development and implementation of a balanced operating budget. (Any major funding reductions outside of the Center's control will be taken into consideration if applicable.)

		NOT MET (No score)	MEETS	score 1	EXCEEDS	score 2	COMMENDABLE	score 3
H.	Close monthly financials within 10 business days	< 50%	50 - 59%		60 - 74.99%		≥ 75%	
I.	**Business Development:**							
1	Cuts at a state/federal level are anticipated/offset with other funding. Service volume to consumers in a full level of care is maintained. Decrease in service volume (%)	> 5%	5 - 2.51%		2.5 - 0.01%		0%	
2	Revenues are stable/improving. % growth in total revenue	Decrease	No Change		0.01 - 1.5%		> 1.5%	
		Totals :		**0**		**0**		**0**

Total possible score for this section: **42**
Sum of scores for this section: **0**
Score **0.0000**

Notes on Financial Indicators - state "acceptable ranges for centers" are: A.1. 60-90 days; A.2. >.25

3. Function and Purpose: **Management of Service Delivery** **FY2026**

Implementation of systems for short/long term; maintenance of svcs to meet needs of the consumers the system serves. All systems are effective, efficient and incorporates a QA & improvement plan

		NOT MET (No score)	MEETS	score 1	EXCEEDS	score 2	COMMENDABLE	score 3
A.	**Client Satisfaction with Services - Chief Operating Officer** (5 pt Likert Scale, 5 is the highest)							
1	MH services - Overall Outcome	≤ 2.9	3.0 - 3.5		3.51 - 3.99		4+	
2	IDD services - Overall Outcome	≤ 2.9	3.0 - 3.5		3.51 - 3.99		4+	
3	SUD services - Overall Outcome	≤ 2.9	3.0 - 3.5		3.51 - 3.99		4+	
4	Primary Care services - Overall Outcome	≤ 2.9	3.0 - 3.5		3.51 - 3.99		4+	
5	Intensive Parenting Support Program - Overall Outcome	≤ 2.9	3.0 - 3.5		3.51 - 3.99		4+	
B.	**Clinical Outcomes**							
1	Quarterly IDD Community Service Target met	< 116	116 - 126		127 - 137		138+	
2	% of Adults receiving MH service monthly	< 40%	40 - 44.99%		45 - 49.99%		≥ 50%	
3	% of Youth receiving MH service monthly	< 65%	65 - 67.99%		68 - 70.99%		≥ 71%	
4	% of Adults showing improvement on HHSC strengths assessment	< 20%	20 - 26.49%		26.5 - 32.99%		≥ 33%	
5	% of Youth showing improvement on HHSC strengths assessment	< 32%	32 - 37.49%		37.5 - 42.99%		≥ 43%	
6	% of adults screened for Social Drivers of Health (SDOH)	< 40%	40 - 47.49%		47.5 - 54.99%		≥ 55%	
7	% adults admitted to in-patient care 3+ times in 180 days	> 0.3 %	0.29 - 0.27%		0.269 - 0.25%		< 0.25%	
8	% of SUD clients discharged from residential care who engage in aftercare services after discharge	< 25%	25 - 39.99%		40 - 54.99%		≥ 55%	

Implementation of systems for short/long term; maintenance of svcs to meet needs of the consumers the system serves. All systems are effective, efficient and incorporates a QA & improvement plan

		NOT MET (No score)	MEETS	score 1	EXCEEDS	score 2	COMMENDABLE	score 3
9	SUD Residential - % successful completion of treatment plan at La Villa of Hope	< 62%	62 - 68.49%		68.5 - 74.99%		≥ 75%	
10	% of clients initiating SUD tx w/in 14 days of SUD diagnosis	< 25%	25 - 37.9%		38 - 50%		> 50%	
11	Consumer benefits - average # of applications submitted/mon	< 30	35 - 49.99		50 - 64.99		≥ 65	
12	Milestone Residential - Number of clients served	< 23	23 - 27		28 - 32		≥ 33	
C.	**Chief Medical Officer: Prescribers, UM, Primary Care (PC) Srvcs**							
1	% of patients referred for Medical Nutrition Therapy are evaluated within 90 days	< 30%	30 - 39.99%		40 - 49.99%		≥ 50%	
2	% of PC patient population with a 3rd party pay source, monthly average	< 22%	22 - 26.99%		27 - 32.99%		≥ 33%	
3	% of Dietitian patients engaged in Medical Nutrition Therapy	< 30%	30 - 39.99%		40 - 49.99%		≥ 50%	
4	Prescribers average quality score	< 85%	85 - 89.99%		90 - 94.99%		≥ 95%	
5	Pharmacy - Average medication cost per client per visit	> $130	$130 - $114.01		$114 - $100		< $100	
6	Community Based Crisis Programs (CBCP) Utilization target	< 750	750 - 774		775 - 799		800+	
7	UM Completion Rate - Adult and Youth Service Auth Renewal	< 70%	70 - 79.99%		80 - 89.99%		≥ 90%	
8	% of PASRR Evaluations submitted within 7 days	< 85%	85 - 89.99%		90 - 94.99%		≥ 95%	
9	% of clients screened for tobacco use	< 80%	80 - 84.99%		85 - 89.99%		≥ 90%	

3. Function and Purpose: **Management of Service Delivery** **FY2026**

Implementation of systems for short/long term; maintenance of svcs to meet needs of the consumers the system serves. All systems are effective, efficient and incorporates a QA & improvement plan

		NOT MET (No score)	MEETS	score 1	EXCEEDS	score 2	COMMENDABLE	score 3
10	Number of programs added, improved or expanded	0	1		2		3+	
11	% of Clinical AI Agent (CAA) Prescriber usage for progress notes	< 50%	50 - 54.99%		55 - 59.99%		≥ 60%	
		TOTALS:		**0**		**0**		**0**

Total possible score for this section: **84**
Sum of scores for this section: **0**
Score **0.0000**

4. Function and Purpose: **Directed Payment Program (DPP) & Crisis Services** **FY2026**

Acceptable reporting and accountability of the Directed Payment Program and effective management of crisis response

		NOT MET (No score)	MEETS	score 1	EXCEEDS	score 2	COMMENDABLE	score 3
A.	% of reporting progress completion on DPP Component One Structured Measures and Component Two Outcome Measures	< 90%	90 - 94.99%		95 - 99.99%		100%	
B.	% of Crisis resolution for 30+ days without hospitalization	< 69%	69 - 73.99%		74 - 78.99%		≥ 79%	
C.	Hospitalization Follow-Up 7 Day	< 47%	47 - 51.99%		52 - 56.99%		≥ 57%	
D.	% of Adult MH clients not requiring psychiatric hospitalization	< 88%	88 - 92.99%		93 - 97.99%		≥ 98%	
E.	% of Youth MH clients not requiring psychiatric hospitalization	< 88%	88 - 92.99%		93 - 97.99%		≥ 98%	
F.	% of **Emergent** crisis response services initiated within 60min of crisis line activation (reporting for baseline only FY26)	< 70%	70 - 79.99%	**N/A**	80 - 89.99%	**N/A**	≥ 90%	**N/A**
G.	% of **Urgen**t crisis response services initiated within 8hrs of crisis line activation (reporting for baseline only FY26)	< 70%	70 - 79.99%	**N/A**	80 - 89.99%	**N/A**	≥ 90%	**N/A**
	Totals :			**0**		**0**		**0**

Total possible score for this section:	**15**
Sum of scores for this section:	**0**
Score	**0.0000**

5. Task and Purpose: **Standards Compliance** **FY2026**

Demonstrated by ensuring all programs/services are operated in compliance with state contracts, applicable regulations, standards and laws, Texas Administrative Code, rules, public responsibility laws, Mental Health Code, etc; and by ensuring the Center performs acceptably on evaluations such as QA / Program / Fiscal Reviews, CARF surveys, etc.

		NOT MET (No score)	MEETS	score 1	EXCEEDS	score 2	COMMENDABLE	score 3
A.	External Site/Desk Reviews of TTBH Services:							
1	Plans of Correction for external site/desk reviews submitted on time	< 90%	90 - 95.99%		96 - 99.99%		100%	
2	# HHSC audits with signif deficiencies cited & confirmed (ex: repeat findings, imm jeopardy)	> 2	2		1		0	
B.	Internal TTBH Service Reviews	< 6	6		7 - 8		9+	
C.	Total annual valid/confirmed sanctions or penalties from HHSC are minimized unless resulting from Board directive	> $25,000	$25,000 - $15,001		$15,000 - $10,001		$10,000 - $0	
D.	QA audits of network/contracted services (inpatient and outpatient services)							
1	# of audits per year	< 2	2 - 4		5 - 8		9+	
2	Indicated follow-up completed w/in 90 days	< 70%	70 - 84.99%		85 - 99.99%		100%	
E.	Continuous survey/certification readiness reviews of accredited or certified programs:							
1	# of audits per year	< 5	5		6		7+	
2	Indicated follow-up completed within 90 Days	< 70%	70 - 84.99%		85 - 99.99%		100%	
F.	Performance Improvement & Implementation Teams (PIIT): Number of PIITs faciliated	< 2	2		3		4+	

5. Task and Purpose: **Standards Compliance** **FY2026**

Demonstrated by ensuring all programs/services are operated in compliance with state contracts, applicable regulations, standards and laws, Texas Administrative Code, rules, public responsibility laws, Mental Health Code, etc; and by ensuring the Center performs acceptably on evaluations such as QA / Program / Fiscal Reviews, CARF surveys, etc.

		NOT MET (No score)	MEETS	score 1	EXCEEDS	score 2	COMMENDABLE	score 3
G.	Clinical Training: Number of best practice trainings QM implements	< 2	2		3		4+	
		Totals :		0		0		0

Total possible score for this section:	**30**
Sum of scores for this section:	**0**
Score	**0.0000**

Evaluation Scoring Summary:

	Average Rating for Section	x	Weight	=	Total Weighted Score
Human Resources	0.0000	x	15	=	0.00
Finance	0.0000	x	15	=	0.00
Service Delivery	0.0000	x	25	=	0.00
DPP_Crisis Services	0.0000	x	25	=	0.00
Standards Compliance	0.0000	x	20	=	0.00

Overall Score: **0.00**

IV. Business Plan for FY 2026

Introduction

The purpose of Tropical Texas Behavioral Health's (Center) *Business Plan* is to identify financial mechanisms that can be used to respond to fluctuations in the Center's revenues in ways that least affect the level and quality of services the Center provides its consumers. The *Business Plan* includes long-term strategies for dealing with reasonably predictable revenue and expense fluctuations and shorter-term strategies that are more effective in addressing unusual, unpredictable, or time-limited budgetary issues as they arise.

The dualistic long-term/short-term approach enables us to make the best use of current resources while we prepare for leaner times when operating within a fee-for-service environment. It maximizes our flexibility in responding to changes in our financial environment without having to reduce or eliminate programs and services when such changes occur.

The Center's primary revenue source is state general revenue received through a contract with Health and Human Services Commission (HHSC). The revenue is state appropriated every biennium and is dependent on the legislative funding of the appropriation request submitted by the Health & Human Services Commission.

Goals & Objectives

Many of the goals and objectives included in the FY 2026 *Strategic Plan* have financial implications. Collaboration by program and financial staff is essential to achieve successful outcomes for the various goals and objectives. Below is a list of Program and Services, and Administrative Support that need to be provided to meet goals and objectives.

1. Program and Services:
   - Client satisfaction surveys
   - Directed Payment Program & Crisis Services
   - Reductions in pharmacy costs
   - Prescribers' average quality scores
   - Technology upgrades
   - Clinical outcomes
   - Inpatient hospitalization usage

2. Administrative Support
   - Maintain a minimum operating fund balance of 150-250 days.
   - Increase the efficiency of the third-party claims billing and collection processes so that a maximum of Medicaid claims is billed within 30 days of service and 100% of the federal Medicaid revenue is collected within 90 days.
   - Keep administrative costs below 13%.
   - Reduce energy consumption Center-wide.
   - Minimize employee turnover, hiring timeliness and # of posted vacant positions.

Environmental Considerations

Programs and Services

Mental Health

The shift to a fee-for-service model has presented many challenges for the mental health programs under the Texas Resilience and Recovery (TRR) model and provider of last resort initiatives for both Mental Health (MH) and Intellectual Developmental Disabilities (IDD) programs. Many of the required services performed by the Center have no payor source other than state general revenue while other services are not covered due to server credentials The rates paid for eligible services at this time are consistent with the Medicaid rates. Those rates are based on historical cost. The rates set for mental health services are based on Medicaid reimbursable rates.

Rehab and Case Management

In FY26, 31.05 % of these services were reimbursed by the Medicaid Managed Care insurance companies. Tropical performs well on these types of services.

YES Waiver Services

Youth Empowerment Services (YES) waiver program includes services for Children and Adolescents at risk of being removed from their families or at risk of parental relinquishment due entirely to the parents not being equipped to properly provide for their severe emotionally disturbed children. The YES waiver program provides for: Art; Music; Animal Assisted, and Recreational Therapies; Community Living Supports; Family, and Paraprofessional Services; Supported Employment, and Employment Assistance; Respite; Adaptive Aids, and Minor Home Modifications. This program also provides a one-time pre-engagement service and a one-time transitional service coordination service for the youth who are aging out of services. The rates we pay to external providers are based on the published rates from the Texas Health and Human Services Commission. We continue to receive positive feedback from the families who have a child or youth in the program and these families are seeing the positive impact on their lives and on the children's behaviors.

