Tri-County Behavioral Healthcare Board of Trustees Meeting

January 26, 2023

Tri-County Behavioral Healthcare

Healthy Minds. Meaningful Lives.

Notice is hereby given that a regular meeting of the Board of Trustees of Tri-County Behavioral Healthcare will be held on Thursday, January 26, 2023. The Business Committee will convene at **9:15 a.m.**, the Program Committee will convene at **9:30 a.m.** and the Board meeting will convene at 10:00 a.m. at 233 Sgt. Ed Holcomb Blvd. S., Conroe, Texas. The public is invited to attend and offer comments to the Board of Trustees between 10:00 a.m. and 10:05 a.m. In compliance with the Americans with Disabilities Act, Tri-County Behavioral Healthcare will provide for reasonable accommodations for persons attending the Board Meeting. To better serve you, a request should be received with 48 hours prior to the meeting. Please contact Tri-County Behavioral Healthcare at 936-521-6119.

AGENDA

I. **Organizational Items**
   - A. Chair Calls Meeting to Order
   - B. Public Comment
   - C. Quorum
   - D. Review & Act on Requests for Excused Absence

II. **Approve Minutes - December 1, 2022**

III. **Program Presentation - Veterans Service Award**

IV. **Executive Director's Report**
   - A. IDD Authority Audit
   - B. HCBS Final Rule
   - C. Pandemic Flexibilities
   - D. Cleveland Facility Updates
   - E. Legislative Updates

V. **Chief Financial Officer's Report - Millie McDuffey**
   - A. FY 2023 1st Budget Revision
   - B. Cost Accounting Methodology (CAM)
   - C. FY 2022 HCS and MEI Cost Reports
   - D. CFO Consortium

VI. **Program Committee**

Action Items

A. Approve the Mental Health Quality Management & Utilization Management Plan for FY 2022-2023 ..... *8-62*

Information Items

B. Community Resources Report *63-65*
C. Consumer Services Reports for November & December 2022 ..... *66-70*
D. Program Updates *71-76*
E. FY 2023 Goals and Objectives Progress Report *77-80*
F. 1st Quarter FY 2023 Corporate Compliance and Quality Management Report *81-83*
G. 2nd Quarter FY 2023 Corporate Compliance Training *84-85*
H. ETBHN Regional Planning & Network Advisory Committee's LPND Review Report *86-87*

VII. Executive Committee

Information Items

VIII. Business Committee

Action Items

Information Items

IX. Executive Session in compliance with Texas Government Code Section 551.071, Consultation with Attorney and Section 551.072, Real Property; 0 Veterans Memorial Parkway, Huntsville, Texas.

Posted By:

Ava Green
Executive Assistant

Tri-County Behavioral Healthcare

P.O. Box 3067
Conroe, TX 77305

BOARD OF TRUSTEES MEETING

December 1, 2022

Board Members Present:

Patti Atkins
Gail Page
Jacob Paschal
Morris Johnson
Sharon Walker
Tim Cannon
Richard Duren

Board Members Absent:

Tracy Sorensen

Tri-County Staff Present:

Evan Roberson, Executive Director
Millie McDuffey, Chief Financial Officer
Sara Bradfield, Chief Operating Officer
Kenneth Barfield, Director of Information Management Systems
Kathy Foster, Director of IDD Provider Services
Melissa Zemencsik, Director of Child and Youth Behavioral Health
Tanya Bryant, Director of Quality Management and Support
Catherine Prestigiovanni, Director of Strategic Development
Stephanie Ward, Director of Adult Behavioral Health
Yolanda Gude, Director of IDD Authority Services
Beth Dalman, Program Director Crisis Services
Darius Tuminas, Controller
Tabatha Abbott, Cost Accountant
Ashley Bare, HR Manager
Ava Green, Executive Assistant

Legal Counsel Present:

Mary Lou Flynn-Dupart, Jackson Walker LLP

Sheriff Representatives Present: None present

Guests: Rev. Carl Williamson, Calvary Baptist Church of Cleveland, Texas

Call to Order: Board Chair, Patti Atkins, called the meeting to order at 10:10 a.m.

Public Comment: There was no public comment.

Cont.

Quorum: There being seven (7) Board Members present, a quorum was established.

Resolution #12-01-01 **Motion Made By:** Richard Duren
Seconded By: Gail Page, with affirmative votes by Sharon Walker, Tim Cannon, Jacob Paschal and Morris Johnson that it be…

Resolved: That the Board approve the absence of Tracy Sorensen.

Program Presentations:

- Life Skills Christmas Carolers from Liberty, Huntsville and Cleveland
- Presentation of Awards to Consumer Christmas Card Contest Winners

Resolution #12-01-02 **Motion Made By:** Morris Johnson
Seconded By: Sharon Walker, with affirmative votes by Gail Page, Tim Cannon, Jacob Paschal and Richard Duren that it be…

Resolved: That the Board approve the minutes of the October 27, 2022 meeting of the Board of Trustees.

Executive Director's Report:

The Executive Director's report is on file.

- CSU Update
- Cleveland Service Facility Planning Update
- Huntsville Property Update

Chief Financial Officer's Report:

The Chief Financial Officer's report is on file.

- FY 2022 Audit
- Public Health Provider – Charity Care Program – (PHP-CCP) Cost Report
- Cost Accounting Methodology (CAM)
- Worker's Compensation Audit
- FY 2023 1st Budget Revision

PROGRAM COMMITTEE:

Resolution #12-01-03 **Motion Made By:** Jacob Paschal
Seconded By: Gail Page, with affirmative votes by Sharon Walker, Tim Cannon, Morris Johnson and Richard Duren that it be…

Resolved: That the Board approve the Local Provider Network Development Plan for FY 2022-2023.

Resolution #12-01-04 **Motion Made By:** Jacob Paschal
Seconded By: Gail Page, with affirmative votes by Sharon Walker, Tim Cannon, Morris Johnson and Richard Duren that it be…

Resolved: That the Board approve the Mental Health (MH) Consolidated Local Service Plan for Fiscal Years 2022-2023.

The Community Resources Reports was reviewed for information purposes only.

The Consumer Services Report for October 2022 was reviewed for information purposes only.

The Program Updates Report was reviewed for information purposes only.

EXECUTIVE COMMITTEE:

The Personnel Report for October 2022 was reviewed for information purposes only.

The Texas Council Risk Management Fund Claims Summary for October 22 was reviewed for information purposes only.

BUSINESS COMMITTEE:

Resolution #12-01-05 **Motion Made By:** Morris Johnson
Seconded By: Richard Duren, with affirmative votes by Gail Page, Jacob Paschal, Tim Cannon and Sharon Walker that it be…

Resolved: That the Board approve the October 2022 Financial Statements.

Resolution #12-01-06 **Motion Made By:** Morris Johnson
Seconded By: Jacob Paschal, with affirmative votes by Sharon Walker, Richard Duren, Tim Cannon and Gail Page that it be…

Resolved: That the Board approve the reappointment of Mr. Len Peck and Mrs. Barbara Duren to serve on the Independence Communities, Inc. Board of Directors for an additional two-year term expiring January 2025.

Resolution #12-01-07 **Motion Made By:** Morris Johnson
Seconded By: Jacob Paschal, with affirmative votes by Gail Page, Sharon Walker, Tim Cannon and Richard Duren that it be…

Resolved: That the Board approve the reappointment of Mrs. Sharon Walker and Mr. Michael Cooley to serve on the Montgomery Supported Housing, Inc. Board of Directors for an additional two-year term expiring January 2025.

Cont.

Resolution #12-01-08

Motion Made By: Morris Johnson

Seconded By: Jacob Paschal, with affirmative votes by Richard Duren, Sharon Walker, Tim Cannon and Gail Page that it be…

Resolved:

That the Board approve the reappointment of Ms. Margie Poole and Mrs. Barbara Duren to serve on the Cleveland Supported Housing, Inc. Board of Directors for an additional two-year term expiring January 2025.

The Board of Trustees Unit Financial Statement for October 2022 was reviewed for information purposes only.

The 2nd Annual Golf Ball Drop Update was reviewed for information purposes only.

The regular meeting of the Board of Trustees adjourned at 11:22 a.m.

Adjournment:

_____

Patti Atkins Date
Chair

Attest:

_____

Jacob Paschal Date
Secretary

Agenda Item: Approve the Mental Health Quality Management and Utilization Management Plan for FY 2022-2023 **Committee:** Program	**Board Meeting Date:** January 26, 2023

Background Information:

In order to address the different expectations for quality management activities across Contracts, Tri-County maintains two Quality Management Plans for the Center. The Mental Health and Substance Use Quality and Utilization Management (MH QM/UM) Plan and the Intellectual and Developmental Disability Quality and Utilization Management (IDD QM/UM). Plans are typically updated on alternating years to ensure compliance with HHSC contract requirements. Should the State's local planning process be formally delayed by HHSC, this plan will remain in effect until which time the Local Plan is updated to ensure that the planning processes continue to align.

The MH QM/UM Plan describes the administrative structures that the Center has in place to evaluate service provision and ensure continuous quality improvement along with contract compliance. The MH QM/UM Plan was reviewed and updated as necessary to ensure compliance with current HHSC contract requirements, Texas Administrative Code (TAC) and Certified Community Behavioral Health Clinic (CCBHC) certification criteria.

Supporting Documentation:

Mental Health QM/UM Plan for Fiscal Years 2022-2023

Recommended Action:

Approve the Mental Health Quality Management and Utilization Management Plan for FY 2022-2023

Tri-County Behavioral Healthcare
Mental Health and Substance Use Disorder
Quality and Utilization Management Plan
FY 2022 – 2023

_____ _____

Evan Roberson, Executive Director Date

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Chapter 1: Introduction to the Quality Management Program

INTRODUCTION

The Mental Health Quality Management and Utilization Management (MH QM/UM) Program provides a framework of activities designed to ensure that Individuals, who are receiving assistance through Tri-County Behavioral Healthcare (Tri-County), are receiving quality services provided by culturally competent and adequately trained staff in a manner that is financially viable, focused on recovery and is Person and Family Centered where appropriate.

The MH QM/UM Program is guided by Tri-County's stakeholders, the performance contract between Tri-County and the Texas Health and Human Services Commission (HHSC), the Board of Trustees, the Center's Local Plan, the Mental Health Planning Network Advisory Committee (MHPNAC), the Regional Planning Network Advisory Committee (RPNAC), Certified Community Behavioral Health Clinic (CCBHC) Guidelines and other selected best practice and accreditation guidelines. The Utilization Management Department is under the direction of the Utilization Management Psychiatrist and in consultation with the MH QM/UM Committee, assumes responsibility for the UM activities of the Center.

The Quality Management and Utilization Management Departments work closely with program managers and direct service staff to ensure the provision of quality services to those we serve while remaining compliant with contract requirements, State and Federal regulations, and by following best practice and selected accreditation guidelines. Quality Improvement is considered an ongoing effort through continuous measurement and assessment, outlined in the Continuous Quality Improvement (CQI) Plan, to ensure that our stakeholders receive the highest quality of services possible while maintaining contract compliance. The accuracy, consistency and timeliness with which service provision information is maintained are key focuses of our Quality Management and Utilization Management programs.

MISSION, VISION AND PHILOSOPHY STATEMENT

Mission

The mission of the Quality Management Program is to ensure the provision of quality services for Individuals with mental illness, substance abuse disorders and intellectual/developmental disabilities that are Linguistically and Culturally appropriate, are Person and Family Centered, enhance the quality of life in our community, and are provided in a cost effective and timely manner in the most appropriate settings by trained, competent, Trauma Informed staff.

Vision

Our vision is to support the behavioral healthcare system to ensure the provision of effective and efficient quality services to meet the needs of our community and improve the lives of those we serve.

To achieve our vision, we will:

- Partner with the community to expand the availability of new and existing resources;
- Follow Evidence Based and Trauma Informed Care Principles including ensuring related staff training.
- Provide technically, Linguistically and Culturally competent staff and services
- Train, encourage and monitor Person Centered and Family Centered Care
- Train, monitor and improve workforce skill and competence with respect to suicide risk assessment, prevention and response.
- Train and monitor privacy practices that follow State and Federal regulations and encourage information sharing when appropriate consent can be obtained for proper Care Coordination of those we serve.
- Uphold the rights of Individuals served.
- Continuously monitor, adjust and track data that can be used for CQI efforts as well as to meet reporting requirements.[1]

Philosophy/Values

The Quality Management Program is based on the premise that the provision of quality services at TCBHC is the responsibility of all staff and that participation in quality activities facilitates improved outcomes for both staff and those we serve. Continuous monitoring, feedback and training are believed to be key to ensuring the availability of competent staff who are trauma informed and that quality services are most effective when they are provided in the most appropriate setting and include culturally and linguistically appropriate services. Dignity and Respect are key values of the Quality Management Department as it is understood that Individuals thrive in environments where they feel safe and that when an individual feels empowered their likelihood of recovery increases. Recovery oriented care that takes in to account personal choice

[1] CCBHC 1.C (Cultural Competence and Other Training)
TCBHC Procedure 6.40 (Required Training);
CCBHC 1.D (Linguistic Competence)
TCBHC Procedure 15.09 (Use of Interpreters and Assistive Aids);
CCBHC 3.A (General Requirements of Care Coordination)
TCBHC 10.15 (Coordination of Services by Responsible Staff)
CCBHC 5.A (Data Collection, Reporting and Tracking)
TCBHC Procedure 19.07 (Data Collection, Reporting, and Tracking)

account personal choice through Person Centered and Family Centered concepts are seen as an integral part of empowering those we serve toward improved quality of life.

DIRECTION OF THE QUALITY/UTILIZATION MANAGEMENT (QM/UM) PROGRAMS

The QM/UM Programs at Tri-County are designed to be systematic, objective, and continuous. These programs focus on monitoring, evaluating, and improving the quality of services at our organization. Through this design, Tri-County is able to continuously evaluate the cost effectiveness, appropriateness, and timeliness of service delivery systems. The QM/UM Program assists Tri-County in assuring existing standards of care are met and accurate information is reported to HHSC and accrediting organizations as requested. These Departments, provide the framework to appropriately communicate with and obtain feedback from stakeholders on customer care and the manner in which the Center conducts its business.

Tri-County values shared responsibility for quality of care and QM activities. Departments throughout the Center participate in designated QM activities, such as the submission of frequent quality assurance reviews conducted by managers to the QM Department. These reviews are conducted as a means of supplementing the formal review processes conducted by QM staff. In addition to these reviews, QM staff continue to review records from varying departments on a regular basis. These reviews allow QM staff to provide feedback to managers and staff related to a variety of areas to include, but not limited to:

- Fidelity to Evidence-Based Practices;
- Medical Necessity;
- Appropriateness of Level of Care;
- Trauma Informed Care;
- Person and Family Centered Care;
- Recovery Oriented Care;
- Fidelity to State Assessments;
- Referrals;
- Follow up/Care Coordination;
- Safety;
- Rights Protection; and
- General Quality Care Issues.

Quality staff are also involved in an ongoing process to ensure that additional trainings are offered to staff as needed and that appropriate trainings are present in staff HR files. The Training Department continues to look for opportunities to assist our Center make enhancements to

provide Person Centered Recovery focused services for those we serve. Additionally, Quality staff work closely with Utilization Management staff to continue to monitor performance measures and other quality data that can help us monitor outcomes, identify patterns and make needed improvements to our system.

MENTAL HEALTH AUTHORITY RESPONSIBILITIES

Tri-County continues to make efforts to develop and manage a network that offers individual choice to the highest extent possible. Tri-County contracts with outside providers when practical. Contractors are required to meet the same professional qualifications as Center employees.[2] The East Texas Behavioral Healthcare Network, our local Mental Health Planning Network Advisory Committee, and the Regional Planning Network Advisory Committee provide best value analysis for Center services. In addition, we analyze Cost Accounting Methodology data and Medicaid Administrative Claiming results to identify areas where improvements are needed.

To expand our service capacity, Tri-County is writing grants and pursuing service contracts whenever feasible. We are also actively pursuing appropriate fundraising opportunities and soliciting donations. Additionally, Tri-County is continuously analyzing and improving Center processes in order to maximize the use of resources while ensuring the continued provision of quality services.

GOALS AND INITIATIVES OF THE QUALITY AND UTILIZATION MANAGEMENT PROGRAMS

The goals of the Quality Management and Utilization Management Programs are designed to ensure that Tri-County's QM and UM activities are measuring, assessing and improving the key elements of the Center's services. These goals are meant to be a foundation for the QM and UM Departments and are not intended to be the only activities of the department. The Continuous Quality Improvement Plan and Utilization Management Plan in combination with the other chapters in this manual serves as the Quality Management Plan for the Center and outline the specifics of these goals and objectives. In addition to the goals and objectives highlighted by the CQI Plan, the QM/UM Department continues to focus on the following ongoing initiatives:

ONGOING INITIATIVES OF THE QUALITY MANAGEMENT PROGRAM

1) Direct the internal program survey process to consistently, effectively and efficiently monitor and evaluate programs at Tri-County Behavioral Healthcare.
2) Direct additional reviews and quality improvement initiatives as need arises.

[2] CCBHC 1.d.5 (Linguistic Competence) – See Protected Health Information Procedure 7.02, p. 6 & 22

3) Successfully coordinate the Center's organizational self-assessment activities as a part of the ongoing evaluation and monitoring process of Tri-County Behavioral Healthcare.
4) Support Tri-County in meeting or exceeding all applicable requirements and standards.
5) Ensure Individuals served are treated with dignity and respect.
6) Ensure that the MH QM/UM committee meets at least quarterly and that key information is communicated out to staff and Management as appropriate.
7) Incorporate the above aspects of care into the activities of other agency committees (i.e. Junior Utilization Management, Safety, MH QM/UM and CQI Committees) and continue to collect and review program information needed to monitor, evaluate and implement needed changes.

ONGOING INITIATIVES OF THE UTILIZATION MANAGEMENT PROGRAM

1) Ensure Tri-County's compliance with HHSC approved Utilization Management Guidelines, contract requirements, CCBHC Guidelines and other accreditation standards, as applicable.
2) Assure that Individuals are provided with notice of their right to appeal in line with requirements surrounding the notification and appeals process.
3) Monitor service delivery outcomes for both children and adults to ensure they are meeting targets specified by HHSC, CCBHC and other accreditation guidelines as applicable.
4) Assure effective management of clinical and financial resources and ongoing improvement of the UM process by reviewing items such as eligibility, appropriateness of services, and fairness and equity of services.
5) Assure effective management of authorizations and reauthorizations of local care for outpatient services, to ensure that they follow processes and procedures set forth in the HHSC approved UM guidelines.
6) Assure that continuity and coordination of services among community service providers is monitored according to the HHSC approved UM guidelines, CCBHC Guidelines and applicable accreditation standards.
7) Monitor the HHSC Submission Calendar and notify staff of upcoming submission dates to ensure timely entry to the State or other accreditation organizations.

REVIEWING AND UPDATING THE MH QM/UM PROGRAM AND CQI PLAN

The Mental Health Quality Management and Utilization Management Program will be reviewed semiannually by the Administrator of Quality Management and needed changes will be communicated to the Director of Quality Management and Support. Potential changes to the program, procedures, and/or the CQI plan will be discussed with at least one Management Team staff. At least annually, the CQI and the Mental Health Quality Management/Utilization

Management Plans and goals are re-evaluated for their effectiveness.[3] If any component of the program is determined not to be effective, new activities including intensified monitoring efforts, re-assignment of staff, and/or the appointment of additional committees or improvement teams will be considered. The Mental Health Quality Management/Utilization Management Plan (including the CQI Plan and Procedure Manual) is reviewed and approved each biennium, in line with the Centers Local Plan, by the Management Team.[4] This plan will be amended, as needed, if any portion of the plan is modified or discontinued. Should the State's local planning process be formally delayed by HHSC, this plan will remain in effect until which time the Local Plan is updated to ensure that the planning processes continue to align.

[3] CCBHC 5.b.1 (Continuous Quality Improvement (CQI) Plan)
[4] TCBHC Quality Management Plan Chapter 5 (Continuous Quality Improvement Plan)

Chapter 2: Quality and Utilization Management Related Responsibilities: Management and Committees

Tri-County is dedicated to promoting a team approach to serving persons with mental illness, substance use, and intellectual and developmental disorders. Tri-County continues to work diligently at increasing the lines of communication between levels of management, quality-related committees, staff, as well as community partners integral to the overall health of those we serve when appropriate consent can be obtained. We continue to strive to enrich the lives of individuals served and their families. Although we adhere to the team philosophy, there must also be individuals and groups of people identified to focus on specific aspects of the Center. Individual, group and committee responsibilities at Tri-County include:

THE BOARD OF TRUSTEES:

- Responsible for the provision of a comprehensive program of services related to mental health, substance use, and intellectual and developmental disabilities in its service area.
- Strives to obtain the highest quality of service for the lowest cost.
- Establishes services for mental health, substance use, and intellectual and developmental disabilities directly, and/or through contractual arrangements stressing accessibility, availability, acceptability, and continuity of care, based on the financial capability of the Center.
- Develops and executes plans for the continued financial stability and the acquisition of adequate resources to accomplish the purposes and objectives of the Center.
- Establishes an on-going quality management program that provides for appropriate review systems which monitor client care.
- Reviews and approves the CQI and umbrella QM/UM Plan in it's entirety each biennium.
- Reviews monthly reports of programmatic and fiscal activities.
- Promotes the goals and objectives of the Center to the community by utilizing the media and other forms of communication.
- Appoints, charges and supports a Planning and Network Advisory Committee that is representative of individual's being served by the Center.[1]

THE EXECUTIVE DIRECTOR:

- Ensures the Executive Management Team (Management Team) implements, oversees and reviews Quality Management activities.
- Ensures the Management Team receives and evaluates internal and external reports for Quality Management activities.

[1] CCBHC 6.b.1 (Governance)

- Ensures that program operations and Policies and Procedures are in compliance with local, state and federal statutes and regulations.
- Evaluates and monitors Quality Management and CQI performance outcomes to ensure compliance with the QM Plan.
- Appoints members to agency committees.
- Ensures that Center goals and objectives are developed annually and that progress toward goals is monitored on at least a quarterly basis.
- Appoints staff to ensure the development and ongoing monitoring of annual CQI goals.
- Implements Board Policies through the development of operational procedures.
- Responsible for overall operations of the Center and compliance with the Performance Contract and applicable accreditation standards.

THE MANAGEMENT TEAM:

The Management Team, which is responsible for implementing, overseeing and monitoring Quality Management activities in their respective areas, consists of the Executive Director, Chief Financial Officer, Chief Operating Officer, Chief Compliance Officer, Medical Director, Director of Quality Management and Support, Director of Information Systems, Director of IDD Authority Services, Director of IDD Provider Services, Director of Adult Outpatient Services, Director of Child and Youth Outpatient Services, and the Director of Strategic Development. The Executive Director may appoint additional expanded Management Team members to ensure informed decision making and ongoing quality care. The Expanded Management Team meets regularly and is responsible for:

- Communicating and discussing important Center topics and updates (i.e. includes but not limited to: program implementation, safety, quality, upcoming changes/guidelines, or other concerns related to Center processes or quality care etc.)
- Review and discussion surrounding progress toward Annual Board Goals.
- Reviewing and discussion related to Center Budget and areas of concern.
- Review and discussion of Emerging issues at the Center.
- Dissemination of key information to respective areas.

In addition to serving as liaisons to all agency committees and working with quality management staff to continuously improve services for those we serve, Management Team members attend meetings with the Board of Trustees and receive regular reports on quality improvement activities and initiatives.

THE ADMINISTRATOR OF QUALITY MANAGEMENT:

The Administrator of Quality Management's duty, in coordination with the Management Team, is to ensure oversight of a quality management plan that describes the on-going method for assessing,

coordinating, communicating, and improving the quality management functions, processes and outcomes of the Center. The Administrator of Quality Management:

- Co-chairs the Mental Health Quality Management/Utilization Management (MH QM/UM) Committee.
- Co-chairs the Continuous Quality Improvement (CQI) Committee.
- Serves as a member of the Junior Utilization Management Committee.
- Serves as a member of the Infection Control Committee.
- Serves as a liaison to the Mental Health Planning Network Advisory Committee.
- Serves as a liaison to the Regional Planning Network Advisory Committee.
- Serves as a member of the Safety Committee.
- Coordinates activities and information between the Quality Management and Utilization Management programs.
- Works closely with utilization management staff and program managers to measure, analyze and improve service capacity and access to services.
- Provides the Management Team with reports, upon request, so they can oversee and review Quality Management activities.
- Completes program survey audits as needs are identified throughout the year.
- Serves as the Rights Protection Officer (RPO) for the Center or assists the RPO with monitoring trends in client abuse, neglect and exploitation and assigns follow-up responsibilities to appropriate staff.
- Serves as the Center's Primary Random Moment in Time Study (RMTS) Contact.
- Develops and ensures stakeholder surveys are distributed in all three local service areas on an as needed basis and monitors results of program specific surveys.
- Monitors the Performance Contract for compliance.
- Assists the Management Team in CCBHC and other applicable accreditation activities.

THE UTILIZATION MANAGER/DIRECTOR:

The Utilization Manager and the Administrator of Quality Management work closely together on the effectiveness in meeting goals and contract requirements in different programs. The Director of Quality Management & Support for Tri County is a Licensed Professional Counselor (LPC) and, prior to working in Quality and Utilization Management, has had over seven years of clinical experience working with both the child and adult populations and serves as the Utilization Manager as outlined in the HHSC performance contract. The Utilization Manager:

- Co-chairs the MH QM/UM Committee.
- Co-chairs the CQI Committee.
- Serves as a member of the Junior Utilization Management Committee.
- Serves as a member of the Regional Utilization Management Committee.

- Monitors and tracks the performance targets for Tri-County.
- Works closely with the Administrator of Quality Management and program managers to assure quality, cost effective, timely and appropriate service provisions.
- Monitors the Performance Contract and applicable accreditation standards, including CCBHC Guidelines, for compliance.

THE RIGHTS PROTECTION OFFICER:

- Chairs the Rights Review Team.
- Serves on the Center's MH QM/UM Committee.
- Serves on the Center's CQI Committee.
- Receives and follows up on complaints until there is resolution.
- Works in coordination with utilization management staff with various appeal processes and discharge reviews, as needed, and serves as the advocate for the individual served.
- Monitors rights, abuse, safety, and health data for trends, and provides information regularly to Management Team representatives to inform program development and improvement activities.
- Assists with the completion of internal audits, as needed.
- Coordinates with the State Ombudsman's office as needed or requested and reports requested information to HHSC within timelines.

THE RISK MANAGER:

- Chairs the Center's Safety Committee.
- Co-Chairs the Center's Corporate Compliance Committee.
- Serves as a member of the Infection Control Committee.
- Serves as a member of the MH QM/UM Committee.
- Serves as a member of the CQI Committee.
- Reviews aggregate critical incident data and ensures it is reported to HHSC in a timely manner.
- Ensures a 24 hour/7 day a week on call process for reporting incidents.
- Oversees Center Risk Data and reports trends to program managers through the QM/UM Committee and the respective Management Team members as needed.

THE RIGHTS REVIEW TEAM (RRT):

The Rights Review Team has been established to assist the Rights Protection Officer with protecting, preserving, promoting, and advocating for the health, safety, welfare, legal, and human rights of individuals served, as needed. The RRT members include the Center's Rights Protection Officer, and two members who have knowledge of current behavior management strategies. Other persons may be included at the meetings, as necessary, to conduct business. The RRT is responsible for:

- Ensuring due process for when a limitation of rights is being considered.
- Reviewing behavior modification plans to ensure that rights are protected.
- Reviewing medication changes for some individuals served, if necessary.

Recommendations from the RRT are reviewed with appropriate Management Team representatives when adverse trends, patterns or barriers are identified.

THE SAFETY COMMITTEE:

In conjunction with the Safety Officer, the Safety Committee creates, implements, and maintains a system of tracking, and reporting. The Safety Committee meets at least quarterly and as often as necessary to conduct business.

THE INFECTION CONTROL COMMITTEE:

The Infection Control Committee has been established and charged with the responsibility for **surveillance** (the continuing scrutiny of all those aspects of the occurrence and transmission of infections that are pertinent to effective control), **prevention** (strategies to reduce the probability of an individual acquiring an infection), and **control** (preventing the transmission of identified infections) of infections. The Infection Control Committee, under the guidance of the Medical Director, has the authority to institute any surveillance, prevention, and control measures if there is reason to believe that any individual served or staff member is at risk.

THE RISK MANAGEMENT TEAM:

The Executive Director or designee, is responsible for the development, implementation, support, monitoring, and evaluation of the comprehensive Risk Management program. Through frequent communication with Management Team members related to risk (i.e. critical incidents, safety, rights and abuse), the Executive Director or their designee, is able to delegate and assign resources to address needs at the Center in accordance with the level of risk (i.e. immediate, high, moderate and low).

THE CONTINUOUS QUALITY IMPROVEMENT COMMITTEE (CQI):[2]

The Continuous Quality Improvement (CQI) Committee meets regularly to provide ongoing operational leadership of continuous quality improvement activities at Tri-County. The Director of Quality Management and Support and the Administrator of Quality Management serve as the committee chairs with consultation and direction provided by the Executive Director and other Center Management Team members. Other members include the Chief Operating Officer, the Director of Child and Youth Outpatient Services, the Director of Adult Outpatient Services, the Director of Crisis Services, the Director of

[2] CCBHC 5.b.1 (Continuous Quality Improvement (CQI) Plan)

Information Technology or designee, the Risk Manager or designee, a Financial representative as needed, IDD Services Representative as needed, and the Rights Protection Officer if not already holding one of the previously named positions. Other staff may be called to serve on the CQI committee depending on the specific initiatives of the Committee (i.e. staff managing scheduling and front door services). The Responsibilities of the Committee include:

- Developing the quality improvement plan to include measurable goals and objectives based on priorities that meet established criteria outlined by the committee.
- Identifying and ranking indicators of quality and intermittently evaluating services based on these indicators.
- Establishing quality improvement initiatives based on Center need, trends, and/or other risk or quality factors evaluated by the Committee.
- Utilizing a PDSA Cycle to ensure improvements are managed through an evidence-based approach.
- Developing a standardized plan for communicating and sharing Quality Improvement information with the Board of Trustees, staff, individuals served and other stakeholders as appropriate.

THE MENTAL HEALTH QUALITY MANAGEMENT/UTILIZATION MANAGEMENT COMMITTEE (MH QM/UM):

The MH QM/UM Committee has a multidisciplinary membership. The Director of Quality Management and the Administrator of Quality Management are the committee chairs. Members include the Medical Director, the Director of Management Information Services, the Billing Manager, the Rights Protection Officer, the Risk Manager, representatives from Adult MH services, Child and Adolescent services, Medication services, and Crisis services and other Financial or services staff as needed. A Management Team member also attends the meetings and serves as a liaison to the Management Team. The committee will meet at least quarterly. To fulfill its responsibility, the MH QM/UM Committee will:

- Review data for MH and SUD services, complaints from individuals served, deaths of individuals served, abuse/neglect allegations, incident reports, safety committee recommendations, program satisfaction surveys, updates and findings from the CQI Committee, and any other data or reports that reflect compliance with quality standards.
- Review clinical records from MH or SUD programs as part of a more comprehensive record review to ensure that all required documentation is present in the chart and is up to quality standards.
- Provide program information about the types of problems found in charts that were reviewed so that process/performance issues can be corrected.
- Review any recommendations of the local Mental Health Planning Network Advisory Committee (MHPNAC) and participate in and submit information to the Regional Planning Network Advisory Committee (RPNAC) as needed.
- Review results of internal audits and program surveys as indicated.

- Ensure the provision of Trauma Informed, Person and Family Centered and Linguistically and Culturally Competent Services.

After review of the above, the MH QM/UM Committee will determine whether there are indications that changes are needed in the delivery of services, to policies and procedures, or to the training needs of staff. The committee's Management Team member will be responsible for presenting the committee recommendations to the Executive Director or representative Management Team members for review.

The MH QM/UM Committee's duty is also to ensure the Center is effectively managing its clinical resources and improving the efficiency of the UM process. To fulfill its responsibility, the MH QM/UM Committee will:

- Review reports that address eligibility determination, level of care assignment, service authorization and reauthorization, staff productivity, inpatient admissions, and cost of services.
- Monitor performance in relation to HHSC defined contract performance including targets, performance measures and outcomes.
- Review summary level appeal information.
- Make recommendations to managers, as necessary, regarding changes to the current service delivery and/or data collection system to ensure timely and efficient adherence to required performance measures, including outcomes.
- Make recommendations, as necessary, to the Management Team on how to efficiently and effectively meet the requirements for various contracts.
- Propose consideration of a variety of strategies that may lead to better use of available resources and possible ways of increasing resources.

