Tri-County Behavioral Healthcare Board of Trustees Meeting

January 30, 2025

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 Wednesday, January 30, 2025. The Business Committee will convene at 9:00 a.m., the Program Committee will convene at 9:30 a.m. and the Board meeting will convene at 10:00 a.m. at 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 5, 2024

III. Program Presentation - Shining Star Award - Suicide Prevention Bernardo Iracheta

IV. Executive Director's Report
- A. Legislative Update
- B. HHSC SUD Grant Submission
- C. Cleveland Facility Update

V. Chief Financial Officer's Report - Millie McDuffey
- A. FY 2025 1st Budget Revision
- B. Cost Accounting Methodology
- C. FY 2024 MEI Cost Reports
- D. Update on Workers' Compensation Annual Audit

VI. Program Committee

Action Items
- A. Approve the Mental Health Quality Management and Utilization Management Plan for FY 2025 ... *9-62*

Information Items
- B. Community Resources Report ... *63-66*
- C. Consumer Services Reports for November & December 2024 ... *67-71*
- D. Program Updates ... *72-77*
- E. FY 2025 Goals and Objectives Progress Report ... *78-84*
- F. 1st Quarter FY 2025 Corporate Compliance and Quality Management Report ... *85-88*
- G. 2nd Quarter FY 2025 Corporate Compliance Training ... *89-90*

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.

Posted By:

Ava Green
Executive Assistant

Tri-County Behavioral Healthcare

P.O. Box 3067
Conroe, TX 77305

BOARD OF TRUSTEES MEETING

December 5, 2024

Board Members Present:

Patti Atkins
Gail Page
Sharon Walker
Richard Duren
Tim Cannon
Carl Williamson
Morris Johnson

Board Members Absent:

Tracy Sorensen
Jacob Paschal

Tri-County Staff Present:

Evan Roberson, Executive Director
Millie McDuffey, Chief Financial Officer
Tanya Bryant, Director of Quality Management and Support
Sara Bradfield, Chief Operating Officer
Kenneth Barfield, Director of Management Information Systems
Kathy Foster, Director of IDD Provider Services
Beth Dalman, Director of Crisis Access
Stephanie Ward, Director of Adult Behavioral Health
Melissa Zemencsik, Director of Child and Youth Behavioral Health
Yolanda Gude, Director of IDD Authority Services
Andrea Scott, Chief Nursing Officer
Ashley Bare, HR Manager
Tabatha Abbott, Manager of Accounting
Ava Green, Executive Assistant
Stephanie Luis, Community Engagement Strategist

Legal Counsel Present: Jennifer Bryant, Jackson Walker LLP

Sheriff Representatives Present: None present

Guest(s): Mike Duncum with WhiteStone Realty Consulting

Call to Order: Board Chair, Patti Atkins, called the meeting to order at 10:05 a.m.

Public Comment: No public comment

Cont.

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

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

Resolved: That the Board approve the absence of Tracy Sorensen and Jacob Paschal.

Resolution #12-05-02 **Motion Made By:** Sharon Walker
Seconded By: Gail Page, with affirmative votes Morris Johnson, Tim Cannon, Carl Williamson and Richard Duren that it be…

Resolved: That the Board approve the minutes of the October 24, 2024 meeting of the Board of Trustees.

Board Presentations: Life Skills Christmas Carolers, Presentation of Awards to Christmas Card Winners and Recognition of Barbara Duren for Housing Board Service.

Board Training: None presented at this meeting.

Agenda was suspended to move up Agenda Item X – G, Cleveland Building Updates, of which Mike Duncum gave an update on the current construction progress of the new Cleveland Site, 402 Liberty St, Cleveland, Texas.

Executive Director's Report:

The Executive Director's report is on file.

- HCS Survey
- Legislative Updates

Chief Financial Officer's Report:

The Chief Financial Officer's report is on file.

- FY 2024 Audit
- Public Health Provider – Charity Care Program (PHP-CCP) Cost Report
- Cost Accounting Methodology (CAM Report)
- FY 2024 HCS and MEI Cost Reports

PROGRAM COMMITTEE:

Resolution #12-05-03 **Motion Made By:** Gail Page
Seconded By: Richard Duren, with affirmative votes Morris Johnson, Tim Cannon, Carl Williamson and Sharon Walker that it be…

Resolved: That the Board approve the Local Provider Network Development Plan for FY 2025.

Resolution #12-05-04 **Motion Made By:** Gail Page
Seconded By: Sharon Walker with affirmative votes Morris Johnson, Tim Cannon, Carl Williamson and Richard Duren that it be…

Resolved: That the Board approve the MH Consolidated Local Service Plan for Fiscal Year 2025.

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

Resolved: That the Board appoint Michelle Lowe as a new Mental Health Planning Network Advisory Committee Member to the remainder of a two year term which expires August 31, 2026.

Resolution #12-05-06 **Motion Made By:** Gail Page
Seconded By: Sharon Walker, with affirmative votes Morris Johnson, Tim Cannon, Carl Williamson and Richard Duren that it be…

Resolved: That the Board appoint Susan Bulick as a new Intellectual and Developmental Disabilities Planning Network Advisory Committee Member to the remainder of a two year term which expires August 31, 2026.

The Community Resources Report was reviewed for information purposes only.

The Consumer Services Report for October 2024 was reviewed for information purposes only.

The Program Updates Report was reviewed for information purposes only.

The Annual Corporate Compliance Report was reviewed for information purposes only.

EXECUTIVE COMMITTEE:

The Personnel Report for October 2024 was reviewed for information purposes only.

The Texas Council Risk Management Fund Claims Summary as of October 2024 was reviewed for information purposes only.

The Texas Council Quarterly Board Meeting Update was reviewed for information purposes only.

BUSINESS COMMITTEE:

Resolution #12-05-07

Motion Made By: Morris Johnson
Seconded By: Richard Duren, with affirmative votes by Gail Page, Sharon Walker, Tim Cannon and Carl Williamson that it be…

Resolved: That the Board approve the October 2024 Financial Statements.

Resolution #12-05-08

Motion Made By: Morris Johnson
Seconded By: Richard Duren, with affirmative votes by Gail Page, Sharon Walker, Tim Cannon and Carl Williamson that it be…

Resolved: That the Board appoint Ms. Lois Livingston to serve on the Independence Communities, Inc. (ICI) Board for a term which expires January 2027.

Resolution #12-05-09

Motion Made By: Morris Johnson
Seconded By: Richard Duren, with affirmative votes by Gail Page, Sharon Walker, Tim Cannon and Carl Williamson that it be…

Resolved: That the Board reappoint Mr. Leonard Peck to serve on the Independence Communities, Inc. Board of Directors for an additional two year term expiring in January 2027.

Resolution #12-05-10

Motion Made By: Morris Johnson
Seconded By: Richard Duren, with affirmative votes by Gail Page, Sharon Walker, Tim Cannon and Carl Williamson that it be…

Resolved: That the Board reappoint Ms. Margie Poole to serve on the Cleveland Supported Housing, Inc. Board of Directors for an additional two year term expiring in January 2027.

Resolution #12-05-11

Motion Made By: Morris Johnson

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

Resolved:

That the Board reappoint Ms. Sharon Walker, Ms. Darin Bailey and Mr. Michael Cooley to serve on the Montgomery Supported Housing, Inc. Board of Directors for an additional two year term expiring in January 2027.

The Board of Trustees Unit Financial Statement for October 2024 was reviewed for information purposes only.

Adjournment:

_____

Patti Atkins Date
Chair

Attest:

_____

Jacob Paschal Date
Secretary

Agenda Item: Approve the Mental Health Quality Management and Utilization Management Plan for FY 2025 **Committee:** Program	**Board Meeting Date:** January 30, 2025

Background Information:

In order to address expectations for quality management activities across performance 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, which includes the Continuous Quality Improvement (CQI) Plan, and the Intellectual and Developmental Disability Quality and Utilization Management (IDD QM/UM) Plan. 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. Due to delays in HHSC's release of the template for the most recent Consolidated Local Service (CLSP) Plan and a change in the plan date, the Center's Quality Management Plan is being named to align with those dates. It should be noted that, despite these delays, Tri-County has maintained compliance with the review timeframes required by the Performance Contract for the QM Plan.

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 2025

Recommended Action:

Approve the Mental Health Quality Management and Utilization Management Plan for FY 2025

Tri-County Behavioral Healthcare

Mental Health and Substance Use Disorder Quality Management Plan 2025

_____ _____

Evan Roberson, Executive Director **Date**

Table of Contents

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) receive 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), Tri-County's Board of Trustees, the Center's Local Plan, the Center's CCBHC Needs Assessment, 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 applicable accreditation guidelines. The Utilization Management Department, under the direction of the Executive Director and 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 applicable certification and accreditation guidelines. Quality Improvement is considered an ongoing effort through continuous measurement and assessment, outlined in the QM Plan Chapters, 'Ongoing Quality Review Activities' along with 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; and
- Continuously monitor, adjust and track data that can be used for CQI efforts as well as to improve clinical outcomes and meet reporting requirements.[1]

Philosophy/Values

The Quality Management Program is based on the premise that the provision of quality services at Tri-County 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 into 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)

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 regular quality assurance reviews conducted by managers and submitted 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 and participate in clinical reviews from varying departments through ongoing review and other quality assurance activities. 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 build workforce knowledge base and improve quality of services. Additionally, Quality, Utilization and Training Department staff work closely with one another to utilize data as a means of providing feedback to providers that result in meaningful improvements that positively impact quality care.

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 improve our service capacity, Tri-County continues to explore possibilities for expansion through grants, additional service contracts (when available) community partnerships, and technological means (i.e. telehealth), whenever feasible. Tri-County actively collaborates with community stakeholders to secure additional funding as available and participates in community awareness and fundraising activities as opportunities are identified. 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 serve 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 effectively monitor and evaluate select programs at Tri-County Behavioral Healthcare.

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

2) Direct additional reviews and quality improvement initiatives as need arises.
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 the rights of individuals served are not violated.
7) Direct follow up when concerns requiring corrective action are identified. Ensure that the MH QM/UM committee meets at least quarterly to ensure that key information is communicated out to staff and management as appropriate.