Supportive Housing

The Supportive Housing Program is intended to provide financial assistance to individuals who are homeless or at risk of becoming homeless or "marginally" homeless in locating, obtaining, and maintaining safe, integrated housing in the community of choice. Services and supports are provided to enrolled individuals based on a Person-Centered Recovery Plan developed in collaboration with the person served. Services are focused on a detailed Self-Sufficiency Transition Plan developed with the client and intended to help the client achieve self-sufficiency. Based on the availability of funds and as clinically indicated, TTBH will provide eligible individuals temporary financial assistance with rent and utilities payments, housewares, furnishings or other basic needs. Funding for supportive housing financial assistance is provided through a contract with the Texas Health and Human Service Commission (HHSC). The Supportive Housing Program services promotes regular integrated housing options in the community. Consistent with the individual's goals and choices, TTBH staff assist individuals in locating, obtaining, maintaining, and retaining regular integrated housing that is safe, affordable, accessible, and chosen by the individual.

Intellectual Developmental Disabilities (IDD)

The Center actively practices "person directed planning". Person Directed Planning empowers the individual and Legally Authorized Representative (LAR) to direct the development of a plan of services and support, this requires listening, acknowledging, and discovering the individual's story. The individual and his or her needs are the basis and focus. Center staff provides employment assistance to individuals interested in employment. Staff do not provide employment services, we refer/link and support by assisting them with referrals, training on how to apply for a job, etc. In January 2021, the 21st Century Cures Act mandated that states implement an electronic visit verification (EVV) system for Medicaid personal care services. This system captures log in and out times for attendants delivering services to TTBH clients. We currently have about 81 attendants using the EVV system.

Respite, Community Support and Individualized Skills and Socialization

The rates set for Home & Community Services (HCS), and Texas Home Living (TxHmL) services are based on services performed primarily by private providers. The costs for the private providers tend to be lower than the costs for community IDD centers due to authority functions required of the community centers. TTBH pay rates to the private attendants to 100% of the direct rate for Foster Care and Individualized Skills and Socialization, and 90% of the direct rate on all other services. These rates are based upon the rates published by Texas Health and Human Services Commission. These rates are also extended to the general revenue clients receiving similar services. HHSC continues to release both TxHmL and HCS slots for GR clients to move into. This will shift general revenue to Medicaid revenues. Currently TTBH is paid at the enhancement rate level 25 for all services.

Service Coordination

Currently the Center is paid based on encounters defined as Type A and Type B. Type A encounters are usually a face-to-face contacts and type B encounters are telephone contacts. Only one Type A encounter will be paid a month at $92.80 and up to three Type B encounters will be paid at $30 each. Payments will be capped based on the number of unduplicated census for the year. Senate Bill 7 from the 2013 Texas Legislature directs HHSC to provide Medicaid acute care services to people who have Intellectual and Developmental Disabilities (IDD) through a managed care system. The change will apply to individuals determined to have IDD who are Medicaid eligible. People may live in a community-based Intermediate Care Facility for Individuals with Intellectual Disabilities or Related Conditions (ICF-IID) or receive services through an ICF-IID waiver program. Individuals who live in state supported living centers and those who receive both Medicaid and Medicare benefits are not included in this initiative. For individuals enrolled in managed care, STAR+PLUS will provide the acute care Medicaid services and HHSC will continue to provide long term services and supports.

Community First Choice (CFC)

Community First Choice (CFC) provides certain services and supports to individuals living in the community who are enrolled in the Medicaid program and meet CFC eligibility requirements. Services and supports may include:

- daily living (eating, toileting, and grooming), independent living in the community, and health-related tasks (personal assistance services);
- acquisition, maintenance, and enhancement of skills necessary for the individuals to care for themselves and to live independently in the community (habilitation);
- provide a backup system or ways to ensure continuity of services and supports (emergency response services); and
- train people how to select, manage and dismiss their own attendants (support management).

Substance Use Services (SUDS)

Tropical Texas Behavioral Health (TTBH) SUDS is a frontline assessment and treatment provider for clients who are unable to afford substance use services or may require assistance locating services for drug and alcohol use.

The Center has a contract with the Texas Health and Human Services Commission (HHSC) to provide Outreach, Screening, Assessment & Referral (OSAR) services for Texans who live within the nineteen (19) counties of Texas Region 11, The nineteen (19) counties of Texas Region 11 are: Aransas, Bee, Brooks, Cameron, Duval, Hidalgo, Jim Hogg, Jim Wells, Kenedy, Kleberg, Live Oak, McMullen, Nueces, Refugio, San Patricio, Starr, Webb, Willacy, & Zapata. TTBH is also accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) as a SUDS outpatient treatment provider for youth and adults within our service areas (Hidalgo, Cameron and Willacy counties) and has the ability to bill Managed Care Organizations. In addition to this contract the Center is the recipient of additional agreements with HHSC State Opioid Response

(SOR) Grants. Starting in late 2017 TTBH received the Texas Targeted Opioid Response (TTOR) Grants for (1) High Fidelity Supported Employment, (2) Peer Supported Re-Entry, (3) Priority Admissions Counselor, and (4) Office Based Opioid Treatment. Clients under the SOR programs are offered specialized opioid overdose education, access to life saving opioid overdose preventive nasal spray (Narcan) and access to Medication Assisted Treatment. Moreover, TTBH offers inpatient SUDS detox stabilization services. TTBH contracts with three local hospitals to provide up to five (5) days of voluntary inpatient stabilization. TTBH also contracts with local community partners for residential treatment services. Individuals who qualify are offered voluntary residential treatment for up to thirty (30) calendar days. Our treatment curriculums are evidence based such as but not limited to Motivational Interviewing and Cognitive Behavioral Therapy. Client plans of care are individualized according to the specific strengths, needs, abilities and preferences of each person served to maximize opportunity for client recovery.

Major Grants & Contracts

Among numerous other small grants TTBH has ~~recently~~ been awarded the following grants and contracts.

JII – Justice Involved Individuals

This is a grant through the state Department of Health and Human Services Commission to TTBH to implement the Mental Health Grant Program as directed by Senate Bill (S.B.) 292, 85th Texas Legislature, Regular Session, 2017. The purpose of this program is to provide matching grants to county-bases community collaboratives to reduce rates of recidivism, arrests, and incarcerations amongst individuals with mental illness and to also reduce wait times for individuals with mental illness placed on forensic commitment to a state hospital. The contract was effective on September 1, 2025, and terminates on August 31, 2027. The total amount of the contract for FY 26 is $799,821.

FEP / CSC - First Episode Psychosis / Coordinated Specialty Care

This is a grant through the state Department of Health and Human Services Commission to TTBH to provide services to individuals who meet the diagnostic criteria for the early stages of a primary psychotic disorder and range in age from 15-30 years. At the end of FY 2020 the state added additional monies for Tropical to expand into Cameron County. FEP-CSC utilizes evidence-based practices in the provision of services which meet CSC criteria and engage in community outreach and education to identify potential candidates.

PATH – Projects for Assistance in Transition from Homelessness

This is a grant through the state Department of Health and Human Services Commission. PATH aims to provide services to persons with serious mental illness or co-occurring substance use disorders who are homeless or at imminent risk of becoming homeless. The program provides outreach services to connect and engage these individuals with mainstream mental health services, primary health care, and substance abuse service systems.

TVFA- Texas Veterans and Families Alliance

TVFA provides Texas veterans, their spouses, and dependents with mental health education and support through curriculum-based training. The program initiates, enhances, and expands peer-to-peer support groups related to behavioral health issues and includes outreach services in order to create awareness of the available community-based behavioral health supports and services for Texas veterans and their families.

TCOOMMI – Texas Correctional Office on Offenders with Medical or Mental Impairments

This program serves mental health consumers who are also engaged in the legal system. Pre-release screenings are provided along with aftercare referrals to individuals being released from correctional settings. TTBH has programs for adults and youth.

OSAR - Outreach, Screening, Assessment, and Referral & TTOR – PAC Texas Targeted Opioid Response (TTOR) – Priority Admissions Counselor

The OSAR program provides coordinated access to a continuum of substance use disorder services for all Texas residents by offering outreach, screening, assessment, and referral services at locations that maximize client access to substance use disorder treatment. OSAR provides these services to individuals who meet the criteria for diagnosis of a substance use disorder and/or provides referrals for family support, housing, and health-related issues. In conjunction with TTOR, OSAR designates a Priority Admissions Counselor at every OSAR site. The PAC is responsible for targeted outreach to individuals with opioid use disorders and provides screening services and overdose prevention education.

TTOR OBOT - TTOR Office-Based Opioid Treatment

TTOR-OBOT aims to provide services to alleviate the adverse physiological effects of withdrawal from the use of opioids. OBOT expends funds to provide adult Texas residents who meet the financial and diagnostic criteria for a moderate or severe opioid use disorder with counseling and behavioral therapies.

TTOR HFSE – High Fidelity Supported Employment

The TTOR – High Fidelity Supported Employment program provides supportive employment services to individuals that are determined to have and/or are recovering from an opioid use disorder. TTOR-HFSE offers support through substance use disorder and medication assisted treatment teams and other necessary skills for potential employment opportunities.

CCBHCIA- Certified Community Behavioral Health Clinic – Improvement and Advancement

The Certified Community Behavioral Health Clinic Improvement and Advancement grant is through the Substance Abuse and Mental Health Services Administration (SAMSHA) from a funding opportunity issued from the Department of Health and Human Services. The purpose of the grant is for TTBH to transform community behavioral health systems and provide comprehensive, integrated, coordinated, and person-centered behavioral health care be enhancing and improving CCBHCs that currently meet the CCBHC certification criteria. Tropical applied and was awarded the grant in September 2022. The award is effective from September 2022 – September 2026.The amount of the award was $4,000,000.

Bureau of Justice Assistance (BJA) – , Harlingen, Brownsville, and Justice and Mental Health Collaborative

This grant is funded through the Office of Justice Programs (OJP). These grants will enhance the Mental Health-Law Enforcement Co-Responder Team program with the city of , Harlingen and Brownsville and the counties of Hidalgo and Cameron. The goal of this grant is to reduce and divert individuals with serious mental illness away from hail and provide linkages to mental health treatment and support services. This program will benefit individuals in crisis who come in contact with law enforcement for misdemeanor offenses determined to be related to the symptoms of their mental illness, who may be appropriate for diversion from the criminal justice system into routine behavioral health care services. Approved expenditures include personnel costs for TTBH staff and contractual costs for the officers working with TTBH staff on the grant. Currently, Tropical Texas Behavioral Health has 3 contracts, , one with Harlingen Police Department, one with Brownsville Police Department, one with Hidalgo County, and one with Cameron County. The Harlingen P.D. and Brownsville P.D. contracts are effective October 1, 2022, to September 30, 2025. The Justice and Mental Health Collaborative grant with Cameron and Hidalgo counties is effective October 1, 2024 to September 30, 2027. The total contract value for all 3 contracts is $781,250 each. $550,000 will be covered by BJA and $231,250 is the match portion that will be covered by TTBH. Total Harlingen and Brownsville contract amounts for Year 3 (October 1, 2023, to September 30, 2024) is $281,250. $225,000 will be covered by BJA and $56,250 will be covered by TTBH. Total Justice and Mental Health Collaborative contract amount for Year 2 is $281,250. $225,000 will be covered by BJA and $56,250 will be covered by TTBH.

Edinburg Police Department Community Crisis Response Team

This grant is funded through Substance Abuse and Mental Health Services Administration SAMHSA. The purpose of this program is to create or enhance a mobile crisis response team with Edinburg Police Department to divert adults, children, and youth experiencing mental health crises from law enforcement. This grant offers the opportunity to create a formal program that will aid those individuals with the greatest needs in our community by promoting effective strategies by law enforcement to identify and reduce the risk of harm to individuals with mental health crisis or co-occurring mental health and substance use disorders and identify the most appropriate services while improving public safety. Approved expenditures for this grant include personnel costs and contractual costs for the officers working with TTBH staff on this grant. The contract is effective September 30, 2023, to September 29, 2027. Total contract value is $3,000,000. Total contract amount for Year 3 September 30, 2025, to September 29, 2026, is $750,000.

Mental Health Awareness Training – Mental Health First Aid Expansion Project

This grant is funded through Substance Abuse and Mental Health Services Administration SAMHSA. This grant will focus on training of non-educators. Approved expenditures include personnel costs for MHAT staff, local travel, and

training materials for MHAT trainings. The contract is effective December 31, 2022, to September 29, 2026. Total contract value is $500,000. Total contract amount for September 30, 2025, to September 29, 2026, is $125,000.

Zero Suicide Program

This grant is funded through Substance Abuse and Mental Health Services Administration SAMHSA. The purpose of this program is to implement the Zero Suicide intervention and prevention model for adults throughout a health system. Approved expenditures include personnel costs for Zero Suicide Staff, local travel, and out of Town travel to the American Association of Suicidology for 2 staff. The contract is effective September 30, 2023 to September 29, 2028. Total contract value is $2,000,000. Total contract amount for FY26 is $400,000.

Needs and Capacity Assessment (NCA) – Diversion Center

This grant is funded through the Health and Human Services Commission. This program will facilitate the transition of individuals with serious mental illness with or without co-occurring substance use disorders from jail and into community-based treatment services. Approved expenditures include personnel costs, out of town travel to a center with a current jail diversion program, and items to furnish the diversion center such as furniture for group counseling, mattresses, and kitchen appliances. Total contract value is $3,520,000. The contract amount for FY26 is $1,760,000.