THE JUNIOR UTILIZATION MANAGEMENT COMMITTEE (JUM):

The Director of Quality Management and Support chairs this committee. The Junior Utilization Management Committee (JUM) consists of the Administrator of Quality Management, the Quality and Utilization Specialist, the Manager of Management Information Services, the Controller and other agency clinical staff as needed. The JUM meets multiple times a month (usually 2-3) to analyze factors that might be affecting Tri-County's ability to meet contract performance expectations, outcome improvement measures, and to review other data that may help to inform the provision of quality services at the Center. To fulfill its responsibilities, the JUM Committee:

- Reviews a list of contract expectations, outcome improvement measures, and other identified metrics (i.e. Social Drivers of Health) and performance up to the date of the meeting.
- Updates the Tri-County Data Point Report which is a document that is accessible to managers, that reflects agency performance on target measures and outcomes.
- Sends emails to managers of programs that are below contract or performance expectations or when data indicates a quality/utilization issue needing to be addressed to inform them of program

areas that are not in compliance with contract or performance expectations and/or that need to be reviewed and/or addressed with staff.

- Reviews contract due dates and sends reminders to staff about upcoming contract deadlines.
- Creates custom reports for problem areas so staff can be more knowledgeable about factors that are affecting quality of care, contract compliance or compliance with CCBHC guidelines or other applicable accreditation standards.
- Scrutinizes data that is submitted to determine possible problems that might be affecting performance and/or quality of care.
- Coordinates with other committees as necessary (i.e. MH QM/UM or CQI) and invites program managers to present compliance concerns to the committee so that the JUM can assist with problem-solving activities.

THE SOFTWARE MANAGEMENT TEAM (SMT):

As part of the upkeep of our clinical software, Tri-County developed a team of staff dedicated to improving our software to reflect complete and accurate data. The Software Management Team meets as needed to review software issues and to correct the billing and data issues that arise from time to time. The team's focus is to ensure that the software meets the needs of our clinical staff and that our data meets both internal and external reporting requirements.

THE GRID REVIEW TEAM (GRT):

- Sets up encounter data modalities to ensure correct submission to HHSC.
- Reviews the Chargemaster Report to ensure that charges are accurate and up to date.
- Reviews the MH service array to ensure that we are in compliance with the performance contract.
- Reviews service code definitions to ensure that they are in line with the service array, Performance Contract and other accreditation standards.
- Meets annually or as needed.

THE CORPORATE COMPLIANCE COMMITTEE:

The Corporate Compliance Officer chairs this committee. The Corporate Compliance Committee is comprised of the Corporate Compliance Officer, the Administrator of Compliance, the Director of Quality Management and Support, the Chief Financial Officer, the Billing Coordinator, the Director of IDD Provider Services, the Director of Information Systems, the Adult Outpatient Services Program Director and other program managers as designated by the Management Team. The Corporate Compliance Committee is scheduled to meet at least quarterly, but the meetings may be scheduled more frequently as determined by the existing needs of the Center.

The Corporate Compliance Committee is responsible for reviewing corporate compliance issues on both a systems level and an individual provider level to determine whether there are changes that the Center

needs to make to ensure compliance with rules and laws related to ethics, services and/or billing. To fulfill its responsibility, the Corporate Compliance Committee will:

- Provide oversight of the Center's Corporate Compliance Plan.
- Review results of internal and external audits and make recommendations for corrective actions (i.e. changes to policies and procedures, staff training) as necessary to assure compliance with federal funding rules.
- Coordinate information and actions with the MH QM/UM Committee.
- Review findings of any Corporate Compliance and Privacy investigations.
- Assure that staff are provided education regarding corporate compliance issues at least quarterly.
- Review Corporate Compliance Programs of Tri-County's large contractors who do not wish to participate in the Tri-County Compliance Program.
- Review the Corporate Compliance Action Plan at least annually to determine if modification or additions are needed.
- Report all Corporate Compliance allegations, findings and dispositions (e.g. increased employee training, termination of employment, corrected billing/financial reports) to the Board of Trustees on at least a quarterly basis.

THE MENTAL HEALTH PLANNING NETWORK ADVISORY COMMITTEE (MHPNAC):

The purpose of the MHPNAC is to advise the Board of Trustees on planning, budget and contract issues, as well as the needs and priorities for the service area. Members are appointed by the Board of Trustees and represent persons with Mental Illness, Substance Use Disorders, or other populations served (i.e. Veterans). The MHPNAC is charged with providing input for the Local Plan regarding local needs and best value. One member of the MHPNAC is asked to sit on the Regional Planning Network Advisory Committee (RPNAC) for the East Texas Behavioral Healthcare Network. Staff from Tri-County serve as liaisons of the MHPNAC to provide support and information, as necessary and appropriate, for the MHPNAC to conduct its business. Liaisons have a voice, but no vote at MHPNAC meetings. Tri-County will make a concerted effort to replace MHPNAC members within 3 months of their leave. The MHPNAC is always given the opportunity to make recommendations to the Board through the Board liaison or the Director of Quality Management and Support. The responsibilities of the MHPNAC include, but are not limited to:

- Advising the Board of Trustees on planning, budgeting, and contract issues, as well as the needs and priorities in Tri-County's service area.
- Obtaining stakeholder input on service needs and delivery and presenting this information to the Board of Trustees and the Executive Director.
- Assisting with advocacy projects related to individuals served and/or the Center.
- Reviewing and providing input on the Local Provider Network Development and Consolidated Local Service Plans.

- Assisting in promoting Tri-County in the community through education efforts, presentations and contact with key community and political leaders.
- Meeting at least 6 times a year.
- Providing an annual report to the Board of Trustees.

THE REGIONAL PLANNING NETWORK ADVISORY COMMITTEE (RPNAC):

Tri-County, as a member of the East Texas Behavioral Healthcare Network (ETBHN), collaborates with member Centers for the provision of certain administrative support. ETBHN formed a Regional Planning Network Advisory Committee made up of at least one (1) MHPNAC member from each ETBHN member Center (although it can be as many as two from each Center). At least one of Tri-County's MHPNAC members, and a Center liaison attend the RPNAC meetings. Tri-County MHPNAC members who are on the RPNAC, Leadership staff and Quality Management staff work with other ETBHN Centers to meet the following goals:

- To assure that the ETBHN network of providers will continuously improve the quality of services provided to all individuals through prudent mediation by network leadership.
- To continuously activate mechanisms to proactively evaluate efforts to improve clinical outcomes and practices.
- To identify and support best value and administrative efficiencies.
- To maintain a process by which unacceptable outcomes, processes and practices can be identified.
- Evaluations shall take place one Center program at a time as determined by the Regional Oversight Committee (ROC). ETBHN will collect and compile data and distribute it to member Centers.

Chapter 3: Ongoing Quality Review Activities

In addition to the Center's Continuous Quality Improvement (CQI) Plan, outlined in Chapter 5, there are several ongoing Quality Review processes and activities that must remain in place to ensure the system of care itself remains interconnected and improvement focused. The following is an outline of additional processes and activities in place at Tri-County Behavioral Healthcare (Tri-County) and should be taken in context with the other chapters of the Quality Management Plan:

USE OF THE MENTAL HEALTH QUALITY MANAGEMENT/UTILIZATION MANAGEMENT COMMITTEE (MH QM/UM)

The Director of Quality Management and Support or designee chairs the MH QM/UM, CQI, and Junior Utilization Management (JUM) Committees while serving as a standing member of the Management Team and the Safety, Infection Control, and Corporate Compliance Committees. This ensures that information is passed between each committee, so that each committee can continue to be effective in meeting the quality assurance goals of the agency. These committees analyze data related to the Center's MH and SUD services to individuals, standards, compliance, and financial resources. Through this involvement, outliers can be determined and improvement plans written. Any needed plans of improvement will be communicated to the representative Management Team member and acted upon in a timely manner. The MH QM/UM Committee will ensure implementation and oversight of improvement initiatives.

MEASURING, ASSESSING AND IMPROVING THE ACCURACY OF DATA REPORTED BY THE LOCAL AUTHORITY

Tri-County continues to work on perfecting the data that is used for measurement of our activities. Tri-County employs specific staff who work to ensure that the mapping of our internal procedure codes to the State grid code is correct. Our staff are dedicated to re-evaluating and adjusting our system to improve its efficiency, as necessary. Tri-County batches encounter data to the State on a daily basis so that reports from the HHSC Data Warehouse can be used daily for monitoring our progress toward meeting performance measures. Each day, select staff review encounter data warnings so that corrections can be made in Tri-County's clinical system that might affect batching accuracy. Additionally, Tri-County staff are doing the following activities:

- CARE reports used for monitoring performance are sent to JUM members as well as program managers for review.
- The billing department monitors weekly service reports for possible billing errors.
- The billing department looks for diagnosis errors as a part of their weekly billing review.

- Monthly billing suspense reports are provided to clinical staff to correct billing errors. These reports are reviewed by the Software Management Team (SMT) as needed.
- Substance Use Prevention and Substance Use Treatment Data:
  Data for persons in the Substance Use Prevention and Substance Use Treatment Programs is captured in the Center's local data system (Anasazi), and in the Clinical Management for Behavioral Health Services system (CMBHS) as required by our contracts with HHSC. Reports from these systems will be monitored by Tri-County staff to determine accuracy and consistency. Data issues will be addressed as they are found and reports will be provided to the Center's Quality Management and Utilization Management Committee.
- Through the Center's CQI Plan and other Center processes outlined in Chapter 2, Center data is assessed and analyzed to ensure that applicable State and National measures are being monitored for improvement. Through this process the Center ensures that measures required by contracts, grants, funding sources, or other applicable accreditation organizations are stable and valid.

INTERNAL PROGRAM SURVEY PROCESS

One of Tri-County's self-assessment initiatives is the program survey process. The Administrator of Quality Management, the Rights Protection Officer, and other Quality Management and Center Staff complete this process. This internal auditing process looks at an identified program's compliance with the MH and/or SUD Contracts, CCBHC guidelines and other applicable standards. The program survey process is continuously analyzed and redeveloped, as needed, to be in line with the current evidence-based practice models, and other acceptable guidelines. Chart audits, interviews with program staff, interviews with the program manager, interviews with individuals served, inspection of the facilities, review of satisfaction surveys, and review of training materials are all a part of this process. Additionally, program outcomes, quality and satisfaction endeavors, financial reports, personnel development, and compliance with privacy standards (i.e. HIPAA and 42 CFR Part 2) are reviewed during this process. A summary of findings from the survey is maintained in the QM Department. Each Summary includes: strengths, weaknesses, and recommendations for improvement.

Each documentation/chart review conducted by quality management staff takes into account applicable evidenced based practices, appropriateness of placement, adequacy of services provided, and quality of individual continuum of care (continuity of care). Documentation and chart review tools used in these audits are developed from a variety of sources, including but not limited to:

- State manuals;
- Fidelity Guidelines;
- HHSC Performance Contracts;
- Texas Administrative Code;
- CCBHC guidelines;
- Evidenced-Based Practices and accreditation standards;

- Other applicable State or Federal or funding source guidelines.

The tools will continue to be changed as necessary to ensure we are measuring compliance with the most current standards and guidelines. The results of each program survey audit are shared with the program manager and designated Management Team member who ensures a Plan of Correction, if necessary, and submits it to the Administrator of Quality Management. Consideration of items needing ongoing quality assurance are reviewed by QM as a part of the corrective action process to ensure continuous quality improvement is addressed as needed. The Center's MH QM/UM Committee also reviews key findings and makes recommendations as needed.

SATISFACTION SURVEY

The Quality Management Department conducts phone surveys with individuals served during each internal program survey in order to monitor and assess satisfaction. Recommendations are made to program managers when indicated. In addition, satisfaction surveys are completed as part of the Center's self-assessment process. Each program conducts their own satisfaction surveys on a quarterly basis using either a standardized questionnaire or a survey they have approved through the Quality Management Department. The results are requested to be reviewed during program survey and are used to make reasonable changes/improvements to the program. In addition, the Administrator of Quality Management facilitates the distribution of additional satisfaction survey, on an intermittent schedule and/or as indicated, to further evaluate services.

STAKEHOLDER INVOLVEMENT AND INPUT

Area organizations in which Tri-County participates and/or collaborates include, but are not limited to:

- Community Resource Coordinating Groups (CRCG)
- Independent School Districts
- Hospitals
- Law Enforcement Agencies
- Homeless Coalitions
- United Way
- Specialty Courts (i.e. MH; Veterans)
- Mental Health Planning Network Advisory Committee (MHPNAC)
- Regional Planning Network Advisory Committee (RPNAC)
- Child Fatality Review Teams
- Montgomery County Behavioral Health and Suicide Prevention Taskforce
- Various other community partnerships.

Tri-County continues to develop community relationships with local independent school districts, hospitals and emergency departments, law enforcement and the criminal justice system as well as other agencies integral to the coordination of care for those we serve. Additionally, Tri-County strives to engage individuals served, their family members, providers, advocates, local officials, volunteers, staff, and other members of the general public in planning initiatives to identify service gaps and priorities for our community and those we serve. Participating in these groups enables Tri-County staff to build relationships through networking and collaboration with representatives from other area agencies.

CORPORATE COMPLIANCE

Tri-County continues to implement and monitor initiatives that are outlined in the Center's Corporate Compliance Plan. Corporate Compliance training is part of the new employee orientation. All employees and the Board of Trustees receive annual training on Corporate Compliance. Mandatory training helps protect the Board of Trustees, employees of all levels, and contractors against the negative consequences of federal healthcare fraud and abuse. The Corporate Compliance Procedure requires that the Center develop an improved culture of sensitivity and awareness of federal funding requirements and compliance obligations. All Corporate Compliance allegations are investigated and, if needed, corrective action is taken. Corporate Compliance training issues are discussed with employees by their supervisor on a quarterly basis. An executive level staff member continues to serve as the Corporate Compliance Officer and the Corporate Compliance Committee meets at least quarterly.

To ensure compliance with regulations, Tri-County's Corporate Compliance program includes the following:

- A Corporate Compliance Policy that includes reference to the Corporate Compliance Action Plan as the guide for Corporate Compliance activities in the Center along with a requirement that that training includes information on:
    - The Federal False Claims Act
    - The State Medicaid False Claims Act
    - Qui Tam
- A Corporate Compliance Action Plan which guides the activities of the Corporate Compliance Program at Tri-County.
- A Community Based Services Agreement that requires any contractors entering into this agreement with Tri-County to either:
    - Participate in the Tri-County Compliance program, or
    - Provide their Corporate Compliance information to our committee for review and approval.
- Corporate Compliance Training at hire, 90 days after hire and annually to ensure a positive culture of compliance as well as a solid understanding of and compliance with regulation.

- An updated Agency Employee Handbook that reflects Corporate Compliance Program requirements.

STAFF DEVELOPMENT

To ensure the provision of quality services, Tri-County staff receive on-going training. Training is provided to staff using various media. In addition to computer-based training, the Training Department also provides a variety of face-to-face training. Included in this training is a Corporate Compliance training review.

As program managers have identified problems or potential problems in their departments, the Training Coordinator and/or Clinical Trainer have developed specific CBT modules as well as provided face-to-face specific training to the program staff.

Tri-County staff may also receive training from the Texas Council Risk Management Fund and other regional and statewide conferences. The Training Department ensures that all staff are current on their training and no lapse occurs. The Human Resource Department, in coordination with the Billing Department, ensures that professional clinical staff licensing and credentials are current. Tri-County is committed to on-going professional training. Through the Clinical Trainer and other staff certified as train the trainers, our Center provides a variety of experts to provide training on such topics as trauma informed care, cultural diversity, customer service, psychological first aid, responsible care, best practices, and engagement and teaching strategies for persons with mental illness and/or substance use diagnoses. The need for and development of additional trainings is an ongoing commitment of the Tri-County Training Department.

It is required by Tri-County that Utilization Management Staff are properly trained and supervised, as required by HHSC or by other policy, law or regulation. It is the responsibility of the Quality Management Department, in consultation with the Utilization Psychiatrist and the Training Department, as necessary, to ensure documentation and supervision are properly maintained.

RIGHTS, ABUSE/NEGLECT, SAFETY, AND HEALTH DATA

Rights related issues as well as abuse and neglect information is tracked, reviewed and reported on a regular basis by the Rights Protection Officer. Tri-County protects the health and safety of individuals served, families and staff through immediate action when warranted, the on-going monitoring and reporting of critical incidents, medication errors, infection control events, maintenance, and safety reports. The MH QM/UM Committee reviews the Critical Incident Reporting (CIR) data quarterly looking for trends in all aspects of the data. If trends are found, improvement plans are requested from the appropriate program. The Safety Committee reviews those incidents involving maintenance and safety issues and communicates concerns to the appropriate Management Team representative. Immediate action is taken when needed and corrective actions may be developed to address less urgent matters and

to ensure ongoing quality improvement. Complaints are tracked through all levels of the organization and each complaint continues to be tracked until it is resolved.

When an allegation is confirmed, the Rights Protection Officer, the Administrator of Quality Management, and the appropriate program manager/Management Team Representative, determine what the Center can do to keep incidents from happening again. Occasionally, staff have received more in-depth, face-to-face training on topics such as positive behavior management, customer service, and abuse, neglect, exploitation. Often these trainings are customized for other programs in an attempt to proactively reduce the incidents of abuse, neglect and exploitation before it occurs. Should any trends or patterns arise this information will be shared with the MH QM/UM and CQI Committees for analysis and recommendation.

PLAN FOR REDUCING CONFIRMED INSTANCES OF ABUSE AND NEGLECT

The Rights Protection Officer continuously monitors information relevant to abuse and neglect of persons served and reviews relevant data quarterly or more frequently as needed. This data includes not only confirmed allegations, but also unconfirmed and inconclusive allegations. The data are reviewed and analyzed by the MH QM/UM Committee for trends or patterns involving particular programs, certain staff or persons served. If trends or patterns are identified, the information is shared with Management Team and the CQI Committee and recommendations for improvements are made and improvement plans are requested if necessary. Tri-County Quality Management Department staff have worked closely with the providers to assist with increased staff training to include documented annual updates in all training areas for new employees as well as current employees. The Safety Committee Chair serves on the MH QM/UM Committee, reviews the data to determine any trends or patterns related to safety that may need review by the Safety Committee for further recommendations.

Tri-County continues its efforts to safeguard the well-being of the individuals they serve. Tri-County has a toll free 1-800 line, which goes directly to the Rights Protection Officer, and individuals served may stay in touch with the Rights Protection Officer without having to make a long distance phone call. Although the 1-800 line is picked up by voicemail after hours, the Rights Protection Officer instructs individuals in their message on how to reach the Department of Family and Protective Services (DFPS) 1-800 line in cases of abuse, neglect or exploitation. If DFPS is contacted about potential abuse, neglect or exploitation, they may contact the after-hours on call phone which ensures that reports can be made to a live caller 24 hours a day, 365 days a year. If the individual seeks an operator after hours by pressing zero during the voicemail message, instructions will be given on how to contact our afterhours crisis service. We continue to pursue a diligent education program on how to exercise rights and contact the Rights Protection Officer as well as the Department of Family and Protective Services when there is a need.

Additionally, Quality Management Department staff conduct interviews with program staff during the program survey process of each department to ensure that staff members are knowledgeable in key areas. Interviews include verification that staff understand areas concerning rights, abuse, neglect, and exploitation issues and how/when to report such information. Also, during the review process, each

facility is checked to ensure that proper information on how to contact the Rights Protection Officer and the Department of Family and Protective Services is posted with easy to understand directions on how to utilize the information.

The Center continues to focus on best hiring practices in order to reduce the turnover rate of our workforce. Significant efforts to retain staff have been taken in the last few years and the Center continues in its commitment to explore new ways to provide quality services to the individuals we serve with our available resources.

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC (CCBHC)

In addition to routine monitoring of clinical outcomes and organizational indicators, continuous quality review activities are monitored to ensure compliance with CCBHC certification and overall adherence to CCBHC standards are formally assessed through the incorporation of CCBHC criteria into the Center's ongoing quality assurance tools and processes. Through the Continuous Quality Improvement (CQI) Plan, CCBHC criteria inclusion in Center audit tools and other Quality Management structures and activities, CCBHC is continually monitored throughout many quality review activities at Tri-County.

ADDITIONAL ONGOING QUALITY REVIEW ACTIVITIES FOR SPECIALTY PROGRAMS

Specific programs at Tri-County require additional focus from the Quality Management Program due to the intensity and/or specialty of the services provided. The following sections outline additional Quality Management activities for these services and should be read in context with the larger Quality Management Plan. The structures explained in umbrella Quality Management Plan are used for monitoring, assessing, and improving all services at the Center and include, but are not limited to, the following:

- The use of the MH QM/UM Committee;
- Measuring, Assessing, and Improving the accuracy of data reported by the Local Authority;
- Internal Program Review process;
- Satisfaction Survey;
- Stakeholder Involvement and Input;
- Staff Development;
- Rights, Abuse/Neglect, Safety, and Health Data; and
- Plan for reducing confirmed instances of Abuse and Neglect.

QUALITY MANAGEMENT OF YOUTH EMPOWERMENT SERVICES (YES) WAIVER

In FY 2016, under direction from the 83rd Legislature, Tri-County Behavioral Healthcare began providing comprehensive and community-based mental health services to children and youth at risk of institutionalization and/or out-of-home placement due to their serious emotional disturbances. The population served includes children and youth ages three (3) to eighteen (18) that reside in Montgomery, Walker, and Liberty counties. In addition to providing Wraparound services (including Intensive Case Management and Individual Skills Training) children and youth enrolled in YES Waiver can receive contracted services including:

- Respite;
- Adaptive Aids and Supports;
- Community Living Supports (CLS);
- Employment Assistance;
- Family Supports;
- Minor Home Modifications;
- Non-Medical Transportation;
- Paraprofessional Services;
- Supportive Employment;
- Transitional Services; and
- Specialized Therapies including Animal-Assisted Therapy, Art Therapy, Music Therapy, Recreational Therapy and Nutritional Counseling.

The program Director for the YES Waiver is a Licensed Professional Counselor with over 20 years of experience in the mental health and social services setting. As required by the Texas Health and Human Services Commission contract, all Tri-County policy and procedure that governs security of confidential information, discrimination, individual rights, use of tobacco, and the participant's right to file a grievance will be followed by the YES Waiver program.

The program staff along with various agency committees including JUM and MH QM/UM will monitor YES Waiver performance target numbers as required by HHSC. Tri-County's Utilization Management staff will assist program staff with the completion of these activities and results will be communicated to the Tri-County Management Team as needed. Additional audit requests will be completed by the Tri-County Quality/Utilization Management staff in cooperation with program staff. Plans of improvement and supporting documentation will be submitted to HHSC as required. Plans of improvement will be monitored by the Quality Management Department. If HHSC makes specific recommendations related to staff training, self-monitoring activities or CMBHS and/or MBOW performance reports, Tri-County staff will implement required changes.

Goals for providing Quality Management of Youth Empowerment Services

Goal 1: The Quality Management Department will collect data, measure, assess, and work to improve dimensions of performance through focus on the following aspects of care:

a. Timeliness of Services
b. Timely Enrollment of Waiver Participants
c. Plans of Care and Statements are based on underlying needs and outcome statements
d. Services are provided according to the Waiver participant's Individual Plan of Care.
e. Provider participation in child and family and team meetings
f. Assuring development and revision of Individual Plans of Care
g. Health and Safety risk factors are identified and updated
h. Collection and analysis of critical incident data
i. Providers are credentialed and trained
j. Adherence to established procedures
k. Continuity of Care

Performance Standard

Quality Management staff will incorporate the above aspects of care into the activities of other agency committees (i.e. Junior Utilization Management, Safety, MH QM/UM Committee) and will continue to collect and review quality assurance of documentation of YES Waiver services in order to monitor, evaluate, and implement needed changes.

Measurable Activities

1. Update, as necessary, review tools to be in compliance with the HHSC YES Waiver contract, the Texas Administrative Code, current evidence-based practice and the YES Waiver Policy and Procedures.
2. Evaluate and assess the program according to the aspects of care listed above.
3. Provide feedback to reviewed programs that include department strengths, weaknesses, and recommendations for improvement.
4. Provide review reports to program managers and the Management Team upon completion
5. Follow up with program managers regarding plans of correction as needed.
6. Provide key updates from internal review to the Mental Health Quality Management/Utilization Management Committee (MH QM/UM), for evaluation.
7. Continually evaluate the quality improvement process for YES Waiver and make modifications as needed to ensure that the process is measuring critical program elements.

Goal 2: The Quality Management Department will ensure that the YES Waiver procedures and processes are in compliance with state regulations.

Performance Standard
Review written procedures applicable to the YES Waiver program to ensure that they are in-line with the YES Waiver manual and that all YES staff review these procedures.

Measurable Activities

1. Upon development, review and as changes are made, ensure that written procedures are maintained in compliance with the Texas Administrative Code, YES Waiver contract, YES Waiver Policy and Procedures and objectives related to the program's mission.
2. Ensure that all staff working in the YES Waiver program are aware of procedural changes and are provided with and read the procedures applicable to their position.
3. Ensure that procedures applicable to YES Waiver are reviewed as a part of the internal program review process for YES Waiver services.
4. Provide feedback to program managers when there are indications that changes may be warranted.

QUALITY MANAGEMENT OF SUBSTANCE USE DISORDER (SUD) SERVICES

Youth Prevention Substance Use and Misuse Services, Selective (YPS) and Universal (YPU)
Tri-County began providing substance use education classes to youth who were at risk of substance use in our three county service area in Fiscal Year 2009. The YPS program uses the Rainbow Day's Kid's Connection (ages 6-11) and Youth Connection (ages 12-17) evidence-based curriculum to provide education to 'at risk' children in Liberty, Montgomery and Walker Counties. The Rainbow Days curriculum is a Curriculum-Based Support Group (CBSG) which has been approved by the Texas Health and Human Services Commission (HHSC) to be presented in schools, after-school programs, head start programs, and other community-based settings. Tri-County provides services in a variety of environments but services will primarily be provided in area Elementary, Intermediate, Junior High and Senior High Schools to children that the schools feel are appropriate for the program. Other potential service locations include homeless shelters, family violence shelters and after-school youth service programs.

In Fiscal Year 2020, Tri-County expanded the prevention program to include youth in the general public through the Youth Prevention Universal (YPU) Contract and is currently providing the All Stars Evidence Based Curriculum to hundreds of youth.

As required by the HHSC contract, all Tri-County policy and procedure that governs security of confidential information, discrimination, individual rights, use of tobacco, and the participant's right to file a grievance will be followed for the Prevention Programs.

The programs will provide participants with the opportunity to complete a satisfaction questionnaire at the conclusion of YPS and YPU services. These questionnaires and other data from the program will be reviewed during internal Program Survey audits and by the Center's MH QM/UM Committee, as needed.

The program staff will report YPS and YPU performance target numbers to the JUM Committee and MH QM/UM Committee and these committees will monitor quarterly performance as required by HHSC. If a waiting list has to be started for the program, this information will also be shared with these committees who will review the information to ensure fairness and equity in the access of services.

Tri-County's Utilization Management Staff will assist Program Staff with the completion of these activities and results will be communicated to the Tri-County Management Team representative for review. Additional audit requests will be completed by Tri-County Quality Management Staff in cooperation with Program Staff. Plans of improvement and supporting documentation will be submitted to HHSC as required and monitored by the QM/UM Departments. If HHSC makes specific recommendations related to staff training, self-monitoring activities, or CMBHS performance reports, Tri-County staff will implement required changes.

Substance Use Disorder Treatment Program (SUDTP)

After receiving local funding and state licensure for 12 adult slots in 2009, Tri-County implemented a SUDTP and later gained licensure for 12 additional slots to include adolescents. Currently, Tri-County holds state licensure for 180 slots for both adults and adolescents. In June 2010, Tri-County was awarded state funding to provide adult and youth outpatient substance use treatment services including treatment of individuals having Co-occurring Psychiatric and Substance Use Disorders (COPSD).

The Substance Use Treatment Program Manager for both Adults and Youth is an LCDC with two years of supervised post-licensure experience. In the outpatient SUDTP at Tri-County, individuals participate in group processing, education on addiction through lectures, films, books, pamphlets, and support groups. Tri-County's substance use treatment program is currently utilizing the evidence-based practices of the Matrix Intensive Outpatient Model, and Cannabis Youth Treatment (CYT) for adolescents.

As required by HHSC contract, all Tri-County policy and procedures that govern security of confidential information, discrimination, individual rights, use of tobacco, and the participant's right to file a grievance will be followed for the SUDTPs.

The SUDTP Director will provide updates to the Center's MH QM/UM Committee as needed. The Program Staff will report SUDTP performance target numbers to the JUM and MH QM/UM Committees and these committees will monitor quarterly performance as required by HHSC, CCBHC or other accreditation organization as applicable. If a waiting list has to be started for the program, this information will also be shared with these committees who will review the information to ensure fairness and equity in the access of services.

Tri-County's Utilization Management staff will assist program staff with the completion of these activities and results will be communicated to the Tri-County Management Team representative for review. Additional audit requests will be completed by Tri-County Quality Management Staff in cooperation with program staff. Plans of improvement and supporting documentation will be submitted to HHSC and/or other accreditation organizations as required. Plans of improvement will be monitored by the Utilization Management and/or Quality Management Departments. If HHSC or applicable accreditation organizations makes specific recommendations related to staff training, self-monitoring activities or CMBHS performance reports, Tri-County staff will implement required changes.

Goals for Providing Quality Management of SUD Treatment and SUD Programs

Goal 1: The Quality Management Department will implement a process to monitor SUDTP services and Prevention services for appropriateness, review progress toward goals, monitor compliance with the HHSC Substance Use Performance Contract, and ensure a documented process to implement improvements as needed.

Performance Standard

Quality Management staff will incorporate the above aspects into ongoing quality assurance activities and other agency committees (i.e. JUM, MH QM/UM) and will continue to collect and review quality assurance of documentation of SUDTP services in order to monitor, evaluate, and implement needed changes.

Measurable Activities:

1. Update, as necessary, review tools to be in compliance with the HHSC Substance Use Performance Contract, The Texas Administrative Code, applicable Memorandums of understanding, CCBHC and current evidence – based practices (i.e. The Matrix Model, Cannabis Youth Treatment (CYT), Rainbow days, Kids and Youth Connections).
2. Evaluate and assess these programs according to aspects of care listed above and outlined throughout the umbrella Quality Management Plan.
3. Provide feedback to reviewed programs that include department strengths, weaknesses and recommendations for improvement.
4. Provide the findings to program managers and the Management Team representative upon completion.
5. Follow up with program managers regarding plans of correction as needed.
6. Provide key updates from internal reviews to the MH QM/UM Committee for evaluation.
7. Continually evaluate the quality improvement process for SUDTP and make modifications as needed to ensure that the process is measuring critical program elements.

Goal 2: The Quality Management Department will ensure that Substance Use Treatment and Substance Use Prevention procedures and processes are in compliance with state regulations.

Performance Standard:

Review written procedures applicable to SUDTP and/or Prevention Programs on an annual basis and ensure that all staff review these procedures.

Measurable Activities:

1. Upon development, review, and as changes are made, ensure that written procedures are maintained in compliance with the Texas Administrative Code, the Substance Use Performance Contracts, CCBHC criteria, and include goals and objectives that relate to the program's mission.
2. Ensure that all staff working in the Substance Use Treatment Program and the Youth Substance Use Prevention Program are aware of procedural changes and are provided with and read the procedures applicable to their position.
3. Ensure that procedures applicable to substance use service provision are reviewed as a part of the internal program review process for substance use services.
4. Provide feedback to program managers when there are indications that changes may be warranted.

Chapter 4: Utilization Management Plan

Utilization Management (UM) is the vehicle through which Tri-County Behavioral Healthcare (Tri-County) ensures people receive quality, cost-effective services in a timely manner and in the most appropriate setting. By implementing UM activities, Tri-County strives to achieve a balance between the needs and quality of life of Individuals seeking services and the demand for services while taking into account the availability of resources. Tri-County, through contract with HHSC, participates in the Texas Resilience and Recovery System of care design which establishes who is eligible to receive services through a uniform assessment that determines the appropriate services through a 'Level of Care (LOC)' designation, establishes guidelines for 'Utilization Management' of Individuals assigned to an LOC, measures particular clinical outcomes to determine the impact of services and outlines the expected cost of services. The following is an outline of the key UM activities that Tri-County participates in to gain information and data in order to better inform management decisions and assist with overall improvement of the system of care. This outline should be read along with the other sections of the QM Plan in order to obtain a full picture of the UM program at Tri-County (i.e. UM related responsibilities and committees are outlined in Chapter 2). The Center's Utilization Manager, under the direction of a UM Psychiatrist and in consultation with the MH QM/UM Committee, assumes the responsibility for the execution of this UM Plan.

PSYCHIATRIST OVERSIGHT OF THE UM PROGRAM

The psychiatrist who provides oversight of the responsibilities of the UM Program and Committee for Tri-County is Jonathan Sneed, D.O. Tri-County Medical Director. Additionally, through participation in the East Texas Behavioral Healthcare Network (ETBHN), Tri-County participates in the Regional UM Committee which is overseen by Mark Janes, M.D. ETBHN Medical Director.