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 or best practice 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, evaluation of staffing, and/or the appointment of additional committees or improvement efforts 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 close alignment with the Center's 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 disabilities. 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. Tri-County has identified individuals and groups that focus on specific aspects of the Center to promote the provision of high-quality services. Individual, group and committee responsibilities at Tri-County include, but may not be limited to:

THE BOARD OF TRUSTEES:

- Responsible for the effective administration of the Center. As such, responsibilities include hiring an Executive Director to guide the provision of a comprehensive program of services related to mental health, substance use, and intellectual and developmental disabilities.
- The Board shall appoint the Executive Director for the Center who shall be responsible for the day to day operation of the Center and the implementation of Board policy.
- The Board shall adopt Board policies that are consistent with Health and Human Services Administrative Code and Chapter 534.008 of the Texas Health and Safety Code.
- The Board shall establish, periodically review, and modify as necessary, personnel policies.
    - For this purpose, the Executive Director shall submit proposed policies to the appropriate Committee of the Board which shall review and recommend personnel policies to the Board.
    - Subject to the policies of the Board, shall be responsible for the selecting, hiring, training, assigning or dismissal of personnel for the administration of services and programs.
- The Board reviews the QM/UM Plan (to include the CQI Plan) in its entirety each biennium.
- The Board reviews monthly reports of programmatic and fiscal activities.
- The Board appoints, charges and supports a Planning and Network Advisory Committee(s) that is representative of individuals being served by the Center.[1]

THE EXECUTIVE DIRECTOR:

It is the policy of the Board of Trustees of Tri-County Behavioral Healthcare that the Executive Director exercises sole authority and responsibility for the management of the affairs of the Center in accordance with the established Board aims, policies and resolutions. These responsibilities include:

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

- The implementation of programs, policies, and priorities established by the Board of Trustees.
- Subject to the policies of the Board, may delegate responsibilities to his or her immediate administrative staff or other Services personnel.
- Performance of management functions which will assure that program services will be available, accessible, and acceptable to the citizens served by Tri-County and coordinated to promote continuity of care.
- Delegation of authority and accountability for program functions to Tri-County staff who are assigned managerial responsibilities.
    - Includes delegation of the Quality Management responsibilities as well as, but not limited to, the Continuous Quality Improvement Plan.
- Coordination of activities with other governmental, public, private groups and agencies concerned with the planning and delivery of health and social services.
- Performance and administrative functions which will provide accountability for funds received and expended and assure that all fiscal regulations are satisfied.
- Implementation of an integrated clinical record system for all Tri-County programs and contract agencies which is designed to provide access to all past and current information regarding the health and treatment status of any consumer and which maintains safeguards to preserve confidentiality and protects the rights of consumers.
- Implementation of a personnel management program which would address such functions as recruitment, staff development, salary structure, termination, complaint procedures, pension and related employee benefits. Salaries and benefits provided should be comparable to those prevailing in the community, or based upon like positions in other Community Centers for similar services.
- Utilization of statistical information for determining needs, planning services, monitoring staff and program activity and evaluating the attainment of objectives.
- Preparation of operational plans and procedures for project implementation which will enable the measurement of progress towards objectives.
- Implementation of an effective community relations function including community information and education.
- Ensures compliance with House Bill 3, of the 59th Texas Legislature, as amended, Rules of the Commissioner Governing Texas Community Mental Health Mental Retardation Center, and other applicable federal and state rules, regulations and standards.
- Preparation of Tri-County procedures to ensure compliance with Board policies.
- Delegation of a Management Team member, or designee, to receive and evaluate internal and external reports for Quality Management activities.
- Evaluation and monitoring of the Quality Management and CQI programs to ensure compliance with the QM Plan.
- Appoint members to agency committees.

- Develops Center goals and objectives annually and ensures that progress toward goals is monitored on at least a quarterly basis.
- Appoints an Executive Team staff who has the responsibility to ensure the development and ongoing monitoring of annual CQI goals.
- Implements Board policies through the development of operational procedures.

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, Chief Nursing Officer, Director of Quality Management and Support, Director of Management Information Systems, Director of IDD Authority Services, Director of IDD Provider Services, Director of Adult Behavioral Health, Director of Child and Youth Behavioral Health, and the Director of Crisis Access. 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.)
- Review and discuss progress toward annual Board goals.
- Review and discuss 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 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 ongoing 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.
- Co-chairs 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, Utilization Management, Compliance, Training and provider programs as needed.
- 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 with CCBHC and other applicable accreditation activities.
- Ensures audit tools are up to date and shared with appropriate staff when changes are indicated.
- Coordinates audit activities and requests, both internally and externally, with direction from the Director of Quality Management and Support.
- Monitors and ensures timely follow up on any corrective action resulting from both internal and external audits.

THE UTILIZATION MANAGER:

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 Administrator of Utilization Management for Tri County is a Licensed Professional Counselor (LPC) and, prior to working in Quality and Utilization Management, has had over six years of clinical experience working with both 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 Junior Utilization Management Committee (JUM).
- Serves as a member of the CQI Committee.
- Serves as a member of the Regional Utilization Management Committee.

- Monitors and tracks the performance targets and other identified outcomes for Tri-County (i.e Directed Payment Methodology measures, CCBHC).
- Works closely with other Center Utilization and Quality Management staff, as needed, to ensure proper implementation of the Utilization Management Plan including, but not limited to, quality, cost effective, timely, and appropriate service provisions.
- Monitors the Performance Contract, Utilization Management Guidelines, and applicable accreditation standards, including CCBHC Guidelines, for compliance.

THE RIGHTS PROTECTION OFFICER:

- Chairs the Rights Review Team and participates in clinical staffing as needed to ensure due process.
- 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 assists with required reporting to HHSC as needed.
- 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. The Rights Protection Officer selects these members prior to each review based on the above requirement and knowledge of needed information or expertise in order to conduct business. Additional members may be assigned to ensure due process for individuals served. 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 monitoring, 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 (i.e. Medical Director is consulted for any medical components). Other members include the Administrator of Utilization Management, Chief Operating Officer, Director of Child and Youth Behavioral Health, Director of Adult Behavioral Health, Director of Crisis Access, Director of Management Information Systems, or designee, 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 based on priority 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 Administrator of Quality Management and the Administrator of Utilization Management are the committee chairs. Members include the Medical Director, the Director of Quality Management & Support, the Director of Management Information Systems, the Billing Manager, the Rights Protection Officer, the Risk Manager, representatives from Adult Behavioral Health , Child and Youth Behavioral Health, Medication Services, Crisis Services and other Financial or services, as needed. A Management Team member maintains oversight of the Committee 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:

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

- Review data for MH and SUD services; complaints from individuals served; risk data to include but not limited to: incidents, deaths of individuals served, and abuse/neglect allegations; safety committee recommendations; program satisfaction survey results; 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 quality related 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 clinical resources and improving the efficiency of the UM process. To fulfill this responsibility, the MH QM/UM Committee will:

- Review reports that address eligibility determination, level of care assignment, service authorization and reauthorization, fairness and equity, over and underutilization/provision of service, inpatient admissions, and cost of services.
- Monitor performance in relation to HHSC defined contract performance including medical necessity, targets, performance measures and outcomes.
- Review summary level appeal information.
- Make recommendations to Center 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 Administrator of Utilization Management and the Administrator of Quality Management co-chair this committee. The Junior Utilization Management Committee (JUM) consists of the Administrator of Utilization Management, the Administrator of Quality Management, the Quality and Utilization Specialist, the Manager of Information Technology Services, the Controller and other agency clinical staff as needed. The Director of Quality and Utilization Management provides oversight and serves as a liaison between the JUM Committee and Management Team. 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 Determinants of Health) and performance up to the date of the meeting.
- Updates the Tri-County Data Point Report which is a document that is provided to identified clinical managers that reflects agency performance on target measures and outcomes.
- Sends emails to Program Directors or their designee when concerns are identified (i.e. the program is below contract or performance expectations, data indicates a quality/utilization/training issue needing to be addressed).
- Creates custom reports, in coordination with the Information Technology department, for problem areas so staff can be more knowledgeable about factors that are affecting quality of care, contract compliance, 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 quality compliance concerns to the committee so that the JUM can assist with problem-solving activities.

THE SOFTWARE MANAGEMENT TEAM (SMT):

In the beginning of Fiscal Year 2024, Tri-County Behavioral Healthcare transitioned to a new electronic health record. Prior to, and following this transition, an implementation team was established in order to streamline the transition and ensure continuity of care for clinical staff and individuals served.

As part of the continued development, utilization, and upkeep of our clinical software, Tri-County's implementation team continues to work with our long-standing Software Management Team. The goal of the Software Management Team is to improve our software to reflect complete and accurate data while ensuring efficiencies and best clinical practices. 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.
- Typically meets annually or as needed.

THE CORPORATE COMPLIANCE COMMITTEE:

The Corporate Compliance Officer and the Administrator of Compliance chair 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 Management Information Systems, the Director of Adult Behavioral Health 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 the Corporate Compliance Program and 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 applicable 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 issues impacting individuals served, planning, budget, contract issues, as well as the needs and priorities for the service area. Members are appointed by the Board of Trustees and 51 percent of the members represent persons with Mental Illness, Substance Use Disorders, or other populations served (i.e. Veterans; individuals with housing instability). 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 three (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, program and Center activities, and delivery of quality services 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 (i.e. planning, recruitment).
- Identifying community needs and goals/objectives through 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.
- Typically meets six (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.

Membership and guidelines for the RPNAC are in line with Center performance Contract and CCBHC criteria. Should local membership fall below the required standards, the RPNAC shall serve as the official Planning Network Advisory Committee per guidelines until the local Committee can recruit full membership.

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, serves as a standing member of the MH QM/UM, CQI, Junior Utilization Management (JUM), 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 provides feedback and recommendations on 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 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 and MBOW reports used for monitoring performance are sent to JUM members as well as program managers for review.
- The Billing Department monitors service reports for possible billing errors.
- The Billing Department looks for diagnosis errors as a part of billing reviews.

- Billing suspense reports are reviewed regularly and provided to clinical staff to correct billing errors. These reports are reviewed by the Software Management Team (SMT) as needed.
- Substance Use Treatment Data:
  Data for persons in the Substance Use Treatment Programs is captured in the Center's local data system (SmartCare), 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 as needed for quality improvement purposes.
- 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/consultation 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 and feedback on the strengths, weaknesses, and recommendations for improvement are provided to the program administrator at the conclusion of the review.

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 planning and self-assessment processes. 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 surveys, as needed, 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
- United Way
- Criminal Justice Programs and Specialty Courts (i.e. MH; Veterans)
- Child Advocacy Agencies
- 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 Fraud Prevention 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 computer-based training 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 ongoing 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, person-centered 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 ongoing 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. The Tri-County Quality Management Department works closely with program providers to assist with increased staff training as needed, and continue to include documented annual updates 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 standards, which are formally incorporated 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 as part of 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
- Plans 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) 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.