MST Multi-Systemic Therapy Expansion

This grant is funded through the Health and Human Services Commission. This program will address service gaps individuals and families experience in our community by promoting effective strategies to improve behaviors and create sustainable solutions for at-risk individuals. This will serve as an expansion to our current MST grant. Approved expenditures include personnel costs, local travel to deliver MST services, and contractual costs with MST Institute. This contract will provide training and support to license TTBH in MST services. Total contract value is $1,384,090 for 2 years. FY26 contract amount is $692,045.

Supporting Mental Health and Resiliency in Texans (SMART)

This grant is funded through the Health and Human Services Commission. This program will promote identification of potential mental health needs and improve access to early intervention and treatment for Children and Families through community-based initiatives. Approved expenditures include personnel costs, local travel to deliver SMART services, and client support costs. Total contract value for FY26 is $266,173.

Rural Mental Health Initiative Grant Program

This grant is funded through the Health and Human Services Commission. This program will expand behavioral health centers to provide outpatient mental health services to adults and childrens and to reduce recidivism and the frequency of arrest, incarceration, and emergency detentions amount persons with mental

illness. Approved expenditures include personnel costs, local travel costs to provide services, and specialized therapies. Total contract value is $1,100,000 for 5 years. Total contract value for FY26 $208,0

CCBHC – Certified Community Behavioral Health Care Clinic

While the state of Texas was not chosen by the Centers for Medicaid and Medicare Services (CMS) to participate in the pilot for this new payment methodology, the state of Texas decided to perform our own pilot. Seven Centers including TTBH were chosen to participate along with one other provider. TTBH received the re-certification as a CCBHC. Under the CCBHC model a provider, which TTBH would be, is paid a monthly rate to provide all services covered to the client. This differs from the current fee for service payment model in that currently TTBH is paid for all services individually, and under CCHBC we would receive one monthly amount regardless of how many services were provided. Another major difference is that under the CCBHC model TTBH would provide a care coordination service to our clients which includes coordinating not only within TTBH but with all providers the client has chosen to use.

Staff Productivity

Client Treatment Hours (CTH)

Staff are held accountable for meeting established targets and are eligible for both team-based and individual financial incentives for meeting and/or exceeding targets. CTH is continually updated since it impacts all client services staff and is a measure of productivity for the Center.

An incentive program was developed to coincide with the productivity initiative. Individual performance has been monitored since 2006 and was replaced by a group incentive program during the summer of 2007 and continues today. Incentives paid were $1,996,413 and $1,701,065for FY 2024 and 2025 respectively. During 2026 we are planning to use the lapsed salaries from budgeted but unfilled positions to cover the monthly incentives.

The TTBH Physician Incentive Program is designed to attract staff. The quarterly incentive in place was changed to a yearly incentive. In 2025, 19 physicians were eligible for the incentive, and all met the quality portion for a total incentive payment of $522,500.

Technology

In response to a national accreditation requirement, TTBH has begun conducting an annual technology assessment, and updating or replacing equipment as necessary.

A significant portion of services are delivered in the community. The staff providing these services use laptop computers while in the community to increase their efficiency. Technology demands have shifted to keep pace with change. Currently, TTBH uses Oracle Millennium software system for clinical services. During 2015 the Center began implementation of a new time and attendance system from Kronos, we have completed the move into Kronos for the HR talent and recruitment. During 2017 the Center converted the fiscal system from Cerner to Financial Edge which is a

web-based software created by Blackbaud. The moves of both the Payroll/HR system and the Fiscal system were required as the prior system no longer supported either system.

The clinical system is a vital component of the service delivery system, especially with the Center's continued improvement to its electronic medical record. To ensure that the system is dependable and reliable, Management Information System (MIS) staff schedule promotions and enhancements after hours. Promotions/enhancements are completed regularly.

Training sessions are held for first-time users of the clinical system, and as needed for existing staff for changes and to correct problems. Key staff actively participate in the Oracle Millennium Users Group. The involvement enables staff to receive current information about the system and participate in system design discussions. Additionally, the MIS Director is also an active participant in the Texas Council Information Management Consortium.

The use of technology at TTBH enhances individual services, efficiency and productivity of personnel, communication with stakeholders and greatly improves our ability to serve isolated populations.

TTBH joined the Tejas Behavioral Health Management Association during FY 2017. Included in the monthly membership fee are a variety of resources available to the Center, which we currently purchase. TTBH will have access to resources such as: MCO/Health Plan negotiations, business and IT consulting including reporting/outcome data analytics. In addition, all current members of the association use the Cerner/Anasazi software platform for clinical services, a potential for talent boost.

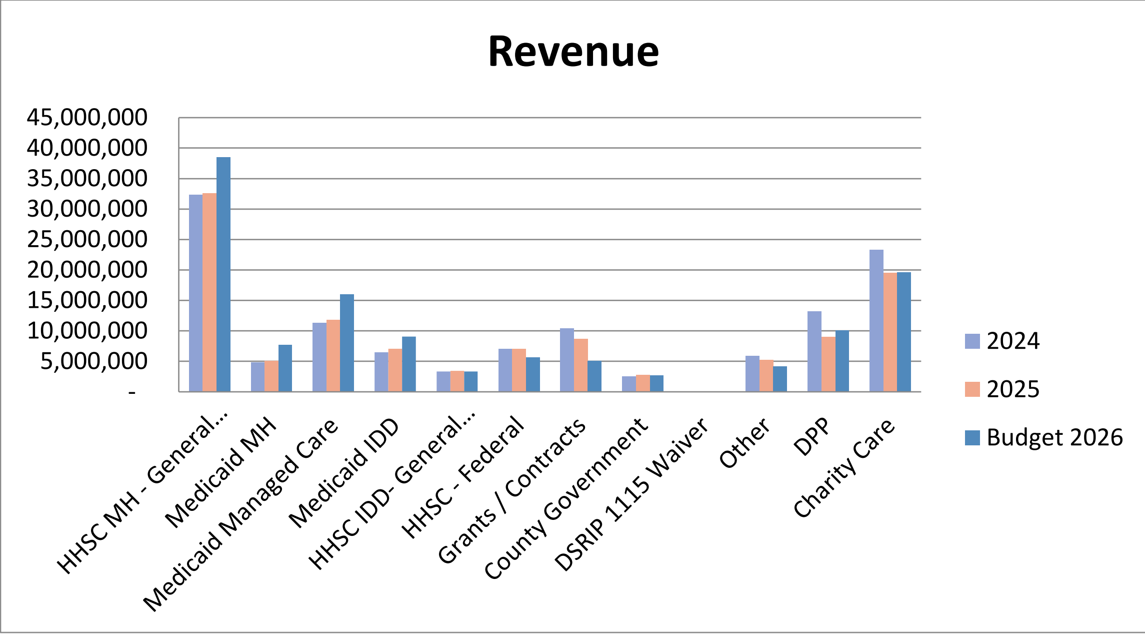
Tropical continues to be a leader in technology among Texas community centers. At the onset of the pandemic, its service team was active and delivering services within weeks' time. We continue to equip our teams with the technology to be able to deliver services remotely and with minor issues.

Financial Considerations

Operating Revenues

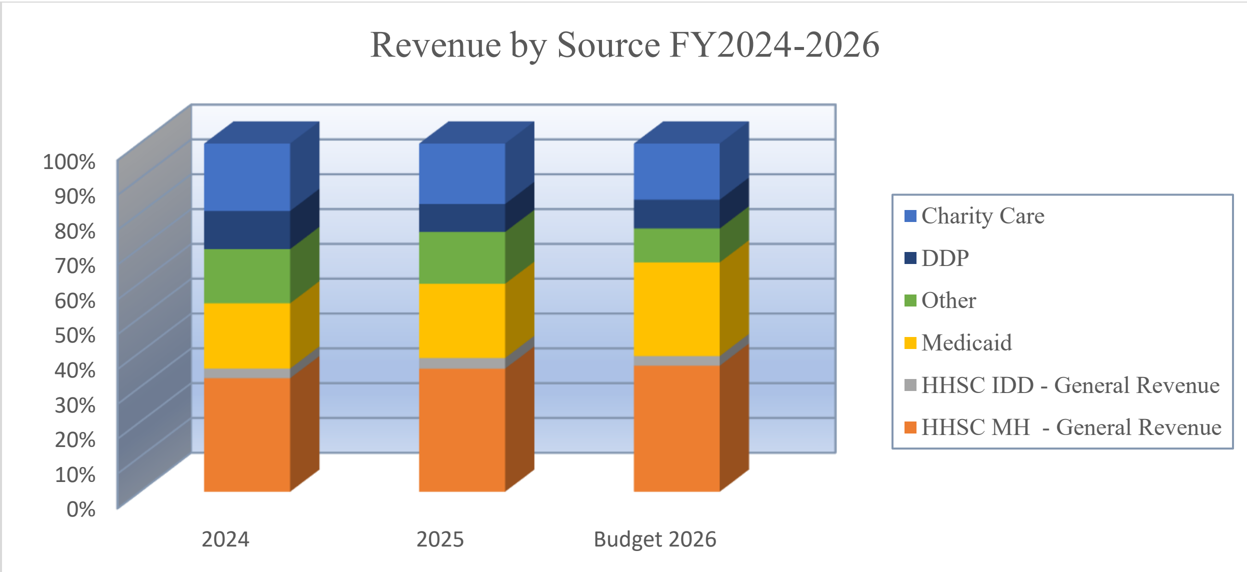
The Center's ability to generate revenue or create new revenue sources is limited by social and economic conditions, state statute, Board policy, and private provider competition. The *Texas Health and Safety Code* defines the services to be provided by a Community MHMR Center. Legal protection does not extend beyond the services listed in the statute and those defined in the Center's *Local Plan.* There have been some modifications made during the last few legislative sessions. It is anticipated that these changes will increase flexibility for MHMR Centers in Texas.

The projected revenue for FY 2026 is $121,644,861. The following graph shows the various revenue sources comparing actual FY 2024 & 2025 to the budgeted amounts for FY 2026.



General Revenue

The percentage of state general revenue received by the Center increased from 35% in 2024 to 39% in 2026. Medicaid earnings have increased from 19% in 2024 to 27% currently, the Center in continuing to receive new funding streams each year. The change in funding streams helped "force" the statewide Community MHMR Centers to become more efficient. Where the Centers used to receive the majority of the funding from the state in recent years more than half of the funding comes from sources other than the state as evidenced thru the graph below:



MH General Revenue FY 2026 is expected to be $44,034,974.

IDD General Revenue FY 2026 is expected to be $3,357,838.

Medicaid Revenue

Medicaid revenue is budgeted to be $32,729,587 in FY 2026.

The Center's goals include an increase in revenue received from Medicaid and other sources. Procedures implemented to expand Medicaid revenue include the following:

- Training staff in verifying and data entering the payor source for every consumer during each visit to a mental health program.
- Monitoring the percentage of consumers with Medicaid to determine if there is an increase or a decrease so that measures can be taken as soon as a change is detected.
- Bi-monthly review of MBOW reports for Potential Medicaid revenue.
- Comparing the Medicaid database with our Consumer Data system to determine if any consumers have third-party coverage which was not previously identified.
- Benefits Eligibility Comparison Application (BECA) implemented. Batches Cerner Data and compares to the Medicaid Eligibility File (TMHP) to identify discrepancies in client's Medicaid, Medicare, and Managed Care coverages.
- Service Request Form Generator creates and faxes the Service Request Forms to the Managed Care companies.

In March 2012, Medicaid Managed care was expanded into the Center's catchment area. Five insurance companies were awarded contracts to provide managed care programs to clients currently enrolled in the State Medicaid program. The Center secured contracts with each of the managed care insurance companies in the area. Since FY 2017, the Center has been re-negotiating the contracts with the Managed Care Organizations due to the integration of both Substance Use Services and Integrated Primary Care to increase the amount of funding that TTBH is able to receive.

Other Revenue Sources

In FY 2026 the Center budgeted $41,522,462 from other revenue sources compared to $45,180,514 in FY 2025. These various revenue streams as a combined total are staying fairly constant as TTBH works to increase the number of grants and the variety of funding streams available to us to serve our clients in all areas of need. The Center continues to expand and diversify the funding sources through various grants and contracts. In late FY 2015, the Center received a Section 501(c)(3) designation with the Internal Revenue Service. This designation allows the Center to continue to qualify for grants awarded by foundations, certain federal agencies, and federal pass-through grants such as Community Development Block Grants.

Fund Balance

The Center's fund balance in the General Fund, as of August 31, 2025, was $82,795,515. The Center has had a positive fund balance since FY 2001.

Financial Ratios

The following financial ratios are completed monthly to monitor the liquidity, days of operating cash available and debt load. The ratios were developed by Capital Markets in order to have an industry standard for Texas Community MHMR Centers.

- Current Ratio — The ability to meet short-term obligations. This is presented in "times". If the ratio is too low, the Center may not be able to pay its obligations. If the ratio is too high, the Center may have money tied up in investments/savings that could be used for the provision of services.
  Acceptable range for community centers: 4.26 +
  Ratio at August 31, 2025 7.97 Times

- Acid Test Ratio — A more stringent measure of liquidity. Eliminates the variable of Converting investments and other tangible assets to cash.
  Acceptable range for community centers: 2.75 +
  Ratio at August 31, 2025 7.11 Times

- Days of Operation — Reserve

  Expresses the unreserved fund balance of the organization in terms of the number of days it can operate if there was no further inflow of revenue. Represented in days.Acceptable range for community centers: 100 +
  Ratio at August 31, 2025 212.90 Days

- Debt Service Coverage Ratio — A measure of how well the Center has managed the assumption of long-term debt. Indicates available cash levels to accommodate debt service payments. Represented in "times".
  Acceptable range for community centers: > 1.25

  This ratio is not currently being calculated as the center has no debt.

