Tri-County Services Board of Trustees' Meeting

September 22, 2011

TRI-COUNTY SERVICES

Serving individuals with mental illness and developmental disabilities

Notice is hereby given that a regular meeting of the Board of Trustees of Tri-County Services will be held on Thursday, September 22, 2011. The Business Committee will convene at 9:00 a.m., the Program Committee will convene at 9:30 a.m. and the Board meeting will convene at 10:00 a.m. at 1506 FM 2854, Conroe, Texas. The public is invited to attend and offer comments to the Board of Trustees between 10:00 a.m. and 10:15 a.m.

AGENDA

Item

I. Organizational Items

A. Chairman Calls Meeting to Order

B. Public Comment

C. Quorum

II. Approve Minutes – August 25, 2011

III. Executive Director's Report – Cindy Sill

A. DSHS
   1. Brief QM Review Results
   2. Managed Medicaid Expansion
   3. PETC (CSU) Update

B. DADS
   1. Texas Home Living Enrollment
   2. Update on Program Changes

C. ETBHN
   1. Business Expansion
   2. New Initiatives
   3. Cost Accounting Methodology (CAM)

D. From the Heart

E. Employee Wellness Clinic

IV. Chief Financial Officer's Report – Millie McDuffey

A. FY 2011 Audit

B. Worker's Compensation Audit

C. Certificate of Deposits

D. CAM Work Group

E. CFO Consortium

VI. Program Committee

Action Items

A. Reappoint Mental Health Planning Network Advisory Committee Members ..... *Page 10*

B. Reappoint Intellectual and Developmental Disabilities Planning Network Advisory Committee Members ..... *Page 11*

Information Items

C. Annual Corporate Compliance Report and 1st Quarter Corporate Compliance Training ..... *Pages 12-14*

D. Planning Network Advisory Committee Annual Reports ..... *Pages 15-17*

E. Community Resources Report for August 2011 ..... *Pages 18-19*

cont.

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www.tricountyservices.org

F. Consumer Services Report August 2011 ..... *Pages 20-21*
G. Program Updates for August 2011 ..... *Pages 22-25*
H. Final FY 2011 Goals & Objectives Progress Report ..... *Pages 26-30*
I. Program Presentation – Adult Jail Diversion

VII. Executive Committee

Action Items

A. Appoint Texas Council Representative and Alternate for FY 2012 ..... *Page 31*

Information Items

B. Board of Trustees Appointment, Reappointment and Oaths of Office ..... *Pages 32-35*
C. Board of Trustees Committee Appointments ..... *Page 36*
D. Personnel Report for August 2011 ..... *Pages 37-38*
E. Analysis of Board Members Attendance at FY 2011 Regular and Called Board Meetings ..... *Pages 39-40*

VIII. Business Committee

Action Items

A. 401(a) Account Review ..... *Page 41*
B. Ratify FY 2012-2013 Department of State Health Services Contract and Approve FY 2012-13 Amendment Packet #1 ..... *Pages 42-85*
C. Approve Texas Council FY 2012 Dues Commitment and Payment Schedule ..... *Pages 86-88*
D. Approve Transfer of Funds to Reserve for Insurance Deductibles ..... *Page 89*
E. Approve Replacement of Air Conditioning Unit at 7045 Hwy 75 South, Huntsville TX ..... *Pages 90-94*

Information Items

F. Review August 2011 Preliminary Financial Statements ..... *Pages 95-107*
G. Board of Trustees' August 2011 Unit Financial Statements ..... *Pages 108-109*
H. Montgomery Supported Housing, Inc. Quarterly Update ..... *Page 110*

IX. Executive Session in compliance with Texas Government Code Section 551.071, Consultation with Attorney.

Posted By:

Sami Tuminas
Executive Assistant

Tri-County Services

P.O. Box 3067
Conroe, TX 77305

BOARD OF TRUSTEES' MEETING

August 25, 2011

BOARD MEMBERS PRESENT:
Cecil McKnight
Len George
Sharon Walker
Brad Browder
Janet Qureshi
Patti Atkins
David Walker
Morris Johnson

BOARD MEMBERS ABSENT:
Mark Maltsberger

TRI-COUNTY STAFF PRESENT:
Cindy Sill, Executive Director
Millie McDuffey, CFO
Evan Roberson, Director of Organizational Support
Don Teeler, Director of Operations
Stacy Blake, Executive Assistant
Shane Burks, Coordinator of Community Resources
Sean McElroy, Staff
Chuck Lowman, Staff
Ava Green, Staff
David Deaton, Legal Counsel

GUESTS:
Tracy Sorensen
Genelle Edwards, Empowerment Options
Penny Wilson, Montgomery County Hospital District

CALL TO ORDER: Chairman, Cecil McKnight, called the meeting to order at 10:04 a.m. at 1506 FM 2854, Conroe, TX.

PUBLIC COMMENT: There were no public comments.

QUORUM: There being eight (8) members present, a quorum was established.

RESOLUTION #08-11-01

MOTION MADE BY: Patti Atkins
SECONDED BY: Morris Johnson, with affirmative votes by Cecil McKnight, Len George, Sharon Walker, Brad Browder, David Walker and Janet Qureshi that it be...

Cont.

RESOLVED: That the Board excuse the absence of Mark Maltsberger.

RESOLUTION #08-11-02

MOTION MADE BY: Morris Johnson
SECONDED BY: Brad Browder, with affirmative votes by Cecil McKnight, Len George, David Walker, Janet Qureshi, Patti Atkins, and Sharon Walker that it be...

RESOLVED: That the Board approve the minutes of the July 28, 2011 meeting of the Board of Trustees.

Presentation of longevity recognitions to Tri-County staff.

EXECUTIVE DIRECTOR'S REPORT:
The Executive Director's report is on file.

Presentation made to Evan Roberson, Director of Organizational Support, in honor of receiving his Master's Degree.

CHIEF FINANCIAL OFFICER'S REPORT:
The Chief Financial Officer's report is on file.

Mark Maltsberger arrived which brought the quorum to nine (9) members present.

PROGRAM COMMITTEE:

RESOLUTION #08-11-03

MOTION MADE BY: Len George
SECONDED BY: Morris Johnson, with affirmative votes by Cecil McKnight, Sharon Walker, David Walker, Brad Browder, Patti Atkins, Janet Qureshi and Mark Maltsberger that it be...

RESOLVED: That the Board approve the FY 2012 Goals & Objectives.

RESOLUTION #08-11-04

MOTION MADE BY: Len George
SECONDED BY: Sharon Walker, with affirmative votes by Cecil McKnight, Janet Qureshi, David Walker, Brad Browder, Patti Atkins, Morris Johnson and Mark Maltsberger that it be...

RESOLVED: That the Board accept the Regional Planning Network Advisory Committee Review of Adult Mental Health Screening and Intake Process.

Cont.

The July Community Resources Report were reviewed for information purposes only.

The July 2011 Consumer Services Reports were reviewed for information purposes only.

The July 2011 Program Updates were reviewed for information purposes only.

Len George, Chairman of the Program Committee, asked the Board for recommendations for Program Presentations for upcoming Board meetings.

EXECUTIVE COMMITTEE:

RESOLUTION #08-11-05

MOTION BY ACCLAMATION MADE BY: Sharon Walker
With affirmative votes by Cecil McKnight, Len George, Patti Atkins, Morris Johnson, David Walker, Janet Qureshi, Brad Browder and Mark Maltsberger that it be...

RESOLVED:

That the Board elects the FY 2012 Board Officers as follows:

- Len George – Chairperson
- David Walker – Vice Chairperson
- Brad Browder – Secretary

RESOLUTION #08-10-06

MOTION MADE BY: Janet Qureshi
SECONDED BY: Mark Maltsberger, with affirmative votes by Cecil McKnight, Len George, Sharon Walker, Patti Atkins, Morris Johnson, David Walker and Brad Browder, that it be...

RESOLVED:

That the Board approve the nomination of incumbents for the Texas Council Risk Management Fund Board Places as follows:

- Place 4 – Judge Van L. York
- Place 5 – J.C. Whitten
- Place 6 – Gus Harris

The July 2011 Personnel Reports were reviewed for information purposes only.

The Texas Council quarterly meeting verbal update was presented by Board member Sharon Walker.

BUSINESS COMMITTEE:

RESOLUTION #08-11-07

MOTION MADE BY: Morris Johnson
SECONDED BY: Sharon Walker, with affirmative votes by Cecil McKnight, Len George, Janet Qureshi, Mark Maltsberger, David Walker, Patti Atkins, and Brad Browder that it be...

RESOLVED:

That the Board approve the July 2011 financial statements.

Cont.

RESOLUTION #08-11-08

MOTION MADE BY: Morris Johnson
SECONDED BY: Brad Browder, with affirmative votes by Cecil McKnight, Len George, Janet Qureshi, Mark Maltsberger, Patti Atkins, David Walker and Sharon Walker that it be...

RESOLVED: That the Board approve the FY 2011 Year End Budget Revision.

RESOLUTION #08-11-09

MOTION MADE BY: Morris Johnson
SECONDED BY: Janet Qureshi, with affirmative votes by Cecil McKnight, Len George, Sharon Walker, Brad Browder, Mark Maltsberger, David Walker and Patti Atkins that it be...

RESOLVED: That the Board approve the proposed FY 2012 Operating Budget.

RESOLUTION #08-11-10

MOTION MADE BY: Morris Johnson
SECONDED BY: Patti Atkins, with affirmative votes by Cecil McKnight, Len George, Janet Qureshi, Mark Maltsberger, Brad Browder, David Walker and Sharon Walker that it be...

RESOLVED: That the Board authorizes the Executive Director to execute the FY 2012-2013 Department of State Health Services Performance Contract when received and that the Board ratify the contract at the September 22, 2011 Board meeting.

RESOLUTION #08-11-11

MOTION MADE BY: Morris Johnson
SECONDED BY: Patti Atkins, with affirmative votes by Cecil McKnight, Len George, Brad Browder, Janet Qureshi, Mark Maltsberger, David Walker and Sharon Walker that it be...

RESOLVED: That the Board approve the FY 2012-2013 Department of Aging and Disabilities Services Contract and authorize the Executive Director to execute.

RESOLUTION #08-11-12

MOTION MADE BY: Morris Johnson
SECONDED BY: Patti Atkins, with affirmative votes by Cecil McKnight, Len George, Brad Browder, Janet Qureshi, Mark Maltsberger, David Walker and Sharon Walker that it be...

RESOLVED: That the Board approve the revisions to the Board policy on Retention of Fund Balance.

Cont.

RESOLUTION #08-11-13

MOTION MADE BY: Morris Johnson
SECONDED BY: Sharon Walker, with affirmative votes by Cecil McKnight, Len George, Patti Atkins, David Walker, Janet Qureshi, Mark Maltsberger, and Brad Browder

RESOLVED:

That the Board approve the FY 2012 ICF/MR Services contract with Empowerment Options.

RESOLUTION #08-11-14

MOTION MADE BY: Morris Johnson
SECONDED BY: Janet Qureshi, with affirmative votes by Cecil McKnight, Len George, David Walker, Patti Atkins, Mark Maltsberger, Brad Browder, and Sharon Walker that it be...

RESOLVED:

That the Board approve the FY 2012 Avail Solutions contract.

RESOLUTION #08-11-15

MOTION MADE BY: Morris Johnson
SECONDED BY: Brad Browder, with affirmative votes by Cecil McKnight, Len George, David Walker, Sharon Walker, Mark Maltsberger, Janet Qureshi and Patti Atkins that it be...

RESOLVED:

That the Board approve the renewal of the Kingwood Pines Inpatient Hospital contract for FY 2012, subject to the Executive Director's and legal counsel's review.

RESOLUTION #08-11-16

MOTION MADE BY: Morris Johnson
SECONDED BY: Sharon Walker, with affirmative votes by Cecil McKnight, Len George, David Walker, Brad Browder, Mark Maltsberger, Janet Qureshi and Patti Atkins that it be...

RESOLVED:

That the Board approve the renewal of the Cypress Creek Inpatient Hospital contract for FY 2012, subject to the Executive Director's and legal counsel's review.

RESOLUTION #08-11-17

MOTION MADE BY: Morris Johnson
SECONDED BY: Patti Atkins, with affirmative votes by Cecil McKnight, Len George, David Walker, Sharon Walker, Mark Maltsberger, Janet Qureshi and Browder that it be...

RESOLVED:

That the Board approve the recommendation to select Will Cox Roofing Company to replace the roof at 1020 Riverwood Court, Conroe, TX for $19,150.

The Medicaid Services Revenue Settle-Up Position for the period of October 2010 to September 2011 was reviewed for information purposes only.

The July 2011 Board of Trustees' Unit Financial statements were reviewed for information purposes only.

This being his last Board meeting, a presentation was made to Board Member Mark Maltsberger, by Chairman Cecil McKnight, for his years of dedicated service to Tri-County.

The regular meeting of the Board of Trustees recessed at 11:38 a.m. to go into Executive Session in compliance with Texas Government Code Section 551.074, Personnel.

The regular meeting of the Board of Trustees reconvened at 11:50 a.m., to go into regular session.

RESOLUTION #08-10-18

MOTION MADE BY: Len George
SECONDED BY: Patti Atkins, with affirmative votes by Cecil McKnight, Morris Johnson, Janet Qureshi, David Walker, Mark Maltsberger, Sharon Walker and Brad Browder, that it be...

RESOLVED:

That the Board extend the Executive Director's contract for 1 more year, for a total of a 5 year contract.

RESOLUTION #08-11-19

MOTION MADE BY: Janet Qureshi
SECONDED BY: Mark Maltsberger, with affirmative votes by Cecil McKnight, Len George, Sharon Walker, Patti Atkins, David Walker Brad Browder and Mark Maltsberger that it be...

RESOLVED:

That the August 25, 2011 meeting of the Board of Trustees be adjourned at 11:53 a.m.

ADJOURNMENT:

[redacted]

Len George Date
Chairman

ATTEST:

[redacted]

Brad Browder Date
Secretary

Executive Director Report
September 22, 2011

Information

- The next regularly scheduled Board meeting has been changed to Thursday, October 20th to accommodate attendance at the quarterly Texas Council meeting. Please mark this change in your calendars.

- Mark your calendars – the annual Center Christmas party will be Saturday, December 3rd, 7 p.m. at River Plantation Country Club. We will send you a notice later.

Operations

- Department of State Health Services (DSHS) – DSHS conducted a brief quality management review on August 25th and there were no significant findings. DSHS staff were very complimentary of the following: our QM plan and specifically recognized Tanya Bryant; our client rights procedures; and children's mental health clinic and its welcoming environment. There was one finding that our client rights officer could not also be our risk management officer and we are making this adjustment internally.

  Medicaid managed care began in Walker and Liberty counties on September 1st. Staff were trained and ready to meet the requirements of these new processes. For our clients who enrolled with one of the managed care plans, we are now required to obtain authorizations for their services and treatment. We now have several managed care plans to which we bill for their services rather than the single payer, state of Texas.

  We are still working with DSHS substance abuse licensing department trying to secure a license for our Huntsville facility. As of this date, we have not received approval.

  Psychiatric Emergency Treatment Center (PETC/CSU) – we recently hired our weekend nurse manager who will start later this month and another full-time nurse as well as a part-time psychiatrist. We are hopeful that we will be able to begin increasing capacity in October.

- Department of Aging and Disability Services (DADS) – We are rapidly enrolling newly eligible individuals into the Texas Home Living (TxHmL) waiver program

and assisting them in selecting their providers. Fortunately, this program offers services to persons who might not otherwise receive assistance.

The Conroe Life Skills program closed and all the consumers have transitioned to other programs, many to our Huntsville program. We had some very positive feedback from one of the consumers. The Autism Spectrum Disorder program was also closed and our behavioral health specialist met with all the consumers and parents and advised them of supports in our area. All the staff who applied for open positions were hired and have transitioned into their new positions; there were several of the impacted staff who chose not to apply for any of the vacant positions.

- East Texas Behavioral Healthcare Network (ETBHN) – Texas Panhandle Center (Amarillo headquarters) has decided to contract for mental health authorizations and that process will begin soon. A group of centers in north Texas is interested in establishing a collaborative relationship with ETBHN rather than organizing themselves and then competing with us. We will explore options at a meeting October 26th.

  ETBHN hired a psychiatrist and recently began providing tele-psychiatry to member centers in need of these services. Some of the rural centers in particular have difficulty recruiting and retaining psychiatrists, particularly child psychiatrists.

  Gulf Coast Center, Spindletop and Tri-County are working together to improve the comparability of our individual Cost Accounting Methodology (CAM) reports that we submit to DSHS and DADS. There is a great deal of variance among centers in how they report and account for services and costs and we believe that we should work to improve these reports.

- From the Heart, our annual holiday giving campaign is beginning; staff and clients/consumers are completing their "needs and wants" forms and the solicitation letters will be mailed later in October. We have had conversations with our major partners, Anadarko and Tradition Bank about their involvement once again this year.

- The August Panda Express fundraiser resulted in $200 and we are optimistic that the September event was as successful. Shane Burks is talking to several other restaurants about similar events.

- The employee health clinic opened September 7th and is open every Wednesday afternoon for two hours. We have a physician assistant who treats employees for minor illnesses and employees are charged $10/visit that is payroll deducted.

So far the clinic has been well received and there have been positive reports. A copy of the flyer that was sent to employees is attached.

Additionally, we will be conducting our annual employee wellness event in early October and we will be offering flu vaccines and cholesterol screenings. This has historically been well received by our employees.

- Tri-County staff contacted county officials and the Red Cross during the recent Montgomery, Grimes and Waller counties wildfire (referred to as the "tri-county" fire in the media) to offer our counseling and disaster support services at the shelters and to other evacuees. Staff also worked with Montgomery County United Way, the lead agency to coordinate the county's disaster response efforts.

- Our consumer/client annual Christmas card contest has begun and once the winning cards are selected, we will send you an order form.

Employee Health Clinic

Opening September 7, 2011

Every Wednesday from 3p- 5p in Conroe, Riverpointe building #3

Call 936-521-6100 to schedule an appointment

The clinic will be equipped to handle the following illnesses:

- Ongoing care for chronic conditions
- Medication refills
- Acute care for illness or injury

Additional Clinic Information for Staff

- PTO will be used for time spent traveling and participating in the clinic.
- Prescriptions provided may be filled using your insurance at any pharmacy you choose.
- Appointments may be scheduled at any time. Please call for availability.
- Each visit will be deducted from your payroll.
- Please bring any current prescription bottles and a list of your current medications to your appointment.
- Glenn Humphress, MS, PA will be the treating clinician.

*** All employee information will remain confidential.**

$10.00 Office Visit Fee

Tri-County has set up an employee health clinic for all staff. This is a benefit for all employees to assist with the rising costs of healthcare and make healthcare more accessible for staff.

Forms to be completed prior to visit (Forms can be found on Nexus under the Employee Health Clinic tab)

- **Complete new patient form (new patients only)**
- **Complete payroll deduction form for each visit**

TRI-COUNTY SERVICES

Serving individuals with mental illness and developmental disabilities

CHIEF FINANCIAL OFFICER'S REPORT
September 22, 2011

FY 2011 Audit – Work is progressing on the FY 2011 audit. We are working on confirmations to be sent out to our banking institutions and also confirmations for our bonds. Carlos is expected to start the field work the first couple weeks in October. We continue to work on account reconciliations to ensure that all entries are made prior to the auditors working on site.

Worker's Compensation Audit – We are scheduled to have a Worker's Compensation auditor on site this week. They will be reviewing our FY 2011 payroll records and contractors contracts for the worker's compensation insurance. The audit should be final by the end of October.

Certificates of Deposit – As a part of our Investment policy, we continue to try and find ways to get a higher rate of return on our bank balances. We have researched banks in Texas and have not found that we would get much of an increase over our high balance savings account interest. We will continue to seek more information and will report back when we have some positive information.

CAM Work Group – Tri-County, Gulf Coast and Spindletop have come together to compare the CAM reports for our 3 centers. A work group will compare the differences in both service side and the financial data from the reports. This will help us explain the differences in costs that we see from our center as compared to other centers. This process will last probably through the completion of the FY 2011 CAM report that is due February 29, 2012. We will report back after this time with what has been found and how this process has helped to improve our future cost reports.

CFO Consortium – The quarterly CFO meeting is scheduled to be held in Austin on October 6th and 7th. We will be going over early on the 5th and have a CAM Work group meeting the afternoon of the 5th. We expect the following topics to be on the agenda: Reconciliation of the state match received from TMHP; CARE Report III issues; LPND Rates; Public Finance Training and as always updates from both DADS and DSHS.

Settlement from UBS – Texas Council has notified us of a settlement that is a result of past interest owed to various Centers that maintained Reserve Fund investments in the Texas Council's Facilities Acquisition Program. The amount that Tri-County will receive is $50,145.

Agenda Item: Reappoint Mental Health Planning Network Advisory Committee Members **Committee:** Program	**Board Meeting Date** September 22, 2011

Background Information:

According to the bylaws for the Mental Health Planning Network Advisory Committee (MHPNAC), one-half of the members are to be reappointed by the Board of Trustees every year, for two year terms. There is no limit on the number of terms that a committee member can serve.

Each of the following members has an expiring term and has been contacted about their participation in the MHPNAC. They have agreed to continue serving on the MHPNAC for an additional two year term which will expire August 31, 2013.

- Judie Hunter – Special Education Teacher for Conroe Independent School District
- Richard Duren – Family Member

We currently have six MHPNAC members, but we are in need of nine members to be in compliance with the contract and would gladly accept additional members beyond contract requirements. If you know of anyone that may be interested in PNAC membership, please contact Evan Roberson.

Supporting Documentation:

None

Recommended Action:

Reappoint Mental Health Planning Network Advisory Committee Members to a Two Year Term Which Expires August 31, 2013

Agenda Item: Reappoint Intellectual and Developmental Disabilities Planning Network Advisory Committee Members **Committee:** Program	**Board Meeting Date** September 22, 2011

Background Information:

According to the bylaws for the Intellectual and Developmental Disabilities Planning Network Advisory Committee (IDDPNAC), one-half of the members are to be reappointed by the Board of Trustees every year, for two year terms. There is no limit on the number of terms that a member can serve.

Each of the following members has an expiring term and has been contacted about their participation in the IDDPNAC. They have agreed to continue serving on the IDDPNAC for an additional two year term which will expire August 31, 2013.

- Judie Hunter – Special Education Teacher at Conroe Independent School District and Parent
- Mary Byrne – Special Education Teacher at Conroe Independent School District and Parent

We currently have six IDDPNAC members, but we are in need of nine members to be in compliance with the contract and would gladly accept additional members beyond contract requirements. If you know of anyone that may be interested in PNAC membership, please contact Evan Roberson.