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 in collaboration with the Quality Management Department, participate in quality assurance activities (as outlined in the larger Quality Management Plan) and concerns are brought to the JUM and/or MH QM/UM Committees for continued monitoring and feedback as needed. Tri-County's Quality and Utilization Management staff provide ongoing support to program staff, as need arises, and any corrective actions needed are communicated to the designated Tri-County Management Team member. Additional audit requests will be completed by the Tri-County Quality/Utilization Management staff in coordination 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 YES Program Administrator, in coordination with 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 ongoing quality assurance and select agency Committee activities (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. Following review, provide feedback to reviewed programs that include department strengths, weaknesses, and recommendations for improvement.
4. Provide review reports to program managers and the designated Management Team member 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 Yes Program Administrator, in coordination with 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

Substance Use Disorder Treatment Program (SUDTP)

Currently, Tri-County holds State licensure for 180 slots for both adults and adolescents. Tri-County receives 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 intensive outpatient SUDTP at Tri-County, the focus of the program is on the maintenance of a healthy lifestyle, which is promoted by increasing knowledge of the harmful impact of substance use while providing tools to manage behavior in healthy ways. The program uses several treatment mechanisms including individual and group counseling, case management and education on the risks and consequences of substance use and overdose prevention. Tri-County's substance use treatment program utilizes evidence-based practices, including the Matrix Intensive Outpatient Model, Cannabis Youth Treatment (CYT), Seeking Safety, and Motivational Interviewing.

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 and CQI Committees as needed. The program staff will report SUDTP performance target numbers to the JUM and MH QM/UM Committees and these committees will monitor 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 as well as compliance with other certification and accreditation entities.

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 coordination 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 Director of SUDTP Services, in coordination with the Quality Management Department, will implement a process to monitor SUDTP 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/CQI) 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. Matrix Model, Cannabis Youth Treatment (CYT), and Seeking Safety).
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 Director of SUDTP Services, in coordination with the Quality Management Department, will ensure that Substance Use Treatment procedures and processes are in compliance with State regulations.

Performance Standard:

Review written procedures applicable to SUDTP 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 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 Pradan Nathan, M.D., 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 and/or contractors, 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 (through ETBHN and other select utilization activities) 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. Tri-County Utilization Management staff coordinate with program and managed care staff to ensure that individuals served, including but not limited to those who have Medicaid 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 Committees, 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. 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, as applicable, 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 from Tri-County or its contractor, if appropriate.

The written notification referred to above must:

1. Be given or mailed to the individual and/or 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/or 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 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 whenever possible;
- 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, death by suicide, fatal and non-fatal overdose and deaths of individuals served, and review of known events, including all-cause mortality;[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]
- **Health Disparities:** An effective CQI Plan focuses on identifying and improving differences in healthcare provided to populations or groups of people that may be closely linked to social determinants of health.[5]
- **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:

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

1) Assessing, evaluating, and measuring Tri-County's services through the collection and analysis of data.[6]
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.
3) Ensuring an effective system wide CQI Plan which includes Texas CCBHC required quality metrics;[7]
4) An outcome review which successfully implements needed changes to key areas (i.e. staffing, services and availability) needed to improve the quality and timeliness of services.[8]
5) Involvement of the Medical Director when quality improvement includes medical components of care.[9]
6) Focus on improved patterns of care delivery (i.e. reductions in emergency department use, rehospitalization, and repeated crisis episodes) and improved health (i.e. mental and physical).[10]
7) Identifying formal CQI projects that include details on implementation, justification for selection, and document progress achieved.[11]

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 (i.e. Medical Director for any medical components). Other members include the Chief Operating Officer, the Director of Child and Youth Behavioral Health, the Director of Adult Behavioral Health, the Director of Crisis Access, the Director of Management Information Systems or designee, the Administrator of Utilization Management, 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.
- Identifying and documenting measurable outcomes based on priorities that meet established criteria outlined by the committee (note: formal projects and goals are updated by the CQI Committee and maintained separate from this plan in the Quality Management department);

[6] CCBHC 5.a.1 (Data Collection, Reporting, and Tracking)
[7] CCBHC 5.b.1 (Continuous Quality Improvement (CQI) Plan)
[8] CCBHC 5.b.1 (Continuous Quality Improvement (CQI) Plan)
[9] CCBHC 5.b.1 (Continuous Quality Improvement (CQI) Plan)
[10] CCBHC 5.b.1 (Continuous Quality Improvement (CQI) Plan)
[11] CCBHC 5.b.1 (Continuous Quality Improvement (CQI) Plan)

- 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.[12] 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 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;

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

7) To continuously work to identify and implement strategies to reduce and prevent suicide attempts and completions, overdoses, and other mortality trends identified for individuals served;
8) To reduce reductions in emergency department use, rehospitalization and repeated crisis episodes;[13] and
9) To establish fidelity checkpoints to ensure adherence to CCBHC certification guidelines, accreditation, as applicable, as well as processes to review evidence-based protocol.

TARGETED GOALS AND OBJECTIVES

As outlined above under the 'Responsibilities of the CQI Committee', the CQI projects, including targeted goals and objectives, are updated annually by CQI Committee and maintained in the Quality Management Department for review as needed.

In addition to formal CQI goals referenced above, the following metrics are required by Texas CCBHC and, as such, successful reporting on each are included as a standing goal for Tri-County. Should changes occur prior to the update of this plan, the most current T-CCBHC criteria will be followed. Below is a list of the required measures to be reported as a T-CCBHC:[14]

1) Time to Services (I-Serve)
2) Depression Remission
3) Controlling High Blood Pressure
4) Unhealthy Alcohol Use
5) Screening for Social Drivers of Health (SDOH)
6) Follow Up After Hospitalization for Mental Illness
7) Follow Up Emergency Department – Mental Health
8) Follow Up Emergency Department – Substance Use Disorder

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;

[13] CCBHC 5.b.2 (Continuous Quality Improvement (CQI) Plan)
[14] CCBHC 5.a.2 (Data Collection, Reporting, and Tracking)

- 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 may use various measurement and assessment tools as needed (**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 Center 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 processes, services, functions or outcomes. Selection of performance indicators 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.

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 Tri-County's priorities. The purpose of an initiative is to improve the performance of existing services or to design new ones. The model utilized at Tri-County 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 Tri-County 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 Tri-County's CQI Plan, activities conducted over the past year, the findings, and any quality improvement initiatives taken in response to the findings and recommendations.[15]

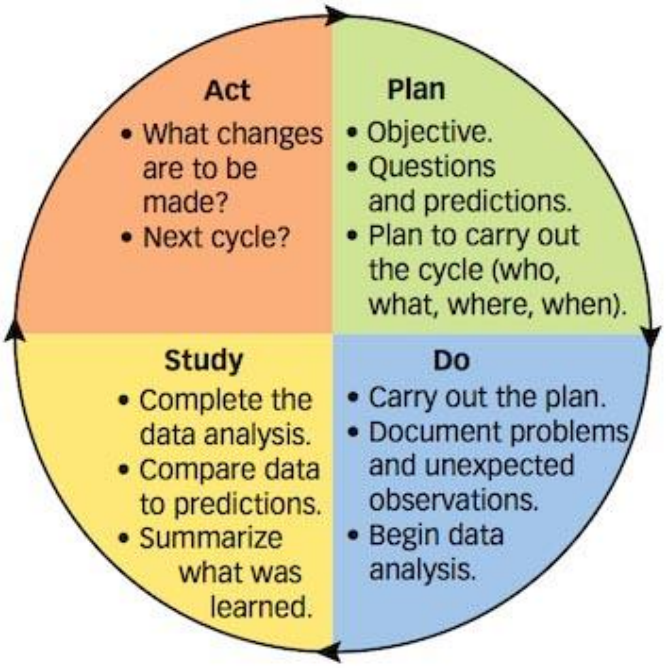
CELEBRATE SUCCESS

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.

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

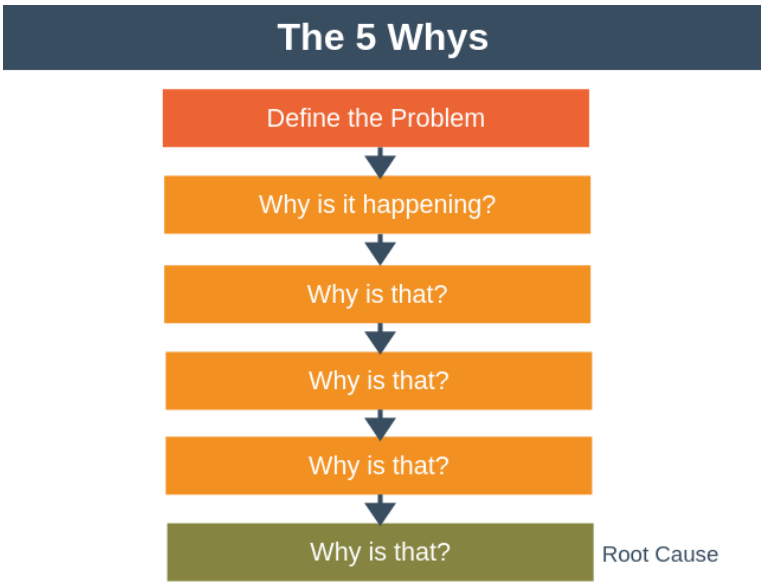
Appendix A

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:



5 Whys Template

Define the Problem
Describe just the problem not its causes

Why?	Countermeasure	Responsible
Describe why the problem happened	*How will you fix this?*	*Who is responsible?*
Why?	Countermeasure	Responsible
Why?	Countermeasure	Responsible
Why?	Countermeasure	Responsible
Why?	Countermeasure	Responsible

QI Suggestion Screening Tool

Use this tool to help think about and prioritize QI suggestions, before taking the time to draft a full charter plan. If we turn this suggestion into a project, what might that look like? What are the potential benefits and consequences?

RESOURCES

How much do we have, and what will we need? Will this change require new equipment or software? Is the change already covered by funding?

CAPACITY

How many people will it reasonably take to complete this project? Is it an individual effort, or something everyone at the agency will have to implement?

DIFFICULTY

How hard will it be to successfully complete this project? Will it be big and complex? Has it been attempted and failed before? Is there buy-in from the stakeholders it will affect?

RISK

What sorts of risks might be involved, and how complicated will they be to manage? Are there political or community considerations?