The ratios are included in the monthly financial statement packet presented to the Board of Trustees. The ratios reported are limited to the General Fund.

Financial ratios are also a key component of the internal monitoring system for the Center. The following graph outlines the acceptable minimum ranges and the Centers ratios. We have consistently been meeting the acceptable ranges and do not anticipate any changes in the near future.

Financial Ratios
Community Services Performance Report

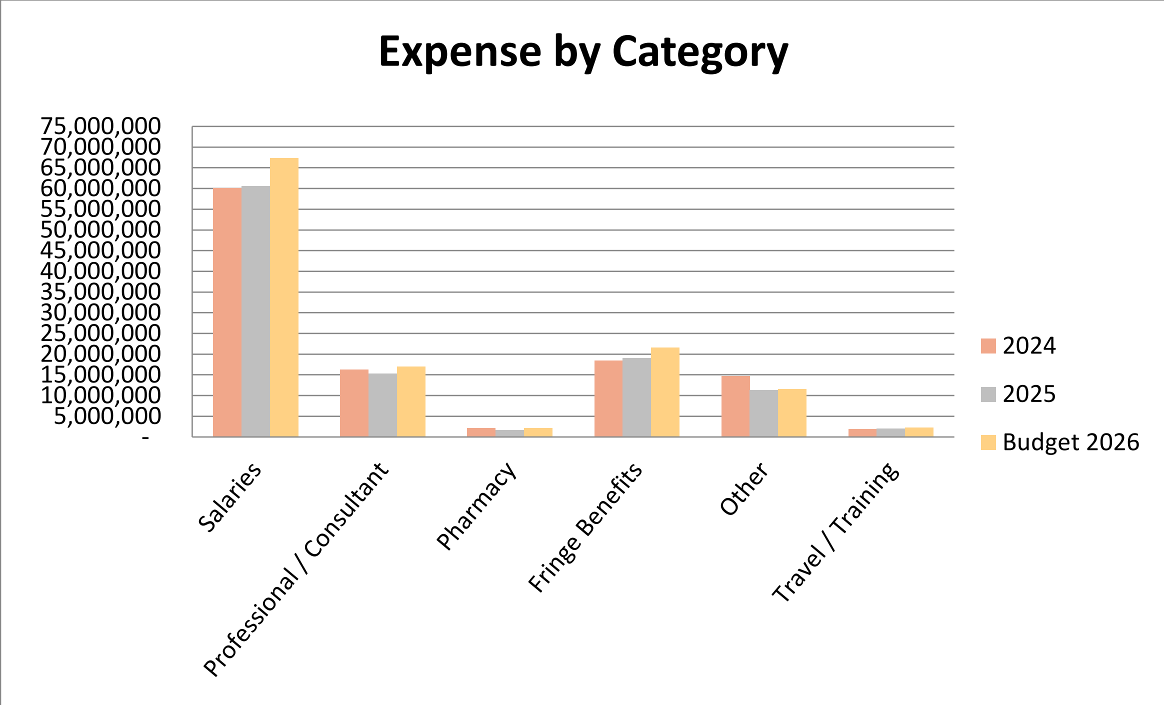
Financial Measure	August 2024	August 2025	Minimum Acceptable Range	Maximum Acceptable Range
Current Ratio	5.25	7.97	1.75	Unlimited
Acid Test Ratio	4.63	7.11	.25	Unlimited
Debt Service Coverage Ratio	N/A	N/A	1	Unlimited
Days of Operation without Further Funding	197.46	212.90	60	Unlimited

Expenditures

The Center's FY 2026 adjusted operating budget totals $121,644,861. As with other service industry organizations, the majority of the expenses are for personnel costs. FTEs in FY 2025 were 1,320 of which 1,137 were filled, and budgeted FTEs for FY 2026 are 1,271.

FY25 fringe rate was 31.43% and our anticipated FY26 is 32% due primarily to an anticipated increase in retirement participation. The Centers retirement plan was revised to include an opt-out clause where employees are automatically enrolled at a 3% rate unless they opt-out of the plan. The opt-out clause has increased participation significantly. In addition, the Center has a retirement match of up to 12%.

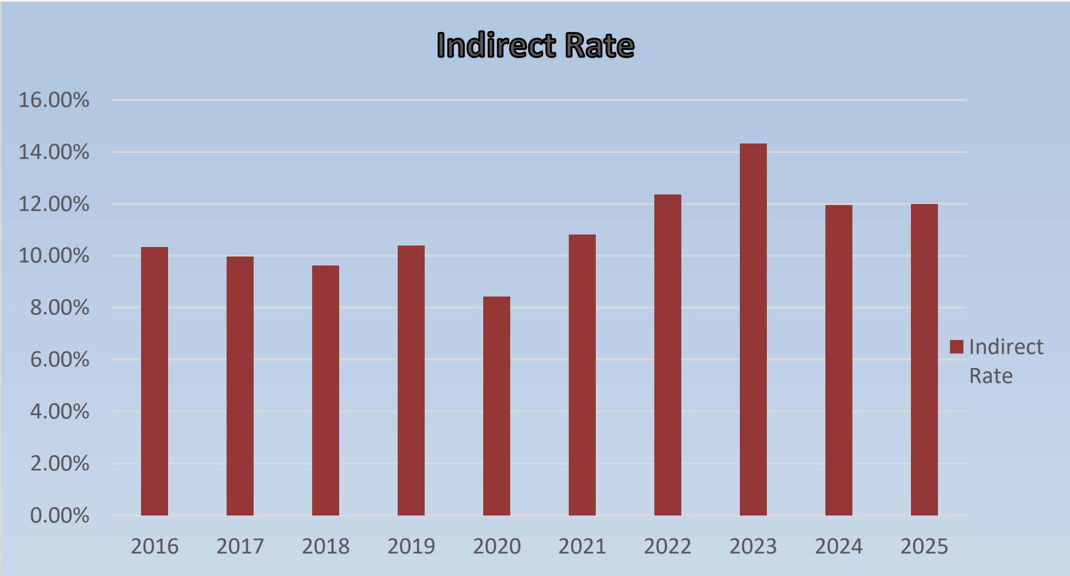
Medication expense represented approximately 1.50% of our FY 2025 operating expenses, and the budget will be 1.67% for the FY 2026. Tropical continues to use the Patient Assistance Program (PAP). PAP allows the Center to request medications on behalf of eligible consumers directly from the manufacturer. In FY25 there were 4,904 PAP applications submitted thru August for a value of $15,332,913.



Indirect Cost

The Center uses the indirect cost percentage as an indicator of its administrative efficiency. The indirect cost is a relationship of the administrative costs to the direct/program costs. The indirect cost percentage was calculated in accordance with the *Audit Guidelines for Community MHMR Centers,* 20th Revision – Summer 2003, the cost principles in the OMB Circular A-87 and the *Cost Accounting Methodology* promulgated by Health & Human Services.

The following graph shows the indirect cost percentage for the past ten (10) years. The guidelines used have changed during that time period which contributed to the variances.



The Center's Performance Contract with HHS includes a 10% funding limitation for state general revenue that can be used to fund administrative costs. Any additional funding needs are covered by various other funding streams. The Center has successfully demonstrated the ability to operate within the funding limitation.

The indirect cost percentage as of August 31, 2025, was 11.29%. Administrative costs are monitored closely to determine where reductions can be made without doing harm to the programs or the Center's system of internal controls.

Capital Projects

Among the center's building projects in FY25 is the finish out of EOP Plaza for office space, storage and the crisis diversion center. TTBH is currently renovating the EOP main building to expand the primary care and warehouse areas. Additionally, the 2nd floor will undergo renovations to add cubicles for the call center, a medication room and workstations in the medical clinic, children's office additions and storage, and registration booths at the front entrance. There will also be some restroom renovations. In addition, there is an EOP main project also includes adding a second elevator and repairing the existing one, scheduled for FY 25. In Harlingen, land has been acquired to build a crisis center, residential center, and diversion center in Cameron County. TTBH has also begun the process of purchasing land in Weslaco for future projects.

The Center's transportation fleet has also been evaluated and we are continuing to update aging vehicles.

Directive Payment Program (DPP)

The new Directed Payment Program for Behavioral Health Services (DPP BHS), which began September 1, 2021, requires an annual application. Program funds will be paid to Managed Care Organizations (MCOs) through two components of the managed care per member per month (PMPM) capitation rates. Component one is comprised of structured measures and semi-annual reporting requirements which equals to 65 percent of the total program value. Component two is comprised of outcome measures and semi-annual reporting requirements which equals to 35 percent of the total program value. The Center is expected to receive $10,049,731 in FY 2026.

Public Health Providers-Charity Care Program (PHP-CCP)

HHSC approved the Public Health Provider-Charity Care Program (PHP-CCP) on December 22, 2021. The program is designed to allow qualified providers to receive reimbursement for the cost of delivering healthcare services, including behavioral health services, immunizations, and other preventative services that are not reimbursed by another source. The program is authorized under the 1115 waiver. Year 1 reimbursed Centers for uncompensated care and Medicaid shortfall. In future periods, the program will consist of only charity care. The cost report is due on November 14th after each demonstration year. The Center is expected to receive $19,612,582 in FY26.

"Tropical Texas Behavioral Health improves the lives of people with behavioral health needs through the efficient and effective provision of quality services delivered with respect, dignity and cultural sensitivity, and a focus on recovery."

QUALITY MANAGEMENT PLAN

FY2025-2026

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Appendix A: TTBH Organizational Chart

Appendix B: Outcomes Management

I. BACKGROUND

Tropical Texas Behavioral Health (TTBH) manages behavioral health, integrated primary care and substance use disorder services for more than 34,000 clients across its service area. TTBH has over 50 years in operation as the Local Mental Health Authority (LMHA) and Local Intellectual and Developmental Disability Authority (LIDDA) for the more than 1.3 million residents of Hidalgo, Cameron, and Willacy counties in Texas, covering a 3,100 square mile area along the southern Texas Gulf Coast and the border with Mexico.

TTBH considers social determinants of health (SDOH) conditions in the local environment which may affect a wide range of health, functioning, and quality of life outcomes and risk for our consumers. These SDOH factors include but are not limited to economic stability, education access and quality, health access and quality, neighborhood and build environment, and social and community context. The following are demographic and specific SDOH conditions TTBH continuously monitors in its catchment area.

The population of the service area in the Rio Grande Valley of South Texas, is comprised of 1.3 million residents, with an ethnic population of approximately 90% Hispanic. Per CMS Office of Minority Health, almost 9% of the US population are persons with limited English proficiency, and 36% of the population have low health literacy. Within the TTBH service area, nearly 80% of residents speak a language other than English, and most of those individuals are Spanish speakers. Individuals with limited English proficiency and low health literacy are almost twice as likely to report poor health status when compared to those whose primary language is English - only 41% of respondents from TTBH's most recent Community Needs Assessment survey reported feeling confident in their ability to complete medical forms independently

The percentage of residents without health insurance coverage are 31.2%, 29% and 22.3% for Hidalgo, Cameron, and Willacy counties, respectively, which is about three times higher than the national average in the U.S. (10%). The population percentages of families living in poverty for Hidalgo, Cameron and Willacy counties are at 28.8%, 24.6%, and 34.3%, respectively as compared to the U.S. (11.4%; based on the U.S. Census Bureau, Quick Facts for Hidalgo, Cameron and Willacy counties in Texas, population estimates, July 1, 2022 (V2022)), with Internal TTBH data from 2024 indicating that 68.84% of clients fall at or below 150% of the federal poverty level – the qualifying threshold for receiving full charity care assistance.

Additionally, HRSA identifies our counties as Medically Underserved Areas and a Health Professional Shortage Area for Primary Care, Psychiatrist, Psychologists, Licensed Professional Counselors and Licensed Chemical Dependency Counselors. The area's high unemployment rate, low literacy rate and high level of poverty place these individuals at greater risk for behavioral health issues.

Per the most recently conducted local Needs Assessment, key issues and concerns identified by stakeholders include:

- lack of available public transportation,
- need for expansion of mental health, substance use, and primary care services,
- need for expanded mobile crisis outpatient services,
- long wait-times for appointments, and
- availability of services for the medically uninsured.

Treatment for mental disorders is hard to find in the RGV. The University of Texas Health Science Center Houston surveyed mental health care in the RGV. The survey concluded that “incidence rates in the RGV are lower than the state of Texas as a whole. Rates for depression, schizophrenia, bipolar disorder, and anxiety disorders all show lower incidence rates as well. This may be attributed to the mental health seeking behavior of RGV residents as well as to a lack of treatment facilities in the region.” The study concluded that, “Overall, it is difficult to determine the true extent in the RGV, residents tend not to seek treatment and when they do, they may not be able to get it.”

TTBH is dedicated to advancing health equity by addressing barriers that impact access to care. Individuals with Limited English Proficiency (LEP) are supported through language-access services to ensure they can receive care without communication obstacles. Care coordinators engage Spanish-speaking and bilingual individuals to facilitate informed decision-making and promote understanding of medical information.