Supporting Documentation:

None

Recommended Action:

Reappoint Intellectual and Developmental Disabilities Planning Network Advisory Committee Members to a Two Year Term Which Expires August 31, 2013

Agenda Item: Annual Corporate Compliance Report and 1st Quarter Corporate Compliance Training **Committee:** Program	**Board Meeting Date** September 22, 2011

Background Information:

The Corporate Compliance Officer is required by Board Policy to submit quarterly reports on Corporate Compliance activities to the Board of Trustees as well as an Annual Report at the end of each fiscal year. The Annual Corporate Compliance Report for FY 2011 is attached along with the educational information that has been provided to Center staff. The education portion is included in this packet for on-going education of the Tri-County Board of Trustees on Corporate Compliance issues.

Supporting Documentation:

FY 2011 Annual Corporate Compliance Report

FY 2012 1st Quarter Corporate Compliance Training

Recommended Action:

For Information Only

Corporate Compliance Program

FY 2011 Annual Report

General Overview:

The Board Policy on Corporate Compliance requires that the Corporate Compliance Officer present an annual report on program activities and investigations from the previous year.

In FY 2011, training continued for all new employees in the monthly extended orientation class and quarterly training was provided to all Tri-County staff and eligible contractors.

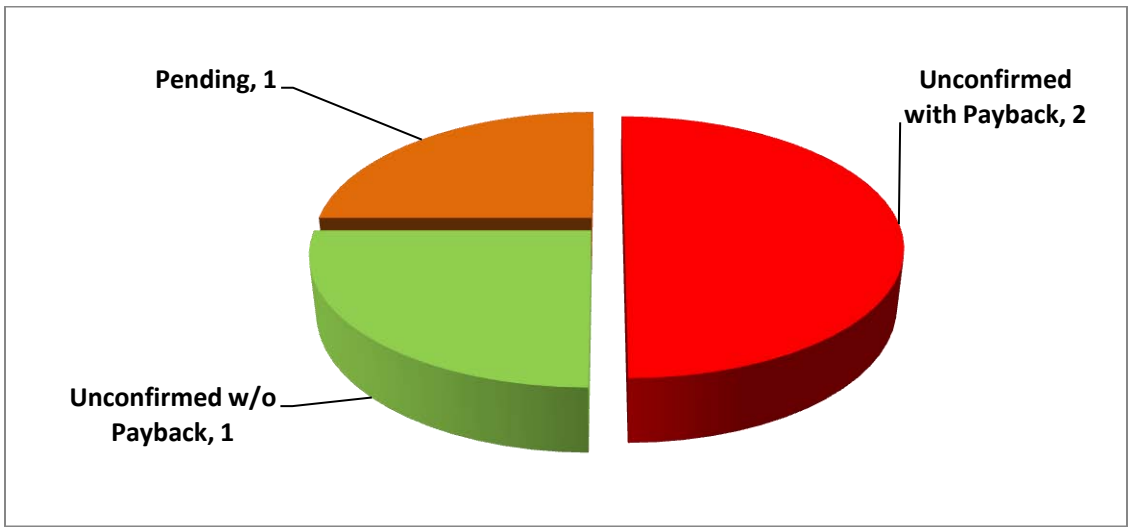
As the Board is likely aware, compliance regulations and auditing have increased at the state and federal level. Staff stays diligent in our pursuit of legal compliance with all regulations.

The Corporate Compliance Committee has reviewed applicable sections of the Office of the Inspector General FY 2011 Work Plan and has made revisions to the Corporate Compliance Action Plan. The Committee also reviews a variety of legal updates on a consistent basis.

Corporate Compliance Investigation Results:

For FY 2011, there were four corporate compliance allegations which were investigated by the Corporate Compliance Officer. Out of the four, three were investigated before the end of FY 2011 and one was pending at the end of the year. Of the three cases investigated in FY 2011, two were unconfirmed with payback and one was unconfirmed without payback. For FY 2011, payback was complete on both cases with payback. In addition, three chart reviews led to billing payback of $2,620.80. The known payback for FY 2011, with one pending case, was $5,999.52.

Total Corporate Compliance Investigations



Corporate Compliance Training

1st Quarter FY 2012

Recovery Audit Contractors Set to Expand to Medicaid Program

As of this spring, providers billing state Medicaid programs, including Community Centers, have another organization reviewing their Medicaid claims. The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, (the "Health Reform Law") expands the Recovery Audit Contractor ("RAC") program to Medicaid, as well as Medicare Part C (Medicare Advantage, the Medicare Managed Care plan) and Part D (Medicare coverage for prescription drugs).

The RAC program originally was created in 2003 to detect and correct improper payments in Medicare Parts A and B (Medicare hospital and supplemental insurance coverage, respectively). Under the Health Reform Law, the scope of the RACs' reviews was expanded, but the goals of the program remain the same: identifying underpayments and overpayments and recouping overpayments.

While the Medicaid RAC program was not required to be implemented until April 1, 2011, each State was required to submit a Medicaid State plan amendment establishing its RAC program to the Centers for Medicare and Medicaid Services ("CMS") by December 31, 2010. In November 2010, CMS issued proposed rules implementing the Medicaid RAC program.

The RAC for Texas is Connolly and Associates.

Like the RACs that review Medicare Parts A and B payments, Medicaid RACs are paid for collecting overpayments on a contingency fee basis. Though the federal government only will contribute toward a state's costs of compensating RACs up to a certain contingency rate, the States have the discretion to set the RACs' compensation.

Appeals Process

States must have in place an appeals process by which entities may challenge adverse Medicaid RAC determinations. To this end, States either may use existing administrative appeals infrastructures or may establish a separate appeals process. Interestingly, CMS allows the States to decide whether their Medicaid RACs should be paid upon discovery of the improper payment (the RACs would be required to repay any amounts received for payments determined through the appeals process to have been proper) or upon completion of the appeals process. In either case, the RACs have a strong incentive to maximize the identification of improper payments.

What Can Providers Do to Prepare?

Billing and coding have been highlighted as one of the top compliance risk areas for health care providers. Addressing these areas involves ensuring that services are properly documented and coded so that they can be correctly billed initially and so that the billing can be substantiated should it be audited. One way to ensure that billing, coding, and documentation of Medicaid services are receiving sufficient compliance program attention is to include the development and implementation of policies and procedures, training, monitoring, and auditing relating to billing, coding, and documentation of medical services in the provider's compliance program annual work plan. Tri-County Quality Management staff have been very active with training activities in this last year.

The 2011 Office of the Inspector General Work Plan includes Home and Community Based Services (HCS) and Mental Health Rehabilitation Services which are significant funders of Community Centers.

Any staff member who is approached by a Recovery Audit Contractor, should immediately contact Evan Roberson or another Leadership Team Member.

Taken in part from an article in *Compliance Watch* by Laura G. Hoffman, Esq., Feldesman Tucker Leifer Fidell LLP

Agenda Item: Planning Network Advisory Committee Annual Reports **Committee:** Program	**Board Meeting Date** September 22, 2011

Background Information:

According to their bylaws, both the Mental Health and Intellectual and Developmental Disabilities Planning Network Advisory Committees are required to make a written report to the Board that outlines the Committees' activities for the year and reports on committee attendance. The end of FY 2011 marks the fourth year since we have separated our Planning Network Advisory Committee (PNAC) into Mental Health and Intellectual and Developmental Disabilities committees. Many of our committee members continue to serve on both PNACs, but we have also added members to each group that are primarily concerned with that group's focus. The attached reports on the two committees' activities are provided for your information.

Supporting Documentation:

Mental Health PNAC Annual Report

Intellectual and Developmental Disabilities PNAC Annual Report

Recommended Action:

For Information Only

Mental Health Planning Network Advisory Committee

Annual Report

For FY 2011

In FY 2011, the Mental Health Planning Network Advisory Committee (MHPNAC) were able to break from Local Planning Network Development activities and focused on other interests. The MHPNAC set goals around advocating through the legislative session and studying consumer wellness and recovery models. In August, Janet Paleo from Prosumers in San Antonio met with the MHPNAC regarding consumer wellness and recovery. Staff will be studying this training model further for possible use in staff training. Staff kept the MHPNAC up to date with the latest legislative information throughout the session and encouraged advocacy for the consumers we serve.

The MHPNAC decided on the following goals for FY 2011:

1. Advise Tri-County staff on any potential activities related to Local Planning Network Development.
2. Advocate for consumer care in the Legislative Session of Texas.
    - Includes potentially writing letters, making calls, and/or making visits
    - Continued local control of the mental health service system
    - Reasonable cuts in General Revenue funding
3. Study new programs for consumer driven treatment evidence based practices and make recommendations to the Board regarding service system enhancements.

In FY 2011, the MHPNAC met five times and had an overall attendance of 65%.

The MHPNAC will set their goals for FY 2012 at the meeting on October 5, 2011.

We currently have six MHPNAC members. Staff needs to find three additional members to be in compliance with contract requirements.

Intellectual and Developmental Disabilities Planning Network Advisory Committee

Annual Report

For FY 2011

The activities of the Intellectual and Developmental Disabilities Planning Network Advisory Committee (IDDPNAC) for FY 2011 were intended to revolve around IDD Local Planning and legislative activities for the year. However, local planning was delayed for IDD services since significant cuts in services were projected early in the session.

In FY 2011, the IDDPNAC set the following goals:

1. The IDDPNAC will review the Local Service Area Planning Guidelines and make recommendations about the design of the planning process.
2. The IDDPNAC will participate in survey distribution for the Local Planning process.
3. The IDDPNAC will participate in the coordination of planning meetings within the local service area.
4. The IDDPNAC will continue to make visits to community providers to learn more about available resources for persons with IDD.
5. The IDDPNAC will invite parents/family members to meetings to listen to their stories, learn about their recent experiences with the Center, discuss issues and concerns that they had, and offer their words of encouragement.

In FY 2011, the IDDPNAC met five times and had an overall attendance of 45%.

The IDDPNAC currently needs three additional members to be in compliance with contract requirements.

Agenda Item: Community Resources Report for August 2011 **Committee:** Program	**Board Meeting Date** September 22, 2011
Background Information: None	
Supporting Documentation: Community Resources Report for August 2011	
Recommended Action: **For Information Only**	

Community Resources Report

Volunteer Hours:

Location	August
Conroe	120
Cleveland	4.5
Liberty	13
Huntsville	11
Total	**148.5**

COMMUNITY ACTIVITIES:

9/1/11	Cleveland Chamber of Commerce Luncheon	Cleveland
9/1/11	Walker County Community Resource Coordination Group	Huntsville
9/2/11	Montgomery County United Way Campaign Cabinet Meeting	The Woodlands
9/6/11	Montgomery County Fair Housing Workgroup Meeting	Conroe
9/7/11	Liberty County Community Resource Coordination Group	Dayton
9/7/11	Montgomery County Community Plan Committee Meeting	Conroe
9/8/11	Huntsville Chamber of Commerce Breakfast	Huntsville
9/12/11	Patient Navigation Task Force Meeting	Conroe
9/13/11	Montgomery County Jail Diversion Working Group	Conroe
9/13/11	Homeless Coalition Board Meeting	Conroe
9/13/11	Montgomery County Fair Housing Workgroup Meeting	Conroe
9/15/11	Montgomery County United Way Kick Off	The Woodlands
9/15/11	Montgomery County United Way Community Well Being Council Meeting	The Woodlands
9/16/11	Panda Express Fundraiser for Tri-County	Conroe
9/20/11	Montgomery County Community Resource Coordination Group	Conroe
9/20/11	Montgomery County United Way Disaster Recovery Taskforce	The Woodlands
9/20/11	Montgomery County Forensic Hospital Advisory Committee Meeting	Conroe
9/21/11	Liberty/Dayton Chamber of Commerce Luncheon	Liberty
9/21/11	Homeless Coalition Board & General Meetings	Conroe

UPCOMING ACTIVITIES:

9/27/11	Montgomery County Jail Diversion Executive Task Force Meeting	Conroe
9/27/11	Aging and Disability Resource Center Meeting	Houston
9/27/11	Montgomery County Area Business Women's Meeting	Conroe
9/27/11	Walker County Community Planning Meeting	Huntsville
9/28/11	Montgomery County United Way Campaign Cabinet Meeting	The Woodlands
10/5/11	Liberty County Community Resource Coordination Group	Dayton
10/6/11	Walker County Community Resource Coordination Group	Huntsville
10/6/11	Cleveland Chamber of Commerce Luncheon	Cleveland
10/13/11	Huntsville Chamber of Commerce Breakfast	Huntsville
10/18/11	Montgomery County Community Resource Coordination Group	Conroe
10/18/11	Montgomery County United Way Disaster Recovery Taskforce	The Woodlands

Agenda Item: Consumer Services Report for August 2011 **Committee:** Program	**Board Meeting Date** September 22, 2011
Background Information: None	
Supporting Documentation: Consumer Services Report for August 2011	
Recommended Action: **For Information Only**	

CONSUMER SERVICES REPORT

August 2011 - FY 2011

Crisis Services, MH Adults/Children	MONTGOMERY COUNTY	CLEVELAND	LIBERTY	WALKER COUNTY	TOTAL
Persons Screened, Intakes, Other Crisis Services	297	22	30	17	**366**
Crisis and Transitional Services (SP 0, SP5)	55	6	5	2	**68**
CrisisStabilization Unit (CSU) Served	49	3	7	4	**63**
Crisis Stabilization Unit (CSU) bed days	173	4	14	19	**210**
Total Contract Hospital Admissions	5	1	1	0	**7**
Total State Hospital Admissions	46	4	4	7	**61**
Persons Served by Program, MH Non-Crisis					
Adult Service Packages (SP 1-4)	684	97	83	109	**973**
Adult Medication Services	499	64	57	94	**714**
Child Service Packages (SP 1.1-4)	299	11	5	51	**366**
Child Medication Services	159	12	2	14	**187**
Adult Jail Diversion Services	21	1	0	0	**22**
Juvenile Detention Diversion Services	4	0	0	0	**4**
TCOOMMI (Adult/Child)	101	4	1	11	**117**
Persons Served by Program, IDD					
Number of New Enrollments for IDD Services	13	0	0	0	**13**
Service Coordination/Case Management	402	26	36	50	**514**
Center Waiver Services (HCS, Supervised Living, TXHmL)	29	7	14	18	**68**
Contractor Provided ICF-MR	18	12	12	6	**48**
Autism Services	14	0	1	1	**16**
Substance Abuse Services					
Children and Youth Prevention Services	0	0	0	0	**0**
Youth Substance Abuse Treatment Services/COPSD	9	0	1	0	**10**
Adult Substance Abuse Treatment Services/COPSD	19	0	2	0	**21**
Waiting/Interest Lists					
Department of State Health Services-Adults	249	25	38	8	**320**
Department of State Health Services-Children	8	0	1	0	**9**
Home and Community Based Services Interest List	1057	94	91	92	**1334**
Persons Served Outside of the State Contracts					
Benefit Package 3 Adult/Child	24	2	8	6	**40**
August Served by County					
Adult Mental Health Services	1271	144	125	162	**1702**
Child Mental Health Services	312	20	6	55	**393**
Intellectual and Developmental Disabilities Services	451	52	43	59	**605**
Total Served by County	**2034**	**216**	**174**	**276**	**2700**
July Served by County					
Adult Mental Health Services	1272	143	105	154	**1674**
Child Mental Health Services	331	13	8	52	**404**
Intellectual and Developmental Disabilities Services	457	52	45	57	**611**
Total Served by County	**2060**	**208**	**158**	**263**	**2689**
June Served by County					
Adult Mental Health Services	1268	149	131	167	**1715**
Child Mental Health Services	363	15	8	57	**443**
Intellectual and Developmental Disabilities Services	469	42	52	56	**619**
Total Served by County	**2100**	**206**	**191**	**280**	**2777**

Agenda Item: Program Updates for August 2011 **Committee:** Program	**Board Meeting Date** September 22, 2011
Background Information: None	
Supporting Documentation: Program Updates for August 2011	
Recommended Action: **For Information Only**	

Program Updates
August 2011

MH Crisis and Admission Services

A. Key Statistics:
   1. Number of new admissions during the month: 63
   2. PETC average daily census: 8.5

B. Program Comments:
   1. Due to Rusk State Hospital diversion status and reduced capacity at the PETC, contract inpatient hospitals were significantly utilized this month.
   2. As a result of reductions in force in this service area, the duties of remaining staff have been redefined to adjust to fewer staff resources.
   3. Weekend and night crisis response services are about 50 persons this month.

MH Adult Services

A. Key Statistics:
   1. Number of adults served during the month: 1702
   2. Number of adults served in Medication Services: 714

B. Program Comments:
   1. The number of adults we are seeing are continuing to increase in Medication Services each month.
   2. A new part time Psychiatrist was hired and began his position in September.
   3. Staff are currently being hired to begin a new site based skills training service in RP5.

MH Child Services

A. Key Statistics:
   1. Number of children served during the month: 393
   2. Number of children served in Medication Services: 187

B. Program Comments:
   1. Much time has been devoted to improve productivity of our staff with some caseload reassignments and improvements in some streamlined documentation efforts.
   2. Due to reductions in the number of staff positions in this service area, we have been focusing on how to serve more clients, with fewer staff, this month.

Criminal Justice Services

A. Key Statistics:
   1. Number of Children and Adults Served Through Texas Office on Offenders with Medical and Mental Impairments (TCOOMMI):
      16 Juvenile; 102 Adults
   2. Number of Jail/Juvenile Diversions:
      5 Jail Diversions in the month of July; 4 Juvenile Diversions

B. Program Comments:
   1. The Juvenile Probation services have been phasing out and many clients are transitioning to the MH Child Adolescent Program.
   2. TCOOMMI negotiations have been successful for some contract modifications which will allow the program to keep all employees, except two Juvenile Rehabilitation positions.
   3. Much time is being spent on increasing adult enrollment to reach a 50 person caseload.

Substance Abuse Services

A. Key Statistics:
   1. Number of children served in prevention services: 0 (no groups during the summer).
   2. Number of adults served in substance abuse/COPSD treatment services: 21 (11 COPSD; 21 Outpatient)
   3. Number of children served in substance abuse treatment services: 10

B. Program Comments:
   1. Two new intern positions were hired and will be funded by United Way.
   2. Substance Abuse services have been negatively impacted recently due to schools being closed and employees taking summer vacations.
   3. We have been very successful scheduling schools for prevention training with much success in the Cleveland schools.

IDD Services

A. Key Statistics:
   1. Total number of admissions for the month: 13
   2. Total number served in the HCS program for the month: 60
   3. Total number served in all IDD services for the month: 605

B. Program Comments:
   1. There has been significant enrollment of Medicaid clients into services which should help us meet financial objectives going forward.
   2. There has been a considerable amount of time spent enrolling clients into TxHmL services as DADS approved additional enrollments.
   3. Closing Conroe Life Skills and transitioning program clients to other services has occupied our time recently.
   4. The Autism Spectrum Disorder Program was closed this month.

Personnel Information

A. We have implemented some changes in the salary and fringe system for RNs at the PETC, which is helping with recruitment.

Support Information

A. **Veterans' Services**:
   1. An outdoor veteran group was held on September 10th in Huntsville. The group went hiking for the day and discussed any issues that may have been weighing them down lately.
   2. Veteran meetings began on campus at Sam Houston State University on September 13th.
B. **Quality Management**: The Administrator of Quality Management has joined the Leadership Montgomery County Board (Steering Committee).
C. **ETBHN/Regional Authorization**: Texas Panhandle Centers will be joining the ETBHN authorization program part time at the end of September with the intent of becoming full time in the future.
D. **Information Services**: Staff were trained throughout the months of August and September on the new Anasazi upgrade and how to use the new Anasazi Treatment Plans.
E. **Intellectual and Developmental Disabilities Planning Network Advisory Committee (IDDPNAC)**: The IDDPNAC met on September 21st and discussed the FY 2012 Goals and Objectives for the committee. They also held officer elections for the new fiscal year and annual volunteer training was completed.

Community Activities

A. Another Panda Express fundraiser was held on September 16th at the Conroe location. The August fundraiser at this restaurant raised $200.

Agenda Item: FY 2011 Goals and Objectives Final Report **Committee:** Program	**Board Meeting Date** September 22, 2011

Background Information:

The Board of Trustees and Leadership Team developed Center goals for FY 2011 and the Leadership Team subsequently developed objectives for each of the goals. At the August 26, 2010 Board of Trustees meeting these Goals and Objectives were approved by the Board.

This is the final report of the FY 2011 Goals and Objectives.

Supporting Documentation:

FY 2011 Goals and Objectives Final Report

Recommended Action:

For Information Only

FY 2011
FINAL
Goals and Objectives
Progress Report

GOAL #1
Successfully Implement and Market the Expanded Substance Abuse Treatment Services

OBJECTIVE #1:
Hire and train staff.

- Both the Youth and Adult Substance Abuse Treatment Programs have struggled to fill positions and stabilize staffing. Currently, all positions are filled and we have added intern positions with United Way Funding.

OBJECTIVE #2:
Market Substance Abuse Treatment Services to community stakeholders and all potential referral sources.

- We have made many efforts to produce significant referrals from the judicial system but without much success in Montgomery County. We have marketed services through other community agencies such as schools and United Way agencies, and we have requested the Department of State Health Services (DSHS) to approve expansion of services into Huntsville.
- We have contacted the Walker County District Judge to advise of Adult and Youth SA Treatment Services.
- The Walker County Adult and Juvenile Probation Departments were contacted as well.

OBJECTIVE #3:
Maximize all funding for Substance Abuse Treatment including DSHS, Medicaid, private insurance and Montgomery County United Way.

- We have had tremendous struggles with the Medicaid Behavioral Health organizations in paying for services provided.
- Additional funding was received from United Way for intern positions.
- We are still spending significant time with DSHS regarding contract compliance requirements.

OBJECTIVE #4:
Funders, consumers, families and quality management reviews reflect effective services.

- A series of assessments of the Substance Abuse program by Tri-County staff and by DSHS found that the programs are implementing the contract appropriately.
- Clients who were interviewed are very satisfied with services.

GOAL #2
Increase Community Awareness of Center

OBJECTIVE #1:

Educate consumers, families and stakeholders about CSU, crisis hotline, Mobile Crisis Outreach Teams, other mental health services and intellectual and developmental disability services.

- We have conducted numerous meetings with judicial, law enforcement, hospitals, and community agencies in an ongoing system of updating and clarifying service information.
- There have been many discussions about TxHmL opportunities.
- Frequent communications have taken place with consumers and families about services.
- When the CSU opened in May, there were numerous newspaper and public service announcements.
- We continue to communicate in various committees that involve key representation from all major community agencies.