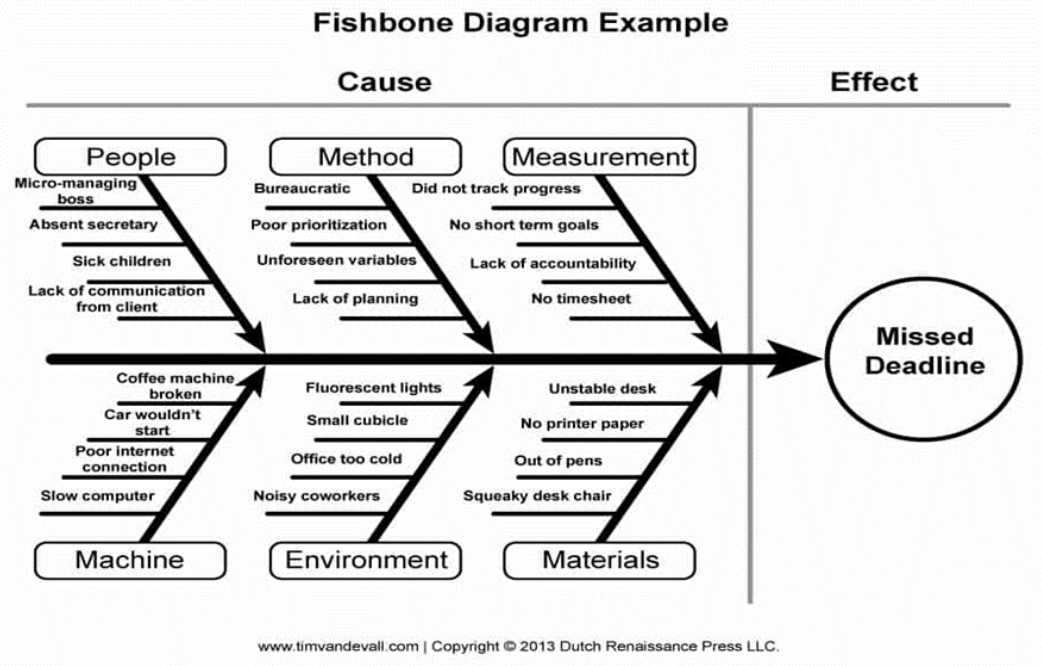
ALIGNMENT

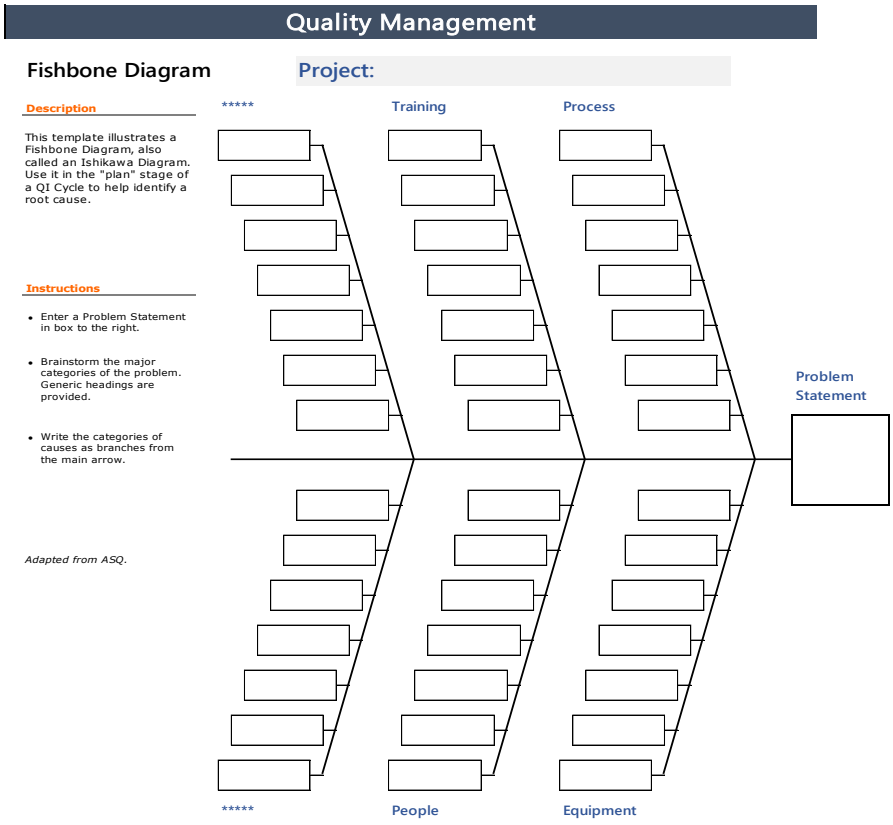
How does this suggestion align with existing agency objectives and goals? Will it help further our current commitments?

IMPACT

What effect is this change likely to have? Will it save an individual staff member a few minutes here and there, or will it dramatically cut costs or improve services for our customers?

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

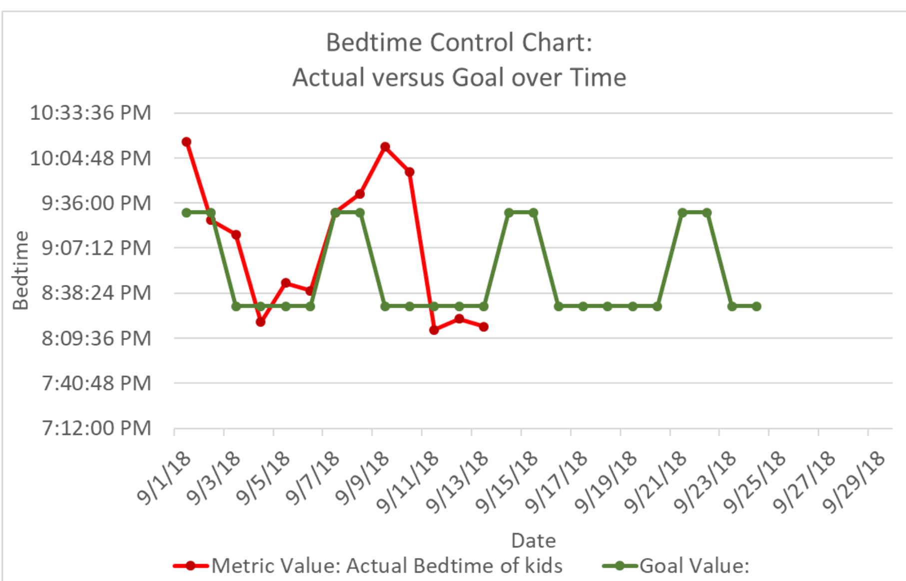
This template is to help you track what you've done, as well as the duration of each PDSA cycle and the total project duration.

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.

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

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.>

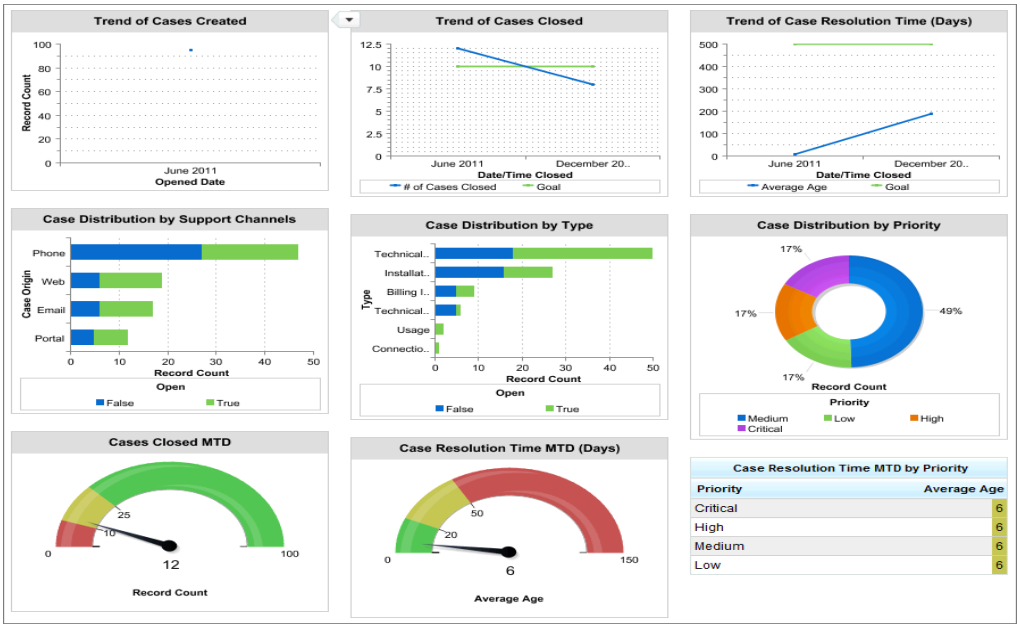
Description

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

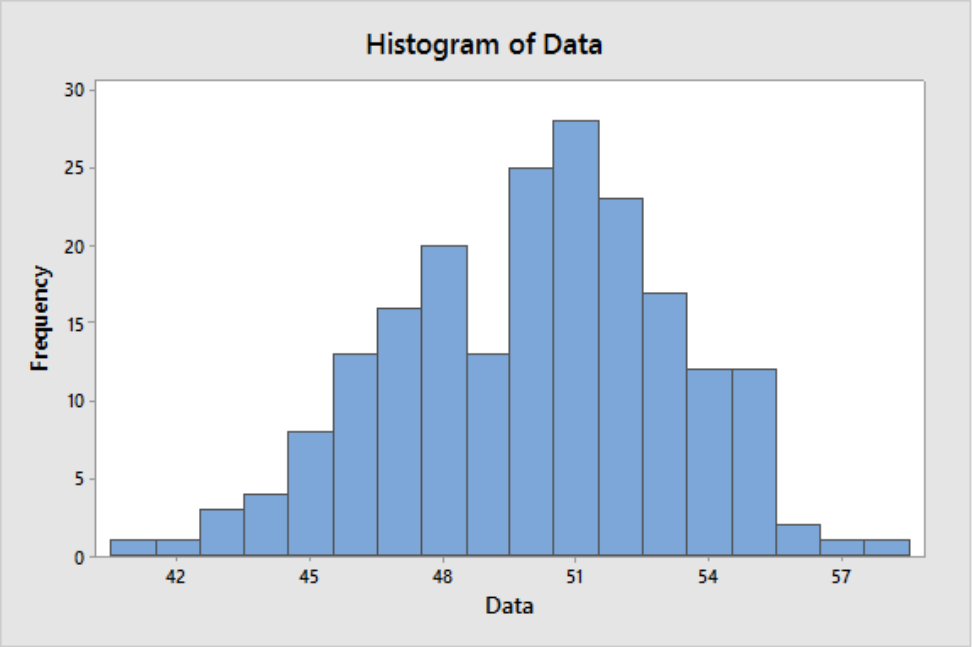
Instructions

- 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.