Screening for health literacy and social determinants of health plays a critical role in identifying gaps in care, particularly for individuals who face challenges navigating the healthcare system. This initiative empowers clients to recognize barriers, develop personalized action plans, and receive targeted support aimed at improving overall quality of life.

A significant portion of the population served by TTBH lacks medical insurance. To address this, TTBH integrates primary care services and allocates funding for specialty medical care. Care coordinators collaborate with primary care providers to monitor medical referrals and ensure continuity of care during transitions. Additionally, the recent addition of a registered dietician enhances nutrition education efforts, which are expected to contribute positively to reducing health disparities.

In the face of these many challenges, TTBH continues to serve the community with gold standard person and family centered care with a culturally appropriate service delivery system. Working collaboratively with clients, their families, advocates, state agencies, and providers, TTBH has created a community-based system of care that joins behavioral health, primary care, and substance use services for clients. TTBH is committed to making sure that our clients receive clinically appropriate, high quality, accessible care.

II. PURPOSE

The Quality Management (QM) program serves as a unifying structure for all Center quality management activities and ensures and improves the quality of services provided across Mental Health (MH), Substance Use Disorder (SUD), Primary Care, and Intellectual and Developmental Disability (IDD) services authorized and managed by the Center. To accomplish this, the Center combines the use of health information technologies with continuous quality improvement processes to provide quality management oversight of authority, administrative, fiscal and service delivery performance. The quality management program ensures that the Center's Executive Management Team (EMT), Board of Trustees, applicable Committees and Advisory groups have the information needed to make informed decisions to support the provision of the highest quality of care. The Center recognizes a responsibility to demonstrate a solid commitment to superior clinical quality and service that is client-focused, clinically appropriate, cost effective, data-driven, and culturally competent. This is achieved through our organization-wide, systematic, and well-coordinated QM program that involves input from and coordination with all stakeholders including clients, leadership, staff, providers, functional areas, and the community.

The Center's performance of these oversight functions significantly impacts the outcomes for individuals, the cost to achieve successful outcomes, and the perception of clients and families of the quality and value of services. The Center has implemented system wide performance evaluation and improvement measures for its network of service providers as well as its business and administrative functions.

The quality management process is vital to demonstrating best value, balancing service cost and quality.

III. PLAN DEVELOPMENT

The Center's Quality Management Plan is a functional and dynamic document, evolving over time. The Plan addresses the following quality management initiatives: oversight of the Center's authority and provider functions; increased accountability; compliance with the requirements and objectives of the performance contract and Texas Resiliency and Recovery (TRR); the integration of Local Planning and Network Development and applicable payor sources, compliance, integration, and consideration of stakeholder input in determining best value and standards for customer service and quality of care.

The quality oversight responsibilities built-in to the Center's role as the local authority include the management and maximization of resources within the local communities to serve as many individuals as possible while obtaining the best results; monitoring client satisfaction as it pertains to provider choice and service quality, and objective evaluation of service providers.

As the Center responds to the increasing need for integrated care to include, behavioral health, primary care, and substance use disorder services in the local service area and continues its efforts to expand its network of local service providers in accordance with the requirements of Local Provider Network Development (LPND), it must be increasingly efficient in its use of available funds and effective in its provision of the highest quality services to as many individuals in need as possible. Quality oversight in this area ensures cost-effective utilization of resources, objective

evaluation of service delivery and provider performance, and the improvement of deficient or non-compliant practices.

To ensure compliance, the Center will continue to utilize a Performance Improvement and Compliance Committee (PICC) to analyze key performance indicators, especially as it pertains to the evaluation of high impact areas. Areas requiring evaluation and oversight are identified in statute, in the requirements of the performance contract, by contract performance and accountability data stored in the state's Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW), and in any plans of correction resulting from external reviews by the various agencies regulating Center services and functions.

The Plan supports the Center's Local Plan, developed with the input of stakeholders, including clients, families, employees, and members of the community. Quality oversight of this area includes reviewing and monitoring progress made toward achieving goals and objectives and modifying the strategies to achieve these as indicated. The effectiveness of the Plan is monitored through reports made to PICC, EMT, Board of Trustees, and other oversight committees, and advisory groups.

The Board of Trustees and leadership of TTBH continue to be highly committed to adapting to changes in the field of integrated care and improving services to the Center's clients and their families wherever possible while observing strict conformance with applicable laws, rules and standards. TTBH is proud of the accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) which commenced in August of 2008. As of the February 2024 CARF survey, the following programs are accredited for a period of three years:

1. Assertive Community Treatment-Mental Health Adults;
2. Outpatient Treatment-Mental Health Adults;
3. Outpatient Treatment-Mental Health Children and Adolescents;
4. Case Management Mental Health Adults;
5. Case Management Mental Health Children and Adolescents;
6. Crisis Intervention Mental Health Adults;
7. Crisis Intervention Mental Health Children and Adolescents;
8. Outpatient Treatment-Alcohol and other Drugs Adults;
9. Outpatient Treatment-Alcohol and other Drugs Children and Adolescents;
10. Supported Living-Adults;
11. Outpatient Treatment-Mental Health Consumer Run Adults;
12. Integrated Behavioral Health and Primary Care Comprehensive Care Adults;
13. Integrated Behavioral Health and Primary Care Comprehensive Care Children and Adolescents; and
14. Governance.

This accreditation represents the highest level of accreditation that can be awarded to an organization and shows organizational conformance to the CARF standards and expectations. An organization receiving a Three-Year Accreditation has gone through a rigorous peer review process and demonstrated to CARF surveyors during on-site visits that programs and services are measurable, accountable, and of the highest quality.

Additionally, TTBH has been certified as a Certified Community Behavioral Health Center since 2016; an integrated service delivery model proposed by the Substance Abuse and Mental Health Services Administration (SAMHSA). TTBH was selected as one of ten state community centers to participate in the program when it was initiated in 2016. TTBH achieved recertification as a CCBHC in 2023 for an additional three-year certification.

In September 2024, TTBH became the first and only Center in Texas to achieve three-year certification as a Suicide Safe Care Center; a designation granted by the Texas Health and Human Services Commission (HHSC) and the Texas Institute in Mental Health (TIEMH). Through certification review, TTBH was able to demonstrate its commitment to "*implementing a series of best practices intended to minimize the risk of suicide for children, adolescents, and adults accessing services from the organization. A Suicide Care Center embraces the Zero Suicide framework, a system-wide transformation toward safer suicide care."*-
Suicide Care in Texas Toolkit: Behavioral Health Services Department, HHSC

IV. CENTER MISSION, VISION and CORE VALUES

The Quality Management Plan is driven by and supports the Center's Mission and Vision:

MISSION STATEMENT:

Tropical Texas Behavioral Health improves the lives of people with behavioral health needs through the efficient and effective provision of quality services delivered with respect, dignity, cultural sensitivity, and a focus on recovery.

VISION STATEMENT:

Tropical Texas Behavioral Health continues its commitment to excellence and will be an innovative provider of comprehensive and compassionate recovery-oriented services to individuals with behavioral health needs. We will treat all stakeholders with honesty, fairness and respect.

PHILOSOPHY/CORE VALUES:

Ethical TTBH is committed to abide by all honest, legal and moral principles in its operations.

Competent TTBH is committed to providing efficient and quality services through qualified, trained and credentialed professional staff.

Trustworthy TTBH is committed to responsibly provide an organized system of care through the careful and planned expenditure of all available resources.

Dedicated TTBH is committed to the caring support of the individuals it is privileged to serve.

Quality TTBH is committed to the provision of excellent customer service driven by the needs of all people it serves.

Advocate TTBH is committed to furthering the interests of those served and to help them lead meaningful lives as members of the community. This includes helping them to achieve their right to belong, to be valued, to participate and to make meaningful contributions.

Resiliency & Recovery: TTBH is committed to using evidence-based practices which ensures the provision of interventions with empirical support to eliminate or manage symptoms and promote recovery.

V. GOALS

The Quality Management Plan is consistent with the organization's mission and reflects the coordinated activities and input of the Quality Management Division, various administrative functions including fiscal services and information technologies, service delivery areas, and internal and external stakeholders including Center governance and leadership. The leadership, staff, stakeholders and clients are accountable for the Plan. All staff are trained at orientation and annually thereafter in the Plan and purpose. FY2026 TTBH's Strategic Plan reflects many of the Center's goals and objectives. They address the Management of Human Resources, Management of Fiscal Resources, Management of Service Delivery, and Standards of Compliance. Additionally, the Center maintains tools that reflect many of the center's performance measurement which span across service delivery areas.

Progress toward these goals is reported semi-annually to the Planning and Network Advisory Council (PNAC) and Board of Trustees. Areas identified as needing improvement may prompt the formation of a Performance Improvement & Implementation Team (PIIT) to further analyze and develop solutions for complex concerns. Additionally, PIITs may be convened for the implementation of new programs or initiatives geared towards achieving the Center's goals. These goals are continuously reassessed in relation to the Center's past performance as well as trends in behavioral healthcare throughout the state and across the nation.

VI. QUALITY MANAGEMENT STRUCTURE AND DESIGN

The Center's Quality Management processes include such quality oversight activities as: developing performance measures based on identified weaknesses; monitoring performance measures to determine effectiveness; and recommending additional and/or alternative improvement activities. Quality Management activities are intended to be proactive, flexible, objective and responsive to the unique characteristics of programs and services. In order to accomplish this, it is necessary to consider the service types, applicable standards and the needs of specific service areas and programs. To this end, numerous technical assistance and support groups and reporting systems are in place to address the challenges and issues facing different service areas and programs. The Center has been restructured to efficiently serve the needs of the clients and meet its stated goals and objectives (see Appendix A: TTBH Organization Chart). This structure provides continuity across the Center and its providers.

The Center's Quality Management Director has operational responsibility for the Quality Management Program and reports directly to the Chief Administrative Officer. The QM Director also reports quality management activities to the Board and to community stakeholders periodically.

The procedures and methodologies used by the Center to execute specific quality management activities include the following:

The Center has designated the EMT, the membership of which includes the Chief Executive Officer, Chief Operating Officer, Chief Administrative Officer, Chief Medical Officer and the Chief Financial Officer, to oversee internal quality management activities. The role of the EMT is long-term in nature and places a heavy emphasis on leadership and motivation. The Management and Information Systems (MIS) Department participates in quality management functions through the development of customized data reports used by management to make decisions pertaining to service delivery. Standing items on the EMT agenda include performance indicators requiring continuous oversight. Additional agenda items are recommended for review as needed.

The Center utilizes a number of standing **Committees** to review and monitor client service activities and functions. Committees carry out a major portion of quality management activities and impact policy, procedures and practices. Committees include representation from all involved service areas in order to make use of the varied expertise and experience of Center staff, providers and other stakeholders. Current Center committees include, but are not limited to, the Performance Improvement and Compliance Committee (PICC), Clinical Records Committee (CRC), Rights and Ethics Committee, Death Review Committee, Medical Staff Committee, Utilization Management Committee (UM) and Staff Advisory Committee (SAC).

The role of the **Performance Improvement and Compliance Committee (PICC)** is to analyze results of key performance indicators, address trends and monitor plans of improvement. Through these activities PICC is usually the group that completes the first steps of the Center's performance improvement process. The PICC is comprised of executive and program management staff. Areas assessed and overseen by PICC for performance improvement include results of monthly supervisor documentation reviews, fidelity monitoring for children's and adult mental health evidenced-based practices (EBPS), client satisfaction surveys, internal and external program

reviews, timeliness of service data entry, corrective action plans, Health Information Management (HIM) reviews of form completion (e.g. privacy, financials, consents, authorizations, treatment plans, etc.), client rights reports (i.e. allegations, rights violations, complaints, technical assistance and appeals), and critical incidents including client suicide attempts and deaths.

Once a process requiring improvement is identified, the PICC may organize a PIIT, a group of staff with specific knowledge of the processes charged with developing necessary performance improvement actions in accordance with a specified reporting deadline.

Performance Improvement and Implementation Teams (PIIT) may be established for the purpose of reviewing specific areas of concern, program/initiative implementation and completing the four steps of the Center's improvement process, referred to as PDSA: Planning the improvement action; Doing (test the action); Study to determine the effect of the action; and Acting to implement the action on a wide scale. A PIT may be made up of staff from a single program or multiple programs based on similarity of functions. PIITs provide a means for:

- Ongoing self-assessment of processes, standards and outcomes;
- Proactive improvement, rather than reactive response;
- Identifying training needs;
- Service driven program implementation and improvements;
- Quality beyond standards compliance; and
- Improved teamwork and trust.

The **Rights and Ethics Committee** meets at least quarterly. The charge of the Rights and Ethics Committee is to review, approve and monitor restrictions placed on clients' rights on behalf of Tropical Texas Behavioral Health in compliance with all applicable laws, rules and regulations. The efforts of the Rights and Ethics Committee are aimed at continuous improvement of the quality and appropriateness of client care. Furthermore, the committee ensures that any restrictions are ethical, humane and in the best interest of the client.

The Rights and Ethics Committee is responsible for review activities including, but not limited to:

- The use of emergency intervention and/or behavior management included in a Person Directed Plan;
- Approval or disapproval of all experimental, nonstandard and research procedures;
- Approval and monitoring of any program designed to increase appropriate behavior(s) that involves restrictions to an individual's rights;
- Approval and monitoring of other programs that, in the opinion of the committee, involve risks to protection and rights of individuals served;
- Measuring, assessing, and reducing critical incidents and incidents of individual abuse, neglect, and exploitation and improving the individual rights protection process.