OBJECTIVE #2:

Promote Center's website to all stakeholders.

- The Center's new website continues to be promoted to stakeholders. A website survey for clients indicates that consumers are happy with the format and information provided.
- Met with HCS Advisory committee to explain the website.
- Further attempts to increase client traffic on the site will continue in FY 2012.
- The resource directory on the site, Network of Care, continues to be heavily used by the community.

OBJECTIVE #3:

Increase media coverage of Center services and events, including newspapers, radio stations, public service announcements and other media.

- Press releases for CSU opening were included in several newspapers.
- There was also radio coverage of CSU opening.
- KSHN aired several Public Service Announcements regarding Tri-County Services.
- Evan Roberson participated in a KSHN radio program.
- A press release about the Independence Place opening was created.
- There was a press release regarding the re-opening of Helen Dishongh (Truman Street).
- The celebration of Burnham Golf Tournament was published in Dayton, Cleveland and Liberty papers.
- Quarterly report card was mailed out to stakeholders.

OBJECTIVE #4:

Implement an educational plan for local and state elected officials regarding diversion of misdemeanor defendants from the criminal justice and state hospital system.

- Working with Executive Jail Diversion Task Force and Indigent Defense Board to divert individuals from jail and state hospitals.
- MH Court Board is interviewing managing attorneys and once hired, the MH court will become active.
- HB748 passed; allows judges to give credit on sentences for time the defendant spent in jail waiting for a determination of incompetency and the time the defendant was confined in a mental health facility or treatment facility after the determination of competency.

GOAL #3
Diversity Center Revenues and Improve Efficiencies

OBJECTIVE #1:
Plan and conduct a gala fundraiser in FY 2011.

- Committee met and initial planning began, including themes, locations and potential invitees.
- 3 possible locations for gala were visited and potential themes are in development.
- The River Plantation country club was selected as the gala site and event is planned for Spring 2012.

OBJECTIVE #2:
Apply for HUD 811 funding for a Liberty County project.

- A HUD 811 application was submitted for a project in Cleveland, Texas. There were no technical corrections required for the application which should be considered a positive sign. Staff do not expect to hear about the application before December 2011 at the earliest.

OBJECTIVE #3:
Apply for funding to support autism spectrum disorder services.

- Tri-County did receive a small grant for supplies for the autism program, but other attempts to find funding for the program were unsuccessful.

OBJECTIVE #4:
Analyze operations to migrate from paper to electronic documentation wherever possible.

- The hiring process forms were converted from paper to electronic documents.
- A project to scan remaining paper documents into the Electronic Medical Record was approved in early July. Staff are currently purchasing program supplies and hiring two staff. Implementation will begin in early FY 2012.
- Activities continue on this objective.

GOAL #4
Recruit and Retain Quality Staff

OBJECTIVE #1:
Increase number of bilingual and culturally competent staff.

- Tri-County currently has 5 bilingual staff and continues to seek candidates who are bilingual and culturally competent through various methods of recruiting and advertising.

OBJECTIVE #2:
Identify and develop successor staff in key management positions.

- Due to employee turnover and reduction in staff, this objective was postponed.

OBJECTIVE #3:
Expand employee wellness opportunities, including employee health clinic.

- Final preparations were completed in August to ensure that the Employee Health Clinic could open the first Wednesday of FY 2012.
- The clinic opened on September 7, 2011 in the River Pointe #3 building in Conroe.

OBJECTIVE #4:

Foster relationships with colleges and universities to secure practicum and intern students.

- Several activities were undertaken to foster relationships with local universities.
- Tri-County continues to be in the rotation for Lone Star Registered Nurse interns and Lone Star family practice physician interns.
- Staff participated in Future Fest, an event sponsored by Sam Houston State University and Lone Star College.
- Routinely have SHSU counseling practicum students supervised by Tri-County staff.
- The Center has paid substance abuse internships, which are financed by Montgomery County United Way.

OBJECTIVE #5:

Expand and enhance employee recognition activities.

- Above and Beyond was implemented this year so that employees could be recognized for going above and beyond in their position. The employees were recognized in the Tri-County Horizon newsletter each month.
- Employees were recognized in the newsletter by the Executive Director for outstanding achievement.

Agenda Item: Appoint Texas Council of Community Centers, Inc. Representative and Alternate for FY 2012 **Committee:** Executive	**Board Meeting Date** September 22, 2011

Background Information:

The representative attends the quarterly Board meetings of the Texas Council of Community Centers, Inc. and gives a verbal update to the Tri-County Board at their subsequent Board meetings. The alternate attends and reports if the representative is unable to do so.

Supporting Documentation:

None

Recommended Action:

Appoint Texas Council of Community Centers, Inc. Representative and Alternate for FY 2012

Agenda Item: Board of Trustees Appointments and Reappointments and Oaths of Office **Committee:** Executive	**Board Meeting Date** September 22, 2011

Background Information:

The Commissioners Courts of their respective counties reappointed those Trustees whose terms expired August 31, 2011.

On August 15, 2011 the Walker County Commissioners' Court appointed Tracy Sorensen, of Huntsville, to replace Mark Maltsberger on the Board of Trustees.

Oaths of Office will be recited at the Board meeting.

Supporting Documentation:

Montgomery County Trustees – Copy of Signed Motion from Montgomery County Commissioner's Court Docket
Sharon Nichols Walker
Walker County Trustees – Letter from Walker County Judge Danny Pierce
Tracy Sorensen - Appointment
Morris Johnson
Liberty County Trustees – Letter from Liberty County Judge Craig McNair
Brad Browder

Recommended Action:

Trustees Will Recite Oaths of Office

MARK TURNBULL
COUNTY CLERK
MONTGOMERY COUNTY

P.O. BOX 959
CONROE, TX 77305

(936) 539-7885
(281) 364-4200 EXT. 7885

COMMISSIONERS' COURT DOCKET, AUGUST 22, 2011
SPECIAL SESSION

THE STATE OF TEXAS ( )
KNOW ALL MEN BY THEIR PRESENTS:
COUNTY OF MONTGOMERY ( )

"5. RE-APPOINTMENT APPROVED - SHARON WALKER - TRI-COUNTY BOARD OF TRUSTEES - COUNTY JUDGE

Motion by Commissioner Chance, seconded by Commissioner Rinehart, to approve the re-appointment of Sharon Walker to the Tri-County Board of Trustees. Motion carried."

I, Mark Turnbull, Clerk, County Court, in and for said County and State, hereby certify that the above and foregoing is a true and correct excerpt of the Commissioners' Court Minutes of Montgomery County, Texas, sitting in Special Session on the 22nd day of August, 2011.

WITNESS MY HAND AND SEAL this the 14th day of September, 2011.

Mark Turnbull, County Clerk
and Ex-Officio Clerk
Commissioners' Court
Montgomery County, Texas

By [redacted]
Deputy County Clerk

COMMISSIONER'S COURT MONTGOMERY COUNTY TEXAS

OFFICE OF THE COUNTY JUDGE

DANNY PIERCE
Walker County Judge
(936) 436-4910
(936) 436-4914 FAX

Walker County Courthouse
1100 University Avenue
Huntsville, Texas 77340

September 13, 2011

Tri-County Services
P.O. Box 3067
Conroe, Texas 77305

Dear Ms. Sill:

During the special session of Commissioners' Court on August 15, 2011, it was unanimously approved to accept the resignation of Mark Maltsberger from the Tri-County Services Board. At the same meeting, is was also unanimously approved to reappoint Mr. Morris Johnson and appoint Ms. Tracy Sorenson to the same board.

If you need any additional information or we can assist you in the future, please let me know.

Sincerely,

[redacted]

Danny Pierce
County Judge
Walker County

CRAIG McNAIR
COUNTY JUDGE

1923 SAM HOUSTON
LIBERTY, TEXAS 77575

THE COUNTY OF LIBERTY

Est. 1836

August 23, 2011

Tri-County MHMR
Attn: Cindy Sill
P.O. Box 3067
Conroe, TX 77305

Re: Reappointment to Board of Trustees

Dear Ms. Sill:

Liberty County Commissioners Court reappointed Brad Browder to the Tri-County MHMR Services Board of Trustees on August 23, 2011.

If you have any questions, please contact my office. Thank you.

Sincerely,

[redacted]

Craig McNair
County Judge

CMN/dh

936/336-4665 craig.mcnair@co.liberty.tx.us FAX: 936/336-4518

Agenda Item: Board of Trustees' Committee Appointments **Committee:** Executive	**Board Meeting Date** September 22, 2011

Background Information:

Len George, Chairman of the Board, will appoint Committee members and their respective Chairs during the regular meeting.

Supporting Documentation:

None

Recommended Action:

For Information Only

Agenda Item: Personnel Report for August 2011 **Committee:** Executive	**Board Meeting Date** September 22, 2011
Background Information: None	
Supporting Documentation: Personnel Report for August 2011	
Recommended Action: **For Information Only**	

TRI-COUNTY SERVICES
PERSONNEL BOARD REPORT
AUGUST 2011

STAFF CLASSIFICATIONS	NEW HIRES		SEPARATED		VOLUNTARY SEPARATION		INVOLUNTARY SEPARATION		BUDGETED POSITIONS	FILLED POSITIONS	MONTHLY TURNOVER PERCENT	YEARLY TURNOVER PERCENT
	MO.	YTD.	MO.	YTD.	MO.	YTD.	MO.	YTD.				
Bachelor's												
Qualified Mental Health Professional	1	17	3	29	1	20	2	9	80	68	4%	43%
Qualified Mental Retardation Professional (State Title)		1							13	12	0%	0%
Licensed Staff		5		2		1		1	14	11	0%	18%
Medical												
Physicians				1				1	6	4	0%	25%
Advanced Practice Nurse		1							2	2	0%	0%
RN's		1		1		1			12	9	0%	11%
LVN's				3		1		2	10	10	0%	30%
Techs/Aides												
MH		2	1	4		3		1	12	9	11%	44%
IDD		6	2	14		7	2	7	48	41	5%	34%
Supervisor/Manager												
MH		1		1				1	13	13	0%	8%
IDD				1				1	5	4	0%	25%
Program Support		3	1	7	1	6		1	39	35	3%	20%
Central Administration		5		4		4			16	14	0%	29%
Business Services				2		2			16	15	0%	13%
Maintenance/Janitorial/Lawn		2		1		1			24	24	0%	4%
GRAND TOTALS	1	44	7	70	3	46	4	24	310	271	3%	26%
Previous YTD											3%	25%

Agenda Item: Analysis of Board Members' Attendance at Regular and Called Board Meetings in FY 2011 **Committee:** Executive	**Board Meeting Date** September 22, 2011
Background Information: None	
Supporting Documentation: Analysis of Board Members' Attendance at Regular and Called Board Meetings for FY 2011	
Recommended Action: **For Information Only**	

Analysis of Board Members' Attendance
Regular Board Meetings and
Special Called Meetings

FY 2011

Board Member	Regular Board Meetings	Percentage of Attendance at Regular Meetings	Special Called Board Meetings (incl. Strategic Planning)	Percentage of Attendance at Special Called Meetings	Percentage of Total Attendance
Cecil McKnight Chair	10/10	100%	1/1	100%	100%
Len George Vice-Chair	10/10	100%	1/1	100%	100%
Janet Qureshi Secretary	9/10	90%	0/1	0%	82%
Morris Johnson	8/10	80%	0/1	0%	73%
David Walker	9/10	90%	1/1	100%	91%
Brad Browder	9/10	90%	0/1	0%	82%
Mark Maltsberger	8/10	80%	0/1	0%	73%
Sharon Walker	10/10	100%	1/1	100%	100%
Patti Atkins	8/10	80%	1/1	100%	82%

Summary of Attendance	**2009**	**2010**	**2011**
Total Regular Meetings Held:	9	10	10
Average Attendance at Reg. Meetings:	80%	81%	90%
Total Special Called Meetings Held:	2	1	1
Average Attendance at Called Meetings:	93%	78%	56%
Total Number of Meetings Held:	11	11	11
Average Attendance at Meetings:	82%	81%	87%
Average Number of Members Present:	6.36	7.09	7.81

NOTE: All absences are excused absences.

Agenda Item: 401(a) Retirement Plan Account Review **Committee:** Business	**Board Meeting Date** September 22, 2011

Background Information:

Terry Hill of ISC Group will present an update of the 401(a) Retirement Plan account activity FY 2011 and will provide a forecast for the future.

Supporting Documentation:

Information to be Distributed by Terry Hill at the Board Meeting

Recommended Action:

Action as Appropriate or Needed

Agenda Item: Ratify FY 2012-13 Department of State Health Services Contract and Approve FY 2012-13 Amendment Packet #1 **Committee:** Business	**Board Meeting Date** September 22, 2011

Background Information:

As you recall, the Center had not received the FY 2012-13 Department of State Health Services (DSHS) contract prior to the August 25th Board meeting; the contract arrived later that day. The Board authorized the Executive Director to sign the contract and have it ratified at the September Board meeting.

Despite the later arrival, there are not substantive changes in the contract. Adult mental health funding is reduced by $138,351; children's waiting list funding is reduced by $24,502 and the crisis transitional funding (Rider 65) was reduced by $29,485. The reductions were not unanticipated, especially for adult and children's mental health as we received additional funds during the summer as one time funding.

There are several new and/or revised requirements in the contract, including, but not limited to: reporting routinely to the Board about QM activities; listing all contractors on our website; quarterly report affirming our security officers; new requirements for tele-medicine; and increasing the outcome measures for adults and children. We are evaluating whether some of our policies and/or procedures will need to be revised.

On September 6th, the Center received a DSHS Amendment Packet #1 that included corrections to the local match amount, the adult target number and our Veterans Services funding award, $47,000 for the biennium.

Supporting Documentation:

FY 2012-13 DSHS Contract

FY 2012-13 Amendment Packet #1

Recommended Action:

Ratify FY 2012-13 Department of State Health Services Contract and Approve FY 2012-13 Department of State Health Services Amendment Packet #1

CONTRACT NO. 2012-039597-
PROGRAM ATTACHMENT NO.001
PURCHASE ORDER NO. 0000377072

CONTRACTOR: TRI-COUNTY MHMR SERVICES

DSHS PROGRAM: Mental Health Performance Contract Notebook

TERM: 09/01/2011 THRU: 08/31/2013

Table of Contents

SECTION I. STATEMENT OF WORK

A. Authority and Administrative Services

1. Local Planning:
   Contractor is the designated Local Mental Health authority (LMHA) for the Local Service Area (LSA). As the LMHA, Contractor is required to:

   a) Maintain, update, and implement a Consolidated Local Service Plan (CLSP) in accordance with Information Item I.

   b) Involve community stakeholders in developing the CLSP, monitoring its implementation, and updating as needed. At a minimum, the LMHA shall invite the stakeholder groups identified in Information Item I.

   c) Maintain, update, and implement a Local Provider Network Development Plan (LPND Plan) in accordance with Information Item I.

   d) Comply with 25 Texas Administrative Code (TAC) Chapter 412, Subchapter P (Provider Network Development) and applicable DSHS directives related to the development and implementation of the Provider Network Development Plan.

   e) Submit the CLSP and the LPND Plan to DSHS according to the Submission Calendar in Information Item S.

   f) Maintain a current version of the CLSP and the LPND Plan on the LMHA's website, with revision dates noted as appropriate for each plan revision.

   g) Annually post on the LMHA's website a list of persons with whom the local authority had a contract or agreement related to the provision of mental health services, except for peer providers. The list shall include the number of peer support contracts and agreements, but not the names of the peer support providers. The list shall include all contracts or agreements in effect during all or part of the previous year, or on the date the list is posted.

   h) Through its local board, appoint, charge and support one or more Planning and Network Advisory Committees (PNACs) necessary to perform the committee's advisory functions, as follows:
      (1) The PNAC shall be composed of at least nine members, 50 percent of whom shall be clients or family members of clients, including family members of children or adolescents, or another composition approved by DSHS;
      (2) PNAC members shall be objective and avoid even the appearance of conflicts of interest in performing the responsibilities of the committee;
      (3) Contractor shall establish outcomes and reporting requirements for each PNAC;
      (4) Contractor shall ensure all PNAC members receive initial and ongoing training and information necessary to achieve expected outcomes. Contractor shall ensure

that the PNAC receives training and information related to 25 TAC Chapter 412, Subchapter P (Provider Network Development) and that the PNAC is actively involved in the development of the LSAP, including the Provider Network Development Plan;

(5) Contractor shall ensure the PNAC has access to all information regarding total funds available through this Program Attachment for services in each program area and required performance targets and outcomes;

(6) Contractor shall ensure the PNAC receives a written copy of the final annual budget and biennial plan for each program area as approved by Contractor's Board of Trustees, and a written explanation of any variance from the PNAC's recommendations;

(7) Contractor shall ensure that the PNAC has access to and reports to Contractor's Board of Trustees at least quarterly on issues related to: the needs and priorities of the LSA; implementation of plans and contracts; and the PNAC's actions that respond to special assignments given to the PNAC by the local board;

(8) Contractor may develop alliances with other LMHAs to form regional PNACs; and

(9) Contractor may develop a combined mental health and mental retardation PNAC. If Contractor develops such a PNAC, the 50 percent client and family member representation shall consist of equal numbers of mental health and mental retardation clients and family members. Expanded membership may be necessary to ensure equal representation.

2. Policy Development and Management
   Contractor shall develop, implement, and update policies and procedures to address the needs of the LSA in accordance with state and federal laws and the requirements of this Program Attachment. Policies shall include consideration of public input, best value and client care issues.

3. Coordination of Service System with Community and DSHS
   Contractor shall:
   a) Adhere to DSHS directives related to Client Benefits Plan as described in Information Item H.

   b) Ensure coordination of services within the LSA. Such coordination shall ensure collaboration with other agencies, including other health and human service agencies, criminal justices entities, Substance Abuse Community Coalition Programs, Prevention Resource Centers, Outreach Screening Assessment and Referral organizations, other child-serving agencies (e.g., Texas Education Agency (TEA), Department of Family and Protective Services (DFPS), Texas Youth Commission (TYC), family advocacy organizations, local businesses, and community organizations. Evidence of the coordination of services shall be maintained. Evidence may include memorandums of agreement, memorandums of understanding, sign-in sheets from community strategic planning activities, or sign-in sheets from community-based focus group meetings.

c) In accordance with applicable rules, ensure that services are coordinated:
   (1) Among network providers; and
   (2) Between network providers and other persons necessary to establish and maintain continuity of services.

d) Designate a physician to act as the Medical Director and participate in medical leadership activities. Submit this staff person's contact information as part of Form S.

e) Ensure client has an appointment scheduled with a physician or designee authorized by law to prescribe needed medications, if the Continuing Care Plan, as defined in 25 TAC Chapter 412, Subchapter D, Mental Health Services – Admission, Continuity, and Discharge, indicates that the LMHA is responsible for providing or paying for psychotropic medications.

f) The appointment shall be on a date prior to the earlier of the following events:
   (1) The exhaustion of the client's supply of medications; or
   (2) The expiration of 14 days from the client's discharge or furlough from a State Mental Health Facility (SMHF).

g) Provide clients a choice among all eligible network providers in accordance with 25 TAC, Chapter 412, Subchapter P (Provider Network Development).

h) Operate a continuity of care and services program for offenders with mental impairments, in compliance with Texas Health & Safety Code Chapter 614, and the guidelines outlined in Information Item T. Contractor shall:
   (1) Assist Community Supervision and Corrections Department (CSCD) personnel with the coordination of supervision for offenders who are LMHA clients. This shall include:
      (a) Providing the local CSCD(s) with the name(s) of LMHA personnel who will serve as the contact(s) for continuity of care and services program referrals from the local CSCD(s);
      (b) Participating in joint staffing related to offenders who are LMHA clients in order to review compliance with treatment and supervision;
      (c) Providing input on modifications of supervision conditions;
      (d) Coordinating with CSCD personnel on imposing new conditions, sanctions and/or a motion to revoke/adjudicate in order to explore all possible alternatives to incarceration;
      (e) Coordinating on the development of a joint supervision and treatment plan if governing standards for the respective participants can be adhered to in the proposed plan; and
      (f) Participating in quarterly meetings with the CSCD Director(s) or her/his designee to review the implementation of activities related to the coordination of supervision.
   (2) Offer and provide technical assistance and training to the CSCD and other

criminal justice entities (pre-trial, jail, courts) on mental health and related issues;
(3) Assist criminal justice and judicial agencies with the identification, and diversion of offenders who have a history of state mental health care through a local continuity of care and services program.
(4) Review available records of each incarcerated individual who has been formally determined to be Incompetent to Stand Trial and assist criminal justice and judicial agencies with diversion of offenders through a local continuity of care and services program. Complete Form Z, Forensic Clearinghouse Waitlist Template, following submission guidelines in DSHS Submission Calendar.

i) Provide services to clients referred by the Texas Youth Commission, pursuant to Title 37, TAC, Chapter 87, Subchapter B, Special Needs Offender Programs, §87.79, Discharge of Mentally Ill and Mentally Retarded Youth.

j) Participate in Community Resource Coordination Groups (CRCGs) for children, youth, and adults in the LSA by providing one or more representatives to each CRCG with expertise in mental health, authority to contribute to decisions and recommendations of the CRCG, and with authority to contribute resources toward resolving problems of individuals needing agency services identified by the CRCG. Participation is required by Texas Government Code §531.055, and duties shall be performed in accordance with Information Item M (Memorandum of Understanding for Coordinated Services to Persons Needing Services from More Than One Agency, revised March 2006).

k) Cooperate with TEA in individual transition planning for child and adult clients receiving special education services, in accordance with 34 CFR part 300 (Assistance to States for the Education of Children with Disabilities).

l) Establish and maintain a continuum of care for children transitioning from the Early Childhood Intervention (ECI) program into children's mental health services described in the Children's Services Attachment, including making best efforts to:
(1) Respond to referrals from ECI programs;
(2) Verify eligibility for mental health services;
(3) Inform the family about the available mental health services, service charges, and funding options such as Medicaid and Children's Health Insurance Program (CHIP);
(4) Participate in transition planning no later than 90 days prior to the child's third birthday;
(5) Assist in the development of a written transition plan to ensure continuity of care;
(6) Support joint training and technical assistance plans to enhance the skills and knowledge base of providers; and
(7) Submit local agency disputes that are not resolved in a reasonable time period (i.e., not to exceed 45 days unless the involved parties agree otherwise) to the ECI or DSHS Mental Health Program Services Unit for resolution at the state level.

m) Designate a staff member to act as Contractor's Suicide Prevention Coordinator, and submit as part of Form S, this staff member's contact information. Contractor's Suicide Prevention Coordinator shall work collaboratively with local staff, LMHA suicide prevention staff statewide, and DSHS's Suicide Prevention Office to reduce suicide deaths and attempts by:
   (1) Developing a collaborative relationship with any existing local suicide prevention coalition;
   (2) Participating in Suicide Prevention Coordinator conference calls scheduled and facilitated by DSHS Suicide Prevention Officer;
   (3) Participating in the development of the local Community Suicide Postvention Protocols as described by the Center for Disease Control Postvention Guideline;
   (4) Participating in the implementation of the local Community Suicide Postvention Protocols when indicated; and
   (5) Participating in local community suicide prevention efforts.