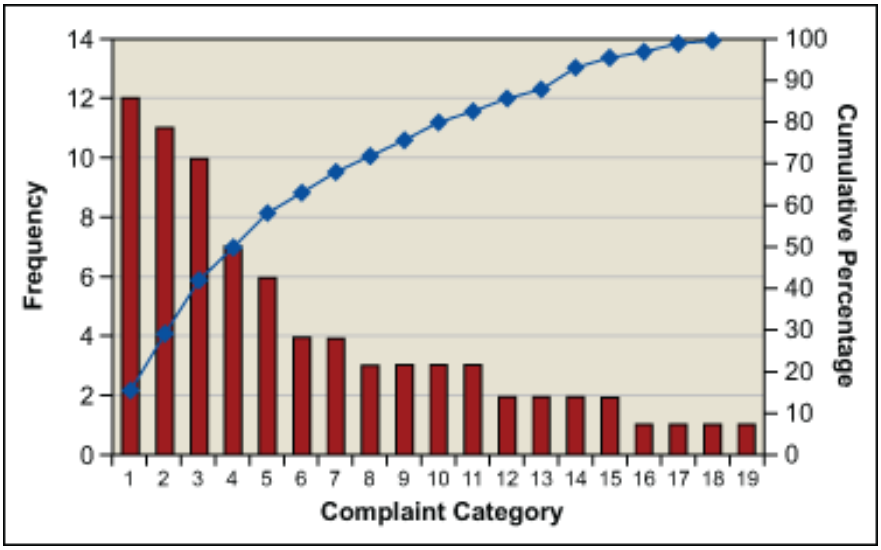
Date	Metric Value: Actual Bedtime of kids	Goal Value:	Intervention?
9/1/2018	10:15 PM	9:30 PM	Yelling
9/2/2018	9:25 PM	9:30 PM	Begging
9/3/2018	9:16 PM	8:30 PM	Pleading
9/4/2018	8:20 PM	8:30 PM	Bribing
9/5/2018	8:45 PM	8:30 PM	Reminding
9/6/2018	8:40 PM	8:30 PM	Nagging
9/7/2018	9:30 PM	9:30 PM	Game
9/8/2018	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			



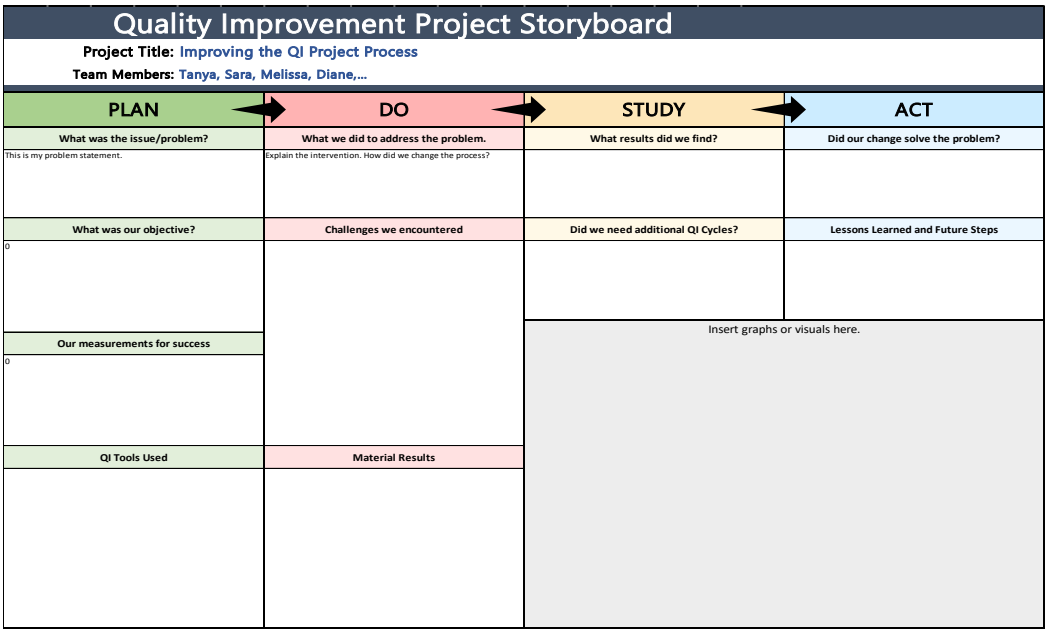
Commonly used to present Quality Improvement Data, histograms work best with small amounts of data that vary considerably so that the information can be used to identify which portions of the data did not meet specifications. This can be helpful when multiple PDSA cycles are conducted on a quality improvement 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 30, 2025
Background Information: None	
Supporting Documentation: Community Resources Report	
Recommended Action: **For Information Only**	

Community Resources Report
December 6, 2024 – January 30, 2025

Volunteer Hours:

Location	November	December
Conroe	121	121
Cleveland	0	6
Liberty	2.55	23.25
Huntsville	0	9.5
Total	**123.55**	**159.75**

COMMUNITY ACTIVITIES

12/6/24	Ben Milam Elementary Winter Wonderland Night (Resource Fair)	Conroe
12/9/24	Youth MHFA ESC Region 6	Huntsville
12/9/24	Walker County Jail In Reach Collaborative - Virtual	Conroe
12/10/24	Walker County Community Resource Coordination Group	Huntsville
12/10/24	Walker County Child Crisis Collaborative	Huntsville
12/10/24	Camp Valor Veterans Collaboration	Conroe
12/10/24	Liberty County Community Coalition Meeting	Cleveland
12/12/24	Secondary Trauma for Human Services Professionals	Conroe
12/13/24	Walker County Juvenile Services Staffing	Huntsville
12/14/24	Liberty Dayton Regional Medical Center Holiday Health Fair	Liberty
12/16/24	Lone Star Maverick Outpost Stakeholder's Meeting	Conroe
12/17/24	Camp Valor Veterans Collaboration	Conroe
12/17/24	Montgomery County Community Resource Coordination Group	Conroe
12/18/24	Zero Suicide Joint Regional Community Meeting - Virtual	Conroe
12/19/24	Suicide Prevention Coordinator's Meeting - Virtual	Conroe
12/19/24	Behavioral Health Suicide Prevention Task Force Meeting	Conroe
12/19/24	Texas A&M AgriLife Extension Office Family & Community Health Program Area Committee	Conroe
12/27/24	Walker County Juvenile Services Staffing	Huntsville
12/31/24	Camp Valor Veterans Collaboration	Conroe
1/6/25	ESC 6 AgriLife Presentation - Crisis Counseling Program	Conroe
1/6/25	Tiny Tots Play/Storytime - Coping Skills for Children and Parents - Crisis Counseling Program	The Woodlands
1/7/25	Camp Valor Veterans Collaboration	Conroe
1/8/25	Walker County Jail In Reach Collaborative - Virtual	Conroe
1/9/25	Liberty County Public Health Key Informant Meeting - Virtual	Conroe
1/9/25	Montgomery County Community Assistance Recovery Efforts & Services Meeting - Virtual	Conroe
1/10/25	Rusk State Hospital Continuity of Care Meeting - Virtual	Conroe
1/10/25	Blended Youth MHFA Hardin ISD (online & in person)	Hardin

1/13/25	Behavioral Health Suicide Prevention Task Force Meeting - Neurodiversity/Special Needs Workgroup	Conroe
1/13/25	Adult MHFA for Veterans and Families	Conroe
1/13/25	Walker County Food Coalition Committee	Conroe
1/14/25	Walker County Child Crisis Collaborative - Virtual	Huntsville
1/14/25	Family & Coalition of East Texas Meeting	Conroe
1/14/25	Camp Valor Veterans Collaboration	Conroe
1/14/25	MCSO, Precinct 1 and Tri-County CIT Program Planning	Conroe
1/15/25	Zero Suicide Joint Regional Community Meeting - Virtual	Conroe
1/15/25	Youth MHFA ESC Region 4 - Virtual	Conroe
1/15/25	Houston High Intensity Drug Trafficking Areas (HIDTA) Substance Use Trends Meeting - Virtual	Conroe
1/15/25	Behavioral Health Suicide Prevention Task Force Meeting - Military Subgroup Meeting	Conroe
1/16/25	Behavioral Health Suicide Prevention Task Force Meeting	Conroe
1/16/25	MHFA for Veterans and Families	Conroe
1/17/25	Behavioral Health Suicide Prevention Task Force Meeting – Addictions Workgroup	Conroe
1/17/25	Military Veteran Peer Network Mentor Meeting	Conroe
1/21/25	Montgomery County Community Resource Coordination Group	Conroe
1/21/25	Behavioral Health Suicide Prevention Task Force - Major Mental Health and First Responders Meeting	Conroe
1/21/25	Huntsville ISD Student Health Advisory Committee	Huntsville
1/21/25	AS+K Training Montgomery County Women's Center	Conroe
1/21/25	Camp Valor Veterans Collaboration	Conroe
1/23/25	Youth MHFA for ESC Region 6	Huntsville
1/23/25	New Suicide Prevention Coordinator's Meeting - Virtual	Conroe
1/23-1/24/25	Leadership Education in Autism and Neurodevelopmental Disabilities (LEND) Conference	Houston
1/25/25	Moorhead Junior High Wellness Fair	Conroe
1/25/25	Caney Creek Feeder Zone Health Fair	Conroe
1/27/25	Behavioral Health Suicide Prevention Task Force Meeting – Major Mental Health	Conroe
1/28/25	Walker County Child Crisis Collaborative	Huntsville
1/28/25	Walker County Community Resource Coordination Group	Huntsville
1/28/25	Adult MHFA for General Public - Virtual	Conroe
1/28/25	Camp Valor Veterans Collaboration	Conroe
1/28/25	Veteran Task Force Meeting	Conroe
1/29/25	Montgomery County Crisis Collaborative & Diversion Task Force Meeting	Conroe