The Rights and Ethics Committee oversight responsibilities include, but are not limited to, the review of behavior management plans, representative payee activities, dietary restrictions, guardianship of persons served, and any other rights restrictions upon approval of the person served and/or LAR. The Rights and Ethics Committee reports to the PICC on an as needed basis.

The Center's **Client Rights Department** also plays a key role in the protection of client rights through the tracking and reporting of allegations of client abuse, neglect and exploitation, and the implementation of related employee training. All new employees receive training pertaining to Client Rights and the Prevention of Abuse, Neglect and Exploitation within the first two weeks of employment and are required to pass a related competency exam. All current employees, contractors, volunteers and interns receive refresher trainings annually, or more frequently if needed, including a competency exam. The Center's Client Rights Department also documents and tracks all allegations of abuse, neglect and exploitation, reports related concerns or trends to the PICC and EMT for appropriate action and implements additional or more frequent employee training as indicated.

The **Health, Safety and Risk Management Committee** meets at least quarterly. The charge of the committee is to review, approve and monitor the center's risk management process and functions. Additionally, there are subcommittees held at each respective clinic location which meet quarterly and report to the main committee. This allows more detailed discussions specific to each clinic location with recommendations and action items shared with the main Health, Safety, and Risk Management Committee as needed.

The Health, Safety and Risk Management Committee is responsible to review activities to include but not limited to:

- Identify any potential loss exposures;
- Analyze and evaluate any identified loss exposures;
- Identify a strategy (including techniques and/or actions) to be taken to counter any potential loss exposures or liabilities;
- Maintain and monitor information on health and safety hazards, concerns and solutions;
- Identify and investigate hazards, accidents and near misses;
- Organize and present improvement strategies to mitigate risk or make recommendations for corrective actions;
- Ensure ongoing compliance to health and safety standards;
- Identify unsafe work place practices/conditions and suggest appropriate remedies;
- Implement the most effective risk reduction strategy;
- Provide ongoing leadership oversight of the efficacy of decisions made regarding risk management/loss prevention activities;
- Ensure appropriate reporting (both internally and externally, as required) of risk management initiatives and activities;
- Implement any necessary changes as may be dictated by a changing service and/or business environment; and
- Review the annual Memorandums for the Record in the areas of safety, client rights, HIPAA, Corporate Compliance.

The Health, Safety and Risk Management Committee will advise the Executive Management Team of any action recommended by the committee.

The Center's **Utilization Management** (UM) program is responsible for the authorization and/or denial of services based on protocols developed by funding entities and applicable legal and

regulatory requirements. UM protocols are reflective of Performance Contract requirements. UM guidelines related to TRR and associated Fidelity requirements. The UM Committee meets monthly and currently analyzes more than thirty data elements related to service access and delivery and utilization of resources. The data are tracked and trended for performance improvement as indicated. As positive and negative trends are identified, service and administrative departments are identified for commendation or advised of the need for corrective actions and performance improvement, respectively. As with all performance indicators, areas identified as especially complex or in need of significant improvement may require the involvement of a PIT.

VII. DATA COLLECTION AND ANALYSIS

The Center is dedicated to the continuous improvement of the behavioral health services it provides and will periodically evaluate the effectiveness and efficiency of access to, and satisfaction with those services, and modify service delivery and administrative processes as appropriate based on the evaluation of review findings. Clinical outcomes and business performance indicators will be evaluated based on benchmarks and targets set forth in the performance contracts with Department of Health and Human Services (HHS), Texas Health and Human Services Commission (HHSC), Substance Abuse and Mental health Services Administration (SAMHSA), Certified Community Behavioral Health Center (CCBHC), applicable CARF standards and the Center's internal performance standards.

Data will be gathered during the course of treatment and services in a language that is understandable to the client. Data pertaining to the efficiency and effectiveness of services and access to services are obtained from reports available in data warehouses such as MBOW and CMBHS, as well as internally developed performance and productivity reports.

Service access, efficiency, effectiveness and related satisfaction indicators apply to all clients served. Efficiency indicators apply to the Center only and measure the agency's productivity and the extent to which available resources are used to achieve the greatest effect.

The Center is committed to obtaining information from staff, stakeholders, and most importantly, clients in order to enhance the organization's ability to deliver services and treatment that promote client's dignity, self-sufficiency, and quality of life. Client and family satisfaction are evaluated using a national satisfaction survey instrument, administered annually by the agency. The Center's MH and IDD services Outcomes Management Questionnaires also provide data related to client's perception of their access to services and their satisfaction with services. These are administered to clients periodically during, and in some cases after, their treatment. Quarterly, the Center collects client satisfaction data related to the short-term crisis inpatient services delivered through contracts with several local private hospitals.

TTBH has been an active participant in the Centers for Medicare and Medicaid Services (CMS)/Texas Health and Human Services (HHSC) Healthcare Transformation and Quality Improvement Program 1115 demonstration waiver. The waiver is transforming the health care delivery system for low-income Texans, increasing access to quality preventative primary care, substance use disorder services, and behavioral health care services as a means to improve both

individual and system level outcomes while containing cost growth. TTBH monitors and reports on twenty-one quality measures to the regional health plan.

Additionally, the data from the following areas are collected and reported frequently to monitor performance:

- Financial Data
- Internal and External Program Reviews (MH and IDD)
- Interest Lists
- CMBHS
- CARE Reports
- Cerner Client Data System
- Performance Contract and MBOW Reports
- Management Reports
- Strategic Plan
- Corporate Compliance
- Provider Profiling Reports
- Staff Training Curriculum and Performance Evaluation Data
- Key Performance Indicators
- Satisfaction Surveys
- Risk Indicators-Critical Incident Reporting System
- Death Review Data
- Suicide Attempt Data

VIII. EVALUATION OF DATA

The processes described above allow for comparative analysis of clinical outcomes and satisfaction for individual clients, specific clinic sites and overall business performance over time. The data are used to assess the Center's performance and determine strengths, weaknesses, gaps and opportunities for improvement. At least annually, the QM Division provides a summary analysis of the outcome's management data to the Center's Executive Management Team to recommend necessary administrative and/or service delivery improvements. Additionally, the Center has developed and implemented an outcomes management policy (see Appendix B: Outcomes Management Policy # SS1-10.02) specifying the procedures for the collection and analysis of clinical and administrative data utilized in the Center's continuous quality improvement activities. Toward that end, the Center will periodically evaluate the effectiveness and efficiency of, access to, and satisfaction with services. The Center will modify service delivery and administrative processes as appropriate based on evaluation findings.

Monitoring
All of the services provided by the Center are monitored at least annually.

The following services are available to all clients:

- Education around eligibility for services
- Benefits Eligibility Assessment

- Outreach, Screening, Assessments, and Referrals (OSAR)
- Substance Use Disorder Services
- Treatment Planning/Person Directed Planning
- Case Management
- Crisis Services
- Mental Health Officer Task Force
- Projects for Assistance in Transition from Homelessness (PATH)

The following services are available to adolescents and adults with a substance use disorder diagnosis:

- Individual counseling/therapy
- Family counseling/therapy
- Group counseling/therapy

The following services are available to adults with an opioid use disorder diagnosis:

- Medication Assisted Treatment
- Peer Re-Entry
- Priority Admissions Counseling
- Supported Employment

The following services are available to adults with specified mental health diagnoses and children and adolescents that demonstrate severe emotional disturbance:

- Care Coordination/Case Management
- Psychiatric Services
- Medication Related Services
- Flex Funds
- Behavioral Skills Training
- Inpatient Services
- Medication Training and Supports
- Patient Assistance Program
- Jail Diversion
- Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI)
- COPSD
- Collaborative Assessment and Management of Suicidality (CAMS)

The following services are available to adult mental health clients:

- Supported Employment
- Supported Housing
- Assertive Community Treatment (ACT)
- Preadmission Screening and Resident Review (PASRR)
- Client Peer Support

- Primary Care
- Chronic Care Management
- Peer Drop in Centers
- Mental Health Officer Task Force
- Substance Use Outpatient Services
- Substance Use Detoxification
- Psychiatric Emergency Service Centers (PESC)

The following services are available to child and adolescent mental health clients:

- Wraparound Planning
- Youth Empowerment Services (YES)
- Transition Planning
- Family Psycho-education
- Flexible Community Supports
- Intensive Case Management
- Routine Case Management
- Family Support Groups
- Family Partner Services
- Counseling (CBT, PCIT)
- Primary Care
- Substance Use Outpatient Services

The following services are available to clients with a diagnosis of Intellectual and Developmental Disability:

- Service Coordination
- Community Living Options Information Process (CLOIP) Services
- Permanency Planning
- Home and Community Based (HCS) Waiver Services
- Texas Home Living (TxHmL) Waiver Services
- Community First Choice (CFC)
- Preadmission Screening and Resident Review (PASRR)
- Respite Services
- Community Supports
- Supported Employment-Employment Assistance
- Day Habilitation Services
- Nursing Services
- Specialized Services
- Crisis Intervention Specialist (CIS) Services
- Individualized Skills and Socialization Services

The following services will be monitored quarterly due to critical importance:

- Continuity of Care
- Medicaid Billing
- Utilization Review

Additionally, activities intended to monitor compliance with all YES Waiver policies and procedures (as outlined in the YES Waiver Policy Manual) will be implemented and any necessary corrective actions identified during Quality Management reviews will be executed.

Trending and Reporting Findings

The results of the analyses including any identified trends will ultimately be sent to the PICC, EMT and Board of Trustees for recommended action. Reports will also be sent to service area director, managers, the Client Rights Officer, and other program directors, managers and supervisors as indicated. Corrective measures and improvements are monitored through follow- up reviews tracked by the QM Division.

IX. DEVELOPMENT OF IMPROVEMENT STRATEGIES

Data collected will be analyzed at least quarterly to determine trends. After the data has been measured, and analyzed, the information gathered is used to identify an opportunity for a continuous quality improvement activity. The purpose is to improve the performance of existing processes or services or to design new ones. The model utilized is called Plan-Do-Study-Act (PDSA) and is outlined below:

- Plan: The first step involves identifying opportunities for improvement. At this point the focus is to analyze the data to identify concerns and to determine anticipated outcomes. Ideas for improving processes are identified. This step requires the most time and effort. Affected workforce members or individuals receiving services are identified, data compiled, and solutions proposed.
- Do: This step involves using the proposed solution, and if successful, implementing the solution usually on a pilot basis as a new part of the process.
- Study: At this stage, data is again collected to compare the results of the new process with those of the previous one.
- Act: This stage involves making the proposed changes a routine part of the targeted activity. It also means involving those who will be affected by the changes, those whose cooperation is needed to implement the changes on a larger scale, and those who may benefit from what has been learned. Finally, it means documenting and reporting findings and follow-up.

Data indicating negative outliers will be addressed through PIITs and/or brought to the attention of the EMT for recommended action. While positive outliers will become best practices, serving as benchmarks for the Center's continuous quality improvement processes, remedial action will be taken to address unacceptable levels of performance outcomes. Submission of plans of improvement to the QM Department will be required to address negative outliers. Follow-up activities and monitoring will be included in the plans to ensure maintenance of improvements. Identified program deficiencies will be prioritized for resolution by the PICC and EMT. Subsequent performance will be evaluated to determine the effectiveness of each plan of improvement.

Death Review Process

It is the policy of TTBH to review and report the deaths of all persons served through Center operated or contracted services and modify or improve Center procedures and practices as indicated, in accordance with applicable state and federal law.

Any TTBH employee who discovers or is notified of the death, or possible death, of a person served will immediately report the information to the Center's Quality Management Department (QM). QM will conduct a preliminary review of death and follow reporting practices in accordance to the Texas Administrative Code (TAC) Title 25, Part 1, Chapter 405, Subchapter K.

If any of the following four (4) TAC criteria are present, an Administrative Death Review and/or a Clinical Death Review will be conducted:

1. the death occurred on the premises of an HHSC-funded or HHSC-contracted program (e.g., the individual dies in his/her sleep at an MHA/MRA funded group home);

2. the death occurred while the individual was participating in HHSC-funded or HHSC-contracted program activities (e.g., the individual dies in a community hospital after being transferred from the community center; the individual drowns while on a psychosocial program outing);

3. other conditions indicate that the death may reasonably have been related to the individual's care or activities as part of the community center program (e.g., the individual overdoses on a psychoactive drug; the individual dies by suicide); or

4. other conditions indicate that although the death is not reasonably related to the individual's care or activities as part of the community center program, an evaluation of policy is warranted (e.g., the individual dies of a chronic illness in a community hospital).

Administrative Death Reviews is an administrative quality assurance review activity to identify non-clinical concerns requiring correction and opportunities to improve the quality of care. These reviews are led by the Chief Medical Officer and QM, and attended by the Center Chief Executive Officer (CEO), Chief Operating Officer, Chief Administrative Officer, the Suicide Prevention Coordinator, and applicable program directors, managers, and supervisors.

Clinical Death Review is a clinical quality assurance review activity conducted to identify clinical concerns requiring correction and opportunities to improve the quality of care pursuant to the statutes that authorize peer review activities in the state of Texas. These reviews are led by the Chief Medical Officer and QM, and attended by the Center Chief Executive Officer (CEO), Chief Operating Officer, Chief Administrative Officer, community liaison, external prescriber not contracted with TTBH, the Suicide Prevention Coordinator, and applicable program directors, managers, and supervisors.