PROCESS FOR ELIGIBILITY DETERMINATION

Intake staff conducts a screening on each Individual to determine whether the requirements are met for admission to services and initial level of care assignment using HHSC criteria. Determinations are conducted to ensure that Tri-County's guidelines deliver treatment in the most effective and efficient manner. Quality and Utilization Management staff, whichever appropriate, review eligibility information prior to authorization, during relevant ongoing quality assurance activities, and during program survey audits as well as when appeals are requested.

PROCESS FOR LEVEL OF CARE ASSIGNMENT

Tri-County assigns each Individual served to the appropriate level of care according to HHSC TRR UM guidelines and conducts retrospective oversight of initial and subsequent level of care assignments to ensure consistent application of TRR UM guidelines. These processes ensure sufficient utilization and resource allocation determinations based on clinical data, practice guidelines and information regarding the Individual's needs with consideration of the Individual's treatment preferences and objections.

The Quality and Utilization Management Department may put additional oversight activities in place when resources are limited to ensure safety and appropriateness of any overrides.

PROCESS FOR AUTHORIZATIONS AND REAUTHORIZATIONS

Tri-County has a partnership with ETBHN to conduct retrospective oversight, initial and subsequent level of care assignments to ensure consistent application of HHSC TRR Utilization Management Guidelines. A position was added to ensure that Individuals affected by Senate Bill 58, which moved much of their mental healthcare into managed care, continue to receive needed levels of care in line with State guidelines and medical necessity.

PROCESS OF OUTLIER REVIEW

Tri-County and ETBHN, as designated by Tri-County, through its MH QM/UM Management Committee, will conduct outlier review. This process will consist of a review of data to identify outliers and to determine the need for change in level of care assignment processes, service intensity or other UM activities. These reviews are conducted to ensure provider treatment is consistent with practice guidelines as is the process for making utilization/resource allocation determinations.

EXCEPTION/ CLINICAL OVERRIDE PROCESS

Tri-County will maintain a system to override the current authorization guidelines when there is a need to make exceptions to, and manage, the amount of service authorized for an Individual, and will report on exceptions or overrides as required by HHSC. Any deviations from recommended levels of care are reviewed by the ETBHN Authorizer and program managers. Quality Management/Utilization Management is included on reviews as needed to ensure appropriateness of level of care placements. All overrides are reviewed on a regular basis at the MH QM/UM Committee Meetings.

INPATIENT ADMISSIONS, STATE HOSPITALIZATIONS AND DISCHARGE

The Center conducts reviews of inpatient admissions to ensure the most clinically appropriate, medically necessary, and effective length of stay at an inpatient facility and reviews related discharge plans to ensure timely and appropriate continuity of care following an inpatient stay.

APPEAL PROCESS

Pursuant to 25 TAC §401.464, Tri-County is dedicated to providing services which are viewed as satisfactory by Individuals receiving those services and their legally authorized representatives (LAR). The purpose of this process is to assure that Individuals:

1. Have a method to express their concerns of dissatisfaction;
2. Are assisted to do so in a constructive way; and
3. Have their concerns of dissatisfaction addressed through a formal review process.

A request to review decisions described in this section may be made by the Individual requesting or receiving services and/or supports, the Individual's LAR or any other individual with the Individual's consent.

Tri-County shall provide written notification in a language and/or method understood by the individual and/or their LAR, of the Tri-County procedure for addressing concerns or dissatisfaction with services or supports. The individual and/or LAR, shall receive this information at the time of admission into services and on an annual basis. The notification shall explain:

1. An easily understood process for Individuals and legally authorized representatives to request a review of their concerns or dissatisfaction by Tri-County;
2. How the Individual may receive assistance in requesting the review;
3. The timeframe for the review; and
4. The method by which the Individual is informed of the outcome of that review.

Tri-County shall notify Individuals and LARs in writing in a language and/or method understood by the Individual and LAR of the following decisions and of the process to appeal by requesting a review of:

1. A decision to change, reduce, or deny the Individual services or supports, at the conclusion of Tri-County's procedural review, which determines whether the Individual meets the criteria for the priority population; and
2. A decision to terminate services or supports and follow-along from Tri-County or its contractor, if appropriate.

The written notification referred to above must:

1. Be given or mailed to the Individual and the LAR within ten (10) business days of the date the decision was made;
2. State the reason for the decision;
3. Explain that the Individual and LAR may contact Tri-County within thirty (30) days of receipt of notification of the denial or change in services if dissatisfied with the decision and request that the decision be reviewed in accordance with this procedure; and
4. Include names, phone numbers and addresses of one or more accessible staff to contact during office hours.

APPEAL OF DECISION TO REDUCE SERVICES AND SUPPORTS

1. If an Individual or LAR believes that the Center or its contract provider has made a decision to involuntarily reduce services by changing the amount, duration, or scope of services and supports provided and is dissatisfied with that decision, then the Individual may request in writing that the decision be reviewed in accordance with Tri-County's Notification and Appeals Process procedure.
2. The review by the Center or its contract provider shall:
    a. Begin within ten (10) business days of receipt of the request for a review, be completed within ten (10) business days of the time it begins, unless an extension is granted by the Executive Director of the Center;

b. Begin immediately upon receipt of the request and be completed within five (5) business days if the decision is related to a crisis service;
c. Be conducted by an Individual(s) who was not involved in the initial decision;
d. Include a review of the original decision which led to the Individual's dissatisfaction;
e. Result in a decision to uphold, reverse or modify the original decision; and
f. Provide the Individual and/or LAR an opportunity to express his or her concerns in person or by telephone to the Individual reviewing the decision. The review shall also allow the Individual to:
    1) Have a representative talk with the reviewer, or
    2) Submit his or her concerns in writing, through various electronic media (i.e. tape, CD, thumb drive), or in some other fashion.

The notification and review process described in the Notification and Appeals Process procedure:

1. Is applicable only to services and supports funded by HHSC and provided or contracted for by its local authorities;
2. Does not preclude an Individual or legally authorized representative's rights to review, appeal, or other actions that accompany other funds administered through Tri-County or its contractor, or to other appeals processes provided for by other state and federal laws or regulations (i.e. Texas Health and Safety Code, Title 7, Chapter 593 (Persons with an Intellectual Disability Act); 42 USC 1396 (Medicaid Statute))

QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT

The Center's QM staff provide oversight to ensure compliance with and the quality of the implementation of Texas Resiliency and Recovery (TRR) practices, monitor fidelity to service models, monitor performance in relation to HHSC-defined performance measures, and coordinate activities with the UM program.

GOALS OF TRI-COUNTY'S UM PLAN

1. Monitor, assess, analyze, and improve accessibility by monitoring timely authorization of UAs and service provision length related to medical necessity.
2. Assure and improve availability of services by monitoring the time to the first service and proper use of any interest list, regardless of funding source, if applicable.
3. Improve quality of services by monitoring outcomes for both children and adults.
4. Monitor, analyze and frequently communicate any concerns with performance and/or quality measures to the appropriate program and clinical staff.

DELEGATED UM ACTIVITIES AND OVERSIGHT

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

analysis, of the above-mentioned Delegated Activities to the ETBHN Regional Oversight Committee, as well as to the Center's Utilization Manager.

Chapter 5: Continuous Quality Improvement (CQI) Plan

The following quality improvement plan serves as the foundation of the commitment of Tri-County Behavioral Healthcare (Tri-County) to continuously improve the quality of the treatment and services provided. Tri-County is committed to the ongoing improvement of the quality of care provided to Individuals served.

QUALITY

Quality services are those services that have an increased probability of resulting in improved outcomes and quality of life for individuals served, follow current professional knowledge, and are safe, effective, timely, person/family centered, trauma informed, recovery oriented and are provided within the guidelines of our current legal framework. Tri-County will place continued focus on improvement to ensure:

- Recovery oriented and trauma informed care;
- Services provided are medically necessary and appropriate to the needs of each individual while incorporating appropriate cultural and linguistic care;
- Services are provided at times and in places that are convenient and accessible to individuals served;
- Evidence-based practices are incorporated into treatment whenever feasible;
- Emotional and physical safety of individuals served and staff remains a key focus along with making adjustments to identified issues quickly and effectively to minimize risk;[1]
- Continued prevention, management and reduction of suicide attempts, suicide, and deaths;[2]
- Person and Family Centered Care are respected through empowering and allowing the individual a voice to identify their needs and expectations, as well as those that they designate to collaborate with the treatment team;
- Continued assessment, evaluation and adjustment of care for individuals readmitted to a hospital within 30 days as well as other populations identified to be at higher risk for frequent hospitalizations;[3]
- Processes and Services are provided in a timely and efficient manner and include appropriate coordination and continuity of care with other providers throughout the episode of care; and
- Rights are protected at all times.

[1] CCBHC 5.b.1 (Continuous Quality Improvement (CQI) Plan)
[2] CCBHC 5.b.2 (Continuous Quality Improvement (CQI) Plan)
[3] CCBHC 5.b.2 (Continuous Quality Improvement (CQI) Plan)

QUALITY IMPROVEMENT PRINCIPLES

Quality Improvement is a systemic approach to assessing, evaluating, improving, and measuring processes and services provided by Tri-County through the following principles:

- **Continuous Improvement:** The highest quality organizations understand that there are almost always opportunities for improvement and that processes must be continually reviewed and adjusted over time through small incremental changes in order to produce the most effective improvement.
- **Data Informed Practices:** Successful CQI processes use data to create feedback loops, inform processes, and measure results to determine effectiveness.[4]
- **Proactive Mindset:** An effective Quality Improvement program is continuous and will allow for identification of best practices and processes early on and prevent poor outcomes and wasted time or resources on corrective action.
- **Stakeholder Focus:** Services and programs that that attain the best quality include input from persons served, their designated family and/or support networks, and other involved community members and strive to meet and/or exceed the expectations of these stakeholders by allowing for collaboration and voice.
- **Recovery-Oriented**: Services are provided through a commitment to promoting and preserving wellness, empowering individuals served to play an active role in their recovery, and providing choice to the highest degree.
- **Leadership Involvement:** Strong leadership, direction, and support of quality improvement activities by the governing body and executive director are key to improvement and ensure that quality improvement efforts remain aligned with the organization's mission, vision, and strategic plans.
- **Workforce Empowerment**: Effective programs involve people at all levels of the organization in improving quality.

CQI ACTIVITIES

Quality Improvement Activities are an integral part in providing the foundation for an effective system wide quality management program. The following framework is supported by Center Management and includes participation from all levels of the organization in an effort to achieve a CQI structure. The primary focal points of the Quality Improvement Program for Tri-County Behavioral Healthcare include:

1) Assessing, evaluating, and measuring Tri-County's services through the collection and analysis of data.[5]
2) Working through identified quality improvement initiatives using a PDSA cycle with special focus on new or problem areas and continuing to look for ways to improve existing services.

[4] CCBHC 5.b.1 (Continuous Quality Improvement (CQI) Plan)
[5] CCBHC 5.a.1 (Data Collection, Reporting, and Tracking)

THE CQI COMMITTEE

The CQI Committee meets regularly to provide ongoing operational leadership of CQI activities at Tri-County. The Director of Quality Management and Support and the Administrator of Quality Management serve as the Committee Chairs with consultation and direction provided by the Executive Director and other Center Management Team members as needed. Other members include the Chief Operating Officer, the Director of Child and Youth Outpatient Services, the Director of Adult Outpatient Services, the Director of Crisis Services, the Director of Information Systems or designee, the Risk Manager or designee, a Financial representative as needed, an IDD services representative as needed, and the Rights Protection Officer if not already holding one of the previously named positions. Other staff may be called to serve on the CQI committee depending on the specific initiatives of the Committee (i.e. staff managing scheduling and front door services).

The Responsibilities of the Committee include:

- Developing the CQI Plan to include measurable outcomes based on priorities that meet established criteria outlined by the Committee;
- Identifying and ranking indicators of quality and intermittently evaluating services based on these indicators;
- Establishing Quality Improvement Initiatives based on Center need, trends, and/or other risk or quality factors evaluated by the Committee;
- Utilizing a Plan, Do, Study, Act (PDSA) Cycle to ensure improvements are managed through an evidence-based approach; and
- Developing a standardized plan for communicating and sharing Quality Improvement information with the Board of Trustees, Staff, Individuals served, and other stakeholders as appropriate.

ROLE OF THE PNAC

The Board of Trustees for Tri-County appoints, charges, and supports the Mental Health Planning and Network Advisory Committee (PNAC) to review and provide input related to the local needs and priorities of the local service area, contracts, special assignments and projects such as providing feedback to the CQI Committee on the CQI Plan and initiatives for the Center. The PNAC is made up of at least nine members, 51% of which are Individuals served, family members, or people in recovery from behavioral health conditions and at least one member has lived experience with homelessness or housing instability.[6] The Director of Quality Management and Support serves as the Staff liaison to the PNAC, able to communicate feedback back to the CQI committee and the Board of Trustees in a timely manner.

GOALS AND OBJECTIVES

Annually, following the initial CQI plan, the CQI Committee is responsible for identifying and defining goals and specific outcomes to be accomplished through the PDSA process. The Director of Quality

[6] CCBHC 6.b.1 (Governance)

Management and Support, the Executive Director, the Board of Trustees, the PNAC, HHSC, or accrediting organizations may request additional initiatives for the Committee to evaluate as Center need arises.

LONG TERM GOALS AND OBJECTIVES

The following are the ongoing long term CQI goals for Tri-County and the specific objectives for accomplishing these goals for the term of this plan:

1) To implement quantifiable measurement practices that assess key processes or outcomes;
2) To bring managers and other Tri-County staff together to review quantifiable data, trends, and other risk/areas of concern;
3) To achieve measurable improvement in the highest priority areas;
4) To meet internal and external reporting requirements;
5) To provide meaningful education and training to managers and Tri-County Staff;
6) To develop or utilize tools, such as Evidence-Based Practice Guidelines, Client Satisfaction Surveys and other Quality Indicators and review these tools intermittently for effectiveness;
7) To continuously work to reduce and prevent suicide attempts and completions of Individuals served;
8) To reduce thirty (30) day rehospitalizations related to behavioral health;[7]and
9) To establish Fidelity checkpoints for overall accreditation (i.e. CCBHC) adherence as well as processes to review other evidence-based protocols.

TARGETED GOALS AND OBJECTIVES

The following are the current targeted goals and objectives identified by Tri-County for the remainder of this plan term:

1) The FY 23 annual average No Show Percentage will be reduced by 3% from the FY 22 annual average No Show percentage for at least one of the following: At least one Clinic Location or overall Center average.
2) The FY 23 percentage of individual suicides in a FLOC will be reduced by 10% from the FY 22 annual percentage or the average percentage over the last 3 years.
3) The FY 23 number of individuals in a FLOC who were re- hospitalized within 30 days of admission to an inpatient hospital setting that is known to the Center will be reduced by at least 2 individuals from FY 22.
4) The FY 23 Percentage of individuals receiving an initial evaluation within 10 days of contact with the Center will be increased by 3 % from the FY 22 year end percentage.

[7] CCBHC 5.b.2 (Continuous Quality Improvement (CQI) Plan)

PERFORMANCE MEASUREMENT

Tri-County utilizes Performance Measurement to regularly assess the results produced by a program or by a service through identifying processes, systems, selecting indicators and analyzing information related to these indicators on a regular basis. Tri-County's CQI Team takes action as needed based on the results of the data analysis and the opportunities for performance they identify.

The CQI Team:

- Assesses the consistency of outcomes to determine whether the information is reliable and whether there is a need for improvement;
- Identifies problems and opportunities to improve the performance of processes;
- Assesses the outcome of the care provided; and
- Assesses changes to determine whether a new or improved process meets performance expectations.

The CQI Team uses various Measurement and Assessment tools (**See Appendix A**) in order to:

- Select a process or outcome to be measured;
- Identify Performance indicators or outcomes;
- Gather Data and combined data as needed to measure the process or outcome quantifiably;
- Review Indicators on a planned and regular schedule;
- Take action when issues of statistical reliability, under performance or when opportunity for improvement presents; and
- Report findings to the organization to include conclusions and actions taken.

Selection of a performance indicator:
A performance indicator is a quantitative tool that provides information about the performance of Tri-County's process, services, functions or outcomes. Selection of a performance indicator is based on the following considerations:

- Relevance to mission – whether the indicator addresses the population served.
- Whether it addresses key areas of practice such as high volume, pattern of issue, or high risk.

Additional factors to consider in selecting an indicator include whether it is correlated to the issue at hand, the validity of the indicator, available resources, stakeholder preference, and if it is meaningful or not.

The following tables represents the current performance indicators being utilized by Tri-County:

Measure of Service Quality	
Indicator	Percentage of Doctor Appointment No Shows
Definition	The FY 23 annual average No Show Percentage will be reduced by 3% from the FY 22 annual average No Show percentage for at least one of the following: At least one Clinic Location or overall Center average.
Data to be collected	Number of individuals seen at the Center for a Pharmacological Management Service and the number of No Shows documented will be compared to produce a percentage.
Frequency of analysis or assessment	No show rate is reviewed in the Junior Utilization Management Committee which is typically held 2-3 times per month.
Preliminary ideas for improvement	Examine reminder process and process for identifying and addressing obstacles to treatment such as transportation.

Measure of Service Quality	
Indicator	The number of completed suicide deaths of Individuals served in the FLOC at Tri-County.
Definition	The FY 23 percentage of individual suicide deaths in a FLOC will be reduced by 10% from the FY 22 annual percentage or the average percentage over the last 3 years.
Data to be collected	The number of Individuals in the FLOC and the number of deaths due to completed suicide for Individuals in the FLOC.
Frequency of analysis or assessment	Monthly
Preliminary ideas for improvement	Continue to utilize risk stratification to identify individuals at high risk and connect them with additional supports and services including increased follow up and safety planning.

Measure of Service Quality	
Indicator	Rehospitalization within 30 days.
Definition	The FY 23 number of individuals in a FLOC who were re-hospitalized within 30 days of admission to an inpatient hospital setting that is known to the Center will be reduced by at least 2 individuals from FY 22.
Data to be collected	Number of individuals in a FLOC compared to the number in a FLOC who are re-hospitalized by Tri-County within 30 days of hospitalization.
Frequency of analysis or assessment	Frequent hospitalizations are reviewed in the Junior Utilization Management Committee which is typically held 2-3 times per month.
Preliminary ideas for improvement	Examine follow up, engagement, referrals and care coordination completed with this population to determine areas of improvement.

Measure of Service Quality	
Indicator	Improvement of the I-Eval CCBHC Measure – Time from initial contact to evaluation.
Definition	The FY 23 Percentage of individuals receiving an initial evaluation within 10 days of contact with the Center will be increased by 3 % from the FY 22 year end percentage.
Data to be collected	Dates of Initial Contact compared to dates of evaluation
Frequency of analysis or assessment	I-Eval measure status is reviewed in the Junior Utilization Management Committee which is typically held 2-3 times per month.
Preliminary ideas for improvement	Review factors that may be affecting the measure (i.e. scheduling practices, client no shows, availability).

QUALITY IMPROVEMENT INITIATIVE

Once the performance of a selected process has been measured, assessed, and analyzed, the information gathered by the above performance indicators is used to identify a CQI initiative to be undertaken. The decision to undertake the initiative is based upon TCBHC priorities. The purpose of an initiative is to improve the performance of existing services or to design new ones. The model utilized at TCBHC is PDSA and is outlined briefly below:

Plan:	The process of identifying needed change to be tested or implemented, identifying quantifiable data that can be used to measure the change and recording baseline data.
Do:	The process of testing the change.
Study:	The pre and post comparison of predetermined measurable outcomes to determine the impact of the change, whether it affected what was expected to be affected.
Act:	Planning the next phase of the improvement cycle or moving to fully implement the change if found to be effective. This phase should include actions to maintain changes (follow up) and includes documentation and communication or reports and/or findings.

EVALUATION

An evaluation is completed at the end of each calendar year. The annual evaluation is conducted by TCBHC and kept on file in the Quality Management Department for 7 years (or greater if required by law or accrediting body). These documents may be reviewed by contracting or accreditation agencies and should be organized and easily accessible. The evaluation summarizes the goals and objectives of TCBHC's CQI Plan, activities conducted over the past year, the findings, and any quality improvement initiatives taken in response to the findings and recommendations.[8]

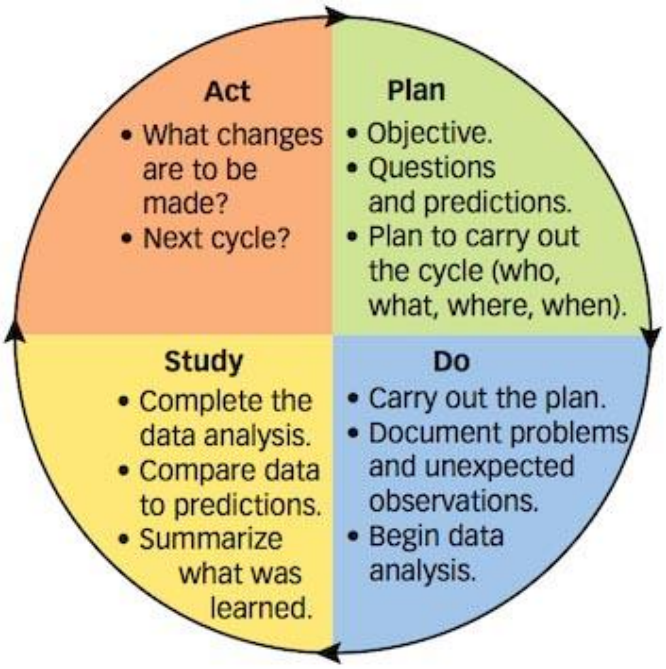
CELEBRATE SUCCESS

When the Evaluation results in positive results and significant improvements, Tri-County will seek ways to provide recognition to employees and programs who were key in making the improvements a success. As well, the information will be shared in a variety of formats that reach employees and stakeholders.

[8] CCBHC 5.b.1 (Continuous Quality Improvement (CQI) Plan)

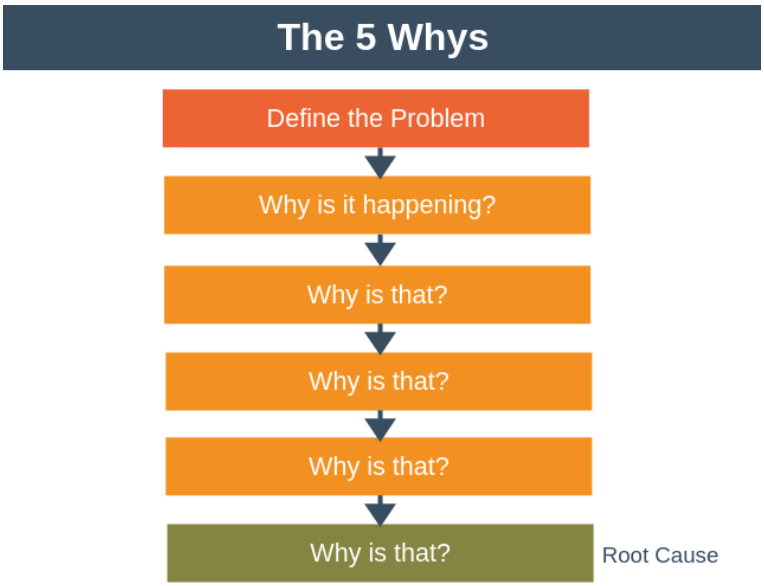
Appendix A

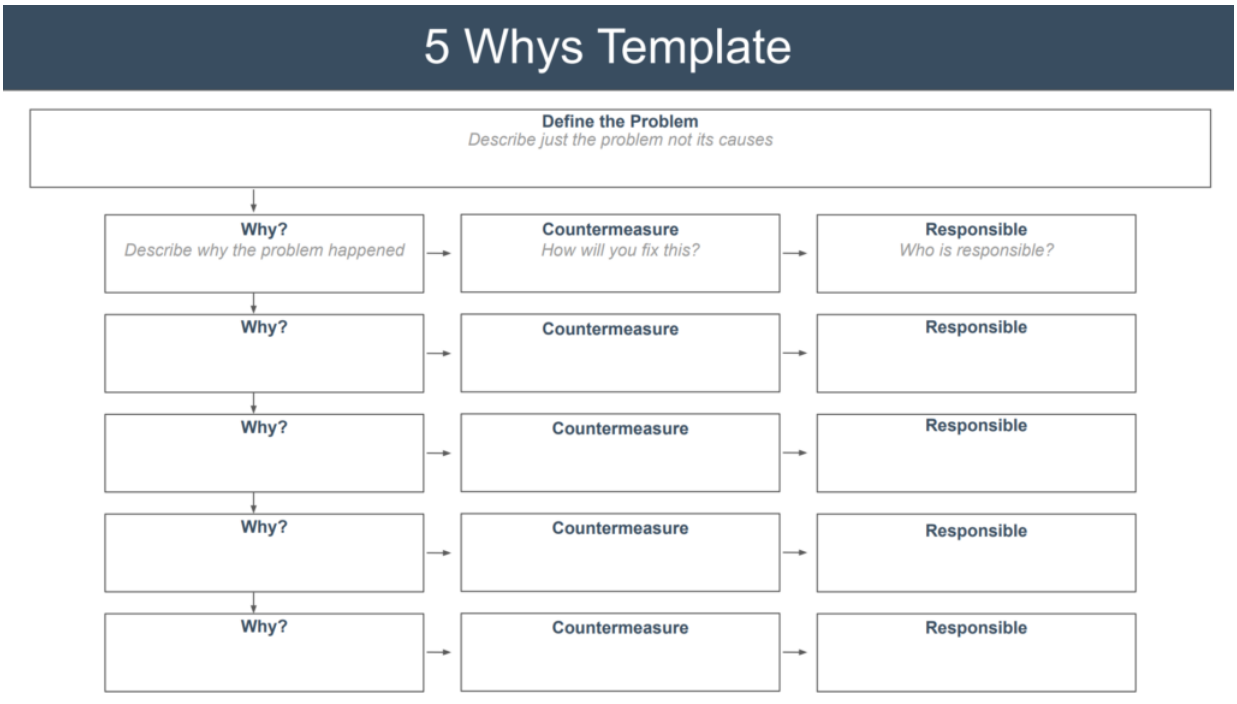
The following is a visual of the PDSA cycle:

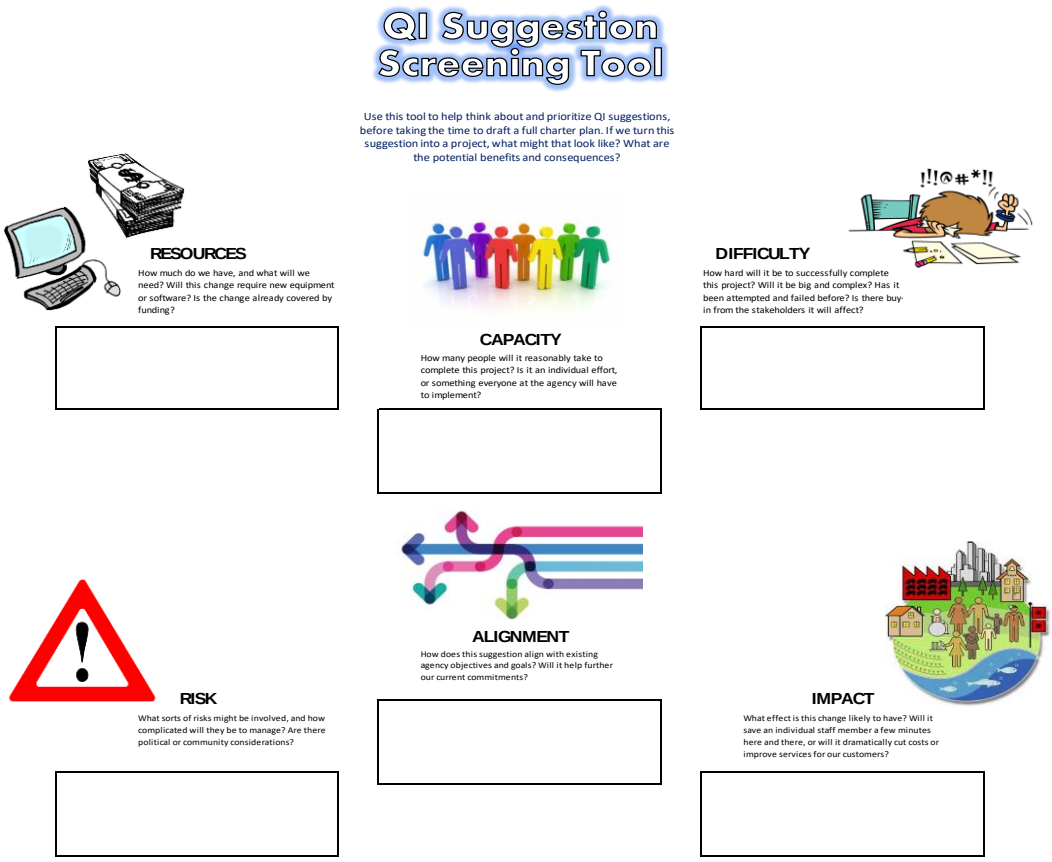


The Following are examples of Tools that the CQI Committee or Programs may use during the Screening Planning phase of PDSA:

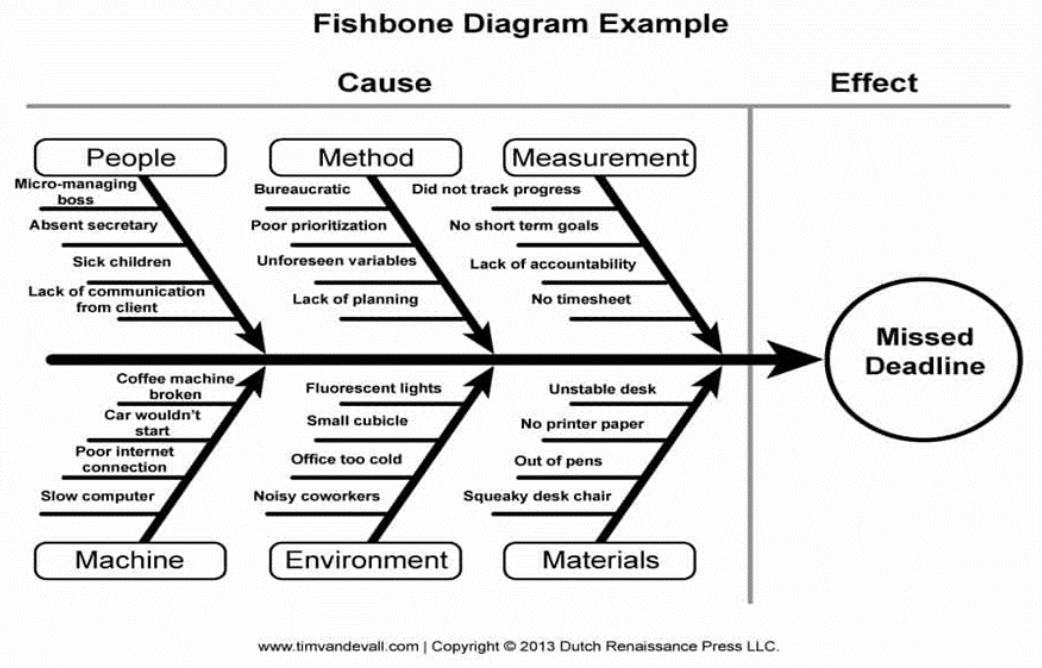
Below is a sample of the 5 Why's Tool followed by a template 5 Why's and Screening Tool that can be used by the CQI Committee:

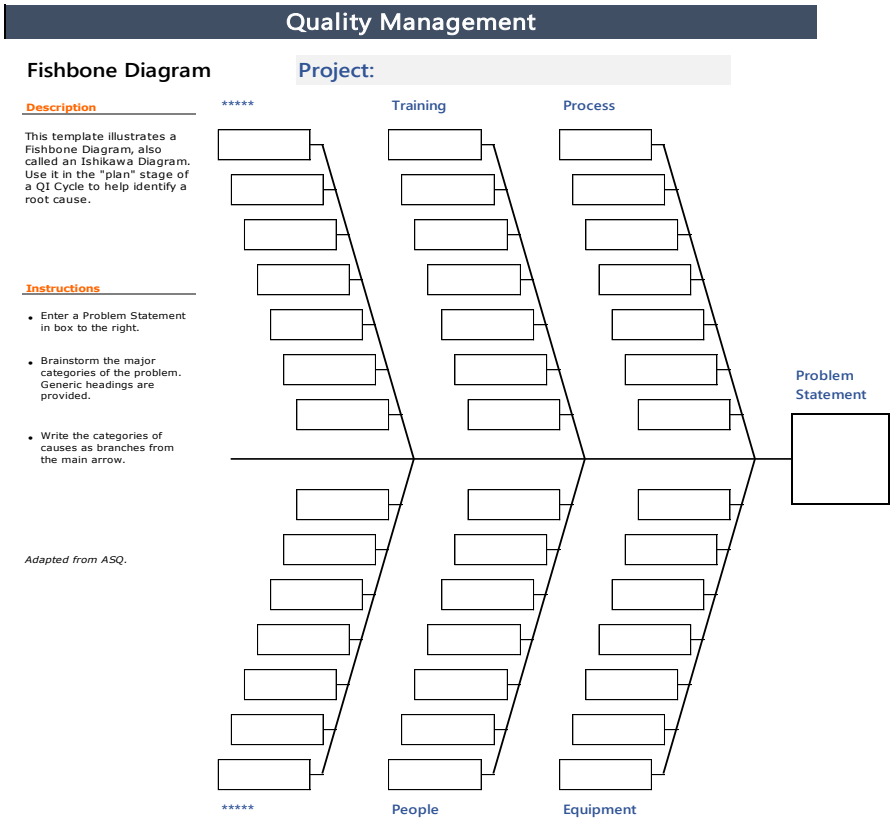

The 5 Whys
Define the Problem
Why is it happening?
Why is that?
Why is that?
Why is that?
Why is that?
Root Cause


5 Whys Template
Define the Problem
Describe just the problem not its causes
Why?
Describe why the problem happened
Countermeasure
How will you fix this?
Responsible
Who is responsible?
Why?
Countermeasure
Responsible
Why?
Countermeasure
Responsible
Why?
Countermeasure
Responsible
Why?
Countermeasure
Responsible



The Fishbone diagram can be used during the planning stage to help identify a root cause. Below is a sample of how it is used followed by a template:



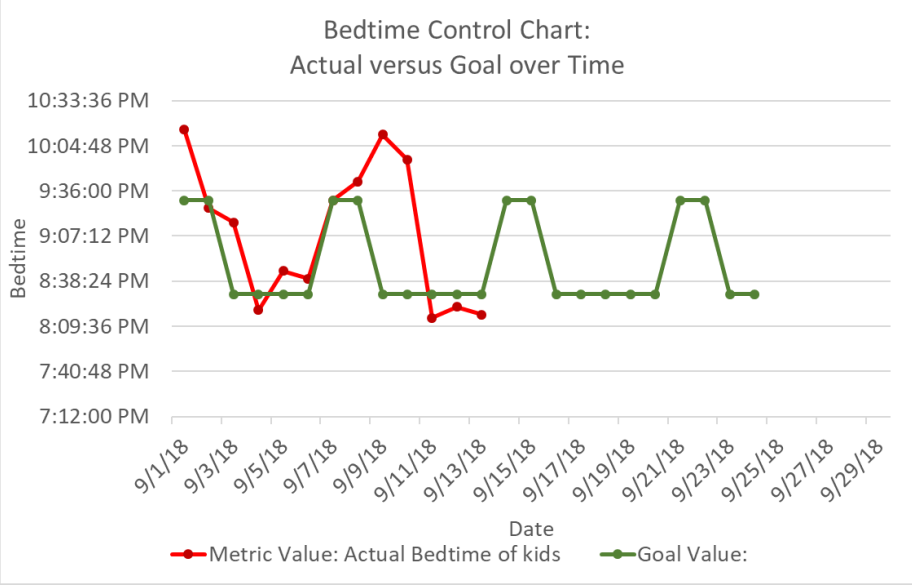


The CQI Events Log can be used to track what you have done and the overall duration of each PDSA cycle as well as the project duration:

CQI Events Log

Description	When?	What did we do?	Who was there?	What was decided/output?	What happens next?
	9/10/2018	Initial meeting to discuss problem	Tanya B., Sara B., Melissa Z.	Drafted problem statement, identified team	Complete project charter
This template is to help you track what you've done, as well as the duration of each PDSA cycle and the total project duration.					
Instructions					
• Fill in the table. Just the basics, keep it to a sentence or a few					
• Add more rows as needed. This is helpful for keeping track of what's happened. Could also use Asana for action item tracking in conjunction with this tool.					