UPCOMING ACTIVITIES

1/31/25	Walker County Juvenile Services Staffing	Huntsville
2/4/25	Camp Valor Veterans Collaboration	Conroe
2/5/25	Autism Spectrum Disorder in College Students - SHSU Psychology Interns - Virtual	Conroe
2/5/25	Montgomery County Child Crisis Collaborative	Conroe
2/5/25	Peet Junior High Career Night	Conroe
2/6/25	Adult MHFA for General Public - Virtual	Conroe
2/11/25	Family & Coalition of East Texas Meeting	Conroe
2/11/25	Camp Valor Veterans Collaboration	Conroe
2/12/25	Walker County Jail In Reach Collaborative - Virtual	Conroe
2/13/25	Montgomery High School Resource Fair	Montgomery
2/13/25	Youth MHFA For Conroe ISD	The Woodlands
2/14/25	Blended Youth MHFA Hardin ISD (online & in person)	Hardin
2/18/25	Camp Valor Veterans Collaboration	Conroe
2/18/25	Montgomery County Community Resource Coordination Group	Conroe
2/19/25	Zero Suicide Joint Regional Community Meeting - Virtual	Conroe
2/20/25	Behavioral Health Suicide Prevention Task Force Meeting	Conroe
2/20/25	Magnolia ISD Parent Resource Event	Magnolia
2/21/25	Blended Adult MHFA for SHSU (online & in person)	The Woodlands
2/25/25	Camp Valor Veterans Collaboration	Conroe
2/25/25	Walker County Child Crisis Collaborative	Huntsville
2/25/25	Walker County Community Resource Coordination Group	Huntsville
2/25/25	Huntsville ISD Student Health Advisory Committee	Huntsville
2/26/25	Blended Adult MHFA for General Public	Conroe
2/26/25	New Waverly ISD Student Health Advisory Committee	New Waverly
2/26/25	Homeless Veteran Stand Down	Conroe
2/26/25	Montgomery County Crisis Collaborative & Diversion Task Force	Conroe
2/27/25	College Park High School Resource Fair	The Woodlands
2/27/25	Quarterly Outpatient Competency Restoration/Crisis Meeting with State Hospitals - Virtual	Conroe
2/27/25	New Suicide Prevention Coordinator's Group - Virtual	Conroe
2/28/25	Walker County Juvenile Services Staffing	Huntsville

Agenda Item: Consumer Services Report for November and December 2024 **Committee:** Program	**Board Meeting Date:** January 30, 2025
Background Information: None	
Supporting Documentation: Consumer Services Report for November and December 2024	
Recommended Action: **For Information Only**	

CONSUMER SERVICES REPORT
November 2024

Crisis Services, MH Adults/Children Served	MONTGOMERY COUNTY	LIBERTY COUNTY	WALKER COUNTY	CONROE CLINICS	PORTER CLINIC	CLEVELAND CLINIC	LIBERTY CLINIC	COUNTY TOTAL
Crisis Assessments and Interventions	325	29	18	-	-	-	-	**372**
Youth Crisis Outreach Team (YCOT)	102	12	3	-	-	-	-	**117**
Crisis Hotline Served	336	51	32	-	-	-	-	**419**
Crisis Stabilization Unit	31	2	0	31	-	1	1	**33**
Crisis Stabilization Unit Bed Days	132	9	0	132	-	4	5	**141**
Adult Contract Hospital Admissions	56	9	3	56	-	6	3	**68**
Child and Youth Contract Hospital Admissions	8	1	2	8	0	0	1	**11**
Total State Hospital Admissions (Civil only)	3	0	0	3	0	0	0	**3**
Routine Services, MH Adults/Children Served								
Adult Levels of Care (LOC 1-5, EO, TAY)	863	184	104	863	-	105	79	**1151**
Adult Medication	840	167	148	840	-	98	69	**1155**
TCOOMMI (Adult Only)	97	28	6	97	-	9	19	**131**
Adult Jail Diversions	3	0	0	3	-	0	0	**3**
Child Levels of Care (LOC 1-5, EO, YC,YES)	710	100	75	483	227	61	39	**885**
Child Medication	272	26	40	185	87	26	0	**338**
Multisystemic Therapy (MST)	15	2	0	-	-	-	-	**17**
School Based Clinics	69	25	34	-	-	-	-	**128**
Veterans Served								
Veterans Served - Therapy	34	2	3	-	-	-	-	**39**
Veterans Served - Case Management	23	3	0	-	-	-	-	**26**
Persons Served by Program, IDD								
Number of New Enrollments for IDD	60	12	4	60	-	10	2	**76**
Service Coordination	662	76	77	662	-	40	36	**815**
Individualized Skills and Socialization (ISS)	6	20	19	-	-	6	14	**45**
Persons Enrolled in Programs, IDD								
Center Waiver Services (HCS, Supervised Living)	26	15	18	26	0	6	9	**59**
Substance Use Services, Adults and Youth Served								
Youth Substance Use Disorder Treatment/COPSD	3	2	0	3	-	2	0	**5**
Adult Substance Use Disorder Treatment/COPSD	31	0	1	31	-	0	0	**32**

Waiting/Interest Lists as of Month End								
Home and Community Based Services Interest List	2037	339	235	-	-	-	-	**2611**
American Rescue Plan Act (ARPA) Funded Therapy								
Expanded Therapy	118	17	0	97	21	9	8	**135**
After Hours Therapy	75	0	0	71	4	0	0	**75**
October Served								
Adult Mental Health	1777	315	282	1777	-	174	141	**2374**
Child Mental Health	998	150	109	677	321	98	52	**1257**
Intellectual and Developmental Disabilities	945	114	96	945	-	48	66	**1155**
Total Served	**3720**	**579**	**487**	**3399**	**321**	**320**	**259**	**4786**
November Served								
Adult Mental Health	1516	273	224	1516	-	156	117	**2013**
Child Mental Health	1025	153	126	727	298	100	53	**1304**
Intellectual and Developmental Disabilities	884	123	90	884	-	70	53	**1097**
Total Served	**3425**	**549**	**440**	**3127**	**298**	**326**	**223**	**4414**

CONSUMER SERVICES REPORT
December 2024

Crisis Services, MH Adults/Children Served	MONTGOMERY COUNTY	LIBERTY COUNTY	WALKER COUNTY	CONROE CLINICS	PORTER CLINIC	CLEVELAND CLINIC	LIBERTY CLINIC	COUNTY TOTAL
Crisis Assessments and Interventions	295	32	18	-	-	-	-	**345**
Youth Crisis Outreach Team (YCOT)	91	7	5	-	-	-	-	**103**
Crisis Hotline Served	311	34	38	-	-	-	-	**383**
Crisis Stabilization Unit	36	5	3	36	-	3	2	**44**
Crisis Stabilization Unit Bed Days	145	31	7	145	-	13	18	**183**
Adult Contract Hospital Admissions	52	3	0	52	-	2	1	**55**
Child and Youth Contract Hospital Admissions	11	1	0	11	0	1	0	**12**
Total State Hospital Admissions (Civil only)	0	0	0	0	0	0	0	**0**
Routine Services, MH Adults/Children Served								
Adult Levels of Care (LOC 1-5, EO, TAY)	772	148	105	772	-	90	58	**1025**
Adult Medication	843	156	170	843	-	86	70	**1169**
TCOOMMI (Adult Only)	98	24	6	98	-	6	18	**128**
Adult Jail Diversions	3	0	0	3	-	0	0	**3**
Child Levels of Care (LOC 1-5, EO, YC,YES)	718	94	87	489	229	59	35	**899**
Child Medication	238	29	43	181	62	24	0	**310**
Multisystemic Therapy (MST)	16	2	1	-	-	-	-	**19**
School Based Clinics	55	30	37	-	-	-	-	**122**
Veterans Served								
Veterans Served - Therapy	25	1	3	-	-	-	-	**29**
Veterans Served - Case Management	13	5	0	-	-	-	-	**18**
Persons Served by Program, IDD								
Number of New Enrollments for IDD	39	7	4	39	-	2	5	**50**
Service Coordination	634	77	64	634	-	44	33	**775**
Individualized Skills and Socialization (ISS)	6	18	19	-	-	6	12	**43**
Persons Enrolled in Programs, IDD								
Center Waiver Services (HCS, Supervised Living)	29	16	18	29	-	4	12	**63**
Substance Use Services, Adults and Youth Served								
Youth Substance Use Disorder Treatment/COPSD	4	2	0	4	-	2	0	**6**
Adult Substance Use Disorder Treatment/COPSD	27	0	1	27	-	0	0	**28**

Waiting/Interest Lists as of Month End								
Home and Community Based Services Interest List	2034	339	235	-	-	-	-	**2608**
American Rescue Plan Act (ARPA) Funded Therapy								
Expanded Therapy	107	13	0	88	19	8	5	**120**
After Hours Therapy	75	0	0	73	2	0	0	**75**
November Served								
Adult Mental Health	1516	273	224	1516	-	156	117	**2013**
Child Mental Health	1025	153	126	727	298	100	53	**1304**
Intellectual and Developmental Disabilities	884	123	90	884	-	70	53	**1097**
Total Served	**3425**	**549**	**440**	**3127**	**298**	**326**	**223**	**4414**
December Served								
Adult Mental Health	1482	282	240	1482	-	154	128	**2004**
Child Mental Health	966	144	136	687	279	101	43	**1246**
Intellectual and Developmental Disabilities	830	124	86	830	-	67	57	**1040**
Total Served	**3278**	**550**	**462**	**2999**	**279**	**322**	**228**	**4290**

Agenda Item: Program Updates **Committee:** Program	**Board Meeting Date:** January 30, 2025
Background Information: None	
Supporting Documentation: Program Updates	
Recommended Action: **For Information Only**	

Program Updates
December 6, 2024 – January 30, 2025

Crisis Services

1. The new Director of Nurses for the Crisis Stabilization Unit started on December 16, 2024 and has been undergoing a series of both agency and facility trainings since starting. The Executive Director has stopped providing direct coverage to the CSU and the Chief Operating Officer plans to be back to regular job responsibilities soon.
2. We continue to struggle to hire and retain Bachelor's level clinical staff for the CSU. These staff are responsible for conducting admission and discharge processes in addition to facilitating and client groups on the unit.
3. The Tri-County Crisis Team provided a total of 782 crisis services to 422 individuals in the month of November. In December, 703 crisis services were provided to 389 individuals. Of the 1,485 crisis services provided in November and December, 42.6% were provided to individuals less than 18 years of age. The vast majority of the individuals receiving crisis services were residents of Montgomery County (82.2%). The remaining were divided between Liberty County (6.7%), Walker County (4.7%), and other counties outside of the Tri-County service area (7.5%).
4. Crisis services are provided in a variety of locations, with increasing emphasis on field-based delivery. These 1,485 crisis services from November and December were provided at multiple sites within the catchment area, with the three most common being the medical hospital (19.9%), the home (34.5%), and the PETC (40.2%).
5. The Youth Crisis Outreach Team has continued to increase service delivery on both the Crisis Response Team and the Crisis Stabilization Team. In November, 305 crisis services were provided to 116 youth, with 79 of those services for youth between the ages of 6 to 11 (25.8%). Of the 305 services from both teams, 43.6% were delivered face-to-face and 59.3% were provided in the home. December experienced only a slight increase with a total of 315 crisis services provided to 104 youth; 28.3% of those services were for youth ages 5 thru 11 years of age and 55.6% provided by the Stabilization Team. Of the total YCOT services in December, 48.6% were delivered face-to-face and 68.9% were provided in the home. The acuity of many of these youth has surpassed our expectations; however, the team has continued making a positive impact by providing specialized crisis interventions, ongoing support for up to 90 days, and successful transitions to ongoing outpatient care. Given of the intensity of the program, we have provided the staff with secondary trauma training and continue to closely monitor their well-being.
6. We currently have three staff vacancies among the different crisis programs: Crisis Intervention Team with MCSO and two YCOT clinicians with the YCOT Crisis Response teams. We have had some success with interviewing applicants for the YCOT clinician positions and expect to have those positions filled soon.
7. The PETC and Crisis team staff worked throughout the Christmas holiday but also managed to have some fun. Secret Santa was one of the popular activities along with a month-long "Crisis Elf on the Shelf" contest. All of the Elf entries have been submitted and the judges will be making their decisions soon for the three most creative individual photos and the top team entries from the month.