4. Resource Development and Management
   Contractor shall:
   a) Identify and create opportunities, including grant development, to make additional resources available to the LSA.

   b) Optimize earned revenues and maximize dollars available to provide services, which shall include implementing strategies to minimize overhead and administrative costs and achieve purchasing efficiencies. Strategies that an LMHA shall consider in achieving this objective include joint efforts with other local authorities on planning, administrative, purchasing and procurement, other authority functions, and service delivery activities.

   c) Assemble and maintain a network of service providers and serve as a provider of services as set forth in 25 TAC, Chapter 412, Subchapter P (Provider Network Development). In assembling the network, the LMHA shall seek to offer clients a choice of qualified providers to the maximum extent possible.

   d) Award subcontracts in accordance with applicable laws and 25 TAC Chapter 412, Subchapter B (Contracts Management for Local Authorities) and Subchapter P (Provider Network Development).

   e) Ensure providers are informed of and in compliance with the applicable terms and conditions of this Program Attachment by developing provider contracts which include the Program Attachment requirements.

   f) Implement network management practices to promote the effectiveness and stability of the provider network, including a credentialing and re-credentialing process that requires external providers to meet the same professional qualifications as internal providers.

g) Implement a provider relations process to provide the support and resources necessary for maintaining an available and appropriate provider network that meets DSHS standards, including:
   (1) Distributing information to providers on an ongoing basis to inform them of DSHS requirements;
   (2) Informing providers of available training and other resources;
   (3) Interpreting contract provisions and clarifying policies and procedures;
   (4) Assisting providers in accessing the information or department they need;
   (5) Resolving payment and other operational issues; and
   (6) Resolving provider grievances and disputes.

h) Ensure the providers are monitored and contracts are enforced in accordance with applicable laws and 25 TAC Chapter 412, Subchapter B.

5. Resource Allocation and Management:
   Contractor shall:
   a) Maintain an administrative and fiscal structure that separates local authority and provider functions.

   b) Maintain a Utilization Management (UM) Committee that includes the following Contractor staff:
      (1) The UM physician;
      (2) UM staff representative;
      (3) Quality management staff representative; and
      (4) Fiscal/financial services staff representative.

   c) Ensure that UM complies with the following for each position listed:
      (1) A qualified UM physician who:
         (a) Is a board eligible or board certified psychiatrist;
         (b) Is licensed to practice medicine in the State of Texas; and
         (c) Provides oversight of the UM program's design and implementation.
      (2) A qualified utilization manager who is licensed to practice in the State of Texas as a:
         (a) Registered nurse or a registered nurse-advance practice nurse;
         (b) Physician assistant;
         (c) Licensed clinical social worker;
         (d) Licensed professional counselor;
         (e) Licensed doctoral level psychologist; or
         (f) Licensed marriage and family therapist.
      (3) Has a minimum of five years experience in direct care of individuals with a serious mental illness and/or children and adolescents with serious emotional disturbances, which may include experience in an acute care or crisis setting;
      (4) Has a demonstrated understanding of psychopharmacology and medical/psychiatric comorbidity through training and/or experience;
      (5) Has one year experience in program oversight of mental health care services; and

(6) Has demonstrated competence in performing UM and review activities.

d) If Contractor delegates UM activities to other staff the following requirements shall be met:
   (1) The UM Director must:
      (a) Be licensed to practice in the State of Texas as a:
         i. Registered nurse or a registered nurse-advance practice nurse;
         ii. Physician assistant;
         iii. Licensed clinical social worker;
         iv. Licensed professional counselor;
         v. Licensed doctoral level psychologist; or
         vi. Licensed marriage and family therapist.
      (b) Have a minimum of three years experience in the treatment of individuals with mental illness or chemical dependency; or
      (c) If the UM Director is not licensed, she/he can oversee the UM Program administratively but not clinically. Clinical oversight must be conducted by an LPHA.
   (2) A Utilization Reviewer or Utilization Care Manager, who is a Qualified Mental Health Professional Community Services (QMHP-CS), shall have at least three years experience in direct care for adults with serious mental illness or children and adolescents with serious emotional disturbances, and directly supervised by a qualified utilization manager.

e) Ensure that UM job functions are included in each UM staff member's job description and documentation of licenses, training, and supervision maintained in the staff member's signed and approved personnel record.

f) Ensure that the UM Committee meets at least quarterly to ensure effective management of clinical resources, fiscal resources, and the efficiency and ongoing improvement of the UM process. Contractor shall ensure and document that members of the UM Committee receive appropriate training to fulfill the responsibilities of the committee. Training is needed when a new member is added to the committee and as needed, at least annually, for the entire committee. Documentation of training contents may be included in committee minutes. The committee shall review:
   (1) Appropriateness of eligibility determinations;
   (2) Use of exceptions and overrides to service authorization ensuring rationale is clinically appropriate and documented in the administrative and clinical record;
   (3) Over and under utilization;
   (4) Appeals and denials;
   (5) Fairness and equity; and
   (6) Cost-effectiveness of all services provided.

g) Implement a UM Program using DSHS's approved UM Guidelines that includes documented and approved processes and procedures for:

(1) Authorization and reauthorization of level of care for outpatient services;
(2) Authorization of inpatient admissions to state hospitals and to community psychiatric hospitals and reauthorization for continued stay when general revenue allocation or local match funding is being used for all or part of that hospitalization;
(3) Verification and documentation that services provided are medically necessary;
(4) The role for UM in ensuring continuity and coordination of services among multiple mental health community service providers;
(5) A timely authorization system designed to ensure medically necessary services are delivered without delay and after requested services have been authorized (backdating of authorizations is not permissible). Crisis services do not require prior authorization; however, the authorization shall be completed within two business days after the provision of the crisis intervention service;
(6) Automatic authorization processes shall be based on a documented agreement with providers that only allows automatic authorization if the level of care recommended is the same as the level of care to be authorized, and only with providers who have documented competence in assessment using the Uniform Assessment (UA);
(7) Timely notification of clients and providers of the authorization determinations;
(8) A timely and objective appeal process in accordance with 25 TAC §401.464 and for Medicaid recipients, in accordance with 25 TAC §412.313(b) (2) (c), and Information Item Q procedures to give notice of fair hearings; and
(9) Maintaining documentation on appeals.

h) Each biennium, review and update the quality management plan that includes the UM Program Plan and ensure that the plan includes a description of:
(1) Requirements relating to the UM Committee credentials, meetings, and training;
(2) How the UM Program's effectiveness in meeting goals shall be evaluated;
(3) How improvements shall be made on a regular basis;
(4) How the content of Items I. A. 5. c) – e) in this Program Attachment are addressed and included as a part of the UM Program Plan; and
(5) The oversight and control mechanisms to ensure that UM activities meet required standards when they are delegated to an administrative services organization or a DSHS-approved entity.

i) Contractor shall comply with the DSHS Resiliency and Disease Management Waiting List Maintenance requirements for all individuals who have requested mental health services from Contractor that Contractor anticipates will not be available upon request for such services:
(1) Initial Intake and Placement on Waiting Lists – Contractor shall develop and ensure the implementation of procedures to triage and prioritize service needs of individuals determined eligible for a service package but for which Contractor has reached or exceeded its capacity to provide the service package. These procedures shall include a process for the assessment of an individual's urgency of needs using the Texas Recommended Assessment Guidelines and a requirement that

they be placed immediately on a waiting list for the unavailable service packages for which they are determined to be eligible. The waiting list shall include individuals who are underserved due to resource limitations as well as those who have been authorized for level of care (LOC) – 8 waiting for all services. Individuals with Medicaid entitlement or whose assessment indicates a need for LOC 0-crisis services shall not be placed on a waiting list. All medically necessary services shall be provided in timeframes specified by DSHS. Clients with Medicaid who are determined to be in need of Case Management and/or Medicaid Mental Health Rehabilitative Services shall be authorized for a Level of Care that meets their needs and shall not be underserved or placed on the waiting list. If an individual is determined to have an urgent need for services (e.g. use of crisis services), they shall be given priority to enter ongoing services.

(2) Specific Requirements for Medicaid Recipients –

i. General - Contractor shall deliver services to an individual who is a Medicaid recipient and has an identified need for Targeted Case Management or Mental Health Rehabilitative Services, and such an individual shall not be put on the waiting list. Individuals who were assessed to need Targeted Case Management or Mental Health Rehabilitative Services but did not become Medicaid eligible until after they were placed on the waiting list may not remain on a waiting list for longer than 60 calendar days. The date of eligibility will be the Medicaid Certification date or the Medicaid Effective date, whichever is later. A person who declines all services from Contractor may be taken off the waiting list.

ii. Mental Health Rehabilitative and Mental Health Targeted Case Management Services (both Intensive and Routine) - Medicaid recipients who are eligible for full Medicaid benefits shall not be placed on a waiting list for medically necessary Targeted Case Management or Mental Health Rehabilitative Services. Contractor shall make these services available to the individual whenever such services are indicated by the uniform assessment and in accordance with the Utilization Management guidelines. If the Uniform Assessment process recommends that an individual receive a service package that includes one or both of these services and a Licensed Practitioner of the Healing Arts (LPHA) determines that the service or services are not medically necessary, the LPHA shall document the reasons that the service is not indicated.

iii. Other Medicaid Mental Health Services - For Medicaid recipients who are eligible for full Medicaid benefits and have an identified need for medically necessary mental health services other than Mental Health Rehabilitative Services and Targeted Case Management (such as counseling or physician's services), Contractor shall remove them from the waiting list and provide these services to the individual or refer the individual to other local Medicaid providers. Contractor shall provide assistance with the referral if requested by the client. Contractor shall document actions taken on behalf of the client.

If Contractor lacks the capacity to deliver the services and no qualified local Medicaid provider is available, Contractor shall identify the nearest qualified Medicaid provider of the needed service or services. If the distance to the nearest available non-local (more than 75 miles from the individual's residence) provider is not, in the individual's opinion, a barrier to the individual accessing services, then Contractor shall refer the individual to the available service provider. Contractor shall document the discussion with the individual and the individual's decision regarding traveling to the non-local provider.

Contractor may place an individual on a waiting list for the needed service only if Contractor lacks the capacity to provide the needed service and there are no other internal or external qualified or accessible providers available to deliver the needed service. In such cases, Contractor shall review the availability of the service monthly in order to ensure that the individual receives the needed service once it becomes available. Contractor shall document the steps taken in the client file.

iv. Policies and Procedures for Waiting List Management – Contractor shall develop and maintain written policies and procedures that ensure that individuals who are already on a waiting list and subsequently establish Medicaid eligibility are identified, removed from the waiting list, and provided services as indicated and in accordance with subsections 2.ii and 2.iii above.

(3) Contractor shall assess clients on the waiting list using the Adult or Child Adolescent Uniform Assessment including the TRAG at least annually.

(4) Monitoring and Maintenance Requirements

(a) Frequency of Monitoring:

i. Contractor shall ensure that individuals on the waiting list(s) who have an LOC-A 8 (waiting for all services) with an LOC-R of Adult Service Packages 3 or 4 and all children on the waiting list are monitored at least once every 30 days from the date of placement on the waiting list to determine the continued need. Contractor shall ensure that individuals on the Waiting List(s) who have an LOC-A 8 (waiting for all services) with an LOC-R of Adult Service Packages 1 or 2 are monitored at least once every 90 days from the date of placement on the waiting list to determine the continued need. This monitoring shall be conducted by a QMHP-CS and shall include a brief clinical screening to determine the current urgency of need.

ii. Contractor shall remove individuals placed on the waiting list when the individual begins to receive the recommended service package, or no longer wants services. Except as described above, Contractor shall allow individuals who seek services to remain on the waiting list if the service need continues to be indicated and the individual desires to remain on the waiting list.

iii. If the client is not able to be contacted during the 30 day period for all Children on the waiting list and Adults with LOC-R of 3 or 4, or during the 90 day period for Adults with LOC-R of 1 or 2, Contractor shall document good faith efforts to contact that person or his/her legally authorized representative (LAR) to determine the continued need for services. Good faith efforts are defined as two or more attempts to contact the client, collateral or LAR regarding service needs. (A "collateral" or "collateral contact" is a source of information that is knowledgeable about the consumer or the consumer's life situation and serves to support or augment the available information relating to a consumer or the consumers needs. Possible collateral contacts include, but are not limited to past or present landlords, employers, school officials, neighbors, teachers, day care providers, and friends. One effort to contact must be in the form of a letter.) Other efforts may be phone calls or letters to client's home, job-site, or school. The QMHP-CS may want to review the CARE system for designated collateral contacts who may assist in locating clients. Contacts with collaterals are subject to DSHS confidentiality requirements. Based on the information gathered, the waiting list data shall be updated. If the client has not been contacted after a good faith effort has been made, the client may be removed from the waiting list. However, the client shall not be removed from the waiting list until at least 30 days after the preceding contact.

(b) Individuals who have limited financial resources
   i. Contractor shall demonstrate that individuals who are placed on the waiting list for medically necessary services receive a screening for benefits assistance in accordance with Section 3.05 of the General Provisions for DSHS Mental Health contracts.
   ii. Contractor shall notify its UM staff of dates relevant to each application (filed by or on behalf of a consumer screened or served by Contractor) for medical or other public assistance. For a Medicaid application, such dates include at a minimum, the date which benefits begin (known as the "effective" date) and the date of notification of benefit (known as the "certification" date).

(c) Waiting List Manual – Contractor shall implement processes defined in the most current version of the Waiting List Maintenance Manual contained in Information Item R.

6. Oversight of Authority and Provider Functions
   Contractor shall:
   a) Objectively monitor and evaluate service delivery and provider performance including providing oversight information to Contractor's Board.

   b) Ensure that each provider's non-compliance is corrected.

c) Require providers to use at least a Level One certified sign language interpreter and to use a Level Three certified sign language interpreter, if available, for persons with hearing impairments.

d) Assist in the completion of Mental Health Adult Client or Child and Family surveys as required by DSHS.

e) Implement a Quality Management Program that includes:
   (1) A structure that ensures the program is implemented system-wide including the involvement of stakeholders;
   (2) Allocation of adequate resources for implementation;
   (3) Oversight by staff members with adequate and appropriate experience in quality management;
   (4) Activities and processes that address identified clinical and organizational problems including data integrity and the processes to evaluate and continuously improve data accuracy;
   (5) An established set of remedies and timeline options for areas that need improvement or correction;
   (6) Routine reporting of Quality Management Program activities to its governing body, providers, other appropriate organizational staff members, and community stakeholders;
   (7) Consistent analysis of grievance, appeal, fair hearings, and expedited hearings, mortality, and incident/accident data as part of the Quality Management process;
   (8) Measuring, assessing, and improving Contractor's local authority functions;
   (9) Processes to systematically monitor, analyze, and improve performance of quality management activities, administrative services, client services and outcomes for individuals;
   (10) A biennial update of the Quality Management Plan approved by the governing board;
   (11) Review of provider treatment to determine whether it is consistent with DSHS' approved evidence-based practices, accuracy of assessments, and treatment planning;
   (12) Ongoing monitoring of the quality of access to services, service delivery, and continuity of services;
   (13) Provision of technical assistance to providers related to quality oversight necessary to improve the quality and accountability of provider services;
   (14) Use of reports and data from DSHS to inform performance improvement activities and assessment of unmet needs of individuals, service delivery problems, and effectiveness of authority functions for the LSA;
   (15) Oversight of all services, contracts, and subcontractors, regardless of the amount of funding;
   (16) Oversight to ensure compliance with and the quality of the resiliency and disease management practices to include monitoring fidelity to the service models defined by DSHS and requiring providers to participate in oversight;

(17) Mechanisms to measure, assess, and reduce incidents of client abuse, neglect and exploitation and improving the client rights protection processes;
(18) Risk Management processes such as competency determinations and the management and reporting of incidents and deaths;
(19) Coordination of activities and information with the UM Program including participation in UM oversight activities as defined and scheduled by DSHS, including but not limited to submitting data and supporting documentation, performance and submitting results of self-audits, and participating in DSHS onsite reviews; and
(20) Oversight of new initiatives such as Crisis Redesign, Local Provider Network Development, Jail Diversion, and Outpatient Competency Restoration.

f) Ensure all providers are implementing Resiliency and Disease Management, as specified by DSHS and providing evidence-based practices in accordance with the Fidelity Manual. Providers who do not meet adequate implementation shall submit a Plan of Improvement (POI) for identified problems and meet the following standards:
(1) Within five business days after receipt of a request from DSHS, develop a POI that adequately addresses the correction of any critical health, safety, rights, abuse and neglect issues identified by DSHS, and that includes a description of local oversight activities to monitor and maintain the correction of the identified problem, and submit to DSHS for approval; and
(2) Within 14 business days after receipt of a request from DSHS, develop a POI that adequately addresses the correction of organizational, clinical or compliance problems identified by DSHS during oversight activities and that includes a description of local oversight activities to monitor and maintain the improvement of the identified problem, and submit to DSHS for approval in accordance with the Submission Calendar.

g) If applicable, submit to DSHS evidence of initial or continued accreditation by a national accreditation organization (e.g., American Association of Suicidology, Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), and The Council on Quality and Leadership (CQL)), in accordance with the Submission Calendar. The submission shall include the accreditation review report and any plan of improvement created by Contractor in response to the accreditation review report.

h) Ensure that Contractor's buildings and associated properties are compliant with the Texas Accessibility Standards (TAS), Texas Health and Safety Code, Texas Department of Licensing and Regulation requirements, and Texas Fire Code or the International Fire Code.

i) Ensure that Contractor's Americans with Disabilities Act (ADA) Self-Evaluation and Transition Plan (ADA Plan) is reviewed by Contractor at least annually and updated as necessary, and ensure that the following information is posted prominently at each service location:
(1) The name, address, telephone number, TDD telephone number, fax number and e-mail address of the ADA and the Rehabilitation Act of 1973 Coordinator(s);

(2) The location at which the ADA Plan may be viewed; and
(3) The process for requesting and obtaining copies of the ADA Plan.

B. Adult Services

1. Community Services
   a) Contractor shall provide the community-based services outlined in Health and Safety Code Chapter 534, §534.053, which are incorporated into services defined in Information Item G.
   b) Contractor shall establish a reasonable standard charge for each service containing an asterisk (i.e., *) in Information Item G.

2. Populations Served
   a) Adult Mental Health (MH) Priority Population - Adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.

   b) Adult MH Target Population - Adults who have a diagnosis of schizophrenia, bipolar disorder, and severe major depression.

   c) Initial Eligibility:
      (1) An individual age 18 or older who has a diagnosis of:
         (a) schizophrenia as defined in the following Diagnostic and Statistical Manual, Fourth Edition - Text Revision (DSM-IV TR) diagnostic codes: 295.10, 295.20, 295.30, 295.40, 295.60, 295.70, 295.90.
         (b) bi-polar disorder as defined in the following DSM-IV TR diagnostic codes: 296.00, 296.01, 296.02, 296.03, 296.04, 296.05, 296.06, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56, 296.60, 296.61, 296.62, 296.63, 296.64, 296.65, 296.66, 296.7, 296.80, 296.89.
         (c) major depression as defined in the following DSM-IV TR diagnostic codes : 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, and 296.36; with a Global Assessment of Functioning (GAF) of 50 or below at intake.
      (2) An individual age 18 or older who has a diagnosis other than those listed in I.B.2.c.1. and whose current Global Assessment of Functioning (GAF) is 50 or less and needs on-going MH services; or
      (3) An individual age 18 or older who was served in children's MH services and meets the children's MH priority population definition prior to turning 18 is considered eligible for one year.

   d) Individuals with only the following diagnoses are excluded from this provision:
      (1) Substance Abuse as defined in the following DSM-IV TR diagnostic codes: 291.0, 291.1, 291.2, 291.3, 291.5, 291.81, 291.89, 291.9, 292.0, 292.11, 292.12,

292.81, 292.82, 292.83, 292.84, 292.89, 292.9, 303.00, 303.90, 304.00, 304.10, 304.20, 304.30, 304.40, 304.50, 304.60, 304.80, 305.00, 305.1, 305.20, 305.30, 305.40, 305.50, 305.60, 305.70, 305.90.

(2) Mental Retardation as defined in the following DSM-IV TR diagnostic codes: 317, 318.0, 318.1, 318.2, 319.

(3) Pervasive Developmental Disorder as defined in the following DSM-IV TR diagnostic codes: 299.00, 299.10, 299.80.

e) Service Determination:

(1) In determining services to be provided to the priority and target populations, the choice of and admission to medically necessary services is determined jointly by the individual seeking service and Contractor.

(2) Criteria used to make these determinations are the recommended LOC (LOC-R) of the individual as derived from the UA, the needs of the individual, Utilization Management (UM) Guidelines, and the availability of resources. Clients authorized for care by Contractor through a clinical override are eligible for the duration of the authorization.

f) Continued Eligibility for Services:

(1) Reassessment by the provider and reauthorization of services by Contractor determines continued need for services. This activity is completed according to the UA protocols and UM Guidelines.

(2) Assignment of diagnosis in CARE is required at any time the Axis I diagnosis changes and at least annually from the last diagnosis entered into CARE.

(3) The LPHA's determination of diagnosis shall include a face-to-face interview with the individual.

(4) Eligibility for clients whose diagnosis is Major Depression includes a GAF of 50 or below at intake only. Changes in GAF scores after the initial eligibility determination do not make clients ineligible.

g) Documentation Required*:*

In order to assign a diagnosis across all 5 axes to an individual, documentation of the required diagnostic criteria, according to DSM-IV TR, as well as the specific justification of GAF score, shall be included in the client record. This information shall be included as a part of the required assessment information.

h) UA Requirements:

(1) The DSHS-approved UA for Adults includes the following instruments:

(a) Texas Recommended Assessment Guidelines (TRAG);

(b) Diagnosis-Specific Clinical Rating Scales; and

(c) Community Data.