The following are examples of Tools that may be used during the Measure and Study phase of PDSA. This is the phase where pre and post comparison of predetermined measurable outcomes are reviewed to determine the impact of the change, whether it affected what was expected to be affected:



Control Chart

Key Performance Metric: <Enter brief description of metric here.>

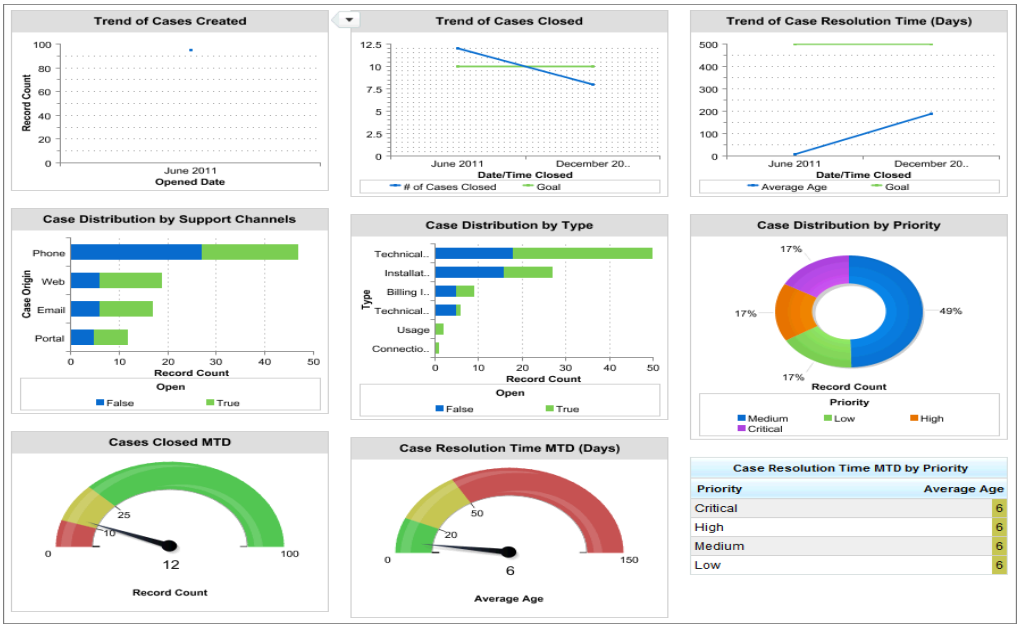
Description

This template is to help you track performance on a key performance metric over time to see trends and the impact of interventions.

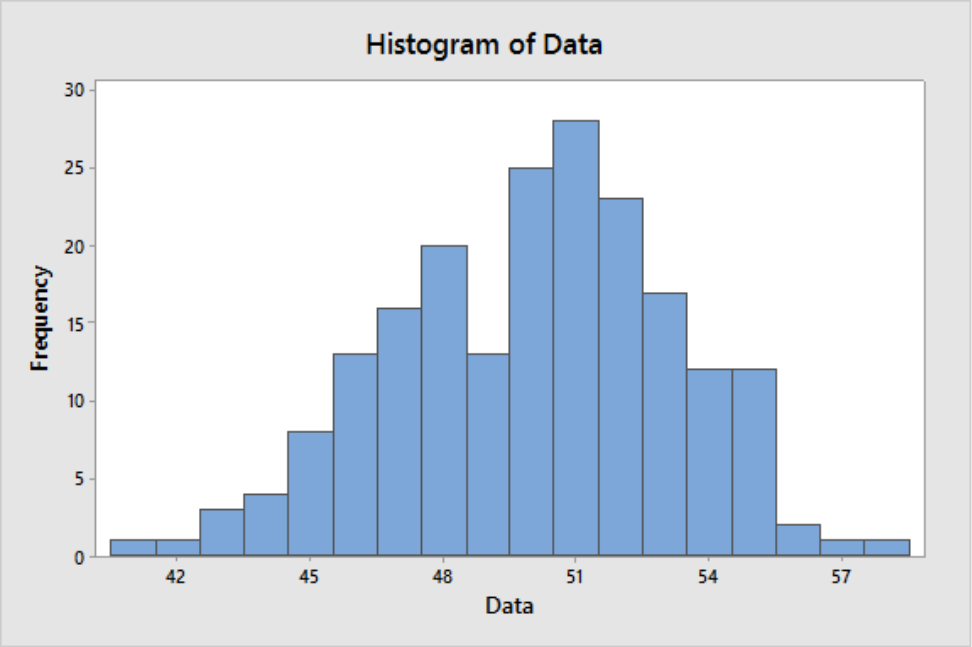
Instructions

- Enter a brief description of the key performance metric at the top.
- Add goal values for each day - can be the same or different.
- Add actual values as you go, and track over time. Note when interventions implemented and the result. Take action when out of range.

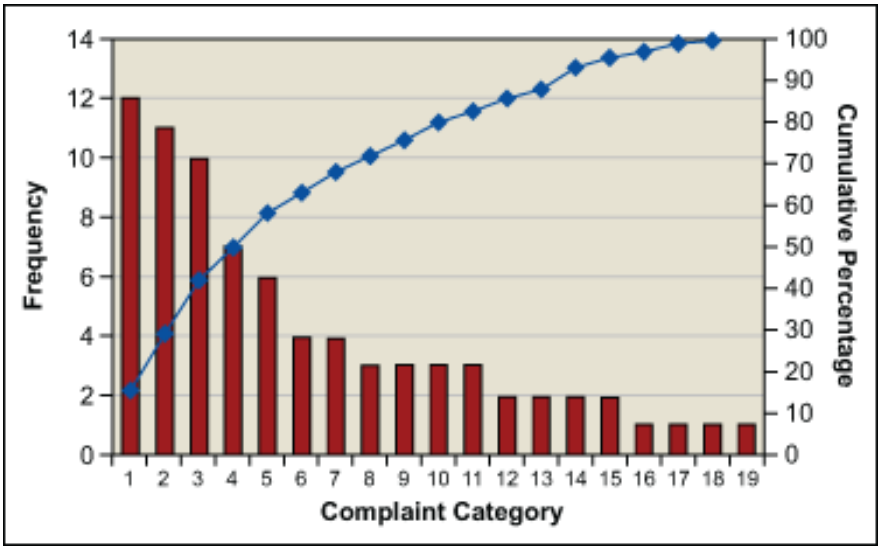
Date	Metric Value: Actual Bedtime of kids	Goal Value:	Intervention?
9/1/2018	10:15 PM	9:30 PM	Yelling
9/2/2018	9:25 PM	9:30 PM	Begging
9/3/2018	9:16 PM	8:30 PM	Pleading
9/4/2018	8:20 PM	8:30 PM	Bribing
9/5/2018	8:45 PM	8:30 PM	Reminding
9/6/2018	8:40 PM	8:30 PM	Nagging
9/7/2018	9:30 PM	9:30 PM	Game
9/8/2018	9:42 PM	9:30 PM	Game
9/9/2018	10:12 PM	8:30 PM	[Movie Night]
9/10/2018	9:56 PM	8:30 PM	Nothing
9/11/2018	8:15 PM	8:30 PM	Bedtime Bonus Day 1
9/12/2018	8:22 PM	8:30 PM	Bedtime Bonus Day 2
9/13/2018	8:17 PM	8:30 PM	Bedtime Bonus Day 3
9/14/2018		9:30 PM	Bedtime Bonus Day 4
9/15/2018		9:30 PM	Bedtime Bonus Day 5
9/16/2018		8:30 PM	
9/17/2018		8:30 PM	
9/18/2018		8:30 PM	
9/19/2018		8:30 PM	
9/20/2018		8:30 PM	
9/21/2018		9:30 PM	
9/22/2018		9:30 PM	
9/23/2018		8:30 PM	
9/24/2018		8:30 PM	
9/25/2018			
9/26/2018			
9/27/2018			
9/28/2018			
9/29/2018			
9/30/2018			



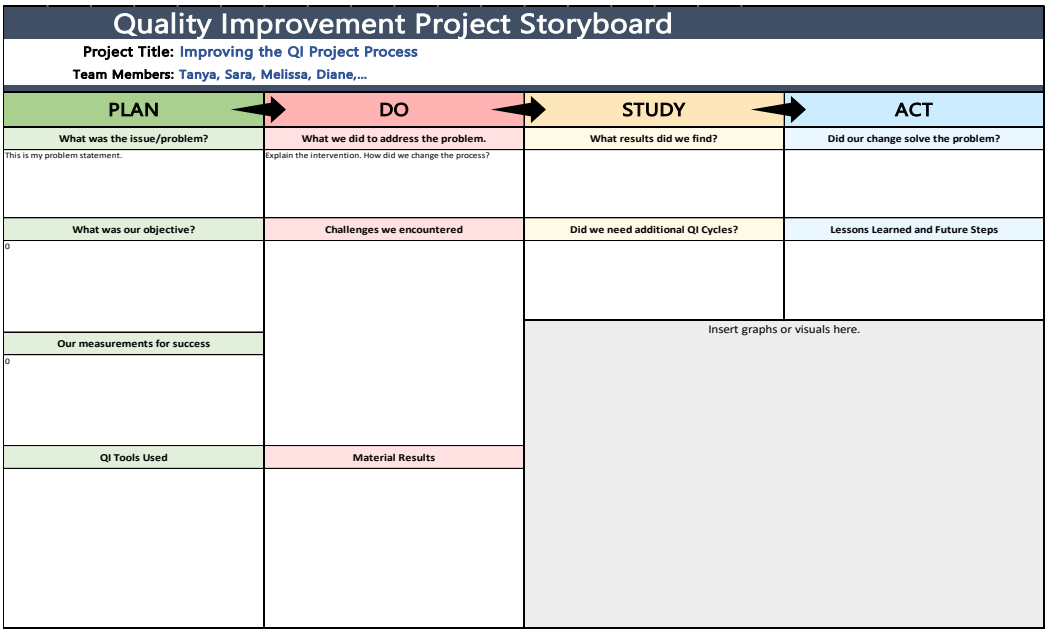
Commonly used to present Quality Improvement Data, histograms work best with small amounts of data that vary considerably so that the information can be used to identify which portions of the data did not meet specifications. This can be helpful when multiple PDSA cycles are conducted on a quality improvement project and you are trying to identify the most effective changes:



A Pareto chart can be helpful in identifying the most important among a large set of factors. For example, it may be helpful in identifying the most frequent reasons for customer complaints:



A storyboard for each successful CQI project will be completed by the CQI Committee as a means of sharing information about successful CQI Projects and to facilitate replication in other areas:



Quality Improvement Project Storyboard

Project Title: Improving the QI Project Process

Team Members: Tanya, Sara, Melissa, Diane,...

PLAN	DO	STUDY	ACT
What was the issue/problem?	What we did to address the problem.	What results did we find?	Did our change solve the problem?
This is my problem statement.	Explain the intervention. How did we change the process?		
What was our objective?	Challenges we encountered	Did we need additional QI Cycles?	Lessons Learned and Future Steps
0			
Our measurements for success		Insert graphs or visuals here.	
0			
QI Tools Used	Material Results		

Below is CQI Report Template that Tri-County CQI Committee may use to document the PDSA process:

Tri-County Behavioral Healthcare

EXAMPLE CQI PROJECT PLAN

STAGE 1: PLAN • **STAGE 2: DO** • **STAGE 3: STUDY** • **STAGE 4: ACT**

Project Title:	Agency: Tri-County Behavioral Healthcare
Project Start Date:	Reporter's Name:
Project End (or expected end) Date (mm/dd/yy):	Reporter's Title: Director of Quality Management & Support
County or Facility:	Reporter's Contact Information:

STAGE 1: PLAN

Define, explore, and structure a quality improvement project.

HELPFUL TOOLS: Fishbone Diagram, Five Why's, Screening Tools, Program Evaluation, Data Collection, Customer and Employee Feedback, previous PDSA results.

1. What problem are you trying to fix (Problem Statement)?
2. What is the root cause of the problem?
3. What evidence (current data) supports you problem?
4. What change do you want to see in the process or problem to correct (Global Aim statement)?
5. What are you trying to acheive (specific aim)?
6. Define a timeline for the following project stages:
   - Plan:
   - Do:
   - Study:
   - Act:
7. Select the affected population(s) check all that apply: __Individual Served __Employee/Agency __General Public __Other
8. Select the areas where this project aims to impact the goals and stratigic priorities of Tri-County:

Impact Area	Program	Tri-County
Access to Care		
Care Coordination		
Communication and Education		
Complainace		
Customer Satisfaction		
Employee Communication and Collaboration		
Employee Engagement/Satisfaction		
Employee Productivity		
External Stakeholders		
Facilities		
Financial		
Health Outcomes/Behaviors		
Information Technology		
Public Perception		
Use of Resources		
Other		
Other		
Other		
Other		

9. Do you have resources to fix the issue?
10. What resources (new and existing) will you requrie and how will you
11. Does the project aim align with the Program's Goals?
12. Does the project aim align with Tri-County's strategic Goals?

CQI Committee Members by Name	Role/Title
Tanya Bryant	Director of Quality Management & Support

14. Incorporating the information gathered throughout the planning process, describe the action plan:
15: Begin constructing a **CQI Storyboard**. Date Started:

STAGE 2: Do

Define, explore, and structure a quality improvement project.

HELPFUL TOOLS: Benchmarking, Change Implementation, Communication, Data Collection, Pilot Testing, PDSA, Process mapping, Program Assessment, Program Evaluation, Sampling, Customer Feedback, etc.

16. Who will implement the Change?
17. How and to whom do you plan to implement the change and how will this be communicated?
18. Will you cinduct a pilot sutdy prior to full-scale implementation?
19. How will you track and measure change (describe data measurment systems)?
20. How will you spread and maintain the new process/change?
21. Incorporating the information gathered throughout the implmentation process, describe the implementation plan:

STAGE 3: STUDY

Define, explore, and structure a quality improvement project.

HELPFUL TOOLS: Benchmarking, Data Collection, Measurement Analysis, Measurement Tools, PDSA, Process Mapping, Program Evaluation, Sampling, Control charts, etc.

22. How will you monitor progress and how often?
23. Define how you will check and verify accuracy of the results:
24. Who will be responsible for maintaining the change?
25. How often will you review the process for needed improvements?
26. How will you address any new areas for improvement?
27. Incorporating the information gathered throughout the evaluation process, describe the evaluation plan:

STAGE 4: ACT
Finalize the documentation of the quality improvement project and plan for future projects. HELPFUL TOOLS: Communication, Culture of Quality, PDSA, etc.
28. Share the status and results of the project with team members/leadership/stakeholders. Date Completed (mm/dd/yy):
29. Discuss the future of this project/change (i.e. future projects, varying approaches etc.):
30. Update the organizational policies and procedures to reflect change(s). Date Completed (mm/dd/yy):
31. Finalize the CQI Storyboard submit and share. Date submitted: (mm/dd/yy):
32. Below, outline the steps taken in each of the PDSA stages that were taken to complete the CQI Project (use this as your place to document detail that was not captured above to finalize the report:
Background
Specific AIM:
Stage 1: Plan
Stage 2: Do
Stage 3: Study
Stage 4: Act
CQI Storyboard

Agenda Item: Community Resources Report **Committee:** Program	**Board Meeting Date:** January 26, 2023
Background Information: None	
Supporting Documentation: Community Resources Report	
Recommended Action: **For Information Only**	

Community Resources Report
December 2, 2022 – January 26, 2023

Volunteer Hours:

Location	November	December
Conroe	82	103.5
Cleveland	0	0
Liberty	10	23
Huntsville	0	9
Total	**92**	**135.5**

COMMUNITY ACTIVITIES:

12/7/22	Huntsville ISD Student Care Meeting	Huntsville
12/7/22	Conroe Noon Lions Club Luncheon	Conroe
12/7/22	Veterans in the Criminal Justice System Training	Conroe
12/7/22	Outreach, Screening, Assessment, and Referral to Treatment (OSAR) Quarterly Meeting - Virtual	Houston
12/7/22	Cleveland ISD Parent Information Fair	Cleveland
12/8/22	Montgomery County System of Care Planning	Conroe
12/12/22	Suicide Training for MET Inc.	Cleveland
12/12/22	Conroe Coalition for the Homeless Meeting	Conroe
12/13/22	Montgomery County Community Resource Collaboration Group	Conroe
12/14/22	Conroe Noon Lions Club Luncheon	Conroe
12/15/22	Ford Elementary Family Night	Conroe
12/16/22	Veterans Treatment Court December Graduation	Conroe
12/16/22	Authorized Provider Network – Determination of Intellectual Disability Best Practices Guidelines - Virtual	Conroe
12/17/22	Veteran Christmas Adopt A Family Event	Conroe
12/20/22	Walker County Community Resource Collaboration Group	Huntsville
12/21/22	Conroe Noon Lions Club Luncheon	Conroe
12/21/22	HerChance Veteran Homelessness Organization Introduction Luncheon	Conroe
12/30/22	Walker County Juvenile Services Staffing	Huntsville
1/5/23	Civil Service Commissioners Meeting	Conroe
1/9/23	Conroe Coalition for the Homeless Meeting	Conroe
1/10/23	American Legion Monthly Meeting	Conroe
1/11/23	Conroe Noon Lions Luncheon	Conroe
1/11/23	Montgomery County Community Supervision & Corrections – Training on MH Diagnosis and Medications	New Caney
1/12/23	Quality Management Consortia	Conroe
1/12/23	Behavioral Health Suicide Prevention Task Force – Major Mental Health Workgroup	Conroe
1/12/23	Leadership Montgomery County	The Woodlands

1/17/23	Behavioral Healthcare Suicide Prevention Task Force -Military Connected Subgroup Meeting	Conroe
1/17/23	Montgomery County Community Resource Collaboration Group	Conroe
1/17/23	Veteran Church Donor Collaboration Meeting	Conroe
1/17/23	IDD Authority/Community Provider Meeting – HCBS Settings Rules and Implementation	Conroe
1/17/23	Montgomery County Community Supervision & Corrections – Training on MH Diagnosis and Medications	Conroe
1/17/23	Montgomery County Sheriff's Office Crisis Intervention Team (CIT) Meeting	Conroe
1/18/23	Behavioral Health Suicide Prevention Task Force – Neurodiversity & Special Needs Workgroup	Conroe
1/18/23	Montgomery County Sheriff's Office Mental Health Training Part One	Conroe
1/18/23	Conroe Noon Lions Luncheon	Conroe
1/19/23	Quarterly Meeting with OCR, Wellpath Hospital and Crisis/Jail Staff	Conroe
1/19/23	Behavioral Health Suicide Prevention Task Force Meeting	Conroe
1/20/23	Authorized Provider Network – Intake Process – Virtual	Conroe
1/20/23	Montgomery County Sheriff's Office Mental Health Training Scenario Test – Part Two	Conroe
1/24/23	Walker County Community Resource Collaboration Group	Huntsville
1/24/23	Liberty County Mental Health Issues Workgroup Meeting	Liberty
1/25/23	Child Fatality Review Team	Conroe
1/25/23	Montgomery County Community Crisis Collaboration Team Meeting	Conroe

UPCOMING ACTIVITIES:

1/27/23	Walker County Juvenile Services Staffing	Huntsville
1/31/23	Huntsville ISD Student Health Advisory Committee	Huntsville
2/2/23	New Waverly ISD Student Health Advisory Committee	New Waverly
2/9/23	Behavioral Health Suicide Prevention Task Force – Major Mental Health Workgroup	Conroe
2/16/23	Behavioral Health Suicide Prevention Task Force Meeting	Conroe
2/21/23	Montgomery County Community Resource Collaboration Group	Conroe
2/22/23	Montgomery County Community Crisis Collaboration Team Meeting	Conroe
2/24/23	Walker County Juvenile Services Staffing	Huntsville
2/28/23	Walker County Community Resource Collaboration Group	Huntsville

Agenda Item: Consumer Services Report for November and December 2022 **Committee:** Program	**Board Meeting Date:** January 26, 2023
Background Information: None	
Supporting Documentation: Consumer Services Report for November and December 2022	
Recommended Action: **For Information Only**	

CONSUMER SERVICES REPORT
November 2022

Crisis Services, MH Adults/Children	MONTGOMERY COUNTY	PORTER	CLEVELAND	LIBERTY	WALKER COUNTY	TOTAL
Persons Screened, Intakes, Other Crisis Services	534	27	64	32	65	**722**
Transitional Services (LOC 5)	0	0	0	0	0	**0**
Psychiatric Emergency Treatment Center (PETC) Served	0	0	0	0	0	**0**
Psychiatric Emergency Treatment Center (PETC) bed days	0	0	0	0	0	**0**
Adult Contract Hospital Admissions	63	0	2	1	1	**67**
Child and Youth Contract Hospital Admissions	1	1	0	1	0	**3**
Total State Hospital Admissions (Civil only)	1	0	0	0	0	**1**
Routine Services, MH Adults/Children						
Adult Levels of Care (LOC 1-4, FEP)	1212	0	143	93	90	**1538**
Adult Medication Services	968	0	102	76	131	**1277**
Child Levels of Care (LOC 1-4,YC,YES, TAY, RTC, FEP)	388	307	60	26	88	**869**
Child Medication Services	201	85	18	6	24	**334**
TCOOMMI (Adult Only)	102	0	11	14	9	**136**
Adult Jail Diversions	1	0	0	0	0	**1**
Persons Served by Program, IDD						
Number of New Enrollments for IDD Services	9	0	0	2	0	**11**
Service Coordination	569	0	21	39	64	**693**
Persons Enrolled in Programs, IDD						
Center Waiver Services (HCS, Supervised Living)	22	0	5	14	16	**57**
Substance Use Services						
Children and Youth Prevention Services	16	358	0	0	15	**389**
Youth Substance Use Disorder Treatment Services/COPSD	19	0	0	0	0	**19**
Adult Substance Use Disorder Treatment Services/COPSD	28	0	2	1	3	**34**

Waiting/Interest Lists as of Month End						
Home and Community Based Services Interest List	1803	0	162	139	208	**2312**
SAMHSA Grant Served by County						
SAMHSA CCBHC Served	94	18	26	10	8	**156**
SAMHSA CMHC Served	295	0	5	14	10	**324**
November Served by Service Area						
Adult Mental Health Services	1584	0	172	118	212	**2086**
Child Mental Health Services	568	342	79	37	97	**1123**
Intellectual and Developmental Disabilities Services	674	0	32	50	72	**828**
Total Served by Service Area	**2826**	**342**	**283**	**205**	**381**	**4037**
October Served by Service Area						
Adult Mental Health Services	1655	0	170	122	206	**2153**
Child Mental Health Services	634	320	75	32	103	**1164**
Intellectual and Developmental Disabilities Services	742	0	34	56	77	**909**
Total Served by Service Area	**3031**	**320**	**279**	**210**	**386**	**4226**

CONSUMER SERVICES REPORT
December 2022

Crisis Services, MH Adults/Children	MONTGOMERY COUNTY	PORTER	CLEVELAND	LIBERTY	WALKER COUNTY	TOTAL
Persons Screened, Intakes, Other Crisis Services	563	12	43	23	48	**689**
Transitional Services (LOC 5)	0	0	0	0	0	**0**
Psychiatric Emergency Treatment Center (PETC) Served	0	0	0	0	0	**0**
Psychiatric Emergency Treatment Center (PETC) bed days	0	0	0	0	0	**0**
Adult Contract Hospital Admissions	67	0	5	0	4	**76**
Child and Youth Contract Hospital Admissions	5	3	0	1	2	**11**
Total State Hospital Admissions (Civil only)	1	0	0	0	0	**1**
Routine Services, MH Adults/Children						
Adult Levels of Care (LOC 1-4, FEP)	1059	0	121	75	78	**1333**
Adult Medication Services	828	0	81	60	91	**1060**
Child Levels of Care (LOC 1-4,YC,YES, TAY, RTC, FEP)	349	285	54	21	82	**791**
Child Medication Services	200	69	16	5	17	**307**
TCOOMMI (Adult Only)	97	0	11	14	10	**132**
Adult Jail Diversions	1	0	0	0	0	**1**
Persons Served by Program, IDD						
Number of New Enrollments for IDD Services	6	0	0	0	0	**6**
Service Coordination	540	0	23	40	57	**660**
Persons Enrolled in Programs, IDD						
Center Waiver Services (HCS, Supervised Living)	22	0	4	14	16	**56**
Substance Use Services						
Children and Youth Prevention Services	0	358	0	0	15	**373**
Youth Substance Use Disorder Treatment Services/COPSD	21	0	0	0	0	**21**
Adult Substance Use Disorder Treatment Services/COPSD	28	0	1	0	4	**33**

Waiting/Interest Lists as of Month End						
Home and Community Based Services Interest List	1742	0	156	134	201	**2233**
SAMHSA Grant Served by County						
SAMHSA CCBHC Served	96	19	35	10	9	**169**
SAMHSA CMHC Served	310	0	5	19	10	**344**
December Served by Service Area						
Adult Mental Health Services	1459	0	128	89	167	**1843**
Child Mental Health Services	537	308	71	28	90	**1034**
Intellectual and Developmental Disabilities Services	636	0	32	54	70	**792**
Total Served by Service Area	**2632**	**308**	**231**	**171**	**327**	**3669**
November Served by Service Area						
Adult Mental Health Services	1584	0	172	118	212	**2086**
Child Mental Health Services	568	342	79	37	97	**1123**
Intellectual and Developmental Disabilities Services	674	0	32	50	72	**828**
Total Served by Service Area	**2826**	**342**	**283**	**205**	**381**	**4037**

Agenda Item: Program Updates **Committee:** Program	**Board Meeting Date:** January 26, 2023
Background Information: None	
Supporting Documentation: Program Updates	
Recommended Action: **For Information Only**	

Program Updates
December 2, 2022 – January 26, 2023

Crisis Services

1. The remodeling in the front of the PETC is complete other than office furniture that has been ordered but has not yet arrived.
2. Staff shortages have been reduced to two CAS staff, one CIT staff (designated to work with the Precinct 1 Mental Health Constables), and the Administrator of Crisis Services licensed position.
3. In November, we provided 295 crisis assessments, 38% of the total were for involuntary clients and 29.5% were for youth. In December, we provided 323 crisis assessments of which 44.9% were involuntary clients and 22.9% were youth. For the first quarter of FY23, we provided a total of 1016 crisis assessments.
4. Of the 74 youth seen in December, 29.7% were transported to the PETC by law enforcement, either under an Emergency Detention Order or as a Courtesy Transport. We are seeing this trend continue in the month of January with increased law enforcement involvement for youth experiencing a mental or behavioral health crisis.
5. On December 7th, at the request of Precinct 1 Mental Health Constables, PETC staff participated in the filming of a training video to be distributed to law enforcement agencies across the state of Texas. This project was sponsored by the Texas Association of Counties and is intended to demonstrate the benefits of law enforcement agencies working in partnership with the Local Mental Health Authority to provide crisis intervention services in their communities.
6. We are working with Montgomery County Sheriff's Office (MCSO) to implement Crisis Intervention Team services as part of a grant secured by MCSO. This team will be similar to the Conroe CIRT program that has proven to be successful and well received by the residents within the Conroe city limits.

MH Adult Services

1. We continue to look for one psychiatrist to fill a full-time position in Conroe. This position is currently being covered by our two Psychiatric Emergency Treatment Team psychiatrists, but they will be heading back to the PETC to serve the Crisis Stabilization Unit when it opens.
2. The First Episode Psychosis team is fully staffed including a team lead who will provide Cognitive Behavioral Therapy, a Peer Provider, a Recovery Specialist, and a Supported Employment and Education Specialist. The team hopes to expand the numbers of individuals served over the next few months. The FEP team serves individuals who are between the ages of 15 to 30 years who are in the early stages of a primary psychotic disorder.
3. The PATH team has started providing psychoeducational groups at the Montgomery County Women's Center and Conroe House of Prayer in efforts to outreach to homeless individuals in the community. The groups have had great participation and seen enthusiasm from both individuals served and community partners.

4. The AOP team has hired two new therapists to be able to provide Cognitive Behavioral Therapy and Cognitive Processing Therapy to adults.
5. We have promoted Tiffany Jackson to the Rural Clinic Administrator role. Tiffany has worked with Tri-County for five years, starting as a field case manager, was promoted to the supervisor over field staff, and now will be leading our Adult services in all three rural clinics.

MH Child and Youth Services

1. The school based team is experiencing staffing challenges after having an unexpected neutral term, unexpected staff leaving to teach at the school, and a staff on maternity leave. Coverage is going to be difficult since two of these staff are bilingual and the third was the main clinician at Moorhead.
2. We are excited that due to growth and recent improvements in Conroe staffing, we are adding a third Skills Training team to serve Montgomery County. We have promoted Katie Scott from her former clinical position to serve as the new Team Lead. Her team will include 11 new C&Y MH Specialists to increase the services provided to youths in Montgomery County.
3. Our Administrator of C&Y Intensive Wraparound Services has worked diligently to grow our Specialty Care Provider Network for children and youth in the YES Waiver. Many centers are struggling to do this, but we now have a good variety of services to offer these children including Equine Therapy, Music Therapy, Art Therapy, Recreational Therapy, Community Living Services, Paraprofessional Services, In-home Respite, Supported Employment, and Employee Assistance.

Criminal Justice Services

The Criminal Justice Services team successfully collaborated with crisis staff, IDD staff, and Montgomery County Jail staff to divert an individual from jail into an inpatient setting to meet his immediate care needs. This particular client has an intellectual disability and psychosis. While psychotic he assaulted his mother and was placed in custody. Care for someone with these types of challenges can be extremely difficult to secure and it took quite a bit of time from several departments to achieve placement.