MH Adult Services

1. The Conroe outpatient clinic has had some success with hiring field-based Qualified Mental Health Specialist and a Coordinator to supervise the team. We have sent several new hires through New Employee Orientation and training and most are now providing direct care. We are hopeful that this team is back on track and will be very productive as we are now able to serve more clients in the community and in their homes.
2. Adult Outpatient services is actively recruiting two licensed therapist positions after staff from both the Conroe Clinic and Rural Clinics resigned from their roles at the same time. We are very grateful for the ARPA Therapy Program stepping in to help cover some adult counseling services allowing for the continuation of these contract required services while we are in the hiring process.
3. The First Episode Psychosis program has filled the Team Lead role and the team is actively working to provide high quality services to a full caseload.
4. The intake team has been able to schedule 76% of walk-in clients for same-day evaluations in quarter two of this fiscal year. This accessibility allows individuals seeking care the ability to connect to services quickly, and greatly reduces the risk of someone no-showing their evaluation, which delays care.
5. One of our Projects for Assistance in Transition from Homelessness (PATH) staff assisted an individual who had been released from jail in establishing medical care, SSDI, and mental health treatment. The individual was closed out of services this week after saving enough money for two months of rent, and moving to live near his father in the Austin area.
6. The Cleveland Team is very excited to start participating in committees to help prepare for the transition to the new facility. The interdepartmental collaboration is a great way to foster improved communication and is bringing out leadership qualities in staff.

MH Child and Youth Services

1. Tri-County Child and Youth Administrators have been selected to chair both the Walker County and the Montgomery County Community Resource Collaboration Groups (CRCGs). We were also offered opportunity to co-chair the Liberty County CRCG. CRCGs are county-based groups of local partners and community members that work with parents, caregivers, and youth to identify and coordinate services and supports, including behavioral health, basic needs and caregiver support. They help people whose needs cannot be met by one single agency and who would benefit from interagency coordination. CRCGs in more populated counties, like Montgomery County, usually meet monthly and staff around four cases per month.
2. Our new Multisystemic Therapy (MST) program has served 26 families in its brief existence. MST Clinicians work intensely to empower parents and caregivers to focus youth on school and other prosocial activities and to decrease delinquent behaviors such as substance use, physical violence, stealing vehicles, illegally accessing firearms, running away, and selling narcotics. Our team has five upcoming successful discharges, the first round in our new program as the duration of treatment is five months and we just started on 9/1/2024.

3. Our MST program has had 65 referrals to date, but can only serve 20 clients at a time. We have invested stakeholders within the Probation Departments of the counties served, as well as with local school administrators. To date, the majority of referrals have come from Montgomery County Juvenile Probation and from our internal Child and Youth Mental Health caseload; however, we have received referrals from Probation departments and school districts in all three counties.

Criminal Justice Services

1. The Outpatient Competency Restoration program has had a positive start to this fiscal year, serving three individuals to date.
2. The Office of Court Administration visited the Montgomery County Mental Health Treatment Court and has nominated it as a Court of Excellence. The Criminal Justice Program Administrator serves on the team along with ADA of Specialty Courts, Defense Council and Probation Counseling Services and was commended for work done to promote collaboration and client care in treatment.

Substance Use Disorder Services

1. We have submitted an application to continue the Substance Use Grant that would allow us to fund existing adult and youth treatment programs through fiscal year 2029. There are several changes to how the budget is monitored, higher targets for performance measures, and the grant will no longer sustain COPSD programming. Although we are planning on expanding substance use services to the new Cleveland facility, we must license the building space before we are able to utilize grant funds there.
2. The Program Director met with the Houston High Intensity Drug Trafficking Area (HIDTA) team to discuss current trends in substance use in our area. Every year, HIDTA publishes an article that reviews information gathered and researched for the greater Houston area that identifies trends and watch items for the community.
3. The SUD program continues to search for a Youth SUD Counselor to serve clients ages 13-17. This has historically been a difficult position to fill, yet is so very important to the community. Currently, the Administrator is covering a small caseload of youth.

IDD Services

1. During the pandemic HHSC successfully rolled out a project using virtual reality technology with the State Supported Living Centers (SSLCs). This technology was used to give home tours to SSLC residents. Due to the success of the project, HHSC is implementing a similar project to facilitate community transitions for Preadmission Screening and Resident Review (PASRR) recipients with Intellectual and/or Developmental Disabilities (IDD) living in nursing facilities who want to transition to the community. TCBHC has opted into the project, which will allow people to experience home settings through Virtual Reality (VR) technology.
    a. LIDDA PASRR staff will be provided all needed equipment to take videos of potential homes including bedrooms, the kitchen, bathroom, other common areas, and with permission, the staff.

b. HHSC will provide the participating Local IDD Authorities with a list of equipment, including recommendations for purchasing, and will develop training manuals for the equipment which will be made available to PASRR Program staff.
2. IDD Provider services has vacancies in both Huntsville and Cleveland ISS Services.
3. IDD Providers is searching for a part time RN to assist in managing caseload.
4. Medicaid eligibility continues to be an issue. We have a client that lost Medicaid effective January 1st and ten client names appeared on the 90 day report that may lose Medicaid if their packets have not been submitted and processed on time.

Support Services

1. **Quality Management (QM):**
    a. The QM Department, in collaboration with the Chief Operating Officer and Project Director have begun a series of internal audits to identify opportunities for quality improvement. These audits were selected based on recent reports published by an oversight entity that outlined areas of concern within the Community Center System. Areas of current review include: Screening and Assessment, Recovery Planning and the Inpatient Care Wait List (ICW). Following review, corrective action will be implemented as needed to address any identified deficiencies or areas needing improvement.
    b. Staff prepared and submitted three record requests from three different insurance companies totaling 17 charts. Records were requested back to January 1, 2023 and 2024 depending upon the request.
    c. In addition to routine and ongoing quality assurance of documentation, staff have continued to review a sample of progress notes prior to billing to ensure compliance and continue to monitor monthly quality assurance reviews which are conducted by Supervisors around the Center and submitted to the Quality Management Department on a regular basis. Additional training and follow-up was provided to staff and supervisors as needed.

2. **Utilization Management (UM):**
    a. Staff reviewed 10% of all discharges for the months of November and December.
    b. Staff reviewed all notes that utilized the COPSD Modifier for the months of November and December.
    c. Staff reviewed 10% of progress notes that utilized the MCOT Modifier for the months of November and December, to ensure continuous quality improvement.

3. **Training:**
    a. In early January, the Clinical Trainer attended a recertification course in San Antonio, Texas, to maintain train the trainer status in Satori Alternatives to Managing Aggression (SAMA).
    b. The Training Department, in coordination with our Center Youth Mental Health First Aid (YMHFA) trained instructors, provided six (6) YMHFA courses to Independent School District and Education Service Center staff in our region. Additionally, one Adult Mental Health First Aid course and one Veterans Mental Health First Aid course were scheduled for the general public.

4. **Veteran Services and Veterans Counseling/Crisis:**
    a. Since December, there have been three graduates from the Montgomery County Veteran Treatment Court. There are a total of 31 participants in the program. The Liberty County Veteran Treatment Court has five participants in their program.
    b. The Veterans Services team collaborated with Habitat for Humanity to help a Veteran with a wife and five children, who have been living in a hotel since the Derecho in May and Hurricane Beryl damaged their home. We are pleased to say the Veteran and his family celebrated Christmas in the their newly renovated home.
    c. We had the Military Veteran Peer Network Mentor Christmas Appreciation Luncheon at Honor Café. There was a great turnout and the mentors appreciated their lunch and fellowship. This is a small token on our part to show our appreciation for the time they spend helping our justice involved veterans.
    d. The Veterans team received holiday donations from two local agencies which allowed us to help provide Christmas to several families, including 21 children.
    e. In December, the Veterans team provided 56 individual and group counseling sessions to 29 different Veterans in the community.

5. **Planning and Network Advisory Committee(s) (MH and IDD PNACs):**
    a. The Regional PNAC meeting was held on December 11, 2024, where members reviewed the draft Local Provider Network Development Plans (LPNDs) for each Center.
    b. The MH and IDD PNAC met for a combined meeting on December 11, 2024 where they received Center updates including updates on financials, performance measures and key program information along with final updates on the MH Consolidated Local Service Area and LPND Plans. The local IDD PNAC is now at nine members. Discussions continued on recruitment efforts for the MH PNAC. One (1) new MH PNAC member did attend the December meeting and both face to face and virtual options have been made available to make it easier for members to attend.

Community Activities

Tri-County is pleased to announce that Wayne Young, CEO of the Harris Center will be joining the Mental Health Crisis/Jail Diversion joint workgroup on January 29th at 10am. Mr. Young will review their successes at the Harris Center with the Ed Emmit Diversion Center in Houston.

Agenda Item: Year to Date FY 2025 Goals and Objectives Progress Report **Committee:** Program	**Board Meeting Date** January 30, 2025

Background Information:

The Management Team met on August 2, 2024 to update the five-year strategic plan and to develop the goals for FY 2025. The strategic plan and related goals were approved by the Board of Trustees at the September 2024 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 2025.