(2) The above instruments are required to be completed once an individual has been screened and determined in need of assessment by Contractor. The initial assessment is the clinical process of obtaining and evaluating historical, social,

functional, psychiatric, developmental or other information from the individual seeking services in order to determine specific treatment and support needs.

(3) Staff administering the instruments must have documented training in the use of the instruments and must be a QMHP-CS, with the exception of the Diagnosis-Specific Clinical Rating Scales which may be administered by a QMHP-CS or Licensed Vocational Nurse (LVN);

(4) The UA shall be administered according to the timeframes delineated in Information Item C at http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm.

i) Assessments in CARE:
Information shall be submitted through WebCARE or through an approved batch process to the CARE system according to the timeframes established by DSHS.

3. Service Requirements
Contractor shall:

a) Comply with UA requirements for adults in accordance with Section I.B.8. The UA is not required for individuals whose services are not funded with funds paid to Contractor under this Program Attachment;

b) Implement a Patient and Family Education Program (PFEP) in accordance with psychosocial treatment recommendations and information for patient/family education available at: http://www.dshs.state.tx.us/Mental-Health/. Recommendations and information related to medications used to treat mental illness may be found at the following website: http://www.nimh.nih.gov/health/publications/mental-health-medications/complete-index.shtml. If clients and/or their families and caregivers have not been educated about their diagnosis, the reason for the lack of education shall be documented in the clinical progress note.

c) Implement Resiliency and Disease Management (RDM) and apply to all clients whose services are funded with Program Attachment funds:

(1) Develop a service delivery system in accordance with the most current version of DSHS's UM Guidelines, Adult TRAG and Fidelity Instruments;

(2) Ensure that each adult who is identified as being potentially in need of services is screened to determine if services may be warranted;

(3) Ensure that clients seeking services are assessed to determine if they meet the requirements of priority population and if so, a full assessment is conducted and documented using the most current version of the DSHS UA instruments. Individuals whose services are not funded with contract funds are exempt from inclusion in RDM regardless of priority population status;

(4) Make available to each client recommended and authorized for a LOC, as indicated by the TRAG, all services and supports within the authorized LOC (LOC-A):

(a) If a non-Medicaid eligible individual cannot be served in the recommended LOC, or if the individual refuses the recommended LOC, individual may be served at the next most appropriate LOC. If no services are available at the

next most appropriate LOC, the non-Medicaid eligible individual shall be placed and monitored on a waiting list;

(b) Medicaid-eligible individuals may not have services denied, reduced, suspended, or terminated due to lack of available resources; and

(c) If a Medicaid-eligible individual refuses the recommended LOC, the individual may be served at the next most appropriate LOC as long as the services within that LOC are appropriate and medically necessary to address the individual's mental illness.

(5) Ensure Medicaid-eligible individuals are provided with any medically necessary Medicaid-funded MH services within the recommended LOC without undue delay;

(6) Ensure that Cognitive-Behavioral Therapy is provided by an LPHA, practicing within the scope of a license, or when appropriate and not in conflict with billing requirements, by an individual with a master's degree in a human services field (e.g., psychology, social work, counseling) who is pursuing licensure under the direct supervision of an LPHA;

(7) Ensure that providers of services and supports within RDM are trained in the DSHS-approved evidence-based practices prior to the provision of these services and supports. DSHS-approved evidence-based practices are:

(a) Assertive Community Treatment: Dartmouth Assertive Community Treatment;

(b) Counseling: Cognitive Behavioral Therapy;

(c) Psychosocial Rehabilitation: SAMHSA Illness Management and Recovery;

(d) Supported Employment: Dartmouth Psychiatric Research Center – Individual; Placement and Support or SAMHSA Supported Employment; and

(e) Supported Housing: SAMHSA Permanent Supported Housing..

(8) Ensure that supervisors of services and supports within RDM are trained as trainers in the DSHS-approved evidence-based practices or have provided the evidence–based practices prior to the supervision of the evidence-based practices;

(9) Use the uniform assessment and other relevant clinical information to document the assessment of individuals seeking services and to reassess current clients in services when update assessments are due or significant changes in functioning occur, to determine the recommended LOC for a client;

(10) Utilize information from the TRAG and other relevant clinical information to:

(a) Recommend a LOC;

(b) Determine whether the client should be transferred to another provider; and

(c) Determine if a client should be discharged from services.

(11) Use the flexible funds that shall be made available by Contractor, in accordance with the UM Guidelines;

(12) Assertive Community Treatment (ACT) includes Urban ACT and Rural ACT programs serving clients with an LOC-R = 4. The baseline of numbers of individuals who need ACT services for Urban ACT and Rural ACT shall be determined by data reports based on the combined average number of clients with an LOC-R = 4 over the last two quarters of FY2010 and the first two quarters of FY2011. The Urban ACT team serves a client base of 60 or more within a local

service area or has a population density of 300 or more persons per square mile in the local service area. The Rural ACT team serves a client base of less than 60 within a local service area. ACT services provided by Contractor shall meet the minimum UM Guidelines for Service Package 4, and shall follow the most current Urban ACT or Rural ACT services Fidelity Instrument, as well as, the rules and guidelines for Urban ACT or Rural ACT;

(13) Contractor shall serve individuals with monies allocated through Crisis Redesign, for engagement, transition, and intensive ongoing services in accordance with UM Guidelines. CARE Report III shall be completed in accordance with Information Item D and submission timelines as outlined in Information Item S. Performance measures are outlined in Section II. G.; and

(14) Maintain access to WebCARE even if it utilizes an approved batch process.

d) Submit encounter data for all services according to the procedures, instructions and schedule established by DSHS, including all required data fields and values in the current version of the DSHS Community Mental Health Service Array. The current version of DSHS Community Mental Health Service Array (i.e., Report Name: INFO Mental Health Service Array Combined) can be found in the Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW), in the General Warehouse Information, Specifications subfolder.

e) Comply with the following Medicaid-related items:
   (1) Contract with DSHS to be a provider of Medicaid MH Rehabilitative Services;
   (2) Contract with DSHS to be a provider of Medicaid MH Case Management and with Health and Human Services Commission (HHSC) to participate in Medicaid Administrative Claiming;
   (3) Recognize that funding earned through billings to Texas Medicaid and Healthcare Partnership (TMHP) for Medicaid MH Case Management and Medicaid MH Rehabilitative Services represents the federal share and the State match; and
   (4) Submit billing for the provision of Medicaid MH Case Management and Medicaid MH Rehabilitative Services to TMHP.

f) Utilize non-contract funds and other funding sources (e.g., any person or entity who has the legal responsibility for paying all or part of the services provided, including commercial health or liability insurance carriers, Medicaid, or other Federal, State, local, and private funding sources) whenever possible to maximize Contractor's financial resources. This includes:
   (1) Enroll in the CHIP and bill CHIP for services covered under that plan;
   (2) Become a Medicaid provider and bill Medicaid for services covered under that plan;
   (3) Provide assistance to individuals to enroll in such programs when the screening process indicates possible eligibility for such programs;
   (4) Comply with the Charges for Community Services Rule as set forth in Title 25, Part 1, Chapter 412, Subchapter C of the Texas Administrative Code to maximize reimbursement from individuals with an ability to pay for services provided;

(5) Bill all other funding sources for services provided under this Contract before submitting any request for reimbursement to DSHS; and
(6) Provide all billing functions at no cost to the client.

g) Provide services to all clients without regard to the client's history of arrest, charge, fine, indictment, incarceration, sentence, conviction, probation, deferred adjudication, or community supervision for a criminal offense.

h) Develop and implement written procedures to identify clients with Co-Occurring Psychiatric and Substance Use Disorders (COPSD), identify available resources, provide referrals and continuity of care for ongoing services as necessary to address the client's unmet substance use treatment needs in accordance with 25 TAC, Chapter 411, Subchapter N. Nothing herein shall prohibit a physician from considering a client's substance use in prescribing medications.

i) Conduct all initial and on-going diagnostic assessments face-to-face or by televideo with the individual to determine priority population eligibility.

j) Submit financial data regarding co-pays, deductibles, and premiums related to Medicare Part D or other information related to expenditures for medications as requested by DSHS and in the form and format prescribed by DSHS.

k) Implement crisis services in compliance with the standards outlined in Information Item V.

l) Submit encounter data on Pre-Admission Screening and Resident Review (PASRR) individuals in accordance with Information Item O. Complete and submit Form O in accordance with the instructions set forth in Information Item O.

C. Children's Services

1. Community Services
   a) Contractor shall provide the community-based services outlined in Health and Safety Code Chapter 534, § 534.053, which are incorporated into services defined in Information Item G.

   b) Contractor shall establish a reasonable standard charge for each service containing an asterisk (i.e., *) in Information Item G.

2. Populations Served
   a) Child and Adolescent Mental Health (MH) Priority Population – children ages 3 through 17 with a diagnosis of mental illness (excluding a single diagnosis of substance abuse, mental retardation, autism or pervasive development disorder) who exhibit serious emotional, behavioral or mental disorders and who:
   (1) Have a serious functional impairment; or

(2) Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or
(3) Are enrolled in a school system's special education program because of serious emotional disturbance.

b) Age Limitations:
(1) Children under the age of three who have a diagnosed physical or mental condition are to be served through the Early Childhood Intervention (ECI) program;
(2) Youth 17 years old and younger must be screened for CMH services. Youth 18 years or older must be screened for Adult Mental Health services; and
(3) Clients receiving Children's MH Services who are approaching their 18th birthday and continue to be in need of services shall either be transferred to Adult MH Services or referred to another community provider, dependent upon the individual's needs. Children reaching 18 years of age who continue to need services may be transferred to Adult MH Services without meeting the adult target population and served for up to one additional year.

c) Service Determination:
(1) In determining services and supports to be provided to the child and family, the choice of and admission to medically necessary services and supports are determined jointly by the child and family seeking services and supports and by Contractor;
(2) Criteria used to make these determinations are from the recommended LOC (LOC-R) of the individual as derived from the Uniform Assessment (UA), the needs of the individual, utilization management guidelines and the availability of resources;
(3) The Global Assessment of Functioning (GAF) is not used to determine eligibility for services; and
(4) Clients authorized for care by Contractor through a clinical override are eligible for the duration of the authorization.

d) Continued Eligibility for Services:
(1) Reassessment by the provider and reauthorization of services by Contractor determines continued need for services. This activity is completed according to the UA protocols and Utilization Management (UM) Guidelines;
(2) Assignment of diagnosis in CARE is required at any time the Axis I diagnosis changes and at least annually from the last diagnosis entered into CARE; and
(3) The LPHA's determination of diagnosis shall include a face-to-face or televideo interview with the individual.

e) Documentation required:
In order to assign a diagnosis across all 5 axes to an individual, documentation of the required diagnostic criteria, according to the Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR), as well as the specific justification of

GAF score, shall be included in the client record. This information shall be included as part of the required assessment information.

f) UA requirements:
DSHS-approved UA for children and adolescents includes the following instruments:
(1) Child/Adolescent Texas Recommended Assessment Guidelines (CA-TRAG); and
(2) Community Data;
   (a) The above instruments are required to be completed once an individual has been screened and determined in need of assessment from Contractor. The initial assessment is the clinical process of obtaining and evaluating historical, social, functional, psychiatric, developmental or other information from the individual seeking services in order to determine specific treatment and support needs.
   (b) Staff administering the instruments shall be a QMHP-CS and have documented training in the use of the instruments.
   (c) The UA shall be administered according to the timeframes delineated in Information Item C located at http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm.
   (d) Assessments in CARE: Information shall be submitted through WebCARE or through an approved batch process to the CARE system according to the timeframes established by DSHS.

3. Service Requirements
Contractor shall:
a) Comply with UA requirements for children in accordance with Section I.B.6. The UA is not required for individuals whose services are not funded with funds paid to Contractor under this Program Attachment.

b) Children's MH case managers can access and use http://www.hhs.state.tx.us/tirn/tirnhome.shtml as required in Texas Government Code (TGC) §531.0244.

c) Provide PFEP in accordance with the guidelines available from SAMHSA (located at http://www.nimh.nih.gov/health/publications/mental-health-medications/complete-index.shtml) or alternative guidelines approved by DSHS, on a schedule determined by DSHS. If clients and/ or their families and caregivers have not been educated about their diagnosis, the reason for the lack of education shall be documented in the clinical progress note.

d) Apply RDM to all client services funded with contract funds in accordance with the following standards:
(1) Provide services in accordance with the most current version of DSHS' Resiliency and Disease Management UM Guidelines, CA-TRAG, Fidelity Instruments, and Information Item V (for Crisis Services);

(2) Each child or adolescent who is identified as being potentially in need of services shall be screened to determine if services may be warranted;
(3) Children and adolescents seeking services are assessed to determine if they meet the requirements of priority population and if so, a full assessment shall be conducted and documented using the most current version of the DSHS UA instruments, including the CA-TRAG. Individuals whose services are not funded with Program Attachment funds are exempt from inclusion in RDM regardless of priority population status;
(4) Make available to each client recommended and authorized for a LOC, as indicated by the CA-TRAG, all services and supports within the authorized LOC (LOC-A);
    (a) If a non-Medicaid eligible child or adolescent cannot be served in the recommended LOC (or if the child, adolescent, or the LAR of the child or adolescent refuses the recommended LOC), the child or adolescent may be served at the next most appropriate LOC. If no services are available at the next most appropriate LOC, the non-Medicaid eligible child or adolescent shall be placed and monitored on a waiting list;
    (b) Medicaid-eligible children and adolescents may not have services denied, reduced, suspended, or terminated due to lack of available resources; and
    (c) If a Medicaid-eligible child, adolescent or the LAR of a child or adolescent refuses the recommended LOC, the child or adolescent may be served at the next most appropriate LOC as long as the services within that LOC are appropriate and medically necessary to address the child or adolescent's emotional disturbance. The LOC should not be reduced if the child, adolescent, or LAR refuses family partner services or family support groups only;
(5) Medicaid-eligible children and adolescents shall be provided with any medically necessary Medicaid-funded MH services within the recommended LOC without undue delay;
(6) Counseling services shall be provided by an LPHA, practicing within the scope of a license, or when appropriate and not in conflict with billing requirements, by an individual with a masters degree in human services field (e.g., psychology, social work, counseling) who is pursuing licensure under the direct supervision of an LPHA;
(7) Providers of services and supports within RDM shall be trained in the DSHS-approved evidence-based practices prior to the provision of these services and supports. DSHS-approved evidence-based practices are described in Information Item G;
(8) Supervisors of services and supports within RDM shall be trained as trainers in the DSHS-approved evidence-based practices or have provided the evidence-based practices prior to the supervision of the evidence-based practices;
(9) Use the CA-TRAG to document the assessment of individuals seeking services and to reassess current clients in services when update assessments are due or service needs have changed to determine the recommended LOC for a client;

(10) Set aside for Flexible Funds totaling $1,500 per child for 10% of those children eligible to receive Service Packages 2.1, 2.2, 2.3, and 2.4. Use of Flexible Funds should occur in accordance with the UM Guidelines;
(11) Hire or contract with a Family Partner (i.e., the experienced parent or primary caregiver of a child or adolescent with serious emotional disturbance) to provide peer mentoring and support to parents/primary caregivers of children and adolescents. Family Partner services are available in all Service Packages, but Contractor shall service a minimum of 15% of children and adolescents receiving services in Service Packages 2.1, 2.2, 2.3 and 2.4;
(12) Ensure the Family Partner receives the appropriate training and supervision;
(13) Family support groups shall be available to the parents of clients with serious emotional disturbances;
(14) Contractor shall serve individuals with monies allocated through Crisis Redesign for engagement, transition, and intensive ongoing services in accordance with UM Guidelines. CARE Report III shall be completed in accordance with Information Item D and submission timelines as outlined in Information Item S. Performance measures are outlined in Section II. G.; and
(15) Maintain access to WebCARE even if Contractor utilized an approved batch process.

e) Submit encounter data for all services according to the procedures, instructions, and schedule established by DSHS, including all required data fields and values in the current version of the DSHS Community Mental Health Service Array. The current version of DSHS Community Mental Health Service Array (i.e., Report Name: INFO Mental Health Service Array Combined) can be found in MBOW) in the CA General Warehouse Information, Specifications subfolder.

f) Comply with the following Medicaid-related requirements:
(1) Contract with DSHS to be a provider for Medicaid MH Rehabilitative Services and Medicaid MH Case Management;
(2) Contract with HHSC to participate in Medicaid Administrative Claiming;
(3) Recognize that funding earned through billings to Texas Medicaid & Healthcare Partnership (TMHP) for Medicaid MH Case Management and Medicaid MH Rehabilitative Services represents the federal share and the State match; and
(4) Submit billing for the provision of Medicaid MH Case Management and Medicaid MH Rehabilitative Services to TMHP.

g) Utilize non-contract funds and other funding sources (e.g., any person or entity who has the legal responsibility for paying all or part of the services provided, including commercial health or liability insurance carriers, Medicaid, or other Federal, State, local, and private funding sources) whenever possible to maximize Contractor's financial resources. Contractor shall comply with the following requirements:
(1) Enroll in the CHIP and bill CHIP for services covered under that plan;
(2) Become a Medicaid provider and bill Medicaid for services covered under that plan;

(3) Provide assistance to individuals to enroll in such programs when the screening process indicates possible eligibility for such programs;
(4) Allow clients that are otherwise eligible for DSHS services, but that cannot pay a deductible required by a third party payor, to receive services up to the amount of the deductible and to use DSHS funds to pay for the deductible;
(5) Maintain appropriate documentation from the third party payor reflecting attempts to obtain reimbursement;
(6) Bill all other funding sources for services provided under this Program Attachment before submitting any request for reimbursement to DSHS; and
(7) Provide all billing functions at no cost to the client.

h) Expend Social Services Block grant (SSBG) funds to provide comprehensive community MH services to clients with serious emotional disturbance. Contractor shall utilize the SSBG under 42 USC §1397 (also known as Title XX of the Social Security Act) for the provision of the following services to clients in the priority population and report this information on Form L.
(1) Case management services, which are services or activities for the arrangement, coordination, and monitoring of services to meet the needs of clients and families. Component services and activities may include individual service plan development, monitoring, securing, and coordinating services; monitoring and evaluating client progress; and assuring that clients' rights are protected;
(2) Counseling services, which are services or activities that apply therapeutic processes to personal, family and situational problems in order to bring about a positive resolution of the problem and improve individual and family functioning or circumstances. Problem areas may include:
(a) Family relationships;
(b) Parent-child problems;
(c) Depression;
(d) Child abuse;
(e) Anxiety; or
(f) Drug abuse when in conjunction with a serious emotional disturbance.
(3) Services for clients in foster care, which are those services or activities associated with the provision of an alternative family life experience for abused, neglected or dependent children, between birth and the age of majority, or the basis of a court commitment or voluntary placement agreement signed by the parent or guardian. Services may be provided to clients in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, pre-adoptive homes or supervised independent living situations. Component services or activities may include assessment of the client's needs, case planning and case management to assure that the client receives proper care in the placement, counseling of the client, the client's parents and the foster parents, and referral and assistance in obtaining other necessary support services;
(4) Prevention and Intervention Services which are those services and activities designed to provide early identification and timely intervention to support families and prevent or ameliorate the consequences of abuse, neglect, or family violence,

or to assist in making arrangements for alternate placements or living arrangements where necessary. Such services may also be provided to prevent the removal of the client from the home. Component services may include assessment and evaluation of the extent of the problem, counseling, developmental and parenting skills training, respite, and service coordination; and

(5) Special services for clients involved or at risk of involvement with criminal activity, which are those services or activities for clients who are, or who may become, involved with the juvenile justice system. Component services or activities are designed to enhance family functioning and modify the client's behavior with the goal of developing socially appropriate behavior. Services may include the following:
   (a) Skills training; and
   (b) Family training.

i) Provide services to all clients without regard to the client's history of arrest, charge, fine, indictment, incarceration, sentence, conviction, probation, deferred adjudication, or community supervision for a criminal offense.

j) Develop and implement written procedures to identify clients with Co-Occurring Psychiatric and Substance Use Disorders (COPSD), identify available resources, and provide referrals and continuity of care for ongoing services as necessary to address the client's unmet substance use treatment needs in accordance with 25 TAC, part 1, chapter 411, Subchapter N. Nothing herein shall prohibit a physician from considering a client's substance use in prescribing medications.

k) Conduct all initial and on-going diagnostic assessments face-to-face or by televideo with the individual to determine priority population eligibility.

l) Implement crisis services in compliance with the standards outlined in Information Item V.

m) Submit encounter data on PASRR individuals in accordance with Information Item O. Complete and submit Form O in accordance with the instructions set forth in Information Item O.

SECTION II. SERVICE TARGETS, OUTCOMES, AND PERFORMANCE MEASURES

Contractor shall meet the following service targets, performance measures, and outcomes:

A. Adult Services

Adult service performance measures shall be assessed 37 calendar days following the close of the second and fourth quarters. Detailed information pertaining to calculations and data sources can be found in Information Item C at:
http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm.

1. Adult Number Served Target:
   a) Target: 1331 (First and second quarter aggregate and a third and fourth quarter aggregate)

   b) Sanctions Associated with this Target are the following:
      (1) If the total number served is greater than or equal to 100%, there is no recoupment;
      (2) If the total number served is 90% to 99% of the target, and the minimum hours threshold for maintaining service capacity is met, there is no recoupment;
      (3) If the total number served is 90% to 99% of the target, and the minimum hours threshold for maintaining service capacity is not met, the recoupment is 1.4% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds;
      (4) If the total number served is 85% to 89%, the recoupment is 2.8% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds;
      (5) If the total number served is 80% to 84%, the recoupment is 5.6% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds;
      (6) If the total number served is 75% to 79%, the recoupment is 11.2% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds; and
      (7) If the total number served is <75%, the recoupment is 22% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds, in addition to other remedies and sanctions specified in Article 19 of the General Provisions.

2. UA Completion Rate:
   a) At a minimum 90% of all adults served or authorized for services during the first and second quarter, or the third and fourth quarter have a completed and current Uniform Assessment.

   b) Sanctions Associated with this Measure are the following:
      (1) Greater than or equal to 90%, there is no recoupment;
      (2) From 80% to 89%, the recoupment is 1.4% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds;
      (3) From 70% to 79%, the recoupment is 2.8% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds;
      (4) From 60% to 69%, the recoupment is 5.6% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication Funds; and
      (5) Less than 60%, the recoupment is 11.2% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication Funds.

3. Service Capacity Measures

a) Minimum Target – Adults receiving at least the minimum number of hours based on service encounters for adults authorized in Service Packages 1 through 4 shall meet the following service capacity thresholds:
   (1) Service Package 1 – 0.5 hours minimum per person, with an LOC-R of 2, 3 or 4 (underserved by choice), per month;
   (2) Service Package 2 – 1.5 hours minimum per person per month;
   (3) Service Package 3 – 3 hours minimum per person per month; and
   (4) Service Package 4 – 3.5 hours minimum per person per month.