Death reviews contain an overview of the person's information, death information, services received, medication, highlights of care. Individual and systemic findings and recommendations are identified. Regardless if a finding is on an individual level, plans of improvement

(POI)/corrective action plans (CAP) address all findings as systemic to ensure enacted changes address any potential gaps in care.

POIs and CAPs focus on areas of staff training, policies, plans, procedures, administrative and operational processes, electronic health records, assessments, and documentation.

Safer Suicide Care

TTBH has implemented the Zero Suicide Framework and it's seven (7) elements* to work towards safer suicide care:

1. **Lead** system-wide culture change committed to reducing suicides.
2. **Train** a competent, confident, and caring workforce.
3. **Identify** individuals with suicide risk via comprehensive screening and assessment.
4. **Engage** all individuals at-risk of suicide using a suicide care management plan.
5. **Treat** suicidal thoughts and behaviors directly using evidence-based treatments.
6. **Transition** individuals through care with warm hand-offs and supportive contacts.
7. **Improve** policies and procedures through continuous quality improvement.

The continuous quality improvement efforts are comprised of the following:

1. Death review data collection and comparative analysis is reported to the Executive Management Team (EMT) and the Zero Suicide Implementation Team on a quarterly basis.
    a. Death review data collection includes deaths by suicide and information such as method of death, level of care, previous attempts.
2. An annual, internal review of interventions provided to clients identified at high risk of suicide and those receiving targeted suicide prevention interventions.
    a. Reviews are utilized to determine areas of improvement within any of the seven (7) elements.
    b. POIs are developed to enhance policies, procedures, trainings, suicide specific screenings, transitions of care, and interventions.
3. A monthly Risk Assessment Report identifying individuals at high risk based on recent suicide attempts and crisis intervention.
    a. Risk assessment report is provided at the beginning of the month to their treatment team for immediate engagement into suicide specific interventions such as the Collaborative Assessment and Management of Suicidality (CAMS).
    b. Monthly reports detailing outreach to these individuals are provided at the end of each month.

*From the Zero Suicide Institute Education Development Center

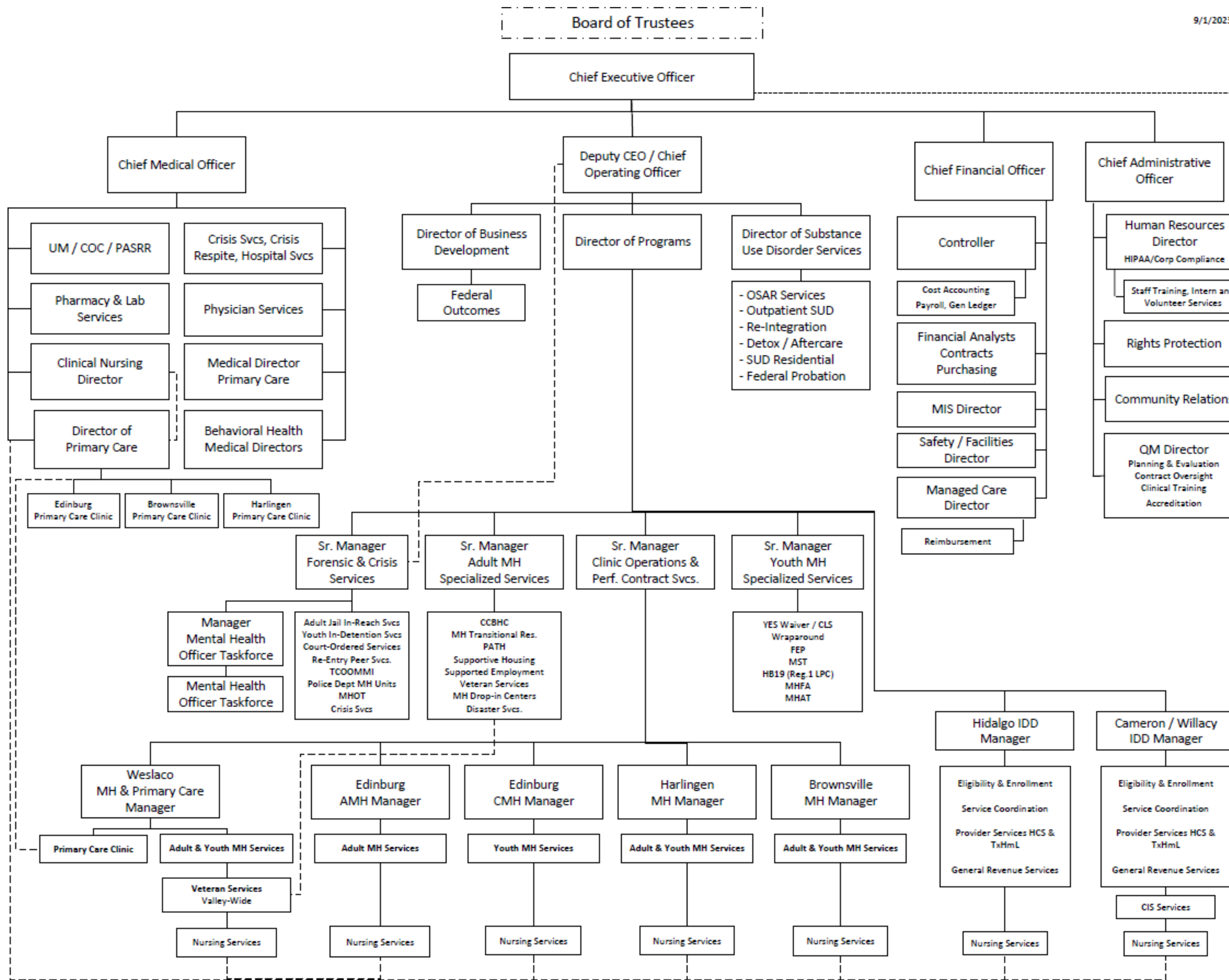
X. DEFICIT REDUCTION ACT AND CORPORATE COMPLIANCE

The Deficit Reduction Act (DRA) of 2005, Federal Anti-kickback Statute, Federal False Claims Act and Medicaid Fraud Prevention Act established a number of processes that healthcare

organizations were required to put into practice to evidence corporate compliance. The Center has developed and implemented a fraud and abuse compliance program and policy (see Appendix C: Policy # SS1-05.04, Corporate Compliance Documentation and Claims Integrity Plan) specifying the responsibilities and obligations of its employees, volunteers and contracted providers regarding submission of reimbursement claims to Medicare, Medicaid and other government payers for services rendered. The policy also applies to all business arrangements with physicians, vendors and other person who may be impacted by federal or state laws relating to claims fraud and abuse. The Center's policy, Corporate Compliance training curriculum and employee handbook contain detailed information concerning the False Claims Act, administrative remedies, civil and criminal penalties for false claims and information regarding whistleblower protections under the law.

As stated in the policy, a report reflecting the Center's corporate compliance activities for the preceding fiscal year and planned activities for the upcoming year is provided annually to the CEO.

Appendix A



Appendix B

Operating Policies: SS1-10.02

Effective Date: 07/01/2008

Reviewed 7/2025 Revised 7/2025

OUTCOMES MANAGEMENT

I. PURPOSE:

To establish and implement procedures for the collection and analysis of clinical and administrative data utilized in the Center's continuous quality improvement activities.

II. POLICY:

TTBH is dedicated to the continuous quality improvement of services provided in Behavioral Health (BH), Substance Use Disorder (SUD), Primary Care, and Intellectual and Development Disability (IDD) services. Toward that end, the Center will periodically evaluate the effectiveness and efficiency of, access to, and satisfaction with services. The Center will modify service delivery and administrative processes as appropriate based on evaluation findings.

III. DEFINITIONS:

Memorandum for Record: For the purposes of this policy the term "memorandum for record" refers to a comprehensive analysis of outcomes data completed annually and submitted to the Performance Improvement and Compliance Committee (PICC) and the Executive Management Team (EMT) for review.

IV. PROCEDURES:

A. At minimum, outcomes will be reported as required for all regulatory agencies, accrediting bodies, contracts, grants, and funders including, but not limited to, the Department of Health and Human Services (HHS), Texas Health and Human Services Commission (HHSC), Substance Abuse and Mental Health Services Administration (SAMHSA), Certified Community Behavioral Health Center (CCBHC) certification and Commission on Accreditation of Rehabilitation Facilities (CARF). The Center's outcomes management process will utilize data from the Center's Electronic Health Record and other applicable methods as required. Data will be gathered during the course of treatment and services in a language that is understandable to the client.

B. The process will allow for comparative analyses of clinical outcomes data for clients, individual clinics, and overall business performance over time. This process will be carried out

quarterly at a minimum. A more comprehensive outcomes review will be carried out annually via the Memorandum for Record (MFR)

C. TTBH will conduct an ongoing assessment of community needs related to behavioral health services through a variety of mechanisms. Formal community needs assessments are completed at a minimum once every three (3) years.

   Performance indicators pertaining to effectiveness, efficiency, service access and satisfaction will apply to clients served. These performance indicators will be obtained from Outcomes Management Questionaries administered periodically during, after, and throughout the course of treatment and services as appropriate. Effectiveness indicators within questionnaires will measure progress in clinical outcomes; access indicators will measure client perceptions regarding the convenience of accessing Center services and their interactions with Center staff; and satisfaction indicators will reflect the extent to which clients value those services.

   Efficiency indicators for all services will be obtained using Utilization Management data available from the state's Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW) database and internal staff productivity reports. Efficiency indicators will apply to the Center and measure the agency's productivity and the extent to which available resources are used to achieve the greatest effect.

D. The data referenced above will supplement other stakeholder input received by the Center including, but not limited to, annual client satisfaction surveys, employee satisfaction surveys, external annual peer review, bi-annual local planning forums, focus groups and surveys, and recommendations from the Board of Trustees and the Planning and Network Advisory Committee.

E. To promote reliability and validity, completeness, and accuracy of the outcomes management data, training on assessment and person and family -centered recovery planning will address the importance of consistency in the administration of the questionnaires in a manner that decreases the potential for client responses to be influenced by the presence of the staff. Quality Management (QM) staff will periodically review data accuracy and report on findings quarterly to the Performance Improvement and Compliance Committee (PICC) or as needed.

F. Clinical outcomes and business performance will be evaluated based on the Health and Human Services Commission (HHSC) performance contracts benchmarks and the Center's productivity standards.

G. The reliability of the client's self-report data will be considered as a possible extenuating/influencing factor in measuring clinical outcomes and in any analysis of performance.

H. At least annually, QM will provide an MFR of the outcomes management data to the Center's Performance Improvement and Compliance Committee (PICC), Executive Management Team (EMT) and Board of Trustees to recommend necessary administrative and/or clinical changes. The findings in the summary will also be included in the Center's strategic plan.

V. REQUIRED DOCUMENTATION:

- IDD Services Satisfaction Questionnaires
- BH Client Satisfaction Survey

VI. REFERENCES:

- CARF Behavioral Health Standards Manual (2025):
  - Section 1: Aspire to Excellence, M: Performance Measurement and Management and N. Performance Improvement
- Texas Department of Health and Human Services Performance Contracts
- Texas Administrative Code Title 26 Health and Human Services, Part 1 Health and Human Services Commission, Chapter 301 IDD-BH Contractor Administrative Functions, Subchapter G Mental Health Community Services Standards, Division 2 Organizational Standards, Rule §301.333 Quality Management
- T-CCBHC Provider Manual
  - 1.a.1: Needs Assessment
- Tropical Texas Behavioral Health Policies:
  - Quality Management Plan

VII. ATTACHMENTS:

None.
FY26 Strategic Plan

UTILIZATION MANAGEMENT PLAN

I. UM Program Overview

UM is a dynamic process that provides timely, accurate and relevant information to facilitate fact-based decision-making by an LMHA or LBHA, resulting in positive outcomes for people receiving services and improved provider practice. The LMHA or LBHA UM staff and the UM Committee identify and monitor patterns of over-utilization, under-utilization and other utilization problems that compromise care or inappropriately use resources. Based on their findings, UM staff and the UM Committee recommend and participate in interventions to make the use of services more effective, efficient and consistent with contractual requirements and local planning processes.

II. Purpose

A. To monitor and improve the effective and efficient utilization of Tropical Texas Behavioral Health's (TTBH) clinical resources.

B. To assist in the relentless pursuit of a higher quality of care through the analysis, review, and evaluation of clinical practices and systems within TTBH.

C. To address any instances of under-utilization, over-utilization, or inefficient utilization of TTBH's resources.

D. To better define who is eligible for services, what services will be provided, reimbursement and the expected outcomes for people and the system.

E. To ensure that people receive the services they need and ensure equitable distribution of available resources.

F. Strive to achieve a balance between the demand for services, availability of resources, and the needs and wellbeing of people in need of mental health services.

III. Objectives

A. Developing, implementing and improving the LMHA or LBHA UM Program to meet the needs of people receiving services at the LMHA or LBHA.

B. Conducting prospective, concurrent and retrospective reviews of authorized services using the HHSC TRR UM Guidelines to ensure people receive and benefit from services.

C. Applying objective criteria when making adverse determinations.

D. Notifying people requesting or receiving services and their providers of adverse determinations, including information on how to file an appeal or fair hearing.

E. Managing appeals in a timely manner according to established procedures.

F. Implementing utilization care management for people with exceptional circumstances and needs to ensure access to needed services.