Substance Use Disorder Services

1. We have added a new administrator to the Substance Use Treatment team. We are anticipating growing our services to provide more Co-Occurring Psychiatric/Substance Use Disorder treatment, as well as expanded services to engage and support individuals who are on the fence about treatment.
2. The SUD team had their first client successfully complete the Medication Assisted Treatment (MAT) program. The MAT program uses a combination of short-term medication therapy, combined with counseling and behavioral interventions to provide a "Whole Person" approach to recovery from alcohol or tobacco.
3. We have successfully recruited a new Prevention Manager from within the team. The new Prevention Manager has served as a Prevention Specialist for over three years and is a Certified Prevention Specialist.

4. We have hired a Bilingual YPS prevention specialist. She has experience in Prevention and is an Associate Prevention Specialist. We are pleased to bridge a gap in our services by being able to provide bilingual presentations, activities, and groups.
5. We have received positive feedback about our presentations with Montgomery County Juvenile Probation and plan to continue conducting our vaping tobacco and marijuana presentation and vaping trivia activity once a month throughout the spring. Both parents and youth attend the presentation and participate in the vaping trivia activity. This seems to open the door for a discussion between parents and youth.

IDD Services

1. HHSC published approved payment rates for Individualized Skills and Socialization (ISS), effective January 1, 2023, for the Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver programs. ISS will replace Day Habilitation services on March 1, 2023, HHSC's agreed upon date to come into compliance with CMS HCBS Settings Rules.
2. The IDD Provider Department must complete application process for each of our sites to be certified as on-site ISS locations. If we do not apply and obtain certification we cannot be a provider.
3. Effective October 16, 2022, HHSC adopted revised rules in Texas Administrative Code (TAC) Title 26 Section 331.17 regarding minimum hiring qualifications for Local Intellectual and Developmental Disability Authority (LIDDA) service coordinators. The rule was revised to allow for an increased pool of skilled applicants. On December 16, 2022, LIDDA's received notification that the rule amendments are only in effect for non-Medicaid General Revenue service coordinators and have not yet been approved for Medicaid service coordinators.
    a. Before the new qualification criteria can be used for Medicaid service coordinators, Centers for Medicare & Medicaid Services (CMS) must approve HHSC's state plan amendment (SPA) request to revise the LIDDA service coordinator minimum qualifications. HHSC submitted the SPA to the CMS in October 2022. CMS has until January 15, 2023, to approve the request.
4. IDD Authority received notification of its Fiscal Year 2023 Quality Assurance Authority Review on January 3, 2023. The review will be conducted via desk and on-site review, with all documents requiring uploading to be submitted by COB, January 23, 2023.
5. The IDD Provider Department is very busy reviewing all room and board agreements that must be completed anytime individual has a change in their social security.
6. The IDD Provider Department has completed the first month of November, and working on December, reporting Critical Incidents through the state's new Critical Incident Management System (CIMS). This system reporting is significantly more detailed than the historical CARE system and allows HHSC access at any time to see the information.
7. The IDD Provider Department has not been audited since January of 2021, so at this point they are running two years behind schedule. This is not a positive thing as they will audit two years' worth of information when they come.
8. IDD Provider vacancies are primarily in the Conroe area, including a coordinator position that enters the HCS billing through TMHP system.

Support Services

1. **Quality Management (QM):**
    a. Staff prepared and submitted two record requests to an insurance company, totaling three charts, for records dating back to January 1, 2021.
    b. In addition to routine and ongoing quality assurance of documentation, Staff reviewed 25 progress notes, prior to billing, to ensure compliance. Additional training and follow up was provided with staff and supervisors when needed.
    c. Quality Management, along with IDD Authority and Human Resources staff, collated, reviewed and submitted Pre-Site documentation requested by HHSC in preparation for the upcoming IDD Authority Audit being held on February 6-9th. In addition to a review of service provision and Human Resource files, the Quality Management Plan, Local Plan, Emergency Plan, PNAC functions and Staff training will be reviewed as a part of this audit.
    d. Quality Management staff conducted a phone survey to elicit feedback from individuals served related to their preferences and needs surrounding telehealth services. This survey was initiated as a part of the Center's efforts to identify and implement feasible changes in line with House Bill 4.
    e. Staff attended the Quality Management Consortia meeting on January 12, 2023 where they received legal updated and important information from HHSC and Texas Council.

2. **Utilization Management (UM):**
    a. Staff reviewed 10% of all Center discharges for December to ensure appropriateness and that proper notifications and appeals forms were provided. Follow up with staff was provided as needed to ensure quality improvement.
    b. Staff reviewed 31 notes that utilized the COPSD Modifier for quality assurance purposes.
    c. The Data Analyst who serves as a member of the SAMHSA Care Coordination Team has resigned due to relocation to Vermont. We are currently seeking a replacement for this position.

3. **Training:**
    a. The Administrator of Quality Management, who serves as the backup trainer for the Training Department, completed the SAMA facilitator training in San Antonio on December 19-22nd.
    b. The training department hosted a Critical Incident Stress Management (CISM) training on January 11-13th. There were 10 staff members who attended the class and approximately 30 participants which included other community partners (EMTs, police officers, and hospital staff).

4. **Veteran Services and Veterans Counseling/Case Management**
    The department has been advised that the Veteran Church Donor Collaboration group will be meeting this month and will be donating a check to the Tri-County's Veterans Department for veterans in need. In years past the group typically donates $1000 - $2000 to their chosen group.

5. **Planning and Network Advisory Committee(s) (MH and IDD PNACs):**
    a. The MH PNAC met on December 7th to review the final LPND and CLSP draft documents following review of the plans by the Regional PNAC. No public comments were made during the comment period. Due to recent turnover, the committee met on January 11th to discuss membership needs and recruitment efforts.
    b. The IDD PNAC met on January 18th to complete Annual training and received information on the new Home and Community Based Services rules including detail surrounding Individualized Social Skills.

Community Activities

The department director will be training the Montgomery County Sheriff's Office on the new Crisis Intervention Response Team recruits over a two day period in basic mental health symptoms, diagnosis, and how to more effectively respond to individuals who are experiencing a mental health crisis.

Agenda Item: Year to Date FY 2023 Goals and Objectives Progress Report **Committee:** Program	**Board Meeting Date** January 26, 2023

Background Information:

The Management Team met on August 12, 2022 to update the five-year strategic plan and to develop the goals for FY 2023. The strategic plan and related goals were approved by the Board of Trustees at the September 2022 Board meeting. Subsequently, the Management Team developed objectives for each of the goals.

These goals are in addition to the contractual requirements of the Center's contracts with the Health and Human Services Commission or other contractors.

This report shows progress year to date for Fiscal Year 2023.

Supporting Documentation:

FY 2023, Year to Date Goals and Objectives Progress Report

Recommended Action:

For Information Only

Year-to-Date Progress Report

September 1, 2022 – January 26, 2023

Goal #1 – Clinical Excellence

Objective 1:

Develop a two-year implementation plan for appropriate clinical use of telehealth, including a plan for accelerating the plan if needed, which incorporates state regulations and clinical best practices by June 1, 2023.

- Staff have developed an initial timeline for project development and have begun to draft a Whitepaper that will outline the considerations for the use of telehealth, implications and impact to our current system of care, and when complete, will include recommendations and final timeline for implementation. Prior to initiating the plan, staff reviewed applicable rules and regulations along with special considerations such as broadband limitations within our service area. We are currently in the process of reviewing evidence-based information surrounding the provision of mental health services using telehealth as well as soliciting feedback from individuals served through phone surveys conducted by our Quality Assurance Department.

Objective 2:

If appropriate operational funding can be secured, reopen the Crisis Stabilization Unit by May 1, 2023 – *or* – If additional funds are not available for CSU operations, design an alternative Crisis program for Board approval by April 1, 2023.

- With the assistance of Justice of the Peace Wayne Mack, Tri-County has secured continued American Rescue Plan Act funding from Montgomery County that will allow us to reopen the Crisis Stabilization Unit, among other things.
- We have a team of staff working on multiple aspects of reopening.
    - Facility modifications, updates and relicensing.
        - The Board will be asked to approve a not-to-exceed budget for CSU modifications at the January 26, 2023 Board meeting. Construction is expected to take eight (8) weeks after it begins.
        - An additional factor in updating the building is that the Department of State Health Services (DSHS) will have to reinspect and relicense the facility after the construction is complete. Communication with DSHS staff has been challenging thus far.
    - Staff hiring and development.
        - The DON position for the CSU is posted.
    - Licensing and operational procedure development.
        - We will have to create a set of procedures for the facility licensors to review and a set of operational, how-to, procedures for the facility.

        - The team working on this has made good progress.
    - Operations, including reestablishing relationships with contractors.
        - We have been in touch with contractors that we have previously used at the facility and are determining if they are interested in our services going forward.
- Our Chief Nursing Officer, Andrea Scott, APRN, will be managing the Crisis Stabilization Unit.

Goal #2 – Professional Facilities

Objective 1:

Break ground on the new Cleveland Service Facility by August 31, 2023.

- The design team has been holding regular meetings with Identity Architects to design the Cleveland Service Facility. After the facility is designed, it will be sent to a Mechanical, Electrical and Plumbing firm to prepare the design for construction bids.
- Building contractor Mike Duncum and Architect David Kastendieck have met with the City of Cleveland Planning and Zoning Department to discuss the project and report that no significant challenges with the site design are expected.
- Regular updates on the project will be provided by the Executive Director or designee to the Board of Trustees.
- At this time, we are still on track to break ground by August 31, 2023.

Objective 2:

Complete a refresh of the Sgt. Ed Building in Conroe to include inside paint, carpet where needed and other general cleanup, the waiting rooms and children's playroom by June 1, 2023.

- A complete walk-through of the Conroe facility has been completed, identifying several areas that need to be addressed to correct general deterioration associated with daily use, including paint throughout the building, replacement of carpet and ceiling tiles, and parking lot maintenance. While some areas, such as carpet may be replaced using stock available at the warehouse, other areas require going out for bid. Three bids have been received to complete pressure washing and restriping in the parking lot, which is anticipated to begin in coming weeks. An agreement has also been signed to have the roof repaired and once complete, the ceiling tiles will be replaced. Finally, the team is waiting on a quote for paint, as well as further information from a structural engineer to evaluate and determine needs associated with building settling.

Goal #3 – Information Technology

Objective 1:

Prepare the Streamline Smartcare Behavioral Health Software System for 'Go-Live' by August 31, 2023.

- Staff have begun a series of weekly implementation meetings emphasizing on Clinical, Billing, and Data migration with the Streamline implementation team. This team consists of the members of the TCBHC Software Management Team (SMT), special TCBHC guest relating to meeting subject matter, and Streamline staff. As of the end of the calendar year 2022, we have completed 71 meetings resulting in 112 hours of interactive meetings so far.

Goal #4 – Employee Retention

Objective 1:

Create an employee leadership development program for Center managers by May 1, 2023.

- Staff have explored leadership development options with a goal of identifying opportunities that are meaningful and worthwhile, while also being accessible to the different levels of management, including staff who are considering a future in leadership, mid-level managers, and those in higher level leadership roles. As part of this initiative, staff have reviewed a variety of certificate programs available through several highly respected colleges and universities, focusing on programs that target advancement of key leadership skills that will benefit the Center, while also considering factors such as cost, time commitment, prestige, effort, and course availability. Staff have further started identifying strategies for developing internal leadership programming designed to enhance supervisor aptitude and encourage growth for both existing supervisors and those who may be interested in future movement.

Goal #5 – Financial

Objective 1:

Implement required business office processes to ensure compliance with the Public Health Provider – Charity Care Pool guidance by February 28, 2023.

- A Center procedure has been developed, establishing guidelines for completing the application for the Charity Care Pool program, including methods for evaluating eligibility, determining fee for service, and payment collection, while ensuring appropriate data collection practices to allow for accurate and timely completion of the annual cost report.

  Financial staff and others involved in the implementation and ongoing maintenance of the CCP program have received training on the program requirements and have started assisting the clients with the application process to determine eligibility, including documentation of completion and Charity Care eligibility in the electronic health record. Notices of the Charity Care Pool program have also been posted in each clinic site and publicized on the website in compliance with charity care requirements. Finally, Business Office procedures, including desk procedures, have been developed and implemented to ensure ongoing compliance with all requirements and standards necessary for cost reporting submission and reimbursement.

Agenda Item: 1st Quarter FY 2023 Corporate Compliance and Quality Management Report **Committee:** Program	**Board Meeting Date** January 26, 2023

Background Information:

The Health and Human Service Commission's Performance Contract Notebook has a requirement that the Quality Management Department provide "routine" reports to the Board of Trustees about "Quality Management Program activities."

Although Quality Management Program activities have been included in the program updates, it was determined that it might be appropriate, in light of this contract requirement, to provide more details regarding these activities.

Since the Corporate Compliance Program and Quality Management Program activities are similar in nature, the decision was made to incorporate the Quality Management Program activities into the Quarterly Corporate Compliance Report to the Board and to format this item similar to the program updates. The Corporate Compliance and Quality Management Report for the 1st Quarter of FY 2023 are included in this Board packet.

Supporting Documentation:

1st Quarter FY 2023 Corporate Compliance and Quality Management Report

Recommended Action:

For Information Only

Corporate Compliance and Quality Management Report
1st Quarter, FY 2023

Corporate Compliance Activities

A. Key Statistics:

There were four compliance concerns reported in the 1st Quarter. The four concerns were investigated or reviewed to completion and listed below:

1. A Quality Management audit found that a TCBHC staff possibly copied and pasted notes or used a template to complete their service documentation. This concern was investigated and confirmed. The staff received a warning and retraining was conducted. Payback was made in the amount of $425.31.
2. A second allegation was received on a separate staff, by that employee's supervisor. This supervisor aired concerns about the employee's work product. The investigation confirmed the staff was logged in and documenting services during the same time frames that the staff claimed to be providing services to others. As a result of the findings, the staff received retraining and coaching from their supervisor. Payback was made in the amount of $371.50.
3. A third alleged concern was reported by the Billing Manager as well as Quality Management. The report alleged an employee was inflating times due to a jump in service performance. An in-depth chart review was conducted. There were no compliance findings; therefore, the performance concerns were forwarded to the HR Manager for further review.
4. Lastly, concerns were reported by the Director of Adult Behavioral Health regarding performance concerns on an individual staff. A review was conducted. There were no compliance findings; therefore, the performance concerns were forwarded to the HR Manager for further review.

B. Committee Activities:

The Corporate Compliance Committee met on November 9, 2022. The Committee reviewed the following:

1. A final summary of the FY22 4th Quarter investigations;
2. FY23 1st Quarter updates;
3. An annual review of the Corporate Compliance Action Plan; and
4. Trending concerns.

Quality Management Initiatives

A. Key Statistics:

1. Staff reviewed and submitted six record requests, totaling 71 charts.

2. Staff conducted several ongoing internal audits including documentation reviews, authorization override requests for clinically complex individuals, and use of the co-occurring psychiatric and substance use modifier.

B. Reviews/Audits:

1. Staff prepared and submitted one record request totaling five charts to Aetna dating back to January 2021.
2. Staff prepared and submitted three record requests totaling 19 charts to Cigna Medicare dating back to January 2021.
3. Staff prepared and submitted two record requests totaling 47 charts to WellCare dating back to January 2021.
4. Staff reviewed 90 notes that used the Co-Occurring Psychiatric and Substance Use Disorder modifier to ensure that the intervention was used appropriately. This review indicated that the majority of staff utilizing this code are using it correctly. Follow up was made with supervisor in one out of the 90 notes documented to initiate additional education and training as needed.
5. Staff reviewed 100 discharges that occurred in Q1 and communicated areas that were needing improvement to supervisory staff.
6. Staff reviewed 68 MH Adult and Child and Youth progress notes for quality assurance purposes. Follow up was provided to supervisors as needed for any re-training purposes.

C. Other Quality Management Activities:

1. The new Administrator of Quality Management started on October 24, 2022 and is undergoing training.
2. The QM department participated in the Texas Children's Health Plan Re-Credentialing Audit on August 30, 2022 for the Conroe location and on October 4th, 11th and 12th for the Rural Areas (Huntsville, Cleveland and Liberty). Formal reports have been received with passing scores for all counties.
3. Quality Management and Program Staff participated in the quarterly on-site Superior Audit on September 15, 2022. Due to the high scores received on this audit, Superior is reducing the frequency of our quarterly audits and will conduct their next review in September of 2023.
4. The Continuous Quality Improvement Committee met on October 28, 2022. The Committee continues to discuss ways to improve show rates, decrease and prevent suicides, identify positive interventions for individuals who are readmitting to hospitals within 30 days and ensuring timely access to care.

Agenda Item: 2nd Quarter FY 2023 Corporate Compliance Training **Committee:** Program	**Board Meeting Date** January 26, 2023
Background Information: As part of the Center's Corporate Compliance Program, training is developed each quarter for distribution to staff by their supervisors. This training is included in the packet for ongoing education of the Tri-County Board of Trustees on Corporate Compliance issues.	
Supporting Documentation: 2nd Quarter FY 2023 Corporate Compliance Training	
Recommended Action: **For Information Only**	

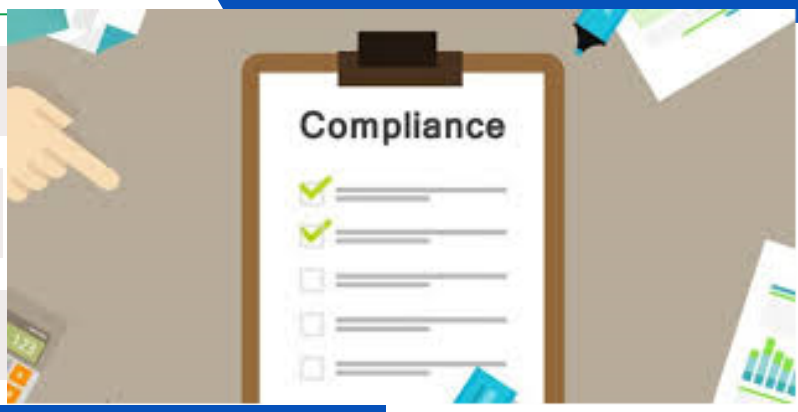
COMPLIANCE NEWSLETTER

FY23, Quarter 2

Tri-County Behavioral Healthcare

Healthy Minds. Meaningful Lives.

NEWSLETTER HIGHLIGHTS



What is TCBHC's Compliance Program?

It's a program to encourage ethical conduct in daily operations and a commitment to compliance with the law.

It's designed to:

- Prevent any accidental and intentional violations of law
- Detect violations if they occur
- Correct any future non-compliance

YOUR CORPORATE COMPLIANCE TEAM

Amy Foerster
Chief Compliance Officer
amyf@tcbhc.org

Heather Hensley
Administrator of Compliance
heatherh@tcbhc.org

Ashley Bare
HR Manager
ashleyba@tcbhc.org

Compliance Concerns Hotline: 866-243-9252

REPORT

Reports are kept confidential and may be made anonymously.
Reports may be made without fear of reprisal or penalties.
Report to your supervisor, or any Compliance team member any concerns of fraud, abuse, or other wrong doing.

Agenda Item: ETBHN Regional Planning and Network Advisory Committee's LPND Review Report **Committee:** Program	**Board Meeting Date** January 26, 2023

Background Information:

The Regional Planning and Network Advisory Committee (RPNAC) reports to each participating East Texas Health Network (ETBHN) Members' Board regarding planning, development, design, management and evaluation of the local provider network. As required by the Local Provider Network Development (LPND) Rule, Center LPND plans are to be posted for a 30-day public comment period and reviewed by stakeholders.

Following Board approval at our last meeting and prior to submission of the LPND plan to the State, the RPNAC met on December 7, 2022 to review Center LPND plans. There were no recommendations that applied to any Center at that time, however, comments discussed at the meeting have been included in the attached ETBHN report for information purposes only.

Supporting Documentation:

ETBHN Regional Planning Network Advisory Committee's LPND Review Report

Recommended Action:

For Information Only

REGIONAL PLANNING AND NETWORK ADVISORY COMMITTEE

2022 PROVIDER NETWORK DEVELOPMENT PLAN

LOCAL AUTHORITY: TRI-COUNTY BEHAVIORAL HEALTHCARE

The Regional Planning and Network Advisory Committee (RPNAC) reports to each participating East Texas Behavioral Health Network (ETBHN) Members' Board / Governing Body regarding planning, development, design, management and evaluation of the local provider network, including but not limited to:

- Client care issues in Network Development;
- Client choice issues in Network Development;
- Ultimate cost-benefit issues in Network Development; and
- Best use of public money in Network Development.

The RPNAC is comprised of Members representing each of the ten participating Centers of ETBHN, appointed by the Local Authority Board / Governing Body of each respective Member Center.

Every two years, the Community Center's Local Plan is developed as required by the Performance Contract with Texas Health and Human Services. Each Center engages in procurement of providers of comprehensive behavioral health services in their service area in an effort to afford client choice. The Plans are posted for public comment and input, and review by the RPNAC is required.

On December 7, 2022, the RPNAC Center Representatives presented their 2022 Provider Network Development Plan to the RPNAC for review. Center Liaisons and ETBHN staff compiled this information and the RPNAC completed their evaluation.

RECOMMENDATIONS:

There were no recommendations that applied to any individual Center; however, there were comments and discussion by and for each Community Center.

The comments were as follows:

- Each Center reported postings on their various public internet venues of the opportunity to provide comprehensive services as part of the service network. Centers have regular stakeholder meetings throughout the year to continue to connect with potential providers.
- No ETBHN Centers received notice of individuals or organizations interested in providing comprehensive services.
- Administrative efficiencies gained by each Center include services received through ETBHN and Texas Council of Community Services, as well as through partnerships with other Centers within the ETBHN Network.

Submitted by Terrie Mayfield, ETBHN Director
December 2022

Agenda Item: Personnel Reports for November through December 2022 **Committee:** Executive	**Board Meeting Date:** January 26, 2023
Background Information: None	
Supporting Documentation: Personnel Reports for November through December 2022	
Recommended Action: **For Information Only**	

Personnel Report

FY23 | November & December 2022

Tri-County Behavioral Healthcare
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OVERVIEW

NEW HIRES
Nov & Dec
29 POSITIONS
YTD
56 POSITIONS

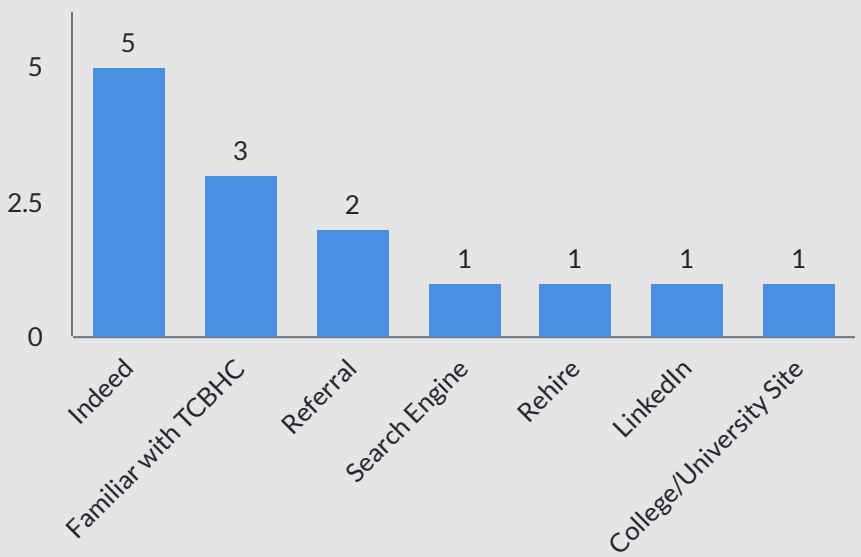
SEPARATIONS
Nov & Dec
13 POSITIONS
YTD
37 POSITIONS

Vacant Positions
96
Frozen Positions
23

Total Budgeted FTE
470.53

RECRUITING

How did last month's new hires hear about TCBHC?



APPLICANTS

Nov & Dec Total Applicants	478
YTD Applicants	977

JOB FAIRS

Sam Houston State University	11/9/2022
Internal C&Y Job Fair	11/14/2022
Lone Star College -Montgomery	11/16/2022
Internal C&Y Job Fair	11/29/2022
Internal Nursing Job Fair	12/16/2022

CURRENT OPENINGS

VACANCIES BY LOCATION

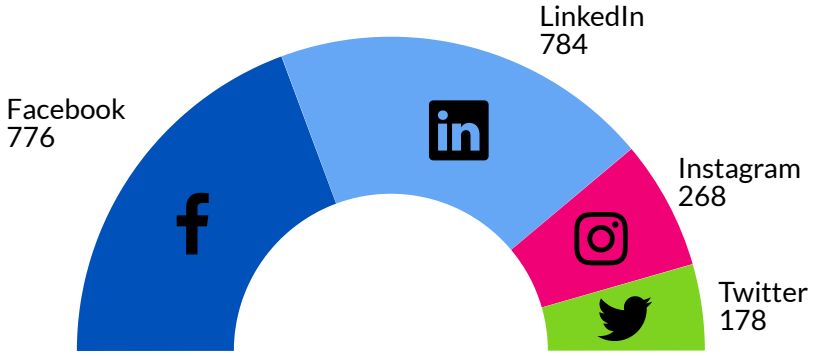
CONROE*	66
PETC*	9
CLEVELAND	6
LIBERTY	5
HUNTSVILLE	7
PORTER	3

*excludes frozen positions

TOP 5 VACANCIES

Mental Health Specialist/Case Manager (Adult, Crisis and C&Y)	50
LVN	8
Direct Care Provider	7
IDD Case Manager	3
Licensed Clinicians	3

SOCIAL MEDIA FOLLOWERS



Tri-County Behavioral Healthcare
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Exit Data

FY23 | November & December 2022

Exit Stats at a Glance

10% YTD Turnover Rate

11 Voluntary Separations

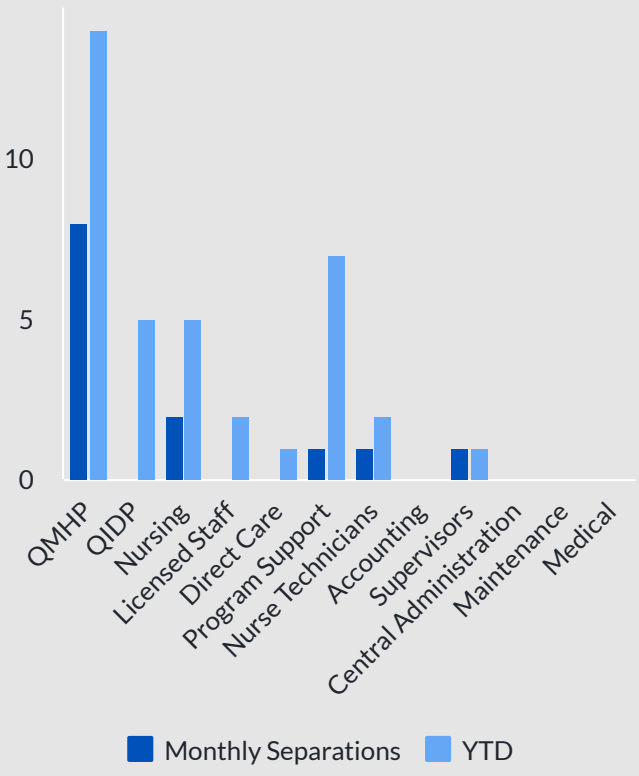
2 Neutral Termination

0 Involuntary Termination

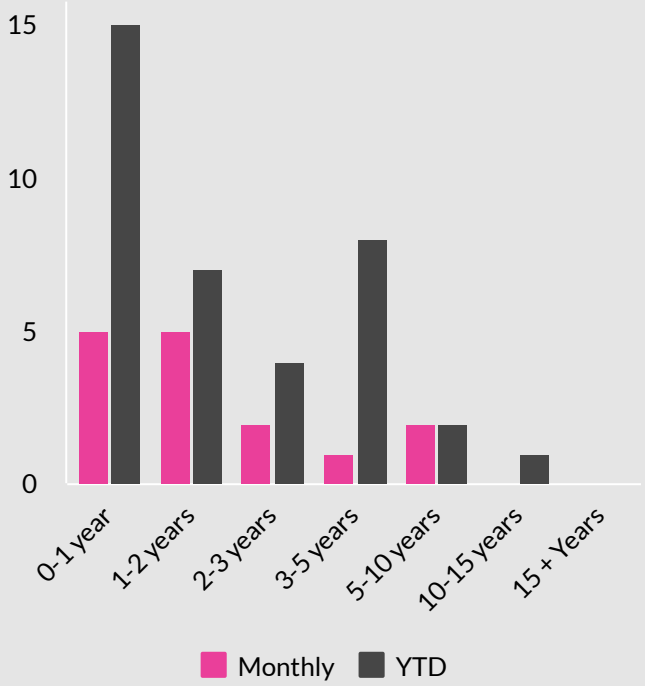
Top Reasons for Separations

1. Another Job
2. Commute
3. Neutral Termination
4. Better Pay
5. Personal/Family, includes Relocating

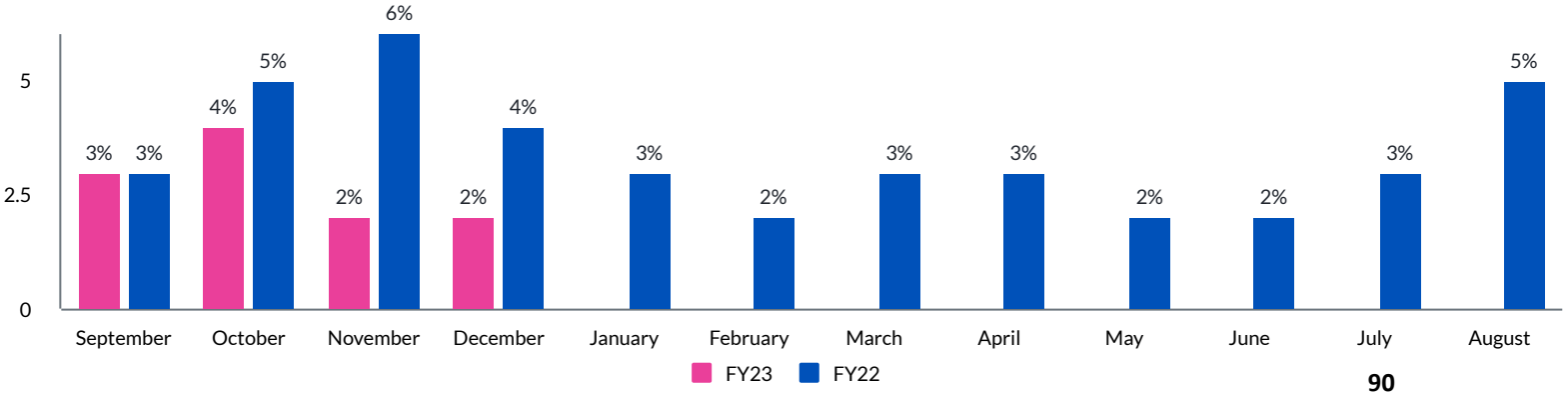
Separations by Category



Separations by Tenure



Monthly Turnover Rates



Agenda Item: Texas Council Risk Management Fund Claims Summaries as of December 2022 **Committee:** Executive	**Board Meeting Date:** January 26, 2023
Background Information: None	
Supporting Documentation: Texas Council Risk Management Fund Claims Summaries as of December 2022	
Recommended Action: **For Information Only**	

TCRMF Claims Summary December 2022

	Worker's Comp Claims	Liability Claims	Property Claims
2019	$10,826.00	$29,330.00	$0.00
2020	$26,111.00	$0.00	$0.00
2021	$8,860.00	$42,997.00	$20,074.00
2022	$4,619.00	$19,417.00	$0.00
2023	$12,810.00	$0.00	$6,522.00

Agenda Item: Texas Council Quarterly Board Meeting Update **Committee:** Executive	**Board Meeting Date** January 26, 2023
Background Information: The Texas Council has requested that Center representatives give updates to Trustees regarding their quarterly Board meeting. A verbal update will be given by Sharon Walker.	
Supporting Documentation: Texas Council Staff Report	
Recommended Action: **For Information Only**	

Agenda Item: Board Trustee Appointment and Oath of Office **Committee:** Executive	**Board Meeting Date** January 26, 2023

Background Information:

At their January 10, 2023 meeting, Liberty County Commissioners' Court appointed Reverend Carl Williamson, Pastor of Calvary Baptist Church in Cleveland, Texas to fill a remaining two-year term due expiring August 31, 2024.

Mr. Williamson completed the training which is required before taking the oath of office on January 24, 2023.

With Mr. Williamson's appointment, the Board of Trustees will be back up to nine members for the fist time since December of 2016.

Oath of Office will be recited at the Board meeting.

Supporting Documentation:

Oath of Office Recitation

Liberty County Trustee – Copy of the letter from Tri-County Behavioral Healthcare to Liberty County Commissioner's Court requesting approval for Reverend Carl Williamson to the Tri-County Behavioral Healthcare's Board of Trustees. Letter was initialed off on by County Judge, Jay Knight after approval at the January 10, 2023 Liberty County Commissioner's Court Meeting.