   At least 80% of adults are receiving the minimum number of hours each month. This is a first and second quarter aggregate and a third and fourth quarter aggregate across Service Packages 1 through 4.

b) Sanctions Associated with the Measure for Service Packages 1 through 4 are the following:
   (1) Greater than or equal to 80%, there is no recoupment;
   (2) From 70% to 79%, the recoupment is 0.2% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds;
   (3) From 65% to 69%, the recoupment is 0.3% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds;
   (4) From 40% to 64%, the recoupment is 0.6% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds; and
   (5) Less than 40%, the recoupment is 1.0% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds.

c) If Contractor meets the expected target for level of functioning, housing, and hospitalization within 30-days of a crisis episode, then DSHS will not impose a sanction for failure to meet the Service Capacity Measures specified in this section. Expected targets for these outcomes are listed in Information Item C.

4. Assertive Community Treatment (ACT) Average Hours
   Adults receiving services based on service encounters for all adults authorized in Service Package 4 shall meet the following service capacity thresholds:
   a) Average Hours per Service Package:
      Service Package 4 – an average of 10 hours per month. Adults in Service Package 4, on average, receive 10 hours per month. This means that across 100% of adults in service package 4, the average number of service hours provided is equal to or greater than 10.
      This is a first and second quarter aggregate and a third and fourth quarter aggregate for Service Package 4.

   b) Sanctions Associated with this Measure are the following:
      (1) Greater than or equal to 100%, there is no recoupment;
      (2) From 90% to 99%, the recoupment is 0.15% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds;

(3) From 80% to 89%, the recoupment is 0.2% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds;
(4) From 75% to 79%, the recoupment is 0.3% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds;
(5) From 40% to 74%, the recoupment is 0.6% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds; and
(6) Less than 40%, the recoupment is 1.0% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds.

c) If Contractor meets the expected target for level of functioning, housing, and hospitalization within 30-days of a crisis episode, then DSHS will not impose a sanction for failure to meet the Service Capacity Measures specified in this section. Expected targets for these outcomes are listed in Information Item C.

5. Adult Service Targets – Supported Employment and Supported Housing

a) Beginning in FY2013, the monthly average of all adults served in a Full Service Package during the fiscal year who have received a supported employment service encounter is greater than or equal to 3%.

b) Beginning FY2013, the monthly average of all adults served in a Full Service Package during the fiscal year who have received a supported housing service encounter is greater than or equal to 3%.

6. Disease Management Outcomes – Adult Mental Health Services:
Adult service outcomes shall be measured 37 calendar days following the close of the fourth quarter. Contractor shall not be subject to sanctions or remedies for each outcome minimum achieved. For adult service outcome minimums that are not achieved by the end of Program Attachment term, remedies and sanctions may be imposed as described in Section 19.02 of the General Provisions with the exception of recoupment under Section 19.02.b.1.

a) Functioning. Target – 38% of all adults served during the fiscal year have acceptable or improving functioning.

b) Criminal Justice Involvement. Target – 44% of all adults served during the fiscal year have acceptable or improving criminal justice involvement.

c) Employment. Target – In FY2013, at least 14.7% of adults in a Full Service Package shall receive a score of "1" (Independent/Competitive/Supported/Self Employment) on Paid Employment Type. This score is recorded on the Adult Uniform Assessment, Section 4: Community Data, B. Paid Employment Type.

d) Housing. Target – 72% of all adults served during the fiscal year have acceptable or improving housing.

e) Co-Occurring Substance Use. Target – 87% of all adults served during the fiscal year have acceptable or improving co-occurring substance use.

f) Crisis Avoidance. Target - Percent of all adults with time in crisis shall not exceed 2.3% for those authorized for a LOC during the fiscal year.

g) Time between Assessment and First Service Encounter. Target - 77% of all adults served during the fiscal year receive their first service encounter (not including screening/assessment) within 14 days of their intake assessment.

B. Children's Services

Children's service performance measures shall be assessed 37 calendar days following the close of the second and fourth quarters. Detailed information pertaining to calculations and data sources can be found in Information Item C at: http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm.

1. Children Number Served Targets
   a) Target: 223 (first and second quarter aggregate, and third and fourth quarter aggregate)

   b) Sanctions Associated with this Target are the following:
      (1) If the total number served is greater than or equal to 100%, there is no recoupment;
      (2) If the total number served is 90% to 99%, and the minimum hours threshold for maintaining service capacity is met, there is no recoupment;
      (3) If the total number served is 90% to 99%, and the minimum hours threshold for maintaining service capacity is not met, the recoupment is 1.4% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds;
      (4) If the total number served is 85% to 89%, the recoupment is 2.8% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds;
      (5) If the total number served is 80% to 84%, the recoupment is 5.6% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds;
      (6) If the total number served is 75% to 79%, the recoupment is 11.2% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds; and
      (7) If the total number served is <75%, the recoupment is 22% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds, in addition to other remedies and sanctions specified in Article 19 of the General Provisions.

2. UA Completion Rate
   a) At a minimum 90% of all children served or authorized for services during the first and second quarter, or the third and fourth quarter have a completed and current Uniform Assessment;

   b) Sanctions Associated with this Measure are the following:
      (1) Greater than or equal to 90%, there is no recoupment;
      (2) From 80% to 89%, the recoupment is 1.4% of Contractors current 2 quarters funding for children's MH services excluding New Generation Medication funds.
      (3) From 70% to 79%, the recoupment is 2.8% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds;
      (4) From 60% to 69%, the recoupment is 5.6% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds;
      (5) Less than 60%, the recoupment is 11.2% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds.

3. Ohio Scales Completion Rate
   a) Minimum Target - 85% of Ohio Scales are completed by the parents or primary caregivers at intake, every 90 days during treatment and at planned discharge;

   b) Sanctions Associated with this Measure are the following:
      (1) Greater than or equal to 85%, there is no recoupment;
      (2) From 75% to 84%, the recoupment is 0.06% of Contractors current 2 quarters for children's MH services excluding New Generation Medication funds.
      (3) From 65% to 74%, the recoupment is 0.3% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds;
      (4) Less than 65%, the recoupment is 2.4% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds.

4. Service Capacity Measures:
   a) Minimum Target – Children and adolescents receiving at least the minimum number of hours based on service encounters for those authorized in Service Packages 1.1, 1.2, 2.1, 2.2, 2.3, 2.4 and 4 must meet the following service capacity thresholds:
      (1) Service Package 1.1 – 1.5 hours minimum per month;
      (2) Service Package 1.2 – 1.5 hours minimum per month;
      (3) Service Package 2.1 – 5 hours minimum per month;
      (4) Service Package 2.2 – 3.5 hours minimum per month;
      (5) Service Package 2.3 – 3.5 hours minimum per month;
      (6) Service Package 2.4 – 3.5 hours minimum per month; and
      (7) Service Package 4 – 0.5 hours minimum per month with an LOC-R of 1.1, 1.2, 2.1, 2.2, 2.3, 2.4 and underserved due to consumer choice.

      At least 80% of children and adolescents receive the minimum number of hours each month. This is a first and second quarter aggregate and a third and fourth quarter

aggregate across Service Packages 1.1 through 4.

b) Sanctions Associated with this Measure are the following:
   (1) Greater than or equal to 80%, there is no recoupment;
   (2) From 70% to 79%, the recoupment is 0.2% of Contractors current 2 quarters funding for children's MH services excluding New Generation Medication funds.
   (3) From 60% to 69%, the recoupment is 0.3% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds in which minimums are not met;
   (4) From 50% to 59%, the recoupment is 0.6% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds in which minimums are not met;
   (5) From 40% to 49%, the recoupment is 1.0% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds in which minimums are not met;
   (6) Less than 40%, the recoupment is 1.5% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds in which minimums are not met.

c) If Contractor meets the expected target for level of levels for Ohio scale functioning, Ohio scale problem severity, and hospitalization within 30-days of a crisis episode, then DSHS will not impose a sanction for failure to meet the Service Capacity Measures specified in this section. Expected target levels are listed in Information Item C.

5. Service Target for Family Partner Services
   a) Service Target – 15% of children and adolescents authorized to receive Service Packages 2.1, 2.2, 2.3, or 2.4 receive Family Partner Services each client month as evidenced by Procedure Code H0038HA.

   b) Sanctions Associated with this Measure are the following:
      (1) Greater than or equal to 15%, there is no recoupment;
      (2) From 9% to 14%, the recoupment is 0.15% of Contractors current 2 quarters for children's MH services excluding New Generation Medication funds;
      (3) From 6% to 8%, the recoupment is 0.3% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds;
      (4) From 3% to 5%, the recoupment is 0.6% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds; and
      (5) Less than 3%, the recoupment is 1.2% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds.

6. Minimum Hours Per Child or Adolescent for Family Partner Services.
   a) Minimum Target – 10 % of children and adolescents authorized in Service Packages

2.1, 2.2, 2.3, or 2.4 receive a minimum of 60 minutes of Family Partner services each client month as evidenced by Procedure Code H0038HA.

b) Sanctions Associated with this Measure:
   (1) Greater than to equal to 10%, there is no recoupment;
   (2) From 5% to 9%, the recoupment is 0.15 % of Contractors current 2 quarters for children's MH services excluding New Generation Medication funds;
   (3) From 3% to 4%, the recoupment is 0.3% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds; and
   (4) Less than 3%, the recoupment is 1.2% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds.

7. Disease Management Outcomes – Child and Adolescent Mental Health Services: Children's service outcomes shall be measured 37 calendar days following the close of the fourth quarter. For children's service outcome minimums that are not achieved by the end of this Program Attachment Term, remedies and sanctions associated with outcomes may be imposed as described in Section 19.02 of the General Provisions.

   a) Functioning. Minimum Target – 38% of all children served during the Fiscal Year (FY) have clinically acceptable or improving functioning.

   b) Problem Severity. Minimum Target – 42% of all children served during the FY have clinically acceptable or improving problem severity.

   c) Juvenile Justice Involvement Avoidance. Minimum Target – 92% of all children served during the FY avoid arrest or avoid re-arrest.

   d) School Behavior. Minimum Target – 71% of all children served during the FY have clinically acceptable or improving school behavior.

   e) Co-Occurring Substance Use. Minimum Target – 87% of all children served during the FY have acceptable or improving co-occurring substance use.

   f) Crisis Avoidance. Minimum Target – Percent of all children with time in crisis will *not* exceed 1.7% for those recommended and authorized for a LOC during the FY.

   g) Time between Assessment and First Service Encounter. Minimum Target – 65% of all children served during the FY receive their first (not screening/ assessment) service encounter within 14 days of their intake assessment.

C. New Generation Medication

Information pertaining to calculations and data sources is in Information Item D at http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm.

Target: 306 Adults and Children served with New Generation Medications are counted toward this target.

D. Legislative Budget Board – Reported from CARE

Information pertaining to calculations and data sources is in Information Item C at http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm.

Percentage of adults and children discharged from state facilities with a community support plan.

1. The number of adults and children discharged from state MH campus-based facilities (state hospital, state center) to Contractor that have a community support plan.

2. Target: Shall not be less than 95%.

E. Additional Adult and Children Outcomes – Reported in CARE

These measures will be automatically tracked through the CARE system and reported Fiscal Year to date:

1. Re-admissions of adults and children:
   Target - Re-admissions are less than or equal to: 5% in the 1st quarter; 10% in the 2nd quarter; 15% in the 3rd quarter; and 20% in the 4th quarter.

2. Follow-up within seven days:
   a) Face-to-face follow-up contacts with individuals discharged from a state facility or state-funded community mental health hospital (including the Montgomery County Mental Health Treatment Facility) within seven days are greater than or equal to 75%; and

   b) Follow-up disposition of individuals discharged from a state facility or state-funded community mental health hospital (including the Montgomery County Mental Health Treatment Facility) within seven days is greater than or equal to 95%.

F. Crisis Response System Outcome Measures

Crisis response system outcomes shall be measured 37 calendar days following the close of the fourth quarter. Contractor shall not be subject to sanctions and remedies for each outcome minimum achieved. For crisis response system outcome minimums/maximums that are not achieved by the end of the Program Attachment term, remedies and sanctions may be imposed as described in Section 19.02 of the General Provisions with the exception of recoupment under Section 19.02.b.1.

1. Crisis Episodes resulting in Psychiatric Maximum Target - No more than 22% of adults, children, and adolescents with a crisis episode are admitted to a State or Community Mental Health Hospital within 30 days after the start of the crisis episode.

2. Community Linkage Minimum Target - No less than 23% of adults, children, and

adolescents with a mental health community LOC-A = 0 will be followed by a mental health community LOC-A = 1 - 5, and/or a service contact at a DSHS-funded substance abuse treatment facility, or at an Outreach, Screening, Assessment and Referral (OSAR) provider within 14 days after the crisis episode.

3. Crisis Follow Up Minimum Target - No less than 90% of adults, children, and adolescents with a mental health community LOC-A = 5 have a crisis follow-up service encounter within 30 days of the LOC-A = 5.

G. Crisis Redesign Service Targets

Information pertaining to calculations and data sources is in Information Item C at http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm.

1. Adults, children, and adolescents served in SP5 "Transitional Services."
   a) Target FY 2012: Expected targets are listed in Information Item C.

   b) Target FY2013: Expected targets are listed in Information Item C.

   c) Remedies and Sanctions associated with this Target will be imposed in accordance with General Provisions, Section 19.02.

2. Adults served in "Intensive Ongoing Service Packages."
   a) Target FY 2012: Expected targets are listed in Information Item C.

   b) Target FY2013: Expected targets are listed in Information Item C.

   c) Remedies and Sanctions associated with this Target will be imposed in accordance with General Provisions, Section 19.02.

3. Children/Adolescents served in "Intensive Ongoing Service Packages."
   a) Target FY 2012: Expected targets are listed in Information Item C.

   b) Target FY 2013: Expected targets are listed in Information Item C.

   c) Remedies and Sanctions associated with this Target will be imposed in accordance with General Provisions, Section 19.02.

H. Medicaid Waiting List Compliance Requirements

DSHS will determine Medicaid Waitlist Compliance 30 calendar days after the last day of each month. Contractor shall be subject to the liquidated damages specified in Section 19.02.b.2.of the General Provisions each month for non-compliance with any of the following requirements:

1. No individual shall be placed on a waiting list without receiving the uniform assessment.

2. Individuals (referenced in Section I.A.5.i.2.) shall be removed from the waiting list and services shall be made available to these individuals within 60 calendar days of the date that the individual who, after being authorized for a LOC-8, gained Medicaid eligibility.

3. No individual with Medicaid that has an indicated need for Mental Health Rehabilitative Services or Mental Health Case Management Services as indicated by the Uniform Assessment shall be placed on a waiting list unless an LPHA documented a determination that such services are not medically necessary or the client refused services.

4. An individual who is a Medicaid recipient with a completed uniform assessment that indicates a need for mental health services other than Mental Health Rehabilitative Services or Mental Health Case Management Services, and is placed on a waiting list for such services, shall have documented attempts to refer the individual to other qualified local providers or the nearest qualified provider.

SECTION III. SERVICE AREA

Counties: Liberty, Montgomery, Walker

SECTION IV. SOLICITATION DOCUMENT

Exempt Governmental Entity

SECTION V. RENEWALS

N/A

SECTION VI. PAYMENT METHOD

Quarterly Allocation

SECTION VII: BILLING INSTRUCTIONS NA

SECTION VIII: BUDGET

Source of Funds:	
Crisis Redesign Services	$1,915,402.00
MH Adult Inpatient Svcs - GR	$98,754.00
MH Adult Med Related Svcs - GR & MHBG	$621,231.00
MH Adult New Gen Med - GR	$873,124.00
MH Adult Other Meds - GR & MHBG	$407,082.00
MH Adult Outpatient Svcs - GR, MHBG, Comm Hosp Outpatient - GR	$2,020,169.00
MH Child Inpatient Svcs - GR	$8,964.59
MH Child Med Related Svcs, GR, MHBG, Title XX Med Related Svcs, TANF Med Related	$104,146.55

MH Child New Gen Med - GR	$2,775.60
MH Child Other Meds - GR, MHBG, Title XX Other Meds	$21,563.38
MH Child Outpatient Svcs - GR & MHBG	$529,402.48
MH Title XX Family Sup Svcs, Child Family Sup Svcs, GR, MHBG, TANF Family Sup Sr	$85,783.40
State Match Payments to TMHP for Medicaid Services	$1,053,086.00
Total Allocation	**$7,741,484.00**

Local Match Requirement: $1,098,136.75

CONTRACT NO.
PROGRAM ATTACHMENT NO
PURCHASE ORDER NO.

CONTRACTOR:

DSHS PROGRAM: Veterans Services

TERM: September 1, 2011 THRU: August 31, 2013

SECTION I. STATEMENT OF WORK:

Contractor shall implement a Community Based Veteran Peer-to-Peer Counseling Project (Project) to enhance or expand the availability of and access to community-based behavioral health services for veterans. The Project shall, at a minimum, enhance and expand veteran-facilitated peer-to-peer counseling related to behavioral health issues for veterans.

Contractor's Project may enhance or expand collaborations with other Local Mental Health Authorities (Partners) in order to achieve economies of scale in order to recruit, retain, and organize the services provided by individuals (Volunteers) who have been trained in a curriculum-based peer-to-peer counseling course such as "Bring Everyone In The Zone", "Operation Resilient Families", or an equivalent curriculum approved by DSHS.

Contractor shall sponsor and/or organize quarterly briefings for Volunteers and members of the Texas Military Forces (TXMF), who have been trained in peer-to-peer mental health counseling (Military Peers) and who have agreed to provide services similar to those provided by the Volunteers. The briefings shall, at a minimum, include information about community based health and human services for veterans, information about community based veteran reintegration initiatives, or information about evidence-based practices aimed at enhancing participants' ability to provide veteran peer-to-peer counseling.

In order to enhance and expand what shall be known as the Military Veteran Peer Network (Network), Contractor shall screen and recruit individuals (Applicants) who want to become members. Because the Network, whose members are Volunteers and Military Peers (Members), is established in order to link them--through phone, email, and regular briefings--Contractor shall brief Members about community based reintegration services, ensuring that each Member is connected to the DSHS-identified Military Veteran Peer Network (Network). Contractor shall assist Members in locating meeting space, introducing them to community service providers, inviting them to participate in community based briefings about peer-to-peer counseling, and briefing them about how to navigate community based health and human services systems including how to access services and make efficacious referrals to community mental health care providers.

Contractor's Project shall ensure that services provided by Volunteers include, at a minimum, responding to requests from veterans who are seeking to access veteran and/or veteran and

military family reintegration services, including but not limited to, meeting with them one-on-one or in group settings, briefing them about and/or referring them to community health and human service providers.

A. Project Design

1. The Project shall, at a minimum, enhance or expand the availability of or access to peer-to-peer counseling and community veteran reintegration services. Contractor shall coordinate veteran reintegration services with community veteran organizations and individuals (Stakeholders) who provide veteran reintegration services including the following:
   a. Programs for substance use screening, assessment, and treatment;
   b. County Service Officers and/or the Texas Veterans Commission;
   c. Veterans Integrated Services Network;
   d. TexVet: Partners Across Texas;
   e. Programs that support housing and employment;
   f . Programs that support female veterans;
   g. Jail diversion programs for veterans and active military service members related to behavioral health services;
   h. Programs being implemented by other veterans or military service organizations;
   i. Community based veteran drop-in centers.

2. Contractor shall maintain a listing of Stakeholders, Volunteers, and Military Peers and, at a minimum, sponsor and/or organize meetings for them. The purpose of the meetings shall be to share information about the activities of the Military Veteran Peer Network and Stakeholders, to update them about community resources and reintegration services for veterans, assess the reintegration service needs of veterans in the community, identify gaps in community reintegration services, and devise tactics to close the gaps. These meetings shall be scheduled quarterly and documented by Contractor.

3. Contractor shall assist Partners, Coordinators, Stakeholders, and Volunteers to initiate, enhance, or expand their efforts to engage Military Peers. At a minimum, Contractor shall maintain and update a listing of Volunteers and Military Peers who reside, or report to a TXMF unit, within Contractor's service area(s). The listing shall be forwarded to the DSHS-identified Network State Coordinator (State Coordinator) quarterly by submitting this information electronically to the email address provided by the State Coordinator.

4. Contractor shall screen Applicants recommended by Stakeholders or Network Members using a written assessment (Assessment) developed by DSHS. Upon completion of each screening, Contractor shall submit applicant's Assessment to DSHS. DSHS will make final Applicant selections and make training available to them.

5. Contractor shall maintain contact with Members who reside within the service area(s). The purpose of the contacts shall be to ensure that Members are actively engaged in delivering services, to determine what supports might be appropriate to assist Members in their efforts to achieve the aims and goals of the Project, and to update information as required in Sec. I. A. 3 & 4 above. Contractor shall contact Members by telephone, email,

or in person and document contacts by submitting to the State Coordinator each quarter the names of individuals contacted and the dates the contacts were made. This information shall be submitted electronically to the email address provided by the State Coordinator.

6. Contractor shall initiate, enhance, or expand access to services for female veterans. Contractor shall recruit at least one (1) female Applicant semi-annually. Contractor also shall coordinate services with female veteran service providers in order to ensure that female veterans have access to female veteran-facilitated peer-to-peer counseling services. Services provided to female veterans shall be documented quarterly using Form V-Vets.

7. Contractor may subcontract part of or the entire award to other organizations or individuals in order to accomplish the aims and goals of the Projects. If Contractor wants to revise any part of this Program Attachment, Contractor shall submit a request to DSHS for such revision in writing, describing the proposed revision(s) and explaining the rationale. DSHS will provide written approval or denial of the request.

B. Designate Program Point of Contact

Contractor shall designate a single point of contact to receive and transmit information required for effective implementation and monitoring of the Project.

C. Project and Fiscal Reporting

Contractor shall meet the following requirements with regard to Project and Fiscal Reporting:

1. Develop and electronically submit periodic service delivery data reports to DSHS using DSHS Form V-VETS Service Delivery; and
2. Follow the submission schedule and reporting requirements for financial information in Client Assignment and Registration System (CARE) Report III.

SECTION II. SERVICE TARGETS, PERFORMANCE MEASURES, AND OUTCOMES:

The following performance measures will be used to assess, in part, Contractor's effectiveness in providing the services described in this Program Attachment, without waiving the enforceability of any of the terms of this contract. All reports shall be submitted electronically to the Performance Contract Mailbox at performance.contracts@dshs.state.tx.us with a copy to the assigned DSHS contract manager.