G. Collaborating with other LMHA and LBHA functions such as QM, Financial Services, and Information Systems in using UM data and with providers in planning interventions to improve provider practice.

H. Coordinating and supporting the activities of the UM Committee.

I. Participating in the future development and evolution of the HHSC TRR UM Guidelines.

IV. Utilization Oversight

The statewide UM Committee will provide guidance to TTBH's utilization management processes through making recommendations which impact policy, implementation and oversight processes.
The State will monitor TTBH's data entered to CMBHS and CARE via Business Objects (MBOW) on a routine basis to determine compliance and performance, to include the outcomes of service delivery. They will review data that reflects patterns of current service utilization and the clinical/assessment decisions used by TTBH to make those decisions. When outliers or trends are detected which reflect unusual or unexpected results, the State will initiate contact and the causes will be explored. The State and TTBH will collaborate to ensure that necessary oversight and improvement

occurs and management decisions can be made. The following will be monitored by the State: Texas Resiliency and Recovery Adult and Child Assessments, UM Clinical Guidelines (Adult and Child), Complaints, Appeals and Overrides, and TTBH's UM Plan

V. UM Program Plan

The UM Manager, under the direction of the UM psychiatrist and in consultation with the UM Committee, assumes responsibility for execution of the UM Plan. The procedures, authority, and accountability outlined in the UM Plan are designed to ensure effective implementation of TTBH's UM Program and to meet the State's rules and contractual requirements. TTBH's UM Program Plan shall be reviewed and updated annually or more frequently as indicated. TTBH is responsible for distributing the UM Plan and for training network providers on relevant aspects of the UM plan.

VI. UM Functions

1.Physician oversight of UM processes. Must be done by a board eligible psychiatrist who possesses a license to practice medicine in Texas. The oversight function includes approval of all policies and procedures related to UM, to include changes based on new technology and availability of resources.

2. Consistent application of the UM Guidelines and processes. This is accomplished through ongoing supervision of staff and management of UM operations.

3. Utilization reviews and authorizations for all service packages as indicated by the State Utilization Management Guidelines.

4. Collection, analysis, and documentation of utilization information. This information is to be used in ongoing analysis of systemic issues that may support clinical and management decisions.

5. Utilization care management. This function exists to accommodate unusual circumstances where telephonic and documentation review might not be sufficient to make an appropriate authorization decision. This function includes coordinating services for persons with special circumstances and needs, and facilitating authorization where it cannot be effectively conducted through the usual processes, necessitating direct contact with the provider, client and/or family members.

6. Utilization Management Committee: Consists of TTBH Physicians, TTBH UM and quality management staff, mental health professionals, financial and information management staff, and other TTBH staff and professionals. The primary function of the UM Committee is to monitor utilization of TTBH's clinical resources to ensure they are being expended effectively and efficiently. The UM Committee assists the promotion, maintenance and availability of high-quality care through the evaluation of clinical practices, services and supports delivered by TTBH and its contracted providers using clinical, encounter and administrative data and performance measures.

7. Provider Submission of Documentation and Request for Continued Stay: TTBH will develop a process for provider submission of clinical information which will include at minimum telephonic and/or electronic submission and will ensure that client-specific information gathered for utilization review remains confidential in accordance with all applicable laws and is shared only with those that have the need for any authority to receive it.

8. Adverse Determinations: An adverse determination applies to a person requesting services that are denied and those persons who are receiving services, who no longer meet UM criteria for that service(s) and for whom the provider and client request additional authorization. The initial recommendations to deny authorization for continued stay is made by the Utilization Manager and/or designee who then refers it to the TTBH UM Physician, who will make a decision based on all available data. The final denial of services based on failure to meet clinical criteria may only be made by a physician.

9. Appeal of Adverse Determinations: TTBH will ensure client access to an objective appeal process when services are denied, limited or terminated. Clients funded by Medicaid are also afforded access to the Medicaid Fair Hearing Process. TTBH will ensure that all providers and clients are provided with information about their right to appeal and the process to do so.

10. TTBH UM Data Submission to the State: TTBH will submit utilization data to the state according to the state MH MBOW LMHA Data Reporting Guidelines and the State's Performance Contract. If TTBH delegates any UM activities to an external entity (to include another LMHA or ASO) TTBH will have a written contract with the UM Contractor that is consistent with all applicable rules and State Performance Contract requirements. TTBH will maintain its UM Committee or designate another appropriate committee to:

- review the reports produced by the UM Contractor,
- make improvements in TTBH processes that impact utilization of resources; and
- evaluate the effectiveness of interventions to improve provider practices.

VII. Utilization Review Activities

Evaluating the adequacy, appropriateness and quality of services provided to persons receiving services is a component of all Utilization Management review processes. Although specified services are routinely reviewed, all TTBH mental health services are subject to review when indicated, without regard to payment source. Decision made by TTBH's UM staff and UM Committee are based on objective and valid criteria and standards approved by the State.

Utilization reviews are conducted for the following purposes:

1. Level of Care Authorization: retrospective oversight of initial and subsequent level of care assignments to ensure consistent application of State UM guidelines.
2. Authorization for Continued Stay: concurrent review to establish need for continued services or review of automatic authorizations.
3. Outlier Review: retrospective and concurrent review of data to identify outliers followed by review of individual cases to determine need for change in level of care assignment or service intensity. May result in referral for peer review or other oversight activities.
4. Inpatient Admission and Discharge Planning: prospective or concurrent review of inpatient admissions to ensure most clinically effective and efficient Length of Stay. Review of discharge plans to ensure timely and appropriate treatment following an inpatient stay.
5. Administrative Review: review of clinical and administrative documentation for timeliness and adequacy of UM processes to include reimbursement, corporate and contract compliance, data verification and rehabilitation plan oversight.

VIII. Inter-Agency Interface

Utilization Management is committed to not only reviewing practices related to resource utilization, but also to taking action to modify inappropriate, inefficient or ineffective utilization. Much of TTBH Utilization Management function overlaps or is reliant on

coordination with, Quality Management, Provider Relations, Claims/Reimbursement, Management of Information Services and other service management functions.

Successful interface among the various authority functions of TTBH is essential for effective and efficient management of resources, identification of gaps in service delivery and resolution of over-and-underutilization of services/resources. Interface between Utilization Management and other authority functions occurs through exchange of data, information and reports, joint participation in a variety of committees and collaboration in planning, projects and operational initiatives.

IX. Utilization Management Reports

Utilization of information from various data sources (e.g.CAM encounter data, CARE, etc.) is available via Business Objects and other programs. Business Objects reports are created in an evolving and ongoing process, and variations of the following data configurations will be available as they are created. Databased information illustrates numerous aspects of service utilization, and will be shared across TTBH functional areas, for management decisions.

1.	Percent of clients receiving services - Adult
2.	Percent of clients receiving services - Child
3.	Percent of clients that show improvement - Adult
4.	Percent of clients that show improvement - Child
5.	Percent of clients that avoid hospitalization – Adult & Child *(Tenure)*
6.	Percent of clients that show improvement – In School
7.	Percent of crisis episodes during the measurement period shall not be followed by admission with a System Agency Inpatient Bed within 30 days of the first day of the crisis episode.
8.	Percent of clients discharged from inpatient who receive follow up within 7 days.
9.	Percent of clients discharged from inpatient who receive face-to-face follow up within 7 days.
10.	Percent of clients DX MDD exhibit a positive response.
11.	Percent of children receiving Family Partner services showing positive response.
12.	Percent of clients readmitted to inpatient care within 30 days of discharge.
13.	Percent of clients with acceptable or improved employment-preparatory skills as evidenced by either the Educational or Volunteering Strengths item on the ANSA.
14.	Percent of adults reflecting improved employment functioning
15.	Percent of adults have acceptable or improved residential stability.
16.	Percent of youth in acceptable or improved family living situation.
17.	Percent of crisis hotline calls shall result in face-to-face encounters.

18.	Percent of youth receiving at least one face-to-face encounter during reporting period.
19.	Percent of adults receiving at least one face-to-face encounter during reporting period.
20.	The percentage of adults authorized in a FLOC with LOC-R 4 who have acceptable or improved functioning in the Life Domain Functioning or the Strengths domain of the ANSA.
21.	UM percent of services in vivo summary (hours) – Adult
22.	Supported employment target rate
23.	Supported Housing target rate
24.	Percent of LOC R – 4 adults underserved due to resource limitation
25.	Medicaid/non-Medicaid clients on wait list - Adult
26.	Medicaid/non-Medicaid clients on wait list - Child
27.	Clients served by not assessed – Adult (Over Served)
28.	Clients served by not assessed – Child (Over Served)
29.	Population by level of care matrix – Adult
30.	Population by level of care matrix – Child
31.	Discharge reason summary – Adult
32.	Discharge reason summary – Child

X. Inter-rater Reliability

Consistent application of valid and reliable criteria across all service settings is an important aspect of the UM process.

Consistent daily application of criteria are monitored in the following manner:

- Management information algorithm information is analyzed to review case determination.
- A series of UM Reports gathered from CMBHS, MBOW, and Client EHR to cross-validate the accuracy of client care data.
- Trends, problematic areas, client care service packages, override determinations and inpatient admission and length of stay are constantly monitored by the utilization management process.

XI. Provider Profiling

One means of assessing utilization is through the use of provider utilization profiles. Profiling may be defined as “gathering data and using relevant methodology, for the purpose of describing and evaluating a provider’s mental health practice performance in relation to the use of resources.” Proper utilization of mental health resources is also an important aspect of quality assessment.

Use of Provider Utilization Profiles:

The primary objective of profiling should be to encourage high-quality service delivery, which includes appropriate utilization of resources and results in improved client satisfaction and outcome. Although some measures used for provider profiling may lack precision, profiling has educational validity for TTBH and providers. Depending on the degree of reliability of measures, provider utilization profiles may also be used for calculating payment and making contract decisions. The profiling report must consider factors that influence utilization rates and outcomes in order to enable providers to educate themselves and allow TTBH a fair basis for payment or termination decisions.

Providers who advocate for necessary and appropriate mental health care and services for clients must be protected from retaliation by TTBH. TTBH must not terminate, demote, or refuse to compensate a provider because the provider advocates in good faith for a client, seeks reconsideration of a decision denying a service, or reports a violation of law to an appropriate authority.

The following should be considered in using provider profiles for various purposes:

- **Provider education –** A provider may be cost-effective in one aspect of his/her practice and not in another. Data on a provider should be classified by TTBH in order to evaluate and educate a provider, in terms of services provided, referral practices, etc. Profiles should inform the provider about cost effective management of client sub-populations. Data can illustrate a provider's cost effectiveness in managing specific types of clients. The provider knows precisely where improvement may be needed.

- **Basis for compensation –** TTBH may elect to provide higher reimbursement to those providers who care for more acute or more complex clients.

- **Retention of providers –** A contract termination decision should never be based exclusively on a provider's profile unless:
  1. problem is ongoing;
  2. the provider has been informed of the problem and given sufficient time to correct the behavior;
  3. with respect to termination for over-utilization, the provider's client population has been carefully considered and appropriately risk adjusted (evaluation of case mix).

- **Credentialing and re-credentialing –** Provider profiles may be considered but should not be determining factors in credentialing decisions.

- **Improving practice patterns & the profiling process –** Quality management processes may be used to identify best practices, ineffective practices, productivity, or to develop a better profile instrument.

Provider Data, Which May Be Used For Profiling:

Certain aspects of providers' practices can be profiled reliably, but others cannot. Provider attributes for which validated objective measures are nonexistent, should not be profiled or used.

Attributes that can be objectively quantified and reliably measured may include:

1. length of stay (LOS);
2. readmission or recidivism rates to identified services;
3. number of requests for special or support services;
4. prescription charges;
5. # days inpatient;
6. # days outpatient;
7. use of crisis services & emergency room visits;
8. lab tests; and
9. individual achievement of clinical outcomes;
10. # of adverse determinations
11. # of appeals

Sources of Data:
TTBH will ensure their data sources are accurate, and have an awareness of the limitations of certain data sources as follows:

- Claim Forms may be insufficient to determine performance results because they do not capture clinical characteristics about clients; outcome of the care provided or detailed information on the severity of the client's condition.
- Coding may hamper data accuracy and reliability related to unclear definitions of diagnosis, condition or treatment or inaccurate coding.
- Medical Records may be incomplete or imprecise. Providers may error in their documentation not directly related to reimbursement.

Potential Profile Focus:

Provider – Tracking fidelity to treatment models, outcomes and costs by diagnosis and treatment.

Hospital or facility – Track recidivism rate, length and duration of services provide comparisons to hospitals with similar demographics, track short and long-term outcomes and charges.

Client – Comparisons of normative data prior and post treatment. Measures medical interventions for cost and outcomes.

Methods of Profiling:

A profile that is constructed to answer specific questions and uses appropriate statistical methods may differentiate providers with a degree of reliability. Before providers are profiled, however, TTBH should involve them in selection of measures and to identify complicating factors such as case mix.

The provider utilization profile must be designed to answer a concise question and be clearly interpretable. Data sources for utilization profiles range from claims databases maintained by TTBH to individual client records kept in providers' offices and at service sites.

A profile should be based on a scientifically drawn sample of eligible subjects or on a complete census. TTBH should not formulate a profile until enough data are acquired to render the profile statistically useful. To attain statistical validity, adequate amounts of data need to be collected over a sufficient time period or data may need to be pooled with other sources.