Final Approved Commissioner's Court minutes will be signed at the next Liberty County Commissioner's Court meeting on January 24, 2023 and may be received by Tri-County Behavioral Healthcare before the Board meeting on January 26th.

Recommended Action:

Recite Oath of Office

ADMINISTERING THE OATH OF OFFICE

I, _____,

do solemnly swear that I will faithfully execute the duties of the office of Trustee of Tri-County Behavioral Healthcare,

and will, to the best of my ability preserve, protect, and defend the Constitution and laws of the United States and of this State,

and I furthermore solemnly swear that I have not directly nor indirectly, paid, offered, or promised to pay,

contributed, nor promised to contribute any money, or valuable thing,

or promised any public office or employment, as a reward for the giving or withholding a vote to secure my appointment,

and further affirm that I, nor any company, association, or corporation of which I am an officer or principal,

will act as supplier of services or goods, nor bid or negotiate to supply such goods or services, for this Center,

so help me God.

LIBERTY COUNTY COMMISSIONERS COURT
Regular Meeting of Commissioners Court
January 10, 2023
9:00 a.m.
1923 Sam Houston St., Room 203 - Liberty, Texas 77575

1. CALL TO ORDER :
2. PLEDGE TO THE U.S. FLAG AND TEXAS FLAG :
3. INVOCATION :
4. NOTICES AND PROCLAMATIONS :
5. PUBLIC COMMENT :
6. DECLARE CONFLICTS OF INTEREST :
7. CONSENT AGENDA :
    1. APPROVAL OF MINUTES

        12/20/2022 - REGULAR MEETING
    2. WARRANTS PAYABLES

        PAYABLES
    3. BUDGET AMENDMENTS

        LCSO - SALE OF BRASS AT GUN RANGE

        CONSTABLE PCT 6 - LINE ITEM TRANSFER FOR TRAINING

        LCSO - RECORD INSURANCE PROCEEDS

    4. MONTHLY REPORTS

        a) COUNTY CLERK - DECEMBER 2022

        b) PERMITS - DECEMBER 2022

        c) TREASURER - NOVEMBER 2022

        d) AGRI-LIFE - NOVEMBER 2022

        e) CONSTABLE 4 - OCTOBER / NOVEMBER 2022

        f) JP 4 - DECEMBER 2022

        g) CONSTABLE 1 - DECEMBER 2022

    5. OATHS & DEPUTATIONS

        LCSO: APPROVE OATH & DEPUTATION OF CHRISTOPHER HERNANDEZ AS DEPUTY SHERIFF
        COUNTY CLERK: APPROVE THE DEPUTATIONS OF DEPUTY COUNTY CLERKS AS FOLLOWS: LORI WRIGHT, ALEXIS WILLIAMS, KYLE WHITE, VALERIA TISCARENO, STEPHANIE WALLACE, TIFFANY THORNTON, CLAUDETTE THOMPSON, SHONDA RILEY, HOPE CROSS, SHELBEIGH DRAKE, ADRIAN DRIVER, KRISTI JENNINGS. KIMBERLY DAVIE, KYLE MILLER, MARILYN TENORIO,

    6. PAYROLL ITEMS

        CONSTABLE PCT 2 - APPROVE INTERMEDIATE CERTIFICATE PAY FOR JOHN TUCKER - $50/mo
        JAIL MAINTENANCE: APPROVE FINAL PAY FOR REFUGIO GONZALEZ
        JAIL MAINTENANCE: APPROVE PROMOTION FOR MARK C JONES
        LCSO: APPROVE UNUSED COMP / HOLIDAY PAY FOR DAVID MEYERS: $14076.85
        LCSO: APPROVE MASTER TELE COMMUNICATOR CERTIFICATE PAY FOR MISTY McMULLEN - $75/mo

25. COUNTY ATTORNEY MATTHEW POSTON

CONSIDER AND APPROVE INTERLOCAL AGREEMENT WITH THE CITY OF DAYTON REQUIRING ASSIGNMENT OF COUNTY EMPLOYEES TO THE TRASH COLLECTION SITE JOINTLY OWNED BY CITY OF DAYTON AND LIBERTY COUNTY AS WELL AS THE EQUAL PARTICIPATION OF BOTH THE CITY AND THE COUNTY IN THE COSTS OF REHABILITATING THE SITE.

26. COUNTY JUDGE JAY KNIGHT

CONSIDER AND APPROVE THE APPOINTMENT OF REVEREND CARL WILLIAMSON TO THE BOARD OF TRUSTEES OF TRI-COUNTY BEHAVIORAL HEALTHCARE. REVEREND WILLIAMSON WILL BE FILLING THE TERM VACATED BY TRUSTEE CECIL McKNIGHT, DECEMBER 2016 AND HIS TERM WILL BE SET TO EXPIRE ON AUGUST 31, 2024

27. COUNTY CLERK LEE CHAMBERS

CONSIDER AND APPROVE THE PURCHASE OF THE ONLINE NOTICE SOFTWARE, TEXTMYGOV, FOR USE IN CONJUNCTION WITH THE PROJECT BY THE COUNTY CLERK'S OFFICE TO PROVIDE ELECTRONIC NOTICE POSTINGS WITH ONLINE ACCESS AND WITH DIGITAL KIOSKS STATIONED IN THE COURTHOUSE. THE COST FOR THE PROGRAM IS $12,500.00 PER YEAR TO BE PAID FROM THE COUNTY CLERK RECORDS MANAGEMENT FUND

28. COUNTY ATTORNEY MATTHEW POSTON

CONSIDER AND APPROVE REMODELING PROPOSAL WITH MYRON MCDOWELL CONSTRUCTION, INC. FOR THE REMODELING OF THE COUNTY ATTORNEY'S OFFICE FOR ADDITIONAL SECURITY FEATURES TO BE INSTALLED FOR A TOTAL OF $32,180.

29. PURCHASING AGENT HAROLD SEAY

CONSIDER AND APPROVE THE PURCHASE OF THREE (3) TAHOES IN THE AMOUNT OF $129,141.10 FROM SILSBEE FORD THROUGH BUYBOARD CONTRACT #521-16.

9. <u>EXECUTIVE SESSION</u> :

THE COMMISSIONERS COURT FOR THE COUNTY OF LIBERTY RESERVES THE RIGHT TO ADJOURN INTO EXECUTIVE SESSION AT ANY TIME DURING THE COURSE OF THIS MEETING TO DISCUSS ANY OF THE MATTERS LISTED ABOVE, AS AUTHORIZED BY TEXAS GOVERNMENT CODE SECTIONS 551.071(CONSULTATION WITH ATTORNEY); 551.072 (DELIBERATION ABOUT REAL PROPERTY); 551.0725 (DELIBERATIONS REGARDING CONTRACT BEING NEGOTIATED); 551.073 (DELIBERATIONS ABOUT GIFTS AND DONATIONS); 551.074 (PERSONNEL MATTERS); 551.076 (DELIBERATIONS ABOUT SECURITY DEVISES); AND 551.087 (ECONOMIC DEVELOPMENT); 418.183 (SECURITY MATTERS).

1. COUNTY ATTORNEY MATTHEW POSTON

RECEIVE ADVICE OF COUNSEL REGARDING UPDATES IN OPEN MEETINGS ACT AND PUBLIC INFORMATION ACT.

Tri-County Behavioral Healthcare

Healthy Minds. Meaningful Lives.

January 5, 2023

Honorable Jay Knight
Liberty County Judge
1923 Sam Houston, Ste. 201
Liberty, TX 77575

Re: Appointment of Reverend Carl Williamson to the Tri-County Behavioral Healthcare Board of Trustees

Dear Judge Knight:

Liberty County has three (3) appointments to the Tri-County Behavioral Healthcare Board of Trustees.

Reverend Carl Williamson, Pastor of Calvary Baptist Church in Cleveland has indicated to our Board Chair that he is interested in participating as a Trustee of the Board. He would be filling the term vacated by Trustee Cecil McKnight in December of 2016. The term for Reverend Williamson would be set to expire on August 31, 2024.

On behalf of the current Board Chair, Patti Atkins, I would like to respectfully request that the Commissioners' Court appoint Reverend Williamson to the Board of Trustees to fill this vacancy. In Liberty County, the Board has felt that it was very important to ensure that the Cleveland, Texas area had strong representation on the Board and they believe that Reverend Williamson, a two-time Cleveland Chamber of Commerce Citizen of the Year, would provide that leadership.

Stability of Board membership is critical to the Center's continued success in delivering services to individuals with mental illness, intellectual/developmental disabilities, substance use disorders and other related services.

Please forward a copy of the Commissioner's Court meeting minutes at which the appointment to the Tri-County Board is made or a letter stating the date of the appointment. This documentation is necessary to meet state law requirements.

I appreciate your assistance with this matter. Please do not hesitate to call me if you have questions or need additional information.

Sincerely,

Evan Roberson
Executive Director

C: Tri-County Behavioral Healthcare Board of Trustees
Patti Atkins, Chair, Liberty County
Gail Page, Vice-Chair, Liberty County

P.O. Box 3067 | Conroe, TX 77305
Tel. 936.521.6100 | Fax 936.760.2898 | Crisis Line 800.659.6994 | www.tcbhc.org

Agenda Item: Approve November 2022 Financial Statements **Committee:** Business	**Board Meeting Date** January 26, 2023
Background Information: None	
Supporting Documentation: November 2022 Financial Statements	
Recommended Action: **Approve November 2022 Financial Statements**	

November 2022 Financial Summary

Revenues for November 2022 were $3,303,348 and operating expenses were $2,984,704 resulting in a gain in operation of $318,644. Capital Expenditures and Extraordinary Expenses for November were $120,265 resulting in a gain of $198,378. Total revenues were 102.39% of the monthly budgeted revenues and total expenses were 97.34% of the monthly budgeted expenses (difference of 5.06%).

Year to date revenues are $10,405,786 and operating expenses are $9,821,719 leaving excess operating revenues of $584,067. YTD Capital Expenditures and Extraordinary Expenses are $377,815 resulting in a gain YTD of $206,252. Total revenues are 101.31% of the YTD budgeted revenues and total expenses are 99.71% of the YTD budgeted expenses (difference of 1.60%)

REVENUES

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

Revenue Source	YTD Revenue	YTD Budget	% of Budget	$ Variance
Title XIX Rehab	369,266	482,622	76.51%	113,356

Rehab – This line item is the Medicaid Rehab Services. This is the 2nd month this fiscal year for Rehab to be on the variance report. We continue to have higher than budgeted staff vacancies. We have seen an increase in applications in some programs but an increase in revenue from staff being hired usually takes between four to six months.

EXPENSES

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

Expense Source	YTD Expenses	YTD Budget	% of Budget	$ Variance
Fixed Assets – Buildings	29,500	0	0%	29,500
Fixed Assets – Building Improvements	93,634	35,034	267.26%	58,600

Fixed Assets – Buildings – This line item reflects the down payment for the land that we are purchasing in Huntsville that was approved by the Board.

Fixed Assets – Building Improvements – This line item reflects the cost to date spent for renovating the Crisis facility. These renovations are to improve the health and safety of the front part of the building that was approved by the Board.

TRI-COUNTY BEHAVIORAL HEALTHCARE
CONSOLIDATED BALANCE SHEET
For the Month Ended November 2022

ASSETS	TOTALS COMBINED FUNDS November 2022	TOTALS COMBINED FUNDS October 2022	Increase (Decrease)
CURRENT ASSETS			
Imprest Cash Funds	1,950	1,950	-
Cash on Deposit - General Fund	6,339,081	8,699,406	(2,360,325)
Cash on Deposit - Debt Fund			-
Accounts Receivable	6,567,091	6,063,838	503,253
Inventory	1,145	1,649	(504)
TOTAL CURRENT ASSETS	12,909,267	14,766,843	(1,857,576)
FIXED ASSETS	21,041,617	21,041,617	-
OTHER ASSETS	268,620	233,085	35,535
TOTAL ASSETS	**$ 34,219,505**	**$ 36,041,545**	**$ (1,822,040)**
LIABILITIES, DEFERRED REVENUE, FUND BALANCES			
CURRENT LIABILITIES	2,102,416	2,438,556	(336,140)
NOTES PAYABLE	694,011	694,011	-
DEFERRED REVENUE	966,868	2,845,540	(1,878,672)
LONG-TERM LIABILITIES FOR			
First Financial Conroe Building Loan	10,073,841	10,116,507	(42,666)
Guaranty Bank & Trust Loan	1,783,707	1,789,411	(5,704)
EXCESS(DEFICIENCY) OF REVENUES OVER EXPENSES FOR			
General Fund	206,252	7,873	198,380
FUND EQUITY			
RESTRICTED			
Net Assets Reserved for Debt Service	(11,857,548)	(11,905,918)	48,370
Reserved for Debt Retirement			-
COMMITTED			
Net Assets - Property and Equipment	21,041,618	21,041,618	-
Reserved for Vehicles & Equipment Replacement	613,711	613,711	-
Reserved for Facility Improvement & Acquisitions	2,228,216	2,283,765	(55,549)
Reserved for Board Initiatives	1,500,000	1,500,000	-
Reserved for 1115 Waiver Programs	502,677	502,677	-
ASSIGNED			
Reserved for Workers' Compensation	274,409	274,409	-
Reserved for Current Year Budgeted Reserve	18,500	12,333	6,167
Reserved for Insurance Deductibles	100,000	100,000	-
Reserved for Accrued Paid Time Off	(694,010)	(694,010)	-
UNASSIGNED			
Unrestricted and Undesignated	4,664,837	4,421,061	243,776
TOTAL LIABILITIES/FUND BALANCE	**$ 34,219,505**	**$ 36,041,545**	**$ (1,822,037)**

TRI-COUNTY BEHAVIORAL HEALTHCARE
CONSOLIDATED BALANCE SHEET
For the Month Ended November 2022

ASSETS	General Operating Funds	Memorandum Only Final August 2021
CURRENT ASSETS		
Imprest Cash Funds	1,950	3,037
Cash on Deposit - General Fund	6,339,081	12,191,566
Cash on Deposit - Debt Fund	-	-
Accounts Receivable	6,567,091	3,516,983
Inventory	1,145	2,808
TOTAL CURRENT ASSETS	12,909,267	15,714,394
FIXED ASSETS	21,041,617	18,541,959
OTHER ASSETS	268,620	260,188
		-
	$ 34,219,505	**$ 34,516,542**
LIABILITIES, DEFERRED REVENUE, FUND BALANCES		
CURRENT LIABILITIES	2,102,416	1,426,803
NOTES PAYABLE	694,011	738,448
DEFERRED REVENUE	966,868	4,430,907
LONG-TERM LIABILITIES FOR		
First Financial Conroe Building Loan	10,073,841	10,668,011
Guaranty Bank & Trust Loan	1,783,707	-
EXCESS(DEFICIENCY) OF REVENUES OVER EXPENSES FOR		
General Fund	206,252	109,284
FUND EQUITY		
RESTRICTED		
Net Assets Reserved for Debt Service - Restricted	(11,857,548)	(10,668,011)
Reserved for Debt Retirement	-	-
COMMITTED		-
Net Assets - Property and Equipment - Committed	21,041,618	18,541,959
Reserved for Vehicles & Equipment Replacement	613,711	613,712
Reserved for Facility Improvement & Acquisitions	2,228,216	2,500,000
Reserved for Board Initiatives	1,500,000	1,500,000
Reserved for 1115 Waiver Programs	502,677	502,677
ASSIGNED		-
Reserved for Workers' Compensation - Assigned	274,409	274,409
Reserved for Current Year Budgeted Reserve - Assigned	18,500	6,167
Reserved for Insurance Deductibles - Assigned	100,000	100,000
Reserved for Accrued Paid Time Off	(694,010)	(738,448)
UNASSIGNED		
Unrestricted and Undesignated	4,664,837	4,510,623
TOTAL LIABILITIES/FUND BALANCE	**$ 34,219,505**	**$ 34,516,542**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
For the Month Ended November 2022
and Year To Date as of November 2022

INCOME:	MONTH OF November 2022	YTD November 2022
Local Revenue Sources	355,253	1,336,831
Earned Income	1,540,596	4,733,130
General Revenue - Contract	1,407,499	4,335,825
TOTAL INCOME	**$ 3,303,348**	**$ 10,405,786**
EXPENSES:		
Salaries	1,672,192	5,553,507
Employee Benefits	319,809	1,020,868
Medication Expense	41,569	122,245
Travel - Board/Staff	28,125	96,484
Building Rent/Maintenance	30,568	75,315
Consultants/Contracts	617,374	2,070,031
Other Operating Expenses	275,066	883,268
TOTAL EXPENSES	**$ 2,984,704**	**$ 9,821,719**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 318,644**	**$ 584,067**
CAPITAL EXPENDITURES		
Capital Outlay - FF&E, Automobiles, Building	40,213	137,657
Capital Outlay - Debt Service	80,052	240,158
TOTAL CAPITAL EXPENDITURES	**$ 120,265**	**$ 377,815**
GRAND TOTAL EXPENDITURES	**$ 3,104,969**	**$ 10,199,534**
Excess (Deficiency) of Revenues and Expenses	**$ 198,378**	**$ 206,252**

Debt Service and Fixed Asset Fund:		
Debt Service	80,052	240,158
Excess (Deficiency) of Revenues over Expenses	**80,052**	**240,158**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
Compared to Budget
Year to Date as of November 2022

	YTD November 2022	APPROVED BUDGET	Increase (Decrease)
INCOME:			
Local Revenue Sources	1,336,831	1,194,493	142,338
Earned Income	4,733,130	4,761,005	(27,875)
General Revenue	4,335,825	4,316,021	19,804
TOTAL INCOME	**$ 10,405,786**	**$ 10,271,519**	**$ 134,267**
EXPENSES:			
Salaries	5,553,507	5,641,458	(87,951)
Employee Benefits	1,020,868	1,023,498	(2,630)
Medication Expense	122,245	133,256	(11,011)
Travel - Board/Staff	96,484	85,719	10,765
Building Rent/Maintenance	75,315	77,000	(1,685)
Consultants/Contracts	2,070,031	2,140,736	(70,705)
Other Operating Expenses	883,268	840,018	43,250
TOTAL EXPENSES	**$ 9,821,719**	**$ 9,941,685**	**$ (119,966)**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 584,067**	**$ 329,834**	**$ 254,233**
CAPITAL EXPENDITURES			
Capital Outlay - FF&E, Automobiles, Building	137,657	47,259	90,398
Capital Outlay - Debt Service	240,158	240,157	1
TOTAL CAPITAL EXPENDITURES	**$ 377,815**	**$ 287,416**	**$ 90,399**
GRAND TOTAL EXPENDITURES	**$ 10,199,534**	**$ 10,229,101**	**$ (29,567)**
Excess (Deficiency) of Revenues and Expenses	**$ 206,252**	**$ 42,418**	**$ 163,834**

Debt Service and Fixed Asset Fund:			
Debt Service	240,158	240,157	**1**
Excess(Deficiency) of Revenues over Expenses	**240,158**	**240,157**	**1**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
Compared to Budget
For the Month Ended November 2022

INCOME:	MONTH OF November 2022	APPROVED BUDGET	Increase (Decrease)
Local Revenue Sources	355,253	298,447	56,806
Earned Income	1,540,596	1,561,564	(20,968)
General Revenue-Contract	1,407,499	1,366,198	41,301
TOTAL INCOME	**$ 3,303,348**	**$ 3,226,209**	**$ 77,139**
EXPENSES:			
Salaries	1,672,192	1,729,465	(57,273)
Employee Benefits	319,809	330,030	(10,221)
Medication Expense	41,569	44,419	(2,850)
Travel - Board/Staff	28,125	28,573	(448)
Building Rent/Maintenance	30,568	44,000	(13,432)
Consultants/Contracts	617,374	655,219	(37,845)
Other Operating Expenses	275,066	266,471	8,595
TOTAL EXPENSES	**$ 2,984,704**	**$ 3,098,177**	**$ (113,473)**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 318,644**	**$ 128,032**	**$ 190,612**
CAPITAL EXPENDITURES			
Capital Outlay - FF&E, Automobiles, Building	40,213	11,753	28,460
Capital Outlay - Debt Service	80,052	80,052	-
TOTAL CAPITAL EXPENDITURES	**$ 120,265**	**$ 91,805**	**$ 28,460**
GRAND TOTAL EXPENDITURES	**$ 3,104,969**	**$ 3,189,982**	$ (85,013)
Excess (Deficiency) of Revenues and Expenses	**$ 198,378**	**$ 36,227**	**$ 162,152**

Debt Service and Fixed Asset Fund:			
Debt Service	80,052	80,052	-
Excess (Deficiency) of Revenues over Expenses	**80,052**	**80,052**	**-**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
With YTD November 2021 Comparative Data
Year to Date as of November 2022

INCOME:	YTD November 2022	YTD November 2021	Increase (Decrease)
Local Revenue Sources	1,336,831	372,225	964,606
Earned Income	4,733,130	3,601,432	1,131,698
General Revenue-Contract	4,335,825	5,242,878	(907,053)
TOTAL INCOME	**$ 10,405,786**	**$ 9,216,535**	**$ 1,189,251**
EXPENSES:			
Salaries	5,553,507	5,081,060	472,447
Employee Benefits	1,020,868	972,552	48,316
Medication Expense	122,245	149,162	(26,917)
Travel - Board/Staff	96,484	56,161	40,323
Building Rent/Maintenance	75,315	40,622	34,693
Consultants/Contracts	2,070,031	1,660,749	409,282
Other Operating Expenses	883,268	631,901	251,367
TOTAL EXPENSES	**$ 9,821,719**	**$ 8,592,208**	**$ 1,229,511**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 584,067**	**$ 624,328**	**$ (40,260)**
CAPITAL EXPENDITURES			
Capital Outlay - FF&E, Automobiles, Building	137,657	36,386	101,271
Capital Outlay - Debt Service	240,158	209,002	31,156
TOTAL CAPITAL EXPENDITURES	**$ 377,815**	**$ 245,389**	**$ 132,427**
GRAND TOTAL EXPENDITURES	**$ 10,199,534**	**$ 8,837,596**	**$ 1,361,938**
Excess (Deficiency) of Revenues and Expenses	**$ 206,252**	**$ 378,939**	**$ (172,687)**

Debt Service and Fixed Asset Fund:			
Debt Service	240,158	209,002	31,156
			-
Excess (Deficiency) of Revenues over Expenses	**240,158**	**209,002**	**31,156**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
With November 2021 Comparative Data
For the Month ending November 2022

INCOME:	MONTH OF November 2022	MONTH OF November 2021	Increase (Decrease)
Local Revenue Sources	355,253	218,731	136,522
Earned Income	1,540,596	1,506,129	34,467
General Revenue-Contract	1,407,499	1,705,519	(298,020)
TOTAL INCOME	**$ 3,303,348**	**$ 3,430,379**	**$ (127,031)**
Salaries	1,672,192	1,861,548	(189,356)
Employee Benefits	319,809	330,806	(10,997)
Medication Expense	41,569	48,725	(7,156)
Travel - Board/Staff	28,125	21,101	7,024
Building Rent/Maintenance	30,568	5,272	25,296
Consultants/Contracts	617,374	781,238	(163,864)
Other Operating Expenses	275,066	198,117	76,949
TOTAL EXPENSES	**$ 2,984,704**	**$ 3,246,808**	**$ (262,104)**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 318,644**	**$ 183,570**	**$ 135,073**
CAPITAL EXPENDITURES			
Capital Outlay - FF&E, Automobiles, Building	40,213	32,193	8,020
Capital Outlay - Debt Service	80,052	69,667	10,385
TOTAL CAPITAL EXPENDITURES	**$ 120,265**	**$ 101,860**	**$ 18,405**
GRAND TOTAL EXPENDITURES	**$ 3,104,969**	**$ 3,348,669**	**$ (243,700)**
Excess (Deficiency) of Revenues and Expenses	**$ 198,378**	**$ 81,710**	**$ 116,668**

Debt Service and Fixed Asset Fund:			
Debt Service	80,052	69,667	10,385
			-
Excess (Deficiency) of Revenues over Expenses	**80,052**	**69,667**	**10,385**

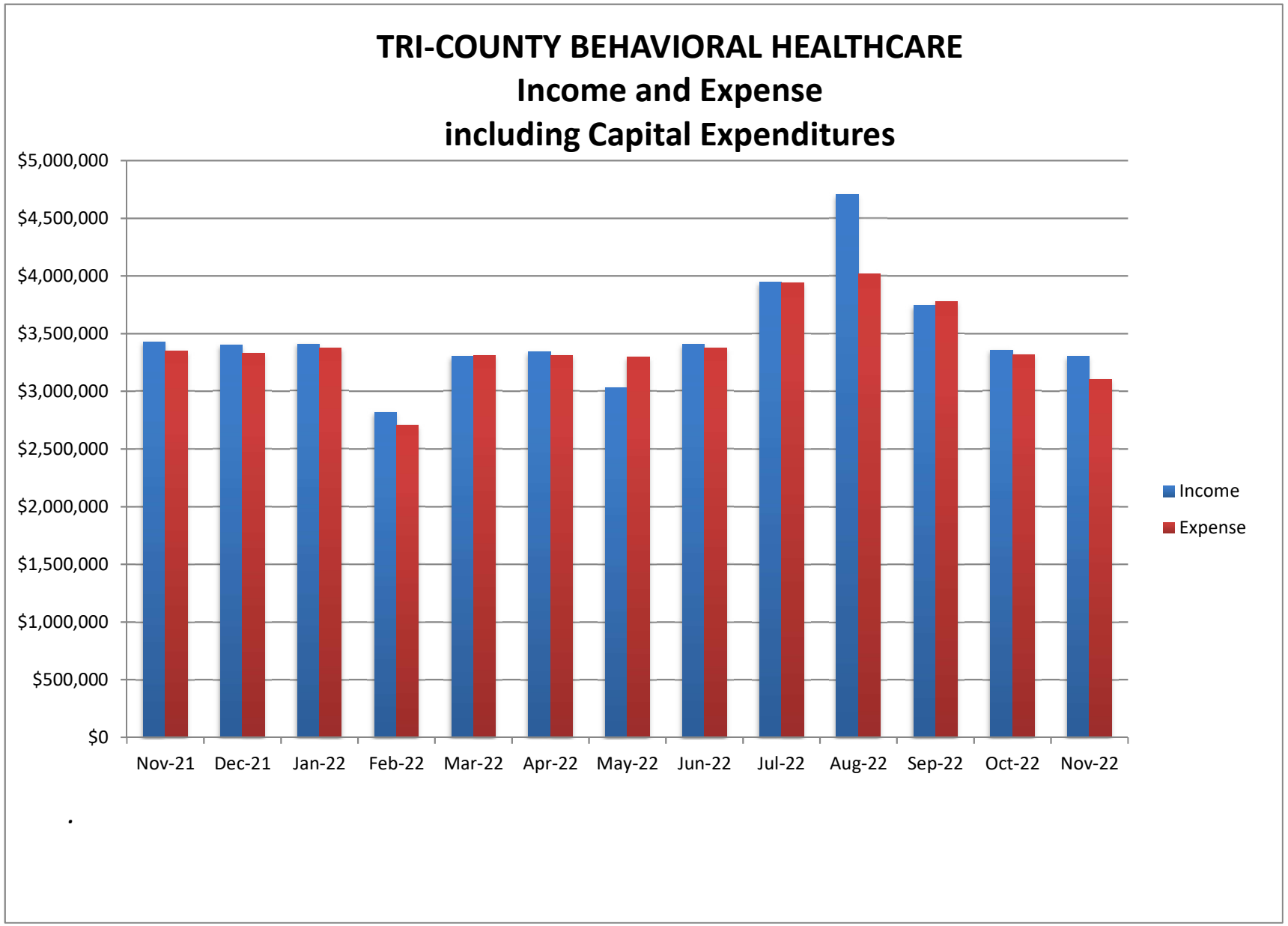
TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
With October 2022 Comparative Data
For the Month Ended November 2022

INCOME:	MONTH OF November 2022	MONTH OF October 2022	Increase (Decrease)
Local Revenue Sources	355,253	524,353	(169,100)
Earned Income	1,540,596	1,406,814	133,782
General Revenue-Contract	1,407,499	1,427,715	(20,216)
TOTAL INCOME	**$ 3,303,348**	**$ 3,358,882**	**$ (55,534)**
EXPENSES:			
Salaries	1,672,192	1,575,760	96,432
Employee Benefits	319,809	313,990	5,819
Medication Expense	41,569	41,071	498
Travel - Board/Staff	28,125	31,171	(3,046)
Building Rent/Maintenance	30,568	19,247	11,321
Consultants/Contracts	617,374	828,522	(211,148)
Other Operating Expenses	275,066	362,702	(87,636)
TOTAL EXPENSES	**$ 2,984,704**	**$ 3,172,464**	**$ (187,760)**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 318,644**	**$ 186,418**	**$ 132,226**
CAPITAL EXPENDITURES			
Capital Outlay - FF&E, Automobiles, Building	40,213	63,765	(23,552)
Capital Outlay - Debt Service	80,052	80,052	-
TOTAL CAPITAL EXPENDITURES	**$ 120,265**	**$ 143,817**	**$ (23,552)**
GRAND TOTAL EXPENDITURES	**$ 3,104,969**	**$ 3,316,281**	**$ (211,312)**
Excess (Deficiency) of Revenues and Expenses	**$ 198,378**	**$ 42,601**	**$ 155,778**

Debt Service and Fixed Asset Fund:			
Debt Service	80,052	80,052	-
Excess (Deficiency) of Revenues over Expenses	**80,052**	**80,052**	**-**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary by Service Type
Compared to Budget
Year To Date as of November 2022

INCOME:	YTD Mental Health November 2022	YTD IDD November 2022	YTD Other Services November 2022	YTD Agency Total November 2022	YTD Approved Budget November 2022	Increase (Decrease)
Local Revenue Sources	898,630	107,612	330,590	1,336,832	1,194,493	142,339
Earned Income	1,073,182	911,427	2,748,522	4,733,131	4,761,005	(27,874)
General Revenue-Contract	3,629,630	435,730	270,464	4,335,824	4,316,021	19,803
TOTAL INCOME	**5,601,442**	**1,454,769**	**3,349,575**	**$ 10,405,787**	**$ 10,271,519**	**$ 134,269**
EXPENSES:						
Salaries	2,985,850	819,023	1,748,634	5,553,507	5,641,458	(87,951)
Employee Benefits	580,347	159,113	281,407	1,020,867	1,023,498	(2,631)
Medication Expense	102,525	-	19,720	122,245	133,256	(11,011)
Travel - Board/Staff	44,432	30,420	21,631	96,483	85,719	10,764
Building Rent/Maintenance	62,735	1,555	11,025	75,314	77,000	(1,686)
Consultants/Contracts	727,343	278,035	1,064,653	2,070,031	2,140,736	(70,705)
Other Operating Expenses	453,043	192,498	237,727	883,267	840,018	43,249
TOTAL EXPENSES	**4,956,275**	**1,480,644**	**3,384,797**	**$ 9,821,719**	**$ 9,941,685**	**$ (119,969)**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**645,167**	**(25,874)**	**(35,223)**	**$ 584,068**	**$ 329,834**	**$ 254,238**
CAPITAL EXPENDITURES						
Capital Outlay - FF&E, Automobiles, Building	117,314	7,469	12,874	137,657	47,259	90,398
Capital Outlay - Debt Service	122481	36,024	81,654	240,159	240,157	2
TOTAL CAPITAL EXPENDITURES	**239,795 #**	**43,493 #**	**94,528**	**$ 377,814**	**$ 287,416**	**$ 90,400**
GRAND TOTAL EXPENDITURES	**5,196,070 ##**	**1,524,137 ##**	**3,479,325**	**$ 10,199,533**	**$ 10,229,101**	**$ (29,569)**
Excess (Deficiency) of Revenues and Expenses	**405,372**	**(69,367)**	**(129,750)**	**$ 206,252 #**	**$ 42,418**	**$ 163,837**
Debt Service and Fixed Asset Fund:						
Debt Service	239,795	43,493	94,528	240,159	240,157	239,795
		-	-	-		-
Excess (Deficiency) of Revenues over Expenses	**239,795**	**43,493**	**94,528**	**240,159**	**240,157**	**239,795**


TRI-COUNTY BEHAVIORAL HEALTHCARE
Income and Expense
including Capital Expenditures
$5,000,000
$4,500,000
$4,000,000
$3,500,000
$3,000,000
$2,500,000
$2,000,000
$1,500,000
$1,000,000
$500,000
$0
Nov-21
Dec-21
Jan-22
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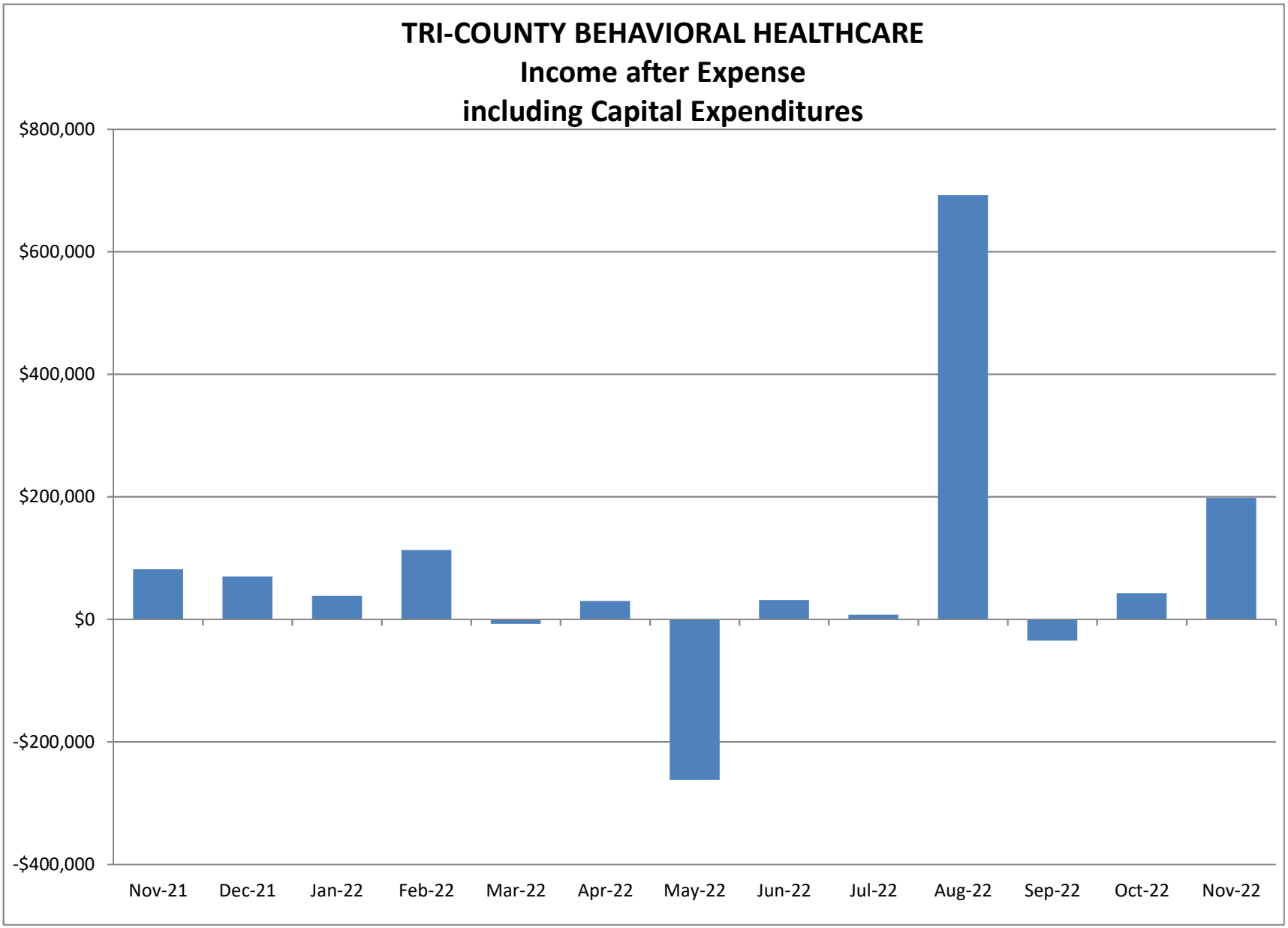
Aug-22
Sep-22
Oct-22
Nov-22
Income
Expense


TRI-COUNTY BEHAVIORAL HEALTHCARE
Income after Expense
including Capital Expenditures
$800,000
$600,000
$400,000
$200,000
$0
-$200,000
-$400,000
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22

Agenda Item: Approve December 2022 Financial Statements **Committee:** Business	**Board Meeting Date** January 26, 2023
Background Information: None	
Supporting Documentation: December 2022 Financial Statements	
Recommended Action: **Approve December 2022 Financial Statements**	

December 2022 Financial Summary

Revenues for December 2022 were $3,693,182 and operating expenses were $3,348,040 resulting in a gain in operation of $345,142. Capital Expenditures and Extraordinary Expenses for December were $327,666 resulting in a gain of $17,475. Total revenues were 106.87% of the monthly budgeted revenues and total expenses were 108.14% of the monthly budgeted expenses (difference of (-1.27%).