A. Contractor shall designate a single point of contact and notify DSHS in writing, with the single point of contact's name and contact information, no later than 10 business days after execution of this contract. This notification requirement continues as written should a change in the single point of contact occur.

B. No later than November 30, 2011, Contractor shall submit to DSHS a written Project Implementation Plan, outlining Contractor's plan for organizing veteran peer-to-peer

counseling and services under the terms of this Program Attachment. At a minimum, the plan shall include the following:

1. A timeline for task(s) to be accomplished and parties responsible for each task, and
2. Anticipated outcomes and objectives.

C. Contractor shall meet anticipated outcomes and objectives as approved by DSHS, and shall report on fiscal data and project progress toward meeting outcomes and objectives using Form V-VETS as outlined in Section II.D. below.

D. Service Delivery Reports

1. Contractor shall electronically submit to DSHS Form V-VETS service delivery data related to this Program Attachment by the following due dates:

a. December 15, 2011
b. March 15, 2012
c. June 15, 2012
d. September 15, 2012
e. December 15, 2012
f. March 15, 2013
g. June 15, 2013
h. September 15, 2013

E. Other Quarterly Submissions

Contractor shall submit the quarterly reports referenced in Section I.A.3. and I.A.5. in accordance with the service delivery report schedule notated in Section II. D.

SECTION III. SOLICITATION DOCUMENT:

N/A

SECTION IV. RENEWALS:

N/A

SECTION V. PAYMENT METHOD:

SECTION VI. BUDGET:

Source of Funds:

Total payments will not exceed XXX. The amount expended by Contractor for administration of the provision of services under this Program Attachment shall not exceed 5% of the total.

Budget and expenditure reporting shall be entered into CARE Report III on line 758 – Other General Revenue, DSHS.

SECTION VII. FUNDING:

If Contractor's total allowable expenditures for the term of this Program Attachment are less than the total amount disbursed by DSHS in Contractor's allocations, Contractor shall be subject to recoupment by DSHS of the difference between the total amount disbursed by DSHS and Contractor's total allowable expenditures.

Agenda Item: Approve FY 2012 Dues Commitment and Payment Schedule for Texas Council of Community Centers **Committee:** Business	**Board Meeting Date** September 22, 2011

Background Information:

There is a slight decrease in the Center's dues from FY 2011.

Supporting Documentation:

Dues Commitment and Payment Schedule

Comparison of FY 2012 Dues with FY 2011 Dues

Recommended Action:

Approve FY 2012 Dues Commitment and Payment Schedule for the Texas Council of Community Centers

FY 2012 Commitment of Dues Payment for Texas Council of Community Centers

CENTER: Tri-County Services

The dues for FY 2012 have been calculated as follows:

Total Dues $28,391.00
LESS: Credit for Texas Council Risk Management Fund Members...(2,586.00) *(REVISED)*

Net Dues 25,805.00

The dues payment may be paid in one payment or in monthly or quarterly installments. Please identify the dues payment methodology you plan to use:

	Monthly	Quarterly	Lump Sum
September 2011	_____	**$6,451.25**	$_____
October	_____		
November	_____		
December	_____	**$6,451.25**	
January 2012	_____		
February	_____		
March	_____	**$6,451.25**	
April	_____		
May	_____		
June	_____	**$6,451.25**	
July	_____		
August	_____		
TOTALS	$_____	**$25,805.00**	$_____

Invoice for each payment required? __X__ Yes _____No

We appreciate your prompt and timely payment!

APPROVED:

_____ _____
Len George, Chair, Board of Trustees Cindy Sill, Executive Director

Date: _____

Texas Council of Community Centers				
FY 2012 Dues Comparison to FY 2011 Dues				
(Revised August 24, 2011)				
		FY 2012	FY 2011	Increase
Center		Dues	Dues	(Decrease)
Access		11,218	11,127	91
Andrews		22,639	24,081	(1,442)
Austin Travis		43,573	43,759	(186)
Betty Hardwick		16,864	17,594	(730)
Bluebonnet		33,911	33,802	109
Border Region		20,768	20,119	649
Brazos Valley		16,770	16,725	45
Burke Center		30,684	31,964	(1,280)
Camino Real		20,287	20,112	175
Center for Health Care Services		48,975	50,743	(1,768)
Center for Life Resources		12,183	12,876	(693)
Central Counties		19,723	20,129	(406)
Central Plains		12,230	12,010	220
Coastal Plains		20,664	20,982	(318)
Community Healthcore		29,178	30,987	(1,809)
Concho Valley		11,164	10,451	713
Dallas		83,195	81,421	1,774
Denton County		23,876	22,631	1,245
El Paso		42,925	42,362	563
Gulf Bend		12,751	12,946	(195)
Gulf Coast		24,858	23,927	931
Harris County		115,063	117,406	(2,343)
Heart of Texas		25,275	25,652	(377)
Helen Farabee		19,272	19,594	(322)
Hill Country		32,875	34,135	(1,260)
Lakes Regional		30,324	27,938	2,386
Lifepath		21,017	20,200	817
Lubbock		27,329	26,040	1,289
Nueces County		18,555	18,559	(4)
Pecan Valley		16,541	16,318	223
Permian Basin		21,672	22,327	(655)
Spindletop		33,415	35,327	(1,912)
Tarrant County		97,424	95,910	1,514
Texana		40,202	40,218	(16)
Texas Panhandle		29,586	27,692	1,894
Texoma		12,870	12,957	(87)
Tri-County		25,805	26,155	(350)
Tropical Texas		38,038	35,684	2,354
West Texas		21,993	22,825	(832)
Totals		1,185,688	1,185,688	0

Agenda Item: Approve Transfer of Funds to Reserve for Insurance Deductibles **Committee:** Business	**Board Meeting Date** September 22, 2011

Background Information:

During the July Board meeting, the Board approved increases for insurance deductibles in our Professional Liability and the Errors and Omissions coverage. This change significantly decreased our insurance premiums for these lines of coverage. During this agenda item discussion, it was also decided that a reserve fund would be set up for insurance deductible costs for possible claims in the future.

Staff is recommending that we transfer $100,000 to the Reserve for Insurance Deductibles.

Supporting Documentation:

None

Recommended Action:

Approve Transfer of Funds to Reserve for Insurance Deductibles

Agenda Item: Approve Replacement of Air Conditioning Unit at 7045 Hwy 75 South, Huntsville TX **Committee:** Business	**Board Meeting Date** September 22, 2011

Background Information:

All of the ten-ton air conditioning units at the Huntsville facility are aging and eight of them were installed in 1984. The air conditioning unit to be replaced was installed around 2000, is not working properly and cannot be repaired. The Maintenance Department placed an Invitation to Bid on The Blue Book for two weeks requesting bids and no vendors from Huntsville or Walker County submitted a bid. There were only three bids received. The lowest bid is from A/C Doctor at a cost of $11,290.

Supporting Documentation:

Quotes from Vendors

References for Vendors

Recommended Action:

Approve Replacement of Air Conditioning Unit at 7045 Hwy 75 South, Huntsville TX

A C Doctor Mechanical
P.O. Box 1357
Tomball, TX 77375

Estimate

Date	Estimate #
8/22/2011	4611

Name / Address

Tri-County MHMRA
Attn: Karen McCombs
103 North Thompson Street
Conroe, TX 77301-2847
(936) 756-9368

Insured & Licensed
TACLA 27004C

Description	Qty	Rate	Total
RE: 7045 State Highway 75 S Huntsville, TX 77340 Replace Exsiting condenser, (Model # CAE120LAA Serial# G070420107) And air handler with YORK condenser and air handler, equipped with 26 KW heat kit. Flush line set and install filters, to convert system from R-22 into R410a. Check for air leaks in duct. Run test system.		11,290.00	11,290.00

Phone #	Phone #	E-mail
281-356-1845	936-321-9888	airconditioningdoctor@gmail.com

Total $11,290.00

I hereby authorize the above work to be done as ordered and outlined above. It is agreed that the seller will retain title to any equipment furnished until complete payment has been made. If settlement is not made as agreed, the seller has the right to remove equipment and material without being held responsible for any damages resulting from the removal of equipment. Deposits are nonrefundable.

Regulated by the Texas Department of Licensing & Regualtion
P.O. Box 12157 . Austin, TX 78711
1-800-803-9202 . 512-463-6599

Customer Authorized Signature **Date**

Technician Signature

HUMBLE PORTER

Air Conditioning & Refrigeration Service

P.O. Box 6442
Kingwood, Texas 77325-6442
281-359-2535 or 281-354-3245
1-800-720-1133
281-354-6795 Fax

www.HumblePorterAir.com

TACLB004780C

DATE: 8/29/2011
PROPOSAL #: 9883

PROFOSAL SUBMITTED TO	WORK TO BE PERFORMED AT
Name : TRI COUNTY SERVICES Street: 7046 HWY 75 S. City: HUNTSVILLE, TX 77320 Phone: Attention: KAREN M karenm@tricountyservices.org	TRI COUNTY SERVICES 7046 HWY 75 S. HUNTSVILLE, TX 77320

We Hereby Propose to:

(1) BID TO REMOVE EXISTING 10 TON SPLIT SYSTEM AND INSTALL NEW 10 TON AIR HANDLER AND CONDENSER.
(2) PRICE INCLUDES TO REMOVE EXISTING DROP CEILING AND REINSTALL AFTER COVER UP INSPECTION.
(3) HPAC PROVIDE HVAC MECHANICAL PERMITS AND LIFT.

Warranty: HPAC PROVIDES ONE YEAR LABOR WARRANTY AND MFG WARRANTY APPLIES.

All material is guaranteed to be as specified, and the above work to be performed in accordance with the drawings and specifications submitted for above work and completed in a substantial workmanlike manner for the sum of :

AMERICAN STANDARD $13285.00 CARRIER $12862.00 RHEEM 12, 904.00

With payment to be made as follows:

• FOR SMOKE DECTECTOR ADD $200.00 FOR SMOKE DETECTOR AND INSTALLATION.

Any alteration or deviation from above specifications involving extra costs, will be executed only upon written orders, and will become an extra charge over and above the estimate. All agreements contingent upon strikes, accidents or delays beyond our control. Owner to carry fire, tornado and other necessary insurance upon above work. Workmen's Compensation or Public Liability Insurance on above work to be taken out by

Humble/Porter Air Conditioning & Heating Service

Respectfully Subm[redacted]

Note-This proposal may be withdrawn by us if not accepted within 60 days.

ACCEPTANCE OF PROPOSAL

The above prices, specifications and conditions are satisfactory and are hereby accepted. You are authorized to do the work as specified. Payment will be made as outlined above.

Accepted: _____ Signature: _____
Date: _____ Signature: _____

GICE AIR SERVICES
AIR CONDITIONING AND HEATING

18883 IRIS LN
PORTER, TX. 77365
(832) 867-7958

ELVIN AVILA
(LICENSE # TACLB320582E)

TRI COUNTY SERVICES
7045 HWY 75 S
HUNTSVILLE TX 77320

1.- **Bid to remove existing 10 ton split system and install new 10 ton air handler and condenser.**
Price includes (2) 20x20 fire dampers, one smoke detector, one 7 day programmable t-stat two stage, one audio visual sensor m#rts2.

2.- **Price includes to remove existing drop ceiling and reinstall after cover up inspection.**

3.- **HPAC provide HVAC mechanical permits and lif:.**

Warranty **HPAC provides one year labor warranty and MFG warranty applies.**

American Standard $14,185.00 **Carrier $13,862.00** **RHEEM $13,804.00**

ACCEPTANCE OF PROPOSAL

The Above prices, specifications and conditions are satisfactory and are hereby accepted. You are authorize to do the work as specified. Payment will be made as outlined.

Accepted:_____ **Signature:** _____

Date: _____ **Signature:** _____

Huntsville Condensor & Air Handler Replacement

Company, Price & Warranty	References	Years in Business
A/C Doctor **$11,290.00** **1 year parts and labor**	**Radco Construction-Mike Orlando-832-309-5543:** They do all of their a/c work. They are a general contracting company and A/C Doctor does their residential as well as commercial units. Happy with their work. **Icon Property Management-Robert Stefen-713-231-7751:** Happy with their work. They do single family home a/c installs and repairs for them. Has been using them for about 4 years. We use this company on a regular basis for our a/c service calls. They have been very reliable for us.	5 Years
HP Air Conditioning **$12,904.00** **1 year mfg and labor**	**Georgetown Apts.-George Hollak-713-907-5663**: Installed close to 800 units for them so far in New Orleans and Brazos, TX. Happy with their work. **Eclectic Townhomes-Santiago Pacheco-832-279-1956:** Installed units in his townhomes as well as his own home. Has had no problems with them and continues to use them.	34 Years
Gice Air Services **$13,804.00** **1 year mfg and labor**	**Empowerment Options-Claudeane Nelson-936-756-6350:** Very happy with their work. She said they can call them anytime of the night and they will show up. They currently use them for most of their work. **Continental Construction-Manuel Garza-281-302-8071:** Says they are very knowledgeable in what they do and that they are professional. They are happy with their service and continue to use them.	

Agenda Item: Review August 2011 Preliminary Financial Statements **Committee:** Business	**Board Meeting Date** September 22, 2011
Background Information: None	
Supporting Documentation: August 2011 Preliminary Financial Statements	
Recommended Action: **For Information Only**	

August 2011 Financial Summary
Preliminary

Revenues for August 2011 were $2,400,608 and operating expenses were $1,772,352 resulting in a gain in operations of $628,256. Capital Expenditures and Extraordinary Expenses for August were $423,471 resulting in a gain of $204,785. Total revenues were 106.79% of the monthly budgeted revenues and total expenses were 119.06% of the monthly budgeted expenses.

Year to date revenues are $25,432,767 and operating expenses are $22,165,955 leaving excess operating revenues of $3,266,812. YTD Capital Expenditures and Extraordinary Expenses are $2,364,467 resulting in a gain YTD of $902,346. Total revenues are 100.68% of the YTD budgeted revenues and total expenses are 98.55% of the YTD budgeted expenses.

REVENUES

YTD Revenue items that are below the budget by more than $10,000:

Revenue Source	YTD Revenue	YTD Budget	% of Budget	$ Variance
No items to report				

EXPENSES

YTD Individual line expense items that exceed the YTD budget by more than $10,000:

Revenue Source	YTD Expenses	YTD Budget	% of Budget	$ Variance
No items to report				

TRI-COUNTY SERVICES
CONSOLIDATED BALANCE SHEET
As of August 31, 2011
Preliminary

	TOTALS COMBINED FUNDS August 2011	TOTALS COMBINED FUNDS July 2011	Increase (Decrease)
ASSETS			
CURRENT ASSETS			
Imprest Cash Funds	3,925	4,025	(100)
Cash on Deposit-General Fund	5,551,241	5,880,803	(329,562)
Cash on Deposit-Debt Fund	437,478	399,365	38,113
Accounts Receivable	1,584,506	1,567,400	17,107
Inventory	33,893	33,689	204
TOTAL CURRENT ASSETS	7,611,043	7,885,282	(274,239)
FIXED ASSETS	5,050,968	5,050,968	-
OTHER ASSETS	45,776	57,688	(11,912)
AMOUNT TO BE PROVIDED FOR THE RETIREMENT OF LONG TERM DEBT	1,720,257	1,720,257	-
TOTAL ASSETS	**14,428,043**	**14,714,194**	**(286,151)**
LIABILITIES, DEFERRED REVENUE, FUND BALANCES			
CURRENT LIABILITIES	1,052,221	700,005	352,216
NOTES PAYABLE	407,690	407,690	-
DEFERRED REVENUE	141,039	1,028,471	(887,432)
LONG-TERM LIABILITIES FOR			
Capital Leases-Equipment	82,567	82,567	-
Bond Series 1995	-	-	-
Bond Series 2004	1,230,000	1,230,000	-
EXCESS(DEFICIENCY) OF REVENUES OVER EXPENSES FOR			
General Fund	902,346	750,529	151,817
Debt Service Fund	(40,026)	(93,327)	53,301
FUND EQUITY			
Reserved for Fixed Assets	5,050,968	5,050,968	-
Reserved for Worker Comp	274,409	274,409	-
Reserved for Debt Retirement	1,230,000	1,230,000	-
Reserved for Debt Service	477,505	492,693	(15,188)
Reserved for Board Policy Requirements	879,405	879,405	-
Reserved for Equipment Reserve	354,290	354,290	-
Reserved for Current Year Budgeted Reserve	74,000	67,833	6,167
Reserved for Inventory Reserve	32,973	32,973	-
Reserved for Operations and Programs	2,000,000	2,000,000	-
Unrestricted and Undesignated	278,658	225,690	52,968
TOTAL LIABILITIES/FUND BALANCE	**14,428,043**	**14,714,194**	**(286,150)**

TRI-COUNTY SERVICES
CONSOLIDATED BALANCE SHEET
As of August 31, 2011
Preliminary

	General Operating Funds	Debt Service Funds	General Fixed Assets	TOTALS Memorandum Only August 2011	August 2010 Final
ASSETS					
CURRENT ASSETS					
Imprest Cash Funds	3,925			3,925	2,975
Cash on Deposit-General Fund	5,551,241			5,551,241	4,887,535
Cash on Deposit-Debt Fund		437,478		437,478	558,805
Accounts Receivable	1,584,506			1,584,506	1,534,673
Inventory	33,893			33,893	32,515
TOTAL CURRENT ASSETS	7,173,565	437,478	-	7,611,043	7,057,981
FIXED ASSETS			5,050,968	5,050,968	5,050,968
OTHER ASSETS	45,776			45,776	44,819
AMOUNT TO BE PROVIDED FOR THE RETIREMENT OF LONG TERM DEBT		1,720,257		1,720,257	2,125,257
TOTAL ASSETS	**7,219,340**	**2,157,735**	**5,050,968**	**14,428,043**	**14,102,677**
LIABILITIES, DEFERRED REVENUE, FUND BALANCES					
CURRENT LIABILITIES	1,052,221			1,052,221	1,569,628
NOTES PAYABLE		407,690		407,690	407,690
DEFERRED REVENUE	141,039			141,039	(35,546)
LONG-TERM LIABILITIES FOR					
Capitol Leases	-	82,567		82,567	82,567
Bond Series 1995	-	-		-	-
Bond Series 2004		1,230,000		1,230,000	1,635,000
EXCESS(DEFICIENCY) OF REVENUES OVER EXPENSES FOR					
General Fund	902,346			902,346	52,969
Debt Service Fund	-	(40,026)		(40,026)	(15,188)
FUND EQUITY					
Reserved for Fixed Assets	-		5,050,968	5,050,968	5,050,968
Reserved for Worker's Compensation	274,409			274,409	274,409
Reserved for Debt Retirement	1,230,000			1,230,000	-
Reserved for Debt Service		477,505		477,505	573,993
Reserved for Board Policy Requirements	879,405			879,405	2,109,405
Reserved for Equipment Reserve	354,290			354,290	354,290
Reserved for Current Year Budgeted Reserve	74,000			74,000	-
Reserved for Inventory Reserve	32,973			32,973	32,973
Reserved for Operations and Programs	2,000,000			2,000,000	2,000,000
Unrestricted and Undesignated	278,658			278,658	144,390
TOTAL LIABILITIES/FUND BALANCE	**7,219,340**	**2,157,735**	**5,050,968**	**14,428,043**	**14,102,677**

TRI-COUNTY SERVICES
Revenue and Expense Summary
For the Month Ended August 2011
and YTD as of August 2011
Preliminary

INCOME:	MONTH OF August 2011	YTD August 2011
Local Revenue Sources	450,292	3,219,225
Earned Income	832,758	10,060,039
General Revenue-Contract	1,117,559	12,153,503
TOTAL INCOME	**2,400,608**	**25,432,767**
EXPENSES:		
Salaries	947,956	11,683,608
Employee Benefits	44,276	2,276,301
Medication Expense	24,529	393,974
Travel-Board/Staff	32,464	376,846
Building Rent/Maintenance	50,853	316,819
Consultants/Contracts	417,571	4,757,770
Other Operating Expenses	254,702	2,360,636
TOTAL EXPENSES	**1,772,352**	**22,165,955**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**628,256**	**3,266,812**
CAPITAL EXPENDITURES		
Capital Outlay-FF&E, Automobiles, Building	385,358	1,906,229
Capital Outlay-Debt Service Bonds	38,113	458,238
TOTAL CAPITAL EXPENDITURES	**423,471**	**2,364,467**
GRAND TOTAL EXPENDITURES	**2,195,823**	**24,530,421**
Excess (Deficiency) of Revenues and Expenses	**204,785**	**902,346**

TRI-COUNTY SERVICES
Revenue and Expense Summary
Compared to Budgeted
Year to Date as of August 2011
Preliminary

	YTD August 2011	APPROVED BUDGET	Increase (Decrease)
INCOME:			
Local Revenue Sources	3,219,225	3,268,972	(49,747)
Earned Income	10,060,039	9,843,210	216,829
General Revenue-Contract	12,153,503	12,147,608	5,895
TOTAL INCOME	**25,432,767**	**25,259,790**	**172,977**
EXPENSES:			
Salaries	11,683,608	11,759,472	(75,864)
Employee Benefits	2,276,301	2,324,318	(48,017)
Medication Expense	393,974	411,104	(17,130)
Travel-Board/Staff	376,846	388,823	(11,977)
Building Rent/Maintenance	316,819	322,163	(5,344)
Consultants/Contracts	4,757,770	4,807,531	(49,761)
Other Operating Expenses	2,360,636	2,440,089	(79,453)
TOTAL EXPENSES	**22,165,955**	**22,453,500**	**(287,545)**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**3,266,812**	**2,806,290**	**460,522**
CAPITAL EXPENDITURES			
Capital Outlay-FF&E, Automobiles	1,906,229	1,979,012	(72,783)
Capital Outlay-Debt Service Bonds	458,238	458,501	(263)
TOTAL CAPITAL EXPENDITURES	**2,364,467**	**2,437,513**	**(73,046)**
GRAND TOTAL EXPENDITURES	**24,530,421**	**24,891,013**	**(360,592)**
Excess (Deficiency) of Revenues and Expenses	**902,346**	**368,777**	**533,569**

Debt Service and Fixed Asset Fund:			
Bond Payments Receipts	458,238	458,501	**(263)**
Bond Payments Disbursements		-	**-**
Interest Income			
Excess(Deficiency) of revenues over Expenses	**458,238**	**458,501**	**(263)**

TRI-COUNTY SERVICES
Revenue and Expense Summary
Compared to Budget
For the Month Ended August 2011
Preliminary

INCOME:	MONTH OF August 2011	APPROVED BUDGET	Increase (Decrease)
Local Revenue Sources	450,292	607,609	(157,317)
Earned Income	832,758	531,624	301,134
General Revenue-Contract	1,117,559	1,108,781	8,778
TOTAL INCOME	**2,400,608**	**2,248,014**	**152,594**
EXPENSES:			
Salaries	947,956	888,765	59,191
Employee Benefits	44,276	(110,392)	154,668
Medication Expense	24,529	(102,456)	126,985
Travel-Board/Staff	32,464	(9,129)	41,593
Building Rent/Maintenance	50,853	116,139	(65,286)
Consultants/Contracts	417,571	442,161	(24,590)
Other Operating Expenses	254,702	229,871	24,831
TOTAL EXPENSES	**1,772,352**	**1,454,959**	**317,393**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**628,256**	**793,055**	**(164,799)**
CAPITAL EXPENDITURES			
Capital Outlay-FF&E, Automobiles	385,358	350,729	34,629
Capital Outlay-Debt Service Bonds	38,113	38,670	(557)
TOTAL CAPITAL EXPENDITURES	**423,471**	**389,399**	**34,072**
GRAND TOTAL EXPENDITURES	**2,195,823**	**1,844,358**	351,465
Excess (Deficiency) of Revenues and Expenses	**204,785**	**403,656**	**(198,871)**

Debt Service and Fixed Asset Fund:			
Bond Payments Receipts	38,113	38,670	(557)
Bond Payments Disbursements		-	-
Interest Income			
Excess(Deficiency) of revenues over Expenses	**38,113**	**38,670**	**(557)**

TRI-COUNTY SERVICES
Revenue and Expense Summary
With August 2010 Comparative Data
Year to Date as of August 2011
Preliminary

INCOME:	YTD August 2011	YTD August 2010	Increase (Decrease)
Local Revenue Sources	3,219,225	1,906,595	1,312,630
Earned Income	10,060,039	9,485,442	574,597
General Revenue-Contract	12,153,503	12,295,854	(142,351)
TOTAL INCOME	**25,432,767**	**23,687,891**	**1,744,876**
EXPENSES:			
Salaries	11,683,608	11,144,706	538,902
Employee Benefits	2,276,301	2,255,434	20,867
Medication Expense	393,974	650,663	(256,689)
Travel-Board/Staff	376,846	365,199	11,647
Building Rent/Maintenance	316,819	436,542	(119,723)
Consultants/Contracts	4,757,770	4,599,065	158,705
Other Operating Expenses	2,360,636	2,464,054	(103,418)
TOTAL EXPENSES	**22,165,955**	**21,915,663**	**250,292**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**3,266,812**	**1,772,228**	**1,494,584**
CAPITAL EXPENDITURES			
Capital Outlay-FF&E, Automobiles	1,906,229	773,191	1,133,038
Capital Outlay-Debt Service Bonds	458,238	719,293	(261,055)
TOTAL CAPITAL EXPENDITURES	**2,364,467**	**1,492,484**	**871,983**
GRAND TOTAL EXPENDITURES	**24,530,421**	**23,408,147**	**1,122,274**
Excess (Deficiency) of Revenues and Expenses	**902,346**	**279,744**	**622,602**

Debt Service and Fixed Asset Fund:			
Bond Payments Receipts	458,238	719,293	(261,055)
Bond Payments Disbursements			-
Interest Income			-
Excess(Deficiency) of revenues over Expenses	**458,238**	**719,293**	**(261,055)**

TRI-COUNTY SERVICES
Revenue and Expense Summary
With August 2010 Comparative Data
For the Month August 2011
Preliminary

INCOME:	MONTH OF August 2011	MONTH OF August 2010	Increase (Decrease)
Local Revenue Sources	450,292	348,095	102,197
Earned Income	832,758	806,124	26,634
General Revenue-Contract	1,117,559	1,135,263	(17,704)
TOTAL INCOME	**2,400,608**	**2,289,482**	**111,126**
EXPENSES:			
Salaries	947,956	948,584	(628)
Employee Benefits	44,276	126,828	(82,552)
Medication Expense	24,529	50,653	(26,124)
Travel-Board/Staff	32,464	33,634	(1,170)
Building Rent/Maintenance	50,853	167,759	(116,906)
Consultants/Contracts	417,571	403,051	14,520
Other Operating Expenses	254,702	377,062	(122,360)
TOTAL EXPENSES	**1,772,352**	**2,107,571**	**(335,219)**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**628,256**	**181,911**	**446,345**
CAPITAL EXPENDITURES			
Capital Outlay-FF&E, Automobiles	385,358	385,427	(69)
Capital Outlay-Debt Service Bonds	38,113	223,481	(185,368)
TOTAL CAPITAL EXPENDITURES	**423,471**	**608,908**	**(185,437)**
GRAND TOTAL EXPENDITURES	**2,195,823**	**2,716,479**	**(520,656)**
Excess (Deficiency) of Revenues and Expenses	**204,785**	**(426,999)**	**631,782**

Debt Service and Fixed Asset Fund:			
Bond Payments Receipts	38,113	223,481	(185,368)
Bond Payments Disbursements			-
Interest Income			-
Excess(Deficiency) of revenues over Expenses	**38,113**	**223,481**	**(185,368)**

TRI-COUNTY SERVICES
Revenue and Expense Summary
With July 2011 Comparative Data
As of August 2011
Preliminary

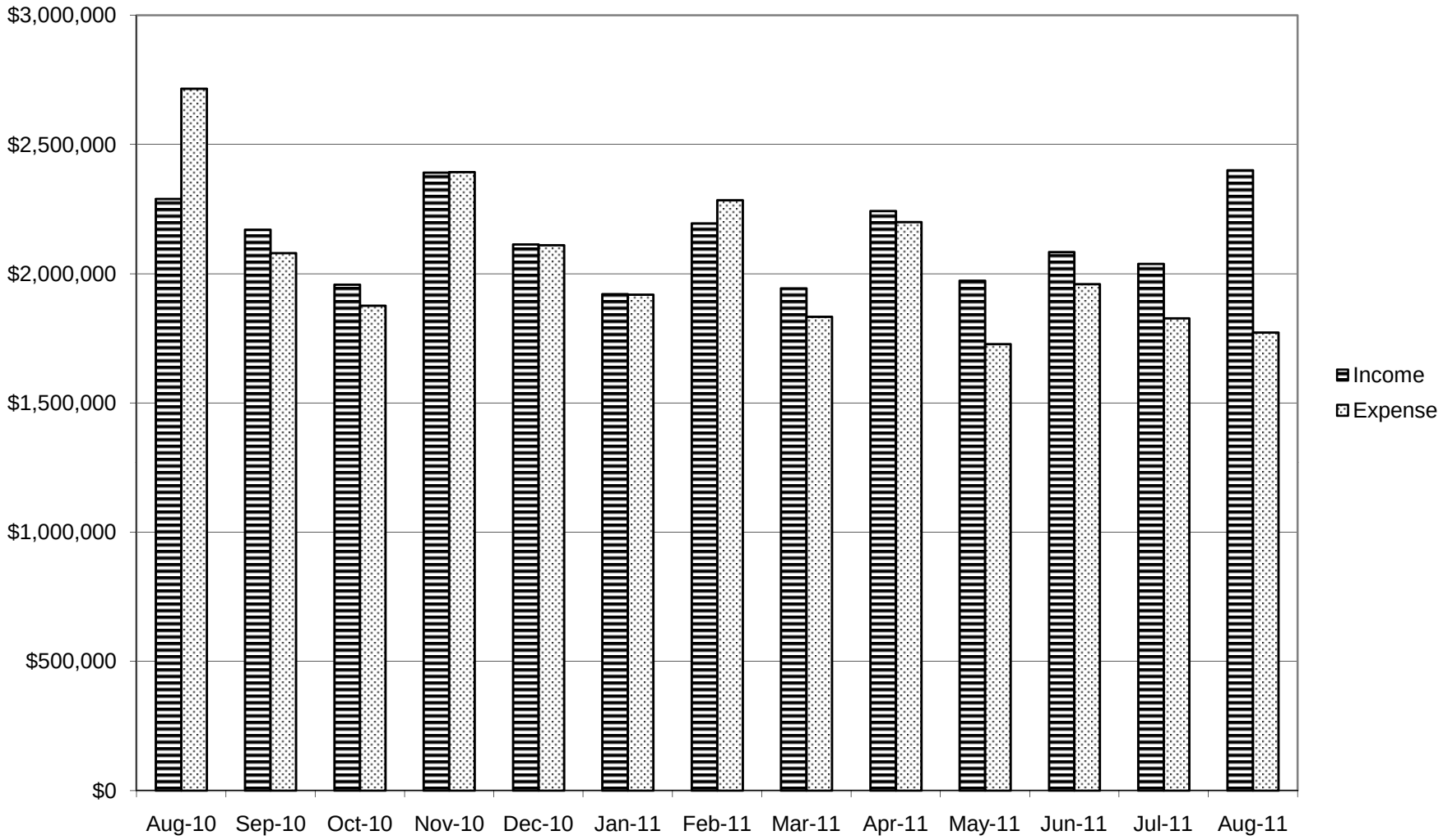
INCOME:	MONTH OF August 2011	MONTH OF July 2011	Increase (Decrease)
Local Revenue Sources	450,292	140,149	310,143
Earned Income	832,758	815,338	17,419
General Revenue-Contract	1,117,559	1,082,656	34,903
TOTAL INCOME	**2,400,608**	**2,038,143**	**362,465**
EXPENSES:			
Salaries	947,956	957,671	(9,715)
Employee Benefits	44,276	193,178	(148,902)
Medication Expense	24,529	32,150	(7,621)
Travel-Board/Staff	32,464	30,560	1,905
Building Rent/Maintenance	50,853	15,274	35,579
Consultants/Contracts	417,571	391,780	25,792
Other Operating Expenses	254,702	207,202	47,500
TOTAL EXPENSES	**1,772,352**	**1,827,814**	**(55,463)**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**628,256**	**210,329**	**417,927**
CAPITAL EXPENDITURES			
Capital Outlay-FF&E, Automobiles	385,358	-	385,358
Capital Outlay-Debt Service Bonds	38,113	38,113	-
TOTAL CAPITAL EXPENDITURES	**423,471**	**38,113**	**385,358**
GRAND TOTAL EXPENDITURES	**2,195,823**	**1,865,927**	**329,895**
Excess (Deficiency) of Revenues and Expenses	**204,785**	**172,216**	**32,569**

Debt Service and Fixed Asset Fund:			
Bond Payments Receipts	38,113	38,113	-
Bond Payments Disbursements			-
Interest Income			
Excess(Deficiency) of revenues over Expenses	**38,113**	**38,113**	**-**

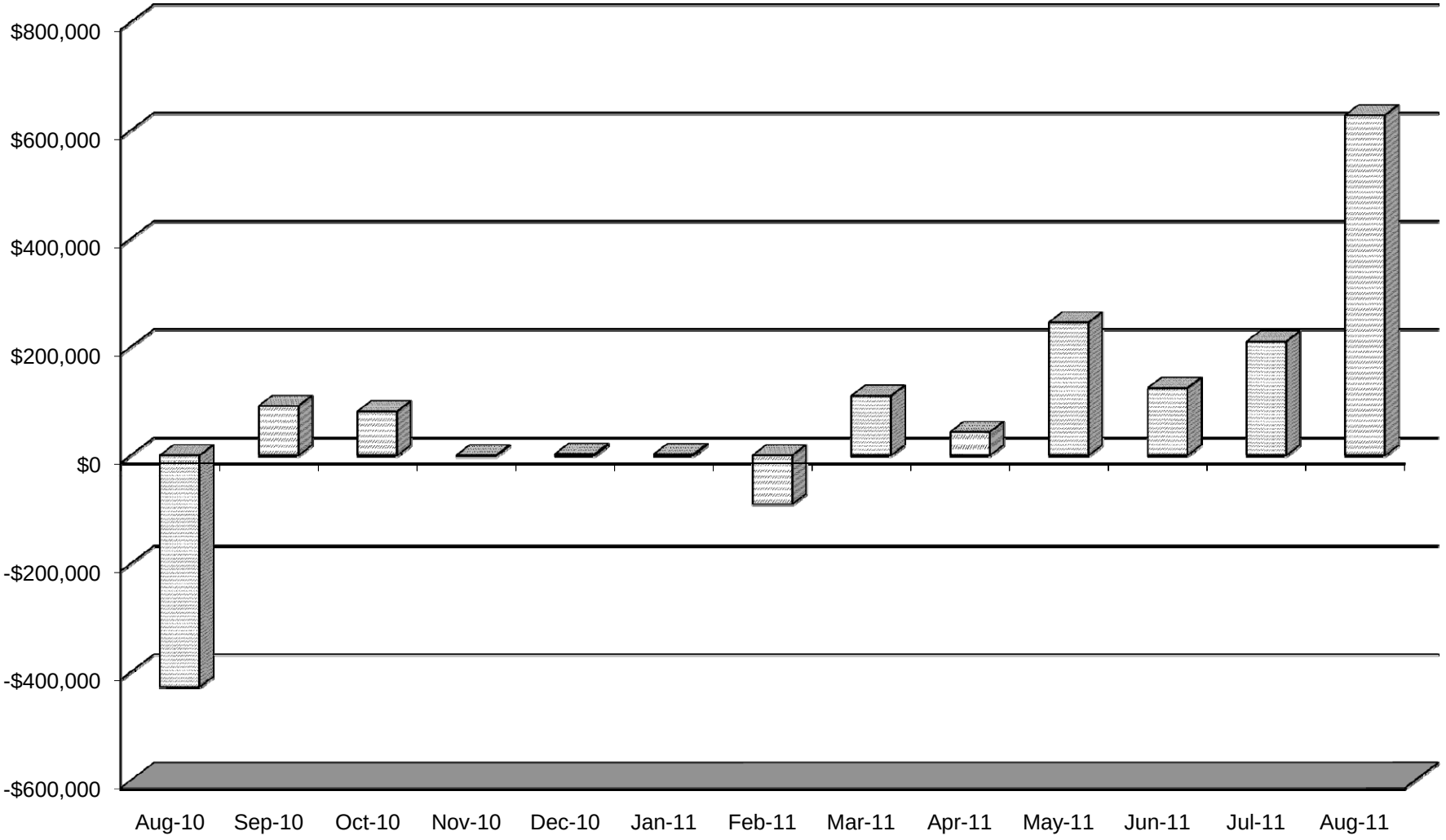
TRI-COUNTY SERVICES
Revenue and Expense Summary by Service Type
Compared to Budget
As of YTD Ended August 31, 2011
Preliminary

INCOME:	YTD Mental Health August 2011	YTD IDD August 2011	YTD Other Services August 2011	YTD Agency Total August 2011	YTD Approved Budget August 2011	Increase (Decrease)
Local Revenue Sources	3,211,420	(164,049)	171,854	3,219,225	3,268,972	(49,747)
Earned Income	2,897,789	5,922,447	1,239,804	10,060,040	9,843,210	216,830
General Revenue-Contract	10,294,279	1,859,224	-	12,153,503	12,147,608	5,895
TOTAL INCOME	**16,403,488**	**7,617,622**	**1,411,658**	**25,432,768**	**25,259,790**	**172,978**
EXPENSES:						
Salaries	8,594,427	2,289,104	800,078	11,683,608	11,759,472	(75,864)
Employee Benefits	1,594,236	521,081	160,984	2,276,301	2,324,318	(48,017)
Medication Expense	382,243	-	11,731	393,974	411,104	(17,130)
Travel-Board/Staff	240,588	91,402	44,857	376,846	388,823	(11,977)
Building Rent/Maintenance	229,287	87,313	220	316,819	322,163	(5,344)
Consultants/Contracts	923,088	3,762,138	72,544	4,757,770	4,807,531	(49,761)
Other Operating Expenses	1,517,305	581,690	261,640	2,360,636	2,440,089	(79,453)
TOTAL EXPENSES	**13,481,174**	**7,332,728**	**1,352,054**	**22,165,955**	**22,453,500**	**(287,546)**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**2,922,314**	**284,894**	**59,604**	**3,266,812**	**2,806,290**	**460,524**
CAPITAL EXPENDITURES						
Capital Outlay-FF&E, Automobiles	1,885,342	16,543	4,344	1,906,229	1,979,012	(72,783)
Capital Outlay-Debt Service Bonds	311,859	114,992	31,387	458,238	458,501	(263)
TOTAL CAPITAL EXPENDITURES	**2,197,201**	**131,535**	**35,731**	**2,364,467**	**2,437,513**	**(73,046)**
GRAND TOTAL EXPENDITURES	**15,678,375**	**7,464,263**	**1,387,785**	**24,530,422**	**24,891,013**	**(360,592)**
Excess (Deficiency) of Revenues and Expenses	**725,113**	**153,359**	**23,873**	**902,346**	**368,777**	**533,570**
Debt Service and Fixed Asset Fund:						
Bond Payments Receipts	311,859	114,992	31,387	458,238	458,501	(146,642)
Bond Payments Disbursements		-	-	-	-	-
Interest Income		-	-	-	-	-
Excess(Deficiency) of revenues over Expenses	**311,859**	**114,992**	**31,387**	**458,238**	**458,501**	**(146,642)**

TRI-COUNTY SERVICES
Income and Expense



TRI-COUNTY SERVICES
Income after Expenses



Agenda Item: August 2011 Board of Trustees' Unit Financial Statement **Committee:** Business	**Board Meeting Date** September 22, 2011
Background Information: None	
Supporting Documentation: August 2011 Board of Trustees' Unit Financial Statement	
Recommended Action: **For Information Only**	

Unit Financial Statement

FY 2011

		August 11 Actuals	August 11 Budgeted	Variance	YTD Actual	YTD Budget	Variance	Percent	Budget
	Revenues								
80103998	Allocated Revenue	$ 3,108.00	$ 3,108.00	$ -	$ 37,300.00	$ 37,300.00	$ -	0.00%	$ 37,300.00
	Total Revenue	$ 3,108.00	$ 3,108.00	$ -	$ 37,300.00	$ 37,300.00	$ -	0.00%	$ 37,300.00
	Expenses								
80105275	Food Items	$ 216.47	$ 208.00	$ 8.47	$ 1,864.23	$ 2,500.00	$ (635.77)	74.57%	$ 2,500.00
80105320	Insurance-Worker Compensation	$ 32.95	$ 23.00	$ 9.95	$ 224.53	$ 250.00	$ (25.47)	89.81%	$ 400.00
80105388	Legal Fees	$ 1,500.00	$ 1,500.00	$ -	$ 18,000.00	$ 18,000.00	$ -	100.00%	$ 18,000.00
80105415	Miscellaneous Expense	$ -	$ -	$ -	$ -	$ -	$ -	0.00%	$ -
80105605	Postage-Express Mail	$ -	$ -	$ -	$ 0.44	$ -	$ 0.44	0.00%	$ -
80105715	Supplies - Office	$ 27.88	$ 25.00	$ 2.88	$ 119.56	$ 300.00	$ (180.44)	39.85%	$ 300.00
80105750	Training	$ -	$ 375.00	$ (375.00)	$ 5,319.00	$ 4,500.00	$ 819.00	118.20%	$ 4,500.00
80105755	Travel - Local	$ 77.77	$ 100.00	$ (22.23)	$ 1,160.91	$ 1,200.00	$ (39.09)	0.00%	$ 1,200.00
80105757	Travel - Non-local Mileage/Air	$ 144.76	$ 333.00	$ (188.24)	$ 2,573.03	$ 4,000.00	$ (1,426.97)	64.33%	$ 4,000.00
80105758	Travel - Non-local Hotel	$ 119.60	$ 458.00	$ (338.40)	$ 2,583.85	$ 5,500.00	$ (2,916.15)	46.98%	$ 5,500.00
80105759	Travel - Meals	$ 36.79	$ 75.00	$ (38.21)	$ 858.56	$ 900.00	$ (41.44)	95.40%	$ 900.00
	Total Expenses	$ 2,156.22	$ 3,097.00	$ (940.78)	$ 32,704.11	$ 37,150.00	$ (4,445.89)	88.03%	$ 37,300.00
	Total Revenue minus Expenses	$ 951.78	$ 11.00	$ 940.78	$ 4,595.89	$ 150.00	$ 4,445.89	-88.03%	$ -

Agenda Item: Montgomery Supported Housing, Inc. Update **Committee:** Business	**Board Meeting Date** September 22, 2011

Background Information:

The Independence Place apartments are now full with eight approved applicants on the waiting list and eight additional applicants are in process for approval. The Montgomery Supported Housing, Inc. Board held their meeting on September 9th at the apartments and discussed the upcoming Final Closing process and operations going forward. In addition, the Board reviewed the Cost Certification Audit and the property's first financial statements.

The Cost Certification Audit was completed by Carlos Taboada and Company, P.C. on August 15th and the audit has been submitted to HUD for review and approval. Once the Cost Certification Audit has been approved, the timeline will begin for Final Closing. Although staff would like to complete Final Closing by the end of September, it seems less likely at this point.

McDougal Property Management determined that the original apartment manager for the site was unable to complete some of the job duties and released him. Currently, Jenet Genwright who manages the apartments in Huntsville is splitting her time between sites. She has done an excellent job at the site in Montgomery as she has in Huntsville for several years. McDougal is actively seeking a manager candidate for Independence Place.

Supporting Documentation:

None

Recommended Action:

For Information Only

UPCOMING MEETINGS

OCTOBER 20, 2011 – Board Meeting

- Approve Minutes from September 22, 2011 Board Meeting
- Community Resources Report for September 2011
- Consumer Services Report for September 2011
- Program Updates for September 2011
- Program Presentation – Avail and Suicide Prevention Calls/Actions
- Personnel Report for September 2011
- Approve September 2011 Financial Statements
- September 2011 Board of Trustees' Unit Financials
- Other Business Committee Issues

THERE WILL BE NO BOARD MEETING IN NOVEMBER DUE TO THE THANKSGIVING HOLIDAY!!

DECEMBER 8, 2011 – Board Meeting

- Approve Minutes from October 20, 2011 Board Meeting
- Life Skills Christmas Carolers
- Longevity Recognition Presentations
- Community Resources Report for October & November 2011
- Consumer Services Reports for October & November 2011
- Program Updates for November 2011
- Year to Date Goals & Objectives Progress Report
- Personnel Reports for October & November 2011
- Texas Council Quarterly Meeting Update
- Approve October 2011 Financial Statements
- Board of Trustees Unit Financial Statements for October 2011
- Other Business Committee Issues