Year to date revenues are $14,098,968 and operating expenses are $13,169,759 leaving excess operating revenues of $929,209. YTD Capital Expenditures and Extraordinary Expenses are $705,481 resulting in a gain YTD of $223,727. Total revenues are 102.62% of the YTD budgeted revenues and total expenses are 101.81% of the YTD budgeted expenses (difference of .81%).

REVENUES

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

Revenue Source	YTD Revenue	YTD Budget	% of Budget	$ Variance
Title XIX Case Management IDD	411,097	455,129	90.32%	44,032
Title XIX Rehab	457,454	694,824	65.83%	237,409

Title XIX Case Management IDD – This line has finally made its way to the variance listing. Staff vacancies again are the problem in most all of our service areas. We will be adjusting this line in our budget revision.

Title XIX Rehab – We have seen this for the last couple of months. Same description with being understaffed and the time it takes to get new staff hired and trained before they start earning actual revenue. This will be adjusted in our budget revision.

EXPENSES

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

Expense Source	YTD Expenses	YTD Budget	% of Budget	$ Variance
Fixed Assets – Buildings	225,094	0	0%	225,094

Fixed Assets – Building Improvements	143,443	46,712	307.08%	96,731

Fixed Assets – Buildings – This line item is the amount paid for the closing costs on the twenty percent down on the land for the new Huntsville property.

Fixed Assets – Building Improvements – This line item reflects the cost to date for renovating the front part of the Crisis facility. These renovations are to improve the health and safety of this location. This item was approved by the Board.

TRI-COUNTY BEHAVIORAL HEALTHCARE
CONSOLIDATED BALANCE SHEET
For the Month Ended December 2022

ASSETS	TOTALS COMBINED FUNDS December 2022	TOTALS COMBINED FUNDS November 2022	Increase (Decrease)
CURRENT ASSETS			
Imprest Cash Funds	$ 1,950	$ 1,950	$ -
Cash on Deposit - General Fund	$ 9,939,244	$ 6,339,081	$ 3,600,163
Cash on Deposit - Debt Fund			$ -
Accounts Receivable	$ 6,167,729	$ 6,567,091	$ (399,362)
Inventory	$ 845	$ 1,145	$ (300)
TOTAL CURRENT ASSETS	$ 16,109,768	$ 12,909,267	$ 3,200,501
FIXED ASSETS	$ 21,041,617	$ 21,041,617	$ -
OTHER ASSETS	$ 248,077	$ 268,620	$ (20,543)
TOTAL ASSETS	**$ 37,399,463**	**$ 34,219,505**	**$ 3,179,959**
LIABILITIES, DEFERRED REVENUE, FUND BALANCES			
CURRENT LIABILITIES	$ 1,779,738	$ 2,102,416	$ (322,678)
NOTES PAYABLE	$ 694,011	$ 694,011	$ -
DEFERRED REVENUE	$ 4,756,097	$ 966,868	$ 3,789,229
LONG-TERM LIABILITIES FOR			
First Financial Conroe Building Loan	$ 10,030,183	$ 10,073,841	$ (43,658)
Guaranty Bank & Trust Loan	$ 1,778,145	$ 1,783,707	$ (5,562)
EXCESS(DEFICIENCY) OF REVENUES OVER EXPENSES FOR			
General Fund	$ 223,727	$ 206,252	$ 17,475
FUND EQUITY			
RESTRICTED			
Net Assets Reserved for Debt Service	$ (11,808,328)	$ (11,857,548)	$ 49,220
Reserved for Debt Retirement			$ -
COMMITTED			
Net Assets - Property and Equipment	$ 21,041,618	$ 21,041,618	$ -
Reserved for Vehicles & Equipment Replacement	$ 613,711	$ 613,711	$ -
Reserved for Facility Improvement & Acquisitions	$ 1,917,982	$ 2,228,216	$ (310,234)
Reserved for Board Initiatives	$ 1,500,000	$ 1,500,000	$ -
Reserved for 1115 Waiver Programs	$ 502,677	$ 502,677	$ -
ASSIGNED			
Reserved for Workers' Compensation	$ 274,409	$ 274,409	$ -
Reserved for Current Year Budgeted Reserve	$ 24,667	$ 18,500	$ 6,167
Reserved for Insurance Deductibles	$ 100,000	$ 100,000	$ -
Reserved for Accrued Paid Time Off	$ (694,010)	$ (694,010)	$ -
UNASSIGNED			
Unrestricted and Undesignated	$ 4,664,837	$ 4,664,837	$ -
TOTAL LIABILITIES/FUND BALANCE	**$ 37,399,463**	**$ 34,219,505**	**$ 3,179,960**

TRI-COUNTY BEHAVIORAL HEALTHCARE
CONSOLIDATED BALANCE SHEET
For the Month Ended December 2022

ASSETS	General Operating Funds	Memorandum Only Final August 2021
CURRENT ASSETS		
Imprest Cash Funds	$ 1,950	$ 3,037
Cash on Deposit - General Fund	$ 9,939,244	$ 12,191,566
Cash on Deposit - Debt Fund	$ -	$ -
Accounts Receivable	$ 6,167,729	$ 3,516,983
Inventory	$ 845	$ 2,808
TOTAL CURRENT ASSETS	$ 16,109,768	$ 15,714,394
FIXED ASSETS	$ 21,041,617	$ 18,541,959
OTHER ASSETS	$ 248,077	$ 260,188
		-
Total Assets	**$ 37,399,463**	**$ 34,516,542**
LIABILITIES, DEFERRED REVENUE, FUND BALANCES		
CURRENT LIABILITIES	$ 1,779,738	$ 1,426,803
NOTES PAYABLE	$ 694,011	$ 738,448
DEFERRED REVENUE	$ 4,756,097	$ 4,430,907
LONG-TERM LIABILITIES FOR		
First Financial Conroe Building Loan	$ 10,030,183	$ 10,668,011
Guaranty Bank & Trust Loan	$ 1,778,145	$ -
EXCESS(DEFICIENCY) OF REVENUES OVER EXPENSES FOR		
General Fund	$ 223,727	$ 109,284
FUND EQUITY		
RESTRICTED		
Net Assets Reserved for Debt Service - Restricted	$ (11,808,328)	$ (10,668,011)
Reserved for Debt Retirement	$ -	$ -
COMMITTED		$ -
Net Assets - Property and Equipment - Committed	$ 21,041,618	$ 18,541,959
Reserved for Vehicles & Equipment Replacement	$ 613,711	$ 613,712
Reserved for Facility Improvement & Acquisitions	$ 1,917,982	$ 2,500,000
Reserved for Board Initiatives	$ 1,500,000	$ 1,500,000
Reserved for 1115 Waiver Programs	$ 502,677	$ 502,677
ASSIGNED		$ -
Reserved for Workers' Compensation - Assigned	$ 274,409	$ 274,409
Reserved for Current Year Budgeted Reserve - Assigned	$ 24,667	$ 6,167
Reserved for Insurance Deductibles - Assigned	$ 100,000	$ 100,000
Reserved for Accrued Paid Time Off	$ (694,010)	$ (738,448)
UNASSIGNED		
Unrestricted and Undesignated	$ 4,664,837	$ 4,510,623
TOTAL LIABILITIES/FUND BALANCE	**$ 37,399,463**	**$ 34,516,542**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
For the Month Ended December 2022
and Year To Date as of December 2022

INCOME:	MONTH OF December 2022	YTD December 2022
Local Revenue Sources	668,294	2,005,126
Earned Income	1,587,442	6,320,571
General Revenue - Contract	1,437,446	5,773,271
TOTAL INCOME	**$ 3,693,182**	**$ 14,098,968**
EXPENSES:		
Salaries	1,974,989	7,528,496
Employee Benefits	357,640	1,378,508
Medication Expense	38,550	160,795
Travel - Board/Staff	22,977	119,461
Building Rent/Maintenance	26,471	101,787
Consultants/Contracts	686,057	2,756,088
Other Operating Expenses	241,356	1,124,624
TOTAL EXPENSES	**$ 3,348,040**	**$ 13,169,759**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 345,142**	**$ 929,209**
CAPITAL EXPENDITURES		
Capital Outlay - FF&E, Automobiles, Building	247,614	385,271
Capital Outlay - Debt Service	80,052	320,210
TOTAL CAPITAL EXPENDITURES	**$ 327,666**	**$ 705,481**
GRAND TOTAL EXPENDITURES	**$ 3,675,706**	**$ 13,875,240**
Excess (Deficiency) of Revenues and Expenses	**$ 17,475**	**$ 223,727**

Debt Service and Fixed Asset Fund:		
Debt Service	80,052	320,210
Excess (Deficiency) of Revenues over Expenses	**$ 80,052**	**$ 320,210**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
Compared to Budget
Year to Date as of December 2022

	YTD December 2022	APPROVED BUDGET	Increase (Decrease)
INCOME:			
Local Revenue Sources	2,005,126	1,583,511	421,615
Earned Income	6,320,571	6,365,362	(44,791)
General Revenue	5,773,271	5,790,229	(16,958)
TOTAL INCOME	**$ 14,098,968**	**$ 13,739,103**	**$ 359,866**
EXPENSES:			
Salaries	7,528,496	7,642,435	(113,939)
Employee Benefits	1,378,508	1,381,935	(3,427)
Medication Expense	160,795	162,675	(1,880)
Travel - Board/Staff	119,461	114,292	5,169
Building Rent/Maintenance	101,787	93,500	8,287
Consultants/Contracts	2,756,088	2,801,926	(45,838)
Other Operating Expenses	1,124,624	1,052,252	72,372
TOTAL EXPENSES	**$ 13,169,759**	**$ 13,249,017**	**$ (79,255)**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 929,209**	**$ 490,086**	**$ 439,121**
CAPITAL EXPENDITURES			
Capital Outlay - FF&E, Automobiles, Building	385,271	59,012	326,259
Capital Outlay - Debt Service	320,210	320,209	1
TOTAL CAPITAL EXPENDITURES	**$ 705,481**	**$ 379,221**	**$ 326,260**
GRAND TOTAL EXPENDITURES	**$ 13,875,240**	**$ 13,628,238**	**$ 247,005**
Excess (Deficiency) of Revenues and Expenses	**$ 223,727**	**$ 110,864**	**$ 112,862**

Debt Service and Fixed Asset Fund:			
Debt Service	320,210	320,209	**1**
Excess(Deficiency) of Revenues over Expenses	**$ 320,210**	**$ 320,209**	**$ 1**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
Compared to Budget
For the Month Ended December 2022

INCOME:	MONTH OF Decembe 2022	APPROVED BUDGET	Increase (Decrease)
Local Revenue Sources	668,294	389,019	279,275
Earned Income	1,587,442	1,607,358	(19,916)
General Revenue-Contract	1,437,446	1,459,519	(22,073)
TOTAL INCOME	**$ 3,693,182**	**$ 3,455,896**	**$ 237,286**
EXPENSES:			
Salaries	1,974,989	2,000,977	(25,988)
Employee Benefits	357,640	358,437	(797)
Medication Expense	38,550	31,419	7,131
Travel - Board/Staff	22,977	28,573	(5,596)
Building Rent/Maintenance	26,471	16,500	9,971
Consultants/Contracts	686,057	661,194	24,863
Other Operating Expenses	241,356	210,234	31,122
TOTAL EXPENSES	**$ 3,348,040**	**$ 3,307,335**	**$ 40,707**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 345,142**	**$ 148,561**	**$ 196,579**
CAPITAL EXPENDITURES			
Capital Outlay - FF&E, Automobiles, Building	247,614	11,753	235,861
Capital Outlay - Debt Service	80,052	80,052	-
TOTAL CAPITAL EXPENDITURES	**$ 327,666**	**$ 91,805**	**$ 235,861**
GRAND TOTAL EXPENDITURES	**$ 3,675,706**	**$ 3,399,140**	**$ 276,566**
Excess (Deficiency) of Revenues and Expenses	**$ 17,475**	**$ 56,755**	**$ (39,280)**

Debt Service and Fixed Asset Fund:			
Debt Service	80,052	80,052	-
Excess (Deficiency) of Revenues over Expenses	**$ 80,052**	**$ 80,052**	**$ -**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
With YTD December 2021 Comparative Data
Year to Date as of December 2022

INCOME:	YTD December 2022	YTD December 2021	Increase (Decrease)
Local Revenue Sources	2,005,126	439,014	1,566,112
Earned Income	6,320,571	5,038,692	1,281,879
General Revenue-Contract	5,773,271	7,138,833	(1,365,562)
TOTAL INCOME	**$ 14,098,968**	**$ 12,616,539**	**$ 1,482,429**
EXPENSES:			
Salaries	7,528,496	7,105,747	422,749
Employee Benefits	1,378,508	1,319,579	58,929
Medication Expense	160,795	195,097	(34,302)
Travel - Board/Staff	119,461	73,880	45,581
Building Rent/Maintenance	101,787	66,584	35,203
Consultants/Contracts	2,756,088	2,205,159	550,929
Other Operating Expenses	1,124,624	828,437	296,187
TOTAL EXPENSES	**$ 13,169,759**	**$ 11,794,483**	**$ 1,375,276**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 929,209**	**$ 822,055**	**$ 107,154**
CAPITAL EXPENDITURES			
Capital Outlay - FF&E, Automobiles, Building	385,271	94,602	290,669
Capital Outlay - Debt Service	320,210	278,670	41,540
TOTAL CAPITAL EXPENDITURES	**$ 705,481**	**$ 373,271**	**$ 332,210**
GRAND TOTAL EXPENDITURES	**$ 13,875,240**	**$ 12,167,754**	**$ 1,707,486**
Excess (Deficiency) of Revenues and Expenses	**$ 223,727**	**$ 448,784**	**$ (225,056)**
Debt Service and Fixed Asset Fund:			
Debt Service	320,210	278,670	41,540
			-
Excess (Deficiency) of Revenues over Expenses	**$ 320,210**	**$ 278,670**	**$ 41,540**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
With December 2021 Comparative Data
For the Month ending December 2022

INCOME:	MONTH OF December 2022	MONTH OF December 2021	Increase (Decrease)
Local Revenue Sources	668,294	66,789	601,505
Earned Income	1,587,442	1,437,261	150,181
General Revenue-Contract	1,437,446	1,895,954	(458,508)
TOTAL INCOME	**$ 3,693,182**	**$ 3,400,003**	**$ 293,179**
Salaries	1,974,989	2,024,687	(49,698)
Employee Benefits	357,640	347,027	10,613
Medication Expense	38,550	45,935	(7,385)
Travel - Board/Staff	22,977	17,719	5,258
Building Rent/Maintenance	26,471	25,962	509
Consultants/Contracts	686,057	544,410	141,647
Other Operating Expenses	241,356	196,536	44,820
TOTAL EXPENSES	**$ 3,348,040**	**$ 3,202,276**	**$ 145,764**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 345,142**	**$ 197,728**	**$ 147,414**
CAPITAL EXPENDITURES			
Capital Outlay - FF&E, Automobiles, Building	247,614	58,215	189,399
Capital Outlay - Debt Service	80,052	69,667	10,385
TOTAL CAPITAL EXPENDITURES	**$ 327,666**	**$ 127,883**	**$ 199,783**
GRAND TOTAL EXPENDITURES	**$ 3,675,706**	**$ 3,330,158**	**$ 345,548**
Excess (Deficiency) of Revenues and Expenses	**$ 17,475**	**$ 69,845**	**$ (52,369)**

Debt Service and Fixed Asset Fund:			
Debt Service	80,052	69,667	10,385
			-
Excess (Deficiency) of Revenues over Expenses	**$ 80,052**	**$ 69,667**	**$ 10,385**

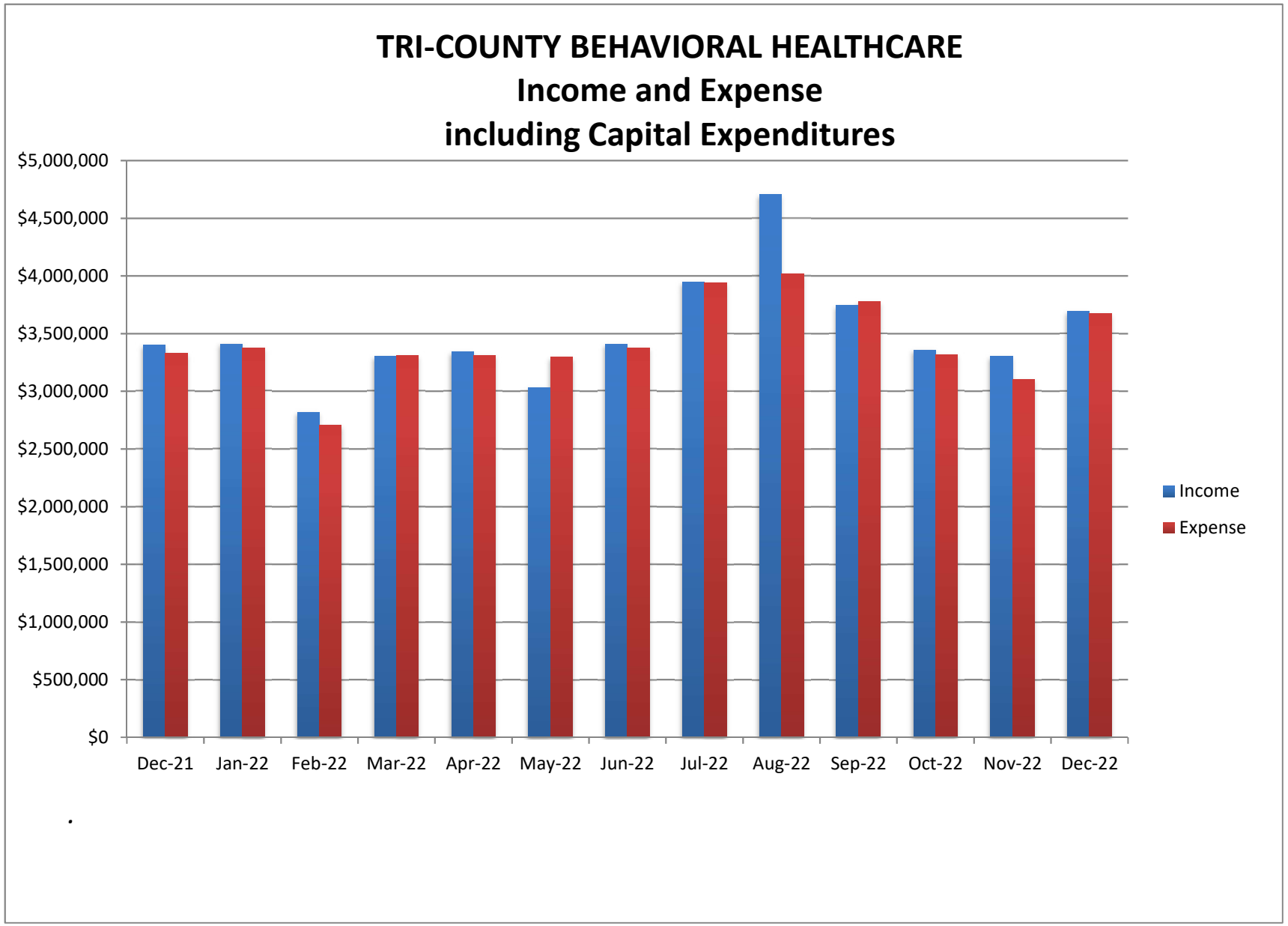
TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
With November 2022 Comparative Data
For the Month Ended December 2022

INCOME:	**MONTH OF December 2022**	**MONTH OF November 2022**	**Increase (Decrease)**
Local Revenue Sources	668,294	355,253	313,041
Earned Income	1,587,442	1,540,596	46,846
General Revenue-Contract	1,437,446	1,407,499	29,947
TOTAL INCOME	**$ 3,693,182**	**$ 3,303,348**	**$ 389,834**
EXPENSES:			
Salaries	1,974,989	1,672,192	302,797
Employee Benefits	357,640	319,809	37,831
Medication Expense	38,550	41,569	(3,019)
Travel - Board/Staff	22,977	28,125	(5,148)
Building Rent/Maintenance	26,471	30,568	(4,097)
Consultants/Contracts	686,057	617,374	68,683
Other Operating Expenses	241,356	275,066	(33,710)
TOTAL EXPENSES	**$ 3,348,040**	**$ 2,984,704**	**$ 363,337**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 345,142**	**$ 318,644**	**$ 26,497**
CAPITAL EXPENDITURES			
Capital Outlay - FF&E, Automobiles, Building	247,614	40,213	207,401
Capital Outlay - Debt Service	80,052	80,052	-
TOTAL CAPITAL EXPENDITURES	**$ 327,666**	**$ 120,265**	**$ 207,401**
GRAND TOTAL EXPENDITURES	**$ 3,675,706**	**$ 3,104,969**	**$ 570,737**
Excess (Deficiency) of Revenues and Expenses	**$ 17,475**	**$ 198,378**	**$ (180,904)**

Debt Service and Fixed Asset Fund:			
Debt Service	80,052	80,052	-
Excess (Deficiency) of Revenues over Expenses	**$ 80,052**	**$ 80,052**	**$ -**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary by Service Type
Compared to Budget
Year To Date as of December 2022

INCOME:	YTD Mental Health December 2022	YTD IDD December 2022	YTD Other Services December 2022	YTD Agency Total December 2022	YTD Approved Budget December 2022	Increase (Decrease)
Local Revenue Sources	1,322,290	173,098	509,737	2,005,125	1,194,493	810,632
Earned Income	1,473,824	1,221,004	3,625,743	6,320,571	4,761,005	1,559,566
General Revenue-Contract	4,858,611	587,430	327,228	5,773,269	4,316,021	1,457,248
TOTAL INCOME	**$ 7,654,725**	**$ 1,981,532**	**$ 4,462,707**	**$ 14,098,965**	**$ 10,271,519**	**$ 3,827,447**
EXPENSES:						
Salaries	4,154,206	1,131,956	2,242,335	7,528,497	5,641,458	1,887,039
Employee Benefits	793,606	216,343	368,560	1,378,509	1,023,498	355,011
Medication Expense	135,918	-	24,877	160,795	133,256	27,539
Travel - Board/Staff	57,280	37,293	24,889	119,462	85,719	33,743
Building Rent/Maintenance	88,346	1,856	11,584	101,786	77,000	24,786
Consultants/Contracts	960,596	347,079	1,448,414	2,756,089	2,140,736	615,353
Other Operating Expenses	588,547	248,461	287,614	1,124,622	840,018	284,604
TOTAL EXPENSES	**$ 6,778,499**	**$ 1,982,988**	**$ 4,408,273**	**$ 13,169,760**	**$ 9,941,685**	**$ 3,228,077**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 876,226**	**$ (1,455)**	**$ 54,433**	**$ 929,205**	**$ 329,834**	**$ 599,370**
CAPITAL EXPENDITURES						
Capital Outlay - FF&E, Automobiles, Building	271,375	36,808	77,087	385,270	47,259	338,011
Capital Outlay - Debt Service	166,509	48,032	105,669	320,210	240,157	80,053
TOTAL CAPITAL EXPENDITURES	**$ 437,884**	**$ 84,840**	**$ 182,756**	**$ 705,481**	**$ 287,416**	**$ 418,064**
GRAND TOTAL EXPENDITURES	**$ 7,216,383**	**$ 2,067,828**	**$ 4,591,029**	**$ 13,875,241**	**$ 10,229,101**	**$ 3,646,141**
Excess (Deficiency) of Revenues and Expenses	**$ 438,341**	**$ (86,295)**	**$ (128,321)**	**$ 223,727** #	**$ 42,418**	**$ 181,305**
Debt Service and Fixed Asset Fund:						
Debt Service	437,884	84,840	182,756	705,481	287,416	418,067
		-	-	-		-
Excess (Deficiency) of Revenues over Expenses	**$ 437,884**	**$ 84,840**	**$ 182,756**	**$ 705,481**	**$ 287,416**	**$ 418,067**


TRI-COUNTY BEHAVIORAL HEALTHCARE
Income and Expense
including Capital Expenditures
$5,000,000
$4,500,000
$4,000,000
$3,500,000
$3,000,000
$2,500,000
$2,000,000
$1,500,000
$1,000,000
$500,000
$0
Dec-21
Jan-22
Feb-22
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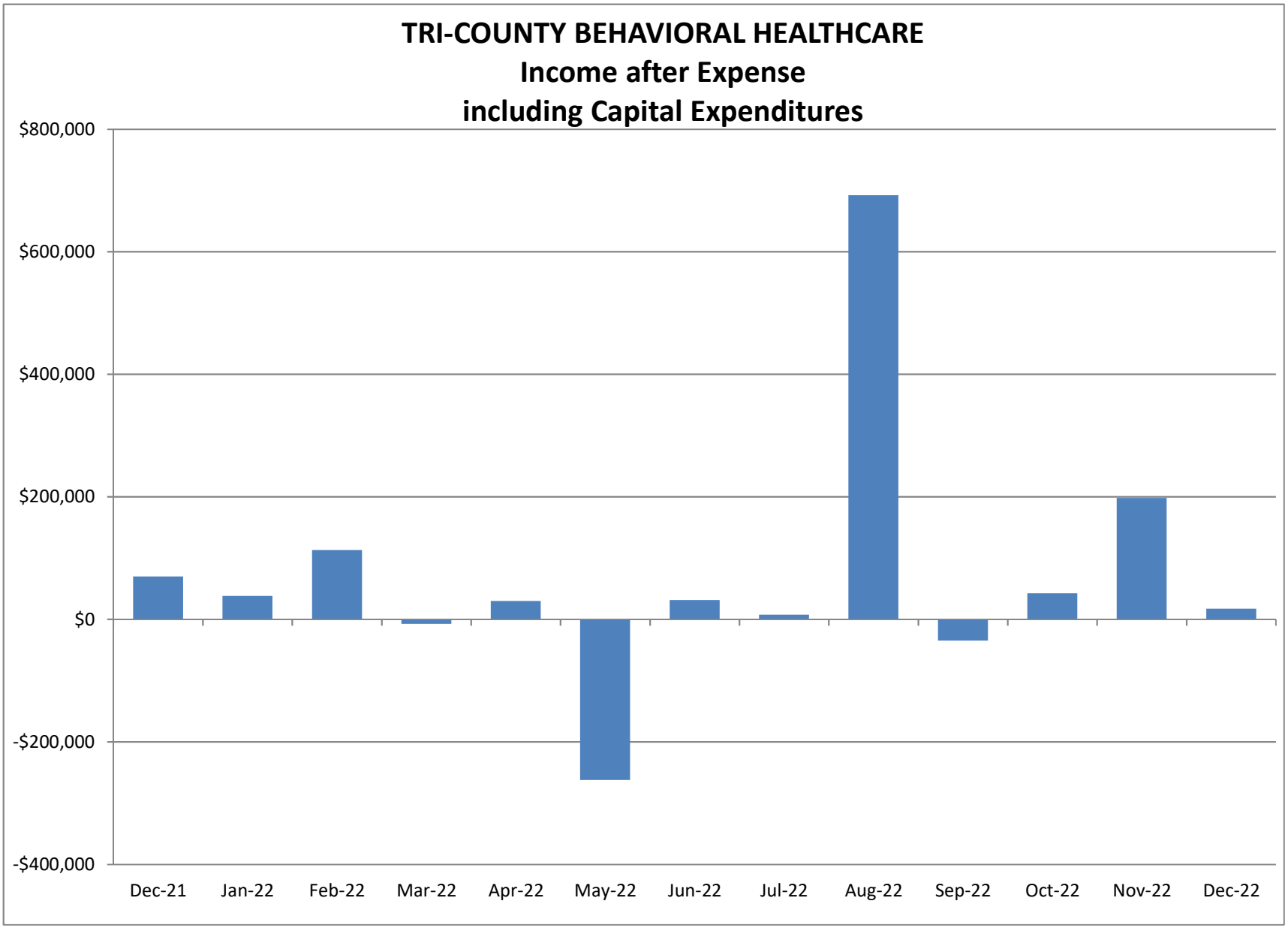
Sep-22
Oct-22
Nov-22
Dec-22
Income
Expense


TRI-COUNTY BEHAVIORAL HEALTHCARE
Income after Expense
including Capital Expenditures
$800,000
$600,000
$400,000
$200,000
$0
-$200,000
-$400,000
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22

Agenda Item: Approve FY 2022 Independent Financial Audit **Committee**: Business	**Board Meeting Date** January 26, 2023
Background Information: Eide Bailly, LLP audited Tri-County's Financial Statements for the fiscal year ending August 31, 2022. There were no material findings related to the financial statements.	
Supporting Documentation: Copy of Preliminary Audited Financial Statements – Mailed to Board Members	
Recommended Action: **Approve FY 2022 Independent Financial Audit**	

Agenda Item: Approve New Bank Account at First Financial Bank **Committee:** Business	**Board Meeting Date** January 26, 2023

Background Information:

As a part of the Business Loan Agreement when we purchased the Huntsville land through First Financial Bank, Tri-County is required to "Establish and maintain depository account(s) with the Lender". The requirement is to establish said account within thirty (30) days of the date of the Agreement, and have a combined collected balance of at least $100,000. The loan was finalized on December 27, 2022. Tri-County shall maintain an average quarterly combined amount of $100,000 while this Agreement is in effect.

We are working with Bank representative to determine what type of account to open. With the last loan we had a Certificate of Deposit and received a reasonable rate of interest and that is what we would like with this account as well.

Supporting Documentation:

Business Loan Agreement will be available for review Board Meeting.

Recommended Action:

Authorize staff to establish a new depository account with First Financial Bank and deposit a minimum of $100,000 in this new account.

Agenda Item: Ratify Execution of Loan for the Purchase of 0 Veterans Memorial Parkway, Huntsville, Texas **Committee:** Business	**Board Meeting Date** January 26, 2023

Background Information:

The Attorney for First Financial Bank in Conroe, the lender for the 0 Veterans Memorial Parkway property in Huntsville, required that specific authority for securing the loan be given by the Board of Trustees. The motion for the purchase of the property, approved at the August 25, 2022 meeting, below, did not specifically include language about securing a loan for the property even though it was part of the discussion.

Resolution #08-25-19

Motion Made By: Morris Johnson

Seconded By: Tracy Sorensen, with affirmative votes by Sharon Walker, Gail Page, Tim Cannon and Richard Duren that it be…

Resolved:

That the Board approve the purchase of 5.7 acres NW corner of Veterans Memorial Parkway and State Highway 30, Huntsville, authorize sale of approximately 28 acres behind our current Huntsville Service Center, with approval of all documents by Jackson Walker LLP, and authorize the Executive Director to execute all required documents.

Jackson Walker and the First Financial legal staff worked together to create the motion below.

Supporting Documentation:

None

Recommended Action:

That the Board hereby, in all respects, ratifies, confirms and approves Evan Roberson's execution of all financing documents needed to complete the purchase of 5.62 acres NW corner of Veterans Memorial Parkway and State Highway 30, Huntsville, Texas (the "Property") in an amount not to exceed $854,125 at an interest rate not to exceed 5.5%, including, without limitation, granting a lien on the Property to secure the loan evidenced by the Note.

Agenda Item: Ratify Health and Human Services Commission Contract No. HHS000994900001, Amendment No. 3 Intellectual and Developmental Disability Authority Services **Committee:** Business	**Board Meeting Date** January 26, 2023

Background Information:

HHSC has amended the Intellectual and Developmental Disability Authority contract to fully fund Enhanced Community Coordination services through the remainder of FY 2023. The contract was increased by $51,918 and went into effect on January 1, 2023. No other contract terms were changed.

Enhanced Community Coordination is a service which provides intensive case management services for persons who are being placed in the community after being residents of Nursing Facilities or State Supported Living Centers. Persons transitioning from these environments need extra support and monitoring to ensure successful placement. The funding for this position is Federal Money Follows the Person funding which was not allocated to HHSC until the first quarter of FY 2023.

Significantly, ECC positions have been difficult to fill across the state because they require at least two years of experience to qualify for the position and many Centers, like ours, have had so much turnover in IDD Authority services that finding someone with two years of experience is very difficult. We have just filled our vacancy which has been open for over a year and a half. In addition, the ECC process is under both Federal and HHSC scrutiny right now and documentation of these services has been the subject of recent HHSC audits.

HHSC needed to receive the signed contract back before the January Board meeting, so the Executive Director has signed the agreement and is requesting ratification.

Supporting Documentation:

Contract will be available for review at the Board meeting.

Recommended Action:

Ratify Health and Human Services Commission Contract No. HHS000994900001, Amendment No. 3, Intellectual and Developmental Disability Authority Services

Agenda Item: Ratify HHSC Treatment Adult Services (TRA) Contract No. HHS000663700009, Amendment No. 2 **Committee:** Business	**Board Meeting Date** January 26, 2023

Background Information:

The HHSC Treatment Adult Services (TRA) contract provides funds for Adult Substance Use Treatment.

This contract amendment includes changes with the contract terms and conditions. There is no change in funding associated with this contract. None of the changes in the Statement of Work appear to be significant for program operations.

HHSC needed to process this contract before the Board meeting so Evan Roberson signed the contract for ratification by the Board.

Supporting Documentation:

Contract Available for Review.

Recommended Action:

Ratify HHSC Treatment Adult Services (TRA) Contract No. HHS000663700009, Amendment No. 2

Agenda Item: Ratify HHSC Co-Occurring Mental Health (COPSD) Substance Use Disorder Services Contract No. HHS000886900001, Amendment No. 1 **Committee:** Business	**Board Meeting Date** January 26, 2023

Background Information:

The HHSC Co-Occurring Psychiatric and Substance Use Disorder (COPSD) contract provides funds for adults and youth with psychiatric diagnoses and substance use disorders.

This contract amendment includes changes with the contract terms and conditions. There is no change in funding associated with this contract. None of the changes in the Statement of Work appear to be significant for program operations.

HHSC needed to process this contract before the Board meeting so Evan Roberson signed the contract for ratification by the Board.

Supporting Documentation:

Contract Available for Review.

Recommended Action:

Ratify HHSC Co-Occurring Mental Health (COPSD) Substance Use Disorder Services Contract No. HHS000886900001, Amendment No. 1

Agenda Item: Ratify Health and Human Services Commission COVID-19 Supplemental Grant Program, Contract No. HHS001108400037, Amendment No. 3 **Committee:** Business	**Board Meeting Date** January 26, 2023

Background Information:

HHSC is using federal COVID-19 dollars to provide funding for Outpatient Capacity Expansion. Initially this contract required a series of budget forms and tracking of individual clients to prove up expanded services, but after negotiation, the Centers were able to convince HHSC to allow use of the funds to address current or future workforce challenges without these associated service targets. Each Center that chose to do so had to request that the performance targets be waived in order to use the funds for workforce.

This contract amendment includes new quarterly financial reporting requirements as the major change.

The contract for FY 2022 was $630,401 and we were provided $336,790 through March of 2023. HHSC will extend this funding in March for the remainder of the fiscal year.

HHSC needed to receive the signed contract back before the January Board meeting, so the Executive Director has signed the agreement and is requesting ratification.

Supporting Documentation:

Contract will be available for review at the Board meeting.

Recommended Action:

Ratify Health and Human Services Commission COVID-19 Supplemental Grant Program, Contract No. HHS001108400037, Amendment No. 3

Agenda Item: Approve Not to Exceed Remodel Budget for the Crisis Stabilization Unit at the Psychiatric Emergency Treatment Center **Committee:** Business	**Board Meeting Date** January 26, 2023

Background Information:

The Crisis Stabilization Unit is a Department of State Health Services licensed facility in the back of Psychiatric Emergency Treatment Center (PETC) building. At the end of FY 22, the Board authorized the remodel of the front portion of the PETC where our Crisis Screening and Assessment program is located but the Board chose to wait on the CSU side of the building until funding could be secured for ongoing operations.

Now that operational funds for the Crisis Stabilization Unit have been secured, we need to remodel the back of the building as well. As was the case for the front of the building, wear on a facility that operates 24/7 is significant. This remodel effort will include a series of updates to flooring, paint, countertops, plumbing fixtures, etc., but will also include any changes to the facility which will be required for re-licensure (e.g. nurse call system).

Mike Duncum has been retained to oversee the project. He has been working with contractors to get estimates for the construction so that he can provide a not to exceed budget estimate for the Board today. Mike Duncum has been retained to oversee the project. Request for Proposals were posted December 29, 2022 on Dodge Construction and January 4, 2023 in Conroe Courier and Humble Observer for a two week run. Bids were due January 20, 2023. Bid packets were sent to seven potential bidders with three bids received by January 19, 2023, the publish date of the board packet. Remaining bids were expected January 20, 2023. Based on received bids, estimated cost to complete the project is not expected to exceed $343,200.00 including a 10% contingency. Estimated time of completion is 60 days notwithstanding delays in long lead items.

Staff are eager to get the construction process started because both the construction and the licensing have the potential of delaying the CSU reopening timeline.

Supporting Documentation:

CSU Remodel Budget Presentation provided at the Board meeting.

Recommended Action:

Approve Not to Exceed Remodel Budget for the Crisis Stabilization Unit at the Psychiatric Emergency Treatment Center

Agenda Item: Montgomery County Sheriff's Office Crisis Intervention Team Grant Update **Committee:** Business	**Board Meeting Date** January 26, 2023

Background Information:

Major Tim Cannon with the Montgomery County Sheriff's Office and Tri-County Behavioral Healthcare Board Trustee, will present an update on the Crisis Intervention Team Grant. Sgt. Mike Evans and/or Lt. Scott Spencer will be available at the Board meeting to answer any necessary questions.

Update:

- Positions have been formally approved and personnel alignments and projected activities have been formed.
- MCSO internal notifications have been made and postings for MCSO personnel have been initiated.
- Sgt. Mike Evans and Lt. Scott Spencer have been assigned to oversee the unit.
- MCSO will now begin working closely with Tri-County to ensure that (two full time) personnel are selected to fill the two Grant funded positions known as Qualified Mental Health Professionals that will ride along with our CIT trained officers.
- After selections are made, combined training with our deputies and civilians from Tri-County will begin.

Supporting Documentation:

None

Recommended Action:

For Information Only

Agenda Item: 1st Quarter FY 2023 Quarterly Investment Report **Committee:** Business	**Board Meeting Date** January 26, 2023
Background Information: This report is provided to the Board of Trustees of Tri-County Services in accordance with Board Policy on fiscal management and in compliance with Chapter 2256: Subchapter A of the Public Funds Investment Act.	
Supporting Documentation: Quarterly TexPool Investment Report Quarterly Interest Report	
Recommended Action: **For Information Only**	

QUARTERLY INVESTMENT REPORT
TEXPOOL FUNDS

For the Period Ending November 30, 2022

GENERAL INFORMATION

This report is provided to the Board of Trustees of Tri-County Behavioral Healthcare in accordance with Board Policy on fiscal management and in compliance with Chapter 2256; Subchapter A of the Public Funds Investment Act.

Center funds for the period have been partially invested in the Texas Local Government Investment Pool (TexPool), organized in conformity with the Interlocal Cooperation Act, Chapter 791 of the Texas Government Code, and the Public Funds Investment Act, Chapter 2256 of the Texas Government Code. The Comptroller of Public Accounts is the sole officer, director, and shareholder of the Texas Treasury Safekeeping Trust Company which is authorized to operate TexPool. Pursuant to the TexPool Participation Agreement, administrative and investment services to TexPool are provided by Federated Investors, Inc. ("Federated"). The Comptroller maintains oversight of the services provided. In addition, the TexPool Advisory Board, composed equally of participants in TexPool and other persons who do not have a business relationship with TexPool, advise on investment policy and approves fee increases.

TexPool investment policy restricts investment of the portfolio to the following types of investments:

Obligations of the United States Government or its agencies and instrumentalities with a maximum final maturity of 397 days for fixed rate securities and 24 months for variable rate notes;

Fully collateralized repurchase agreements and reverse repurchase agreements with defined termination dates may not exceed 90 days unless the repurchase agreements have a provision that enables TexPool to liquidate the position at par with no more than seven days notice to the counterparty. The maximum maturity on repurchase agreements may not exceed 181 days. These agreements may be placed only with primary government securities dealers or a financial institution doing business in the State of Texas.

No-load money market mutual funds are registered and regulated by the Securities and Exchange Commission and rated AAA or equivalent by at least one nationally recognized rating service. The money market mutual fund must maintain a dollar weighted average stated maturity of 90 days or less and include in its investment objectives the maintenance of a stable net asset value of $1.00.

TexPool is governed by the following specific portfolio diversification limitations;

100% of the portfolio may be invested in obligations of the United States.

100% of the portfolio may be invested in direct repurchase agreements for liquidity purposes.

Reverse repurchase agreements will be used primarily to enhance portfolio return within a limitation of up to one-third (1/3) of total portfolio assets.

No more than 15% of the portfolio may be invested in approved money market mutual funds.

The weighted average maturity of TexPool cannot exceed 60 days calculated using the reset date for variable rate notes and 90 days calculated using the final maturity date for variable rate notes.

The maximum maturity for any individual security in the portfolio is limited to 397 days for fixed rate securities and 24 months for variable rate notes.

TexPool seeks to maintain a net asset value of $1.00 and is designed to be used for investment of funds which may be needed at any time.

STATISTICAL INFORMATION

Market Value for the Period

Portfolio Summary	September	October	November
Uninvested Balance	($784,625.43)	$1,112.97	$476.61
Accrual of Interest Income	$35,457,148.67	$40,369,447.22	$56,624,448.52
Interest and Management Fees Payable	($45,232,820.64)	($48,026,936.34)	($72,462,365.49)
Payable for Investments Purchased	($50,000,000.00)	($40,000,000.00)	0.00
Accrued Expense & Taxes	($24,628.34)	($24,391.93)	($24,433.91)
Repurchase Agreements	$8,489,894,000.00	$8,465,762,000.00	$9,064,748,000.00
Mutual Fund Investments	$1,627,085,200.00	$1,627,085,200.00	$1,794,085,200.00
Government Securities	$8,240,028,519.54	$9,878,233,578.21	$9,800,011,481.26
U.S. Treasury Bills	$1,612,773,092.10	$2,110,396,392.97	$2,289,379,578.44
U.S. Treasury Notes	$4,418,516,964.15	$2,109,177,673.29	$1,688,271,317.62
TOTAL	**$24,327,712,850.05**	**$24,142,974,076.39**	**$24,620,633,703.05**

Book Value for the Period

Type of Asset	Beginning Balance	Ending Balance
Uninvested Balance	$5.36	$1,364.73
Accrual of Interest Income	$11,137,696.22	$13,525,041.84
Interest and Management Fees Payable	($425,930.67)	($688,543.99)
Payable for Investments Purchased	$0.00	($111,728,212.96)
Accrued Expenses & Taxes	($27,399.41)	($26,852.48)
Repurchase Agreements	$8,278,948,315.00	$8,024,258,623.00
Mutual Fund Investments	$1,370,074,000.00	$1,369,074,000.00
Government Securities	$3,209,972,745.56	$4,055,096,073.87
U.S. Treasury Bills	$6,099,505,647.99	$4,581,010,158.65
U.S. Treasury Notes	$3,254,778,947.31	$3,849,817,778.84
TOTAL	**$22,223,964,027.36**	**$21,780,339,431.50**

Portfolio by Maturity as of November 30, 2022

1 to 7 days	8 to 90 day	91 to 180 days	181 + days
82.2%	12.8%	0.9%	4.1%

Portfolio by Type of Investments as of November 30, 2022

Treasuries	Repurchase Agreements	Agencies	Money Market Funds
16.1%	36.8%	39.8%	7.3%

SUMMARY INFORMATION

On a simple daily basis, the monthly average yield was 2.41% for September, 2.93% for October, and 3.61% for November.

As of the end of the reporting period, market value of collateral supporting the Repurchase Agreements was at least 102% of the Book Value.

The weighted average maturity of the fund as of November 30, 2022 was 20 days.

The net asset value as of November 30, 2022 was 0.99946.

The total amount of interest distributed to participants during the period was $72,462,371.47.

TexPool interest rates did not exceed 90 Day T-Bill rates during the entire reporting period.

TexPool has a current money market fund rating of AAAm by Standard and Poor's.

During the reporting period, the total number of participants increased to 2,747.

Fund assets are safe kept at the State Street Bank in the name of TexPool in a custodial account.

During the reporting period, the investment portfolio was in full compliance with Tri-County Behavioral Healthcare's Investment Policy and with the Public Funds Investment Act.

Submitted by:

_____ _____
Sheryl Baldwin Date
Manager of Accounting / Investment Officer

_____ _____
Millie McDuffey Date
Chief Financial Officer / Investment Officer

_____ _____
Evan Roberson Date
Executive Director / Investment Officer

TRI-COUNTY BEHAVIORAL HEALTHCARE
QUARTERLY INTEREST EARNED REPORT
FISCAL YEAR 2023
As Of November 30, 2022

BANK NAME	INTEREST EARNED				
	1st QTR.	2nd QTR.	3rd QTR.	4th QTR.	YTD TOTAL
Alliance Bank - Central Texas CD	$ -				$ -
First Liberty National Bank	$ 0.46				$ 0.46
JP Morgan Chase (HBS)	$ 11,474.99				$ 11,474.99
Prosperity Bank	$ 165.64				$ 165.64
Prosperity Bank CD (formerly Tradition)	$ 12.51				$ 12.51
TexPool Participants	$ 290.16				$ 290.16
Total Earned	$ 11,943.76	$ -	$ -	$ -	$ 11,943.76

Agenda Item: Board of Trustees Unit Financial Statements as of November & December 2022 **Committee:** Business	**Board Meeting Date** January 26, 2023
Background Information: None	
Supporting Documentation: November & December 2022 Board of Trustees Unit Financial Statements	
Recommended Action: **For Information Only**	

Unit Financial Statement

FY 2023

November 30, 2022

	November 2022 Budget	November 2022 Actual	Variance	YTD Budget	YTD Actual	Variance	Percent	Budget
Revenues								
Allocated Revenue	$ 1,927	$ 1,927	$ -	$ 5,781	$ 5,781	$ -	100%	$ 23,125
Total Revenue	$ 1,927	$ 1,927	$ -	$ 5,781	$ 5,781	$ -	100%	$ 23,125
Expenses								
Insurance-Worker Compensation	$ 13	$ -	$ 13	$ 38	$ 9	$ 28	402%	$ 150
Legal Fees	$ 1,500	$ 1,500	$ -	$ 4,500	$ 4,500	$ -	100%	$ 18,000
Training	$ 75	$ -	$ 75	$ 225	$ -	$ 225	0%	$ 900
Travel - Local	$ 42	$ -	$ 42	$ 125	$ -	$ 125	0%	$ 500
Travel - Non-local mileage	$ 35	$ -	$ 35	$ 106	$ 207	$ (101)	51%	$ 425
Travel - Non-local Hotel	$ 217	$ -	$ 217	$ 650	$ 274	$ 376	237%	$ 2,600
Travel - Meals	$ 46	$ -	$ 46	$ 137	$ -	$ 137	0%	$ 550
Total Expenses	$ 1,927	$ 1,500	$ 427	$ 5,781	$ 4,990	$ 791	116%	$ 23,125
Total Revenue minus Expenses	$ (0)	$ 427	$ (427)	$ (0)	$ 791	$ (791)	-16%	$ -

Unit Financial Statement

FY 2023

December 31, 2022

	December 2022 Budget	December 2022 Actual	Variance	YTD Budget	YTD Actual	Variance	Percent	Budget
Revenues								
Allocated Revenue	$ 1,927	$ 1,927	$ -	$ 7,708	$ 7,708	$ -	100%	$ 23,125
Total Revenue	$ 1,927	$ 1,927	$ -	$ 7,708	$ 7,708	$ -	100%	$ 23,125
Expenses								
Insurance-Worker Compensation	$ 13	$ 6	$ 6	$ 50	$ 16	$ 34	318%	$ 150
Legal Fees	$ 1,500	$ 1,500	$ -	$ 6,000	$ 6,000	$ -	100%	$ 18,000
Training	$ 75	$ -	$ 75	$ 300	$ -	$ 300	0%	$ 900
Travel - Local	$ 42	$ -	$ 42	$ 167	$ -	$ 167	0%	$ 500
Travel - Non-local mileage	$ 35	$ -	$ 35	$ 142	$ 207	$ (65)	68%	$ 425
Travel - Non-local Hotel	$ 217	$ -	$ 217	$ 867	$ 274	$ 593	317%	$ 2,600
Travel - Meals	$ 46	$ -	$ 46	$ 183	$ -	$ 183	0%	$ 550
Total Expenses	$ 1,927	$ 1,506	$ 421	$ 7,708	$ 6,496	$ 1,212	119%	$ 23,125
Total Revenue minus Expenses	$ (0)	$ 421	$ (421)	$ (0)	$ 1,212	$ (1,212)	-19%	$ -

Agenda Item: HUD 811 Update **Committee:** Business	**Board Meeting Date** January 26, 2023

Background Information:

As you are aware our HUD 811 housing projects are funded with the expectation that they remain viable for the next forty (40) years. Once this time period is met, HUD considers the program obligation met (i.e. loan paid in full). Each of the Housing Boards is appointed by the Board of Trustees and each organization is a component unit of Tri-County Behavioral Healthcare. As a Liaison to these projects, Tri-County has established a quarterly reporting mechanism to keep the Board of Trustees updated on the status of these projects.

Supporting Documentation:

First Quarter FY 2023 HUD 811 Report

Recommended Action:

For Information Only

1st Quarter FY 2023 HUD 811 Report

The Cleveland Supported Housing, Inc. Board (CSHI)

The CSHI Board held a meeting on December 9, 2022 where they reviewed financial statements, project status reports and reviewed the engagement letter from the selected auditor for the upcoming year. The property is currently at 100% occupancy and there are three approved people on the waiting list.

The CSHI Board currently has three members which is the minimum membership allowable per the bylaws. For this reason, we are actively seeking recommendations for additional membership as they become available. Please contact Tanya with any potential leads.

The Montgomery Supported Housing, Inc. Board (MSHI)

The MSHI Board held a meeting on December 13, 2022 where they reviewed financial statements, project status reports and reviewed the engagement letter from the selected auditor for the upcoming year. The property is currently at 100% occupancy and there are four approved people on the waiting list

The MSHI Board currently has four members and we continue to seek recommendations for additional members as they become available. Tri-County staff met with MSHI Board President Sharon Walker and a potential new member on January 10th to share information about Independence Place Apartments and serving on the MSHI Board. We will provide additional information as we receive updates on this individual's interest. Please contact Tanya with any additional leads.

The Independence Communities, Inc. Board (ICI)

The ICI Board voted to cancel their meeting scheduled for December 13, 2022 and will reconvene for the annual meeting which is tentatively scheduled for March 21, 2023. As of December 2022, they had zero vacancies. There are currently three approved applications on the one-bedroom waiting list and two on the two-bedroom waiting list.

There has been one resident that was given a notice of nonrenewal and their term has ended, however, the resident filed a complaint with HUD and refused to vacate the unit. We will provide more information to the Board as it is available.

The ICI Board currently has four members with the addition of a new member, Cynthia Cunningham. We continue to actively seek recommendations for additional membership as they become available. Please contact Tanya with any potential leads.

Agenda Item: Tri-County's Consumer Foundation Board Update and End of Year Review **Committee:** Business	**Board Meeting Date** January 26, 2023

Background Information:

Tri-County's Consumer Foundation Board of Directors met on December 2, 2022 where they accepted financial statements through November 30, 2022 and set the spending amount for Q1 2023. The Board reviewed the 2022 fundraiser and discussed 2023 fundraiser ideas including a crawfish boil at Pacific Yard House, a Pickle Ball Tournament, and the 3rd Annual Fall Festival-Golf Ball Drop that will possibly be held at The Woodlands Golf Course. The Board suggested staff contact Kirby's Ice House, In-N-Out Burger, the Giving Machine, and Tejas Bingo for potential donations.

Ten applications were approved during the last quarter of 2022 via email after being reviewed by the Board.

The year 2022 was the Foundation's busiest year on record for financial assistance requests, increasing from 17 in 2021 to 54 in 2022. In addition, the requested dollar amounts more than doubled, from $13,187.64 in 2021 to $31,033.89 in 2022. The final account balance for the Foundation including $18,930.98 in donations and fundraising, is $48,573.00.

Supporting Documentation:

None

Recommended Action:

For Information Only

UPCOMING MEETINGS

February 23, 2023 – Board Meeting

- Longevity Presentations
- ISC Group Retirement Presentations
- Approve Minutes from January 26, 2023 Board Meeting
- Community Resources Report
- Consumer Services Report for January 2023
- Program Updates
- Personnel Report for January 2023
- Texas Council Risk Management Fund Claims Summary for January 2023
- Approve Financial Statements for January 2023
- FY 23 Budget Revision
- 401(a) Retirement Plan Account Review
- Board of Trustees Unit Financial Statement as of January 2023

March 23, 2023 – Board Meeting

- Approve Minutes from February 23, 2023 Board Meeting
- Community Resources Report
- Consumer Services Report for February 2023
- Program Updates
- FY 2023 Goals and Objectives Progress Report
- 2nd Quarter FY 2023 Investment Report
- 2nd Quarter FY 2023 Corporate Compliance and Quality Management Report
- 3rd Quarter FY 2023 Corporate Compliance Training
- Personnel Report for February 2023
- Texas Council Risk Management Fund Claims Summary as of February 2023
- Approve Financial Statements for February 2023
- Board of Trustees Unit Financial Statement as of February 2023

Tri-County Behavioral Healthcare Acronyms

Acronym	Name
1115	Medicaid 1115 Transformation Waiver
AAIDD	American Association on Intellectual and Developmental Disabilities
AAS	American Association of Suicidology
ABA	Applied Behavioral Analysis
ACT	Assertive Community Treatment
ADA	Americans with Disabilities Act
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ADL	Activities of Daily Living
ADRC	Aging and Disability Resource Center
AMH	Adult Mental Health
ANSA	Adult Needs and Strengths Assessment
AOP	Adult Outpatient
APM	Alternative Payment Model
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
ARDS	Assignment Registration and Dismissal Services
ASH	Austin State Hospital
BCBA	Board Certified Behavior Analyst
BJA	Bureau of Justice Administration
BMI	Body Mass Index
C&Y	Child & Youth Services
CAM	Cost Accounting Methodology
CANS	Child and Adolescent Needs and Strengths Assessment
CARE	Client Assignment Registration & Enrollment
CBT	Computer Based Training & Cognitive Based Therapy
CC	Corporate Compliance
CCBHC	Certified Community Behavioral Health Clinic
CCP	Crisis Counseling Program
CDBG	Community Development Block Grant
CFC	Community First Choice
CFRT	Child Fatality Review Team
CHIP	Children's Health Insurance Program
CIRT	Crisis Intervention Response Team
CISM	Critical Incident Stress Management
CMH	Child Mental Health
CNA	Comprehensive Nursing Assessment
COC	Continuity of Care
COPSD	Co-Occurring Psychiatric and Substance Use Disorders
COVID-19	Novel Corona Virus Disease - 2019
CPS	Child Protective Services
CPT	Cognitive Processing Therapy
CRCG	Community Resource Coordination Group
CSC	Coordinated Specialty Care
CSHI	Cleveland Supported Housing, Inc.
CSU	Crisis Stabilization Unit
DADS	Department of Aging and Disability Services
DAHS	Day Activity and Health Services Requirements
DARS	Department of Assistive & Rehabilitation Services
DCP	Direct Care Provider
DEA	Drug Enforcement Agency
DFPS	Department of Family and Protective Services
DO	Doctor of Osteopathic Medicine
DOB	Date of Birth
DPP-BHS	Directed Payment Program - Behavioral Health Services

DRC	Disaster Recovery Center
DRPS	Department of Protective and Regulatory Services
DSHS	Department of State Health Services
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSRIP	Delivery System Reform Incentive Payments
DUA	Data Use Agreement
Dx	Diagnosis
EBP	Evidence Based Practice
ECI	Early Childhood Intervention
EHR	Electronic Health Record
EOU	Extended Observation Unit
ETBHN	East Texas Behavioral Healthcare Network
EVV	Electronic Visit Verification
FDA	Federal Drug Enforcement Agency
FEMA	Federal Emergency Management Assistance
FEP	First Episode Psychosis
FLSA	Fair Labor Standards Act
FMLA	Family Medical Leave Act
FTH	From the Heart
FY	Fiscal Year
HCBS-AMH	Home and Community Based Services - Adult Mental Health
HCS	Home and Community-based Services
HHSC	Health & Human Services Commission
HIPAA	Health Insurance Portability & Accountability Act
HR	Human Resources
HUD	Housing and Urban Development
ICAP	Inventory for Client and Agency Planning
ICF-IID	Intermediate Care Facility - for Individuals w/Intellectual Disabilities
ICI	Independence Communities, Inc.
ICM	Intensive Case Management
IDD	Intellectual and Developmental Disabilities
IDD PNAC	Intellectual and Developmental Disabilities Planning Network Advisory Committee
IHP	Individual Habilitation Plan
IMR	Illness Management and Recovery
IP	Implementation Plan
IPC	Individual Plan of Care
IPE	Initial Psychiatric Evaluation
IPP	Individual Program Plan
ISS	Individualized Skills and Socialization
ITP	Individual Transition Planning (schools)
JDC	Juvenile Detention Center
JUM	Junior Utilization Management Committee
LAR	Legally Authorized Representative
LBHA	Local Behavioral Health Authority
LCDC	Licensed Chemical Dependency Counselor
LCSW	Licensed Clinical Social Worker
LIDDA	Local Intellectual & Developmental Disabilities Authority
LMC	Leadership Montgomery County
LMHA	Local Mental Health Authority
LMSW	Licensed Master Social Worker
LMFT	Licensed Marriage and Family Therapist
LOC	Level of Care (MH)
LOC-TAY	Level of Care - Transition Age Youth
LON	Level Of Need (IDD)
LOSS	Local Outreach for Suicide Survivors
LPHA	Licensed Practitioner of the Healing Arts
LPC	Licensed Professional Counselor
LPC-S	Licensed Professional Counselor-Supervisor

LPND	Local Planning and Network Development
LSFHC	Lone Star Family Health Center
LTD	Long Term Disability
LVN	Licensed Vocational Nurse
MAC	Medicaid Administrative Claiming
MAT	Medication Assisted Treatment
MCHC	Montgomery County Homeless Coalition
MCHD	Montgomery County Hospital District
MCO	Managed Care Organizations
MCOT	Mobile Crisis Outreach Team
MD	Medical Director/Doctor
MDCD	Medicaid
MDD	Major Depressive Disorder
MHFA	Mental Health First Aid
MIS	Management Information Services
MOU	Memorandum of Understanding
MSHI	Montgomery Supported Housing, Inc.
MTP	Master Treatment Plan
MVPN	Military Veteran Peer Network
NAMI	National Alliance on Mental Illness
NASW	National Association of Social Workers
NEO	New Employee Orientation
NGM	New Generation Medication
NGRI	Not Guilty by Reason of Insanity
NP	Nurse Practitioner
OCR	Outpatient Competency Restoration
OIG	Office of the Inspector General
OSAR	Outreach, Screening, Assessment and Referral (Substance Use Disorders)
PA	Physician's Assistant
PAP	Patient Assistance Program
PASRR	Pre-Admission Screening and Resident Review
PATH	Projects for Assistance in Transition from Homelessness (PATH)
PCIT	Parent Child Interaction Therapy
PCP	Primary Care Physician
PCRP	Person Centered Recovery Plan
PDP	Person Directed Plan
PETC	Psychiatric Emergency Treatment Center
PFA	Psychological First Aid
PHI	Protected Health Information
PHP-CCP	Public Health Providers - Charity Care Pool
PNAC	Planning Network Advisory Committee
PPB	Private Psychiatric Bed
PRS	Psychosocial Rehab Specialist
QIDP	Qualified Intellectual Disabilities Professional
QM	Quality Management
QMHP	Qualified Mental Health Professional
RAC	Routine Assessment and Counseling
RCF	Residential Care Facility
RCM	Routine Case Management
RFP	Request for Proposal
RN	Registered Nurse
ROC	Regional Oversight Committee - ETBHN Board
RPNAC	Regional Planning & Network Advisory Committee
RSH	Rusk State Hospital
RTC	Residential Treatment Center
SAMA	Satori Alternatives to Managing Aggression
SAMHSA	Substance Abuse and Mental Health Services Administration
SASH	San Antonio State Hospital

SH	Supported Housing
SHAC	School Health Advisory Committee
SOAR	SSI Outreach, Access and Recovery
SSA	Social Security Administration
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
SSLC	State Supported Living Center
STAR Kids	State of Texas Reform-Kids (Managed Medicaid)
SUD	Substance Use Disorder
SUMP	Substance Use and Misuse Prevention
TAC	Texas Administrative Code
TANF	Temporary Assistance for Needy Families
TAY	Transition Aged Youth
TCBHC	Tri-County Behavioral Healthcare
TF-CBT	Trauma Focused CBT - Cognitive Behavioral Therapy
TCCF	Tri-County Consumer Foundation
TCOOMMI	Texas Correctional Office on Offenders with Medical & Mental Impairments
TCRMF	Texas Council Risk Management Fund
TDCJ	Texas Department of Criminal Justice
TEA	Texas Education Agency
TIC/TOC	Trauma Informed Care-Time for Organizational Change
TMHP	Texas Medicaid & Healthcare Partnership
TP	Treatment Plan
TRA	Treatment Adult Services (Substance Use Disorder)
TRR	Texas Resilience and Recovery
TxHmL	Texas Home Living
TRY	Treatment Youth Services (Substance Use Disorder)
TVC	Texas Veterans Commission
TWC	Texas Workforce Commission
UM	Utilization Management
UW	United Way of Greater Houston
WCHD	Walker County Hospital District
WSC	Waiver Survey & Certification
YES	Youth Empowerment Services
YMHFA	Youth Mental Heath First Aid
YPS	Youth Prevention Services
YPU	Youth Prevention Selective

Updated January 2023