Supporting Documentation:

FY 2025, Year to Date Goals and Objectives Progress Report

Recommended Action:

For Information Only

Year-to-Date Progress Report

September 1, 2024 – January 30, 2025

Goal #1 – Clinical Excellence

Objective 1: **Enhance the Intellectual and Developmental Disability services intake process to ensure a more efficient, streamlined, and client-centered experience. By reducing wait times, simplifying documentation, and/or utilizing available tools, we aim to refine the IDD intake process including ensuring clearer understanding of the process, improve communication with our clients, and increase client satisfaction by June 30, 2025.**

- IDD Authority successfully identified four (4) distinct phases that make up the IDD Authority Intake process. Each phase is designed to clearly identify where clients are in the intake process and to move them through more efficiently, while fostering a clearer understanding of what is occurring. The four (4) phases are as follows: Phase I - Pre-Intake (document collection and scheduling for Determination of Intellectual Disabilities), Phase II - Scheduling with Admissions and Enrollments Coordinator (clients are contacted in chronological order to begin services), Phase III - Service Planning & Development (initial consents signed, plan for services is developed, and Case Manager assigned), and Phase IV - Supplemental Service Planning & Development (for qualified individuals, Community First Choice or CFC enrollment is completed). By April 2025, the goal is to eliminate the backlog in Phase II, so that clients are not waiting to begin services, allowing intake to occur as soon as the Determination of Intellectual Disabilities (DID) is completed.
- In analyzing intake data at the beginning of this process, it was discovered that many clients seeking IDD services were from families who speak Spanish as their primary language. With additional ARPA funding for FY25, IDD Authority was able to hire bilingual Intake staff to help address this need. IDD Authority has successfully cleared the Spanish-speaking clients waiting in Phase II, some of whom had been waiting for service planning (Phase III) since the onset of the Pandemic.
- Since September 2024, the program has achieved an 80% reduction in clients waiting for a Case Manager and a 39% reduction in clients waiting for a DID.
- In January IDD Authority Intake Services created the “IDD Authority Intake Satisfaction Survey” and an accompanying QR code that is provided to clients, families and advocates at the end of Service Planning (Phase III or

IV) that will assist in improving our client's experience with the IDD Intake process. The survey gauges wait times, ease of submitting records, flexibility in scheduling appointments, Intake team response times, satisfaction with the person-centered planning process, and overall satisfaction with the IDD Intake process. A plan has also been created to go back and survey all clients who completed the IDD Intake process beginning in September of 2024, to capture this very important data.

Objective 2: **Regularly conduct client satisfaction surveys to gather valuable feedback, identify areas for improvement, and enhance the quality of our services. A summary of survey results will be reported to the Board of Trustees two times in FY 2025 at the February and August Board meetings. By actively listening to our clients and addressing their concerns, we aim to increase satisfaction, strengthen client relationships, and ensure that our offerings consistently meet or exceed expectations, leading to higher retention and loyalty.**

- The Quality Management Department has developed two different surveys to collect information related to client satisfaction and areas of quality improvement. Phone calls are underway and QM staff have begun initial visits with individuals coming to the medication clinic in Conroe. Plans are in place to visit additional clinics. Further, an additional survey option is being explored at this time to ensure feedback is available from other groups, who may not utilize on-site services.
- The Intellectual and Developmental Disability Department has developed a survey to gain insight into client satisfaction and areas of needed improvement related to Objective 1 of the Board Goals and Objectives and have taken steps to initiate this survey at the time of this update.

Goal #2 – Community Connectedness

Objective 1: **Staff will work with community members to develop a plan for a Mental Health and Substance Use Disorder Diversion Center which meets community needs and can be endorsed by a majority of stakeholder members who participate in planning by May 31, 2025. The Diversion Center will aim to reduce reliance on the criminal justice system, offer an alternative to incarceration, and address the root causes of mental health and substance use challenges.**

- In response to the Sequential Intercept Model (SIM) mapping event, where the need for a Diversion Center in the community was identified, several planning meetings have been held, bringing together key community stakeholders and partners to further discuss the need, develop a plan for the community, and understand cost.

- In January, the Collaborative will welcome Wayne Young, CEO of Harris Center, to speak on the Diversion Center model implemented in Harris County. This opportunity will allow for further understanding of what is required of the model, including staffing, cost, building and program design, as well as what will be needed to move this project forward.

Goal #3 – Information Technology

Objective 1: **Implement a secure portal in SmartCare to reduce administrative burden, ensure accurate and accessible medical records, and support informed decision-making to deliver high-quality care while ensuring compliance with healthcare regulations and data security standards by July 31, 2025.**

- Shortly after adding this goal to our Board Goals for fiscal year 2025, Streamline announced that they would be changing the partner that supplies their third-party portal software.
- Streamline selected a few established sites to serve as pilots for the new software, but we were not one of the sites that they selected.
- At this time, we have no timeline available on when the new portal software will be available for implementation, but we have asked to be considered for early implementation.
- A portal is required functionality for our next CCBHC recertification in 2027.

Objective 2: **Successfully transition to Microsoft Windows 11 to leverage the latest technological advancements, improve operational efficiency and ensure compatibility with modern applications while maintaining data integrity and minimizing disruption during the migration process by July 31, 2025.**

- Tri-County currently uses Microsoft Windows 10 as our computer operating system, but support for Windows 10 will be discontinued by Microsoft in September of 2025 and all users will be required to migrate to Windows 11 before support is discontinued.
- Some of our existing computers do not have the processor power to operate Windows 11 and will need to be replaced. Other computers may be able to download the update, but may be to slow to use the operating system effectively.
- A large number of computers may have to be purchased, formatted and installed before yearend. Management Information Systems has been evaluating computers and currently estimates that we will need to purchase at least $150,000 in computers this fiscal year (which is consistent with most years).

- In addition, MIS has been converting the computers of stronger users to Windows 11 to ensure that other software works appropriately with this operating system and so that we test overall functionality and usability of Windows 11. Thus far, feedback from the Superusers has been that it works with other software appropriately, but that the operating system is not intuitive to use.

Goal #4 – Staff Development

Objective 1: **Develop and implement strategies that reduce staff turnover by 10% from FY 2024 number by fostering a positive work environment, enhancing employee engagement, and offering professional development opportunities. Measured YTD on July 31, 2025 as compared to YTD on July 31, 2024.**

- The team has been working with both the State and Federal government in pursuit of getting all Tri-County Behavioral Healthcare locations designated as Health Provider Shortage Areas (HPSA). Once HPSA designations are achieved, it will provide Tri-County Behavioral Healthcare access to apply for several student loan repayment programs. These programs can offer substantial financial relief for staff in eligible roles, such as physicians, nurses, licensed clinicians, and substance use professionals. The team strongly believes that access to these programs will aid Tri-County Behavioral Healthcare in both the recruitment and retention of key employees.
- Once Tri-County Behavioral Healthcare is granted HPSA designation, the team will apply for certification with any/all loan repayment and scholarship programs employees may be eligible for. At this time, the team has identified the following programs that they intend to pursue:
  - Texas Higher Education Coordinating Board for mental health professionals and nursing loan repayment;
  - State Loan Repayment Program for prescribers, RN, and licensed clinical staff;
  - SUD Treatment and Recovery Loan Repayment for Licensed Chemical Dependency Counselors (LCDCs);
  - National Health Service Corps, which is a federal program offering loan repayment and scholarship opportunities for physicians;
  - Once certification is achieved, the team intends to communicate information about the program(s) Center-wide, along with application instructions and other resources.
- The Chief Nursing Officer completed a staff engagement survey and presented this information to the Executive Team at our annual retreat in November.

Goal #5 – Fiscal Responsibility

Objective 1: **Strategically pursue and secure grants to support program development, enhance organizational capacity, and drive impactful initiatives by building strong partnerships, improving grant writing capabilities, and aligning with funders' priorities to maximize the positive outcomes for the communities we serve. Staff will complete at least four new or renewal grants by August 31, 2025.**

- In Fiscal Year 2025, the Center has applied for two grant opportunities, the first from Texas Veterans Commission (TVC) to expand existing Veterans' services and the second a grant from Texas Health and Human Services Commission to extend the existing Substance Use Disorder Treatment programming.
- The TVC grant was submitted in November with a proposal that will support the addition of a licensed clinician to provide therapy, as well as a Veteran Peer allowing for expansion of current services in Montgomery and Liberty counties and to begin providing services in Walker County. If awarded funding, services would begin July 2025 and continue through August 31st, 2026. Opportunities to extend funding will be available for an additional one year, if program goals are met.
- In January, a grant application was submitted to support ongoing outpatient Substance Use Disorder Treatment programming. The grant, which is a federal grant passed through the State, will allow continued funding for an additional five years for the existing adult and youth programs. If awarded, funding would be active starting September 2025.
- The Center has further submitted an application in collaboration with Sam Houston State University and have been awarded a Psychiatric Residency grant through the Health Resources and Services Administration (HRSA). This grant, which will be managed by Sam Houston State University, will fund up to four psychiatry residents per year, for four years. Residents will rotate through the adult and youth outpatient clinics as well as crisis, providing psychiatric services and expanding capacity at no cost to the Center. The program is scheduled to begin in July 2025, pending accreditation by the Accreditation Council for Graduate Medical Education (AGME), which is expected in February.

Objective 2: **Increase overall revenue by diversifying income streams, optimizing operational efficiency, and enhancing customer retention by implementing transparent financial practices, providing staff with the necessary tools and training, and**

fostering a culture of responsible fiscal management. Goal will be measured throughout the year and finally on August 31, 2025.

- The Chief Financial Officer and the Controller have been meeting monthly with the Executive Team to provide detailed updates on the budget and to provide guidance on how to improve revenue and decrease costs.
- Included in the training is a comparison of current years revenue earned, as compared to each year going back to 2018. Variances in the numbers were identified and reasons for the differences explained by year, such as COVID years, low number of staffs, Medicaid unwinding etc.
- The next step is to have monthly meetings with the mid- level managers and review more in depth current direct care workers productivity levels and see where we can adjust and assist in helping to achieve an increase in the numbers of clients served.

Goal # 6 – Professional Facilities

Objective 1: **To create a welcoming and functional environment that meets the needs of staff, clients, and stakeholders, while fostering growth, enhancing service delivery, and contributing to the long-term success of the organization, we will ensure the successful opening of the new Cleveland Service facility by June 30, 2025.**

- As progress continues on building construction, with updates and completion status provided during a weekly contractor meeting, a transition team, comprised of key Management Team members and other personnel, has been formed and is meeting regularly to make decisions, develop strategies, processes, and procedures, and implement plans to ensure a smooth transition to the new Cleveland Service Facility.
- Staff impacted by the move have further been invited to participate in monthly transition meetings, held in the existing Cleveland building to provide information, guidance, set expectations, and share updates with the staff. The goal of these meetings is to ensure that staff understand what to expect from the move, including their roles in making this transition successful. These meetings also serve as opportunity to set the tone for the change in culture that this new site affords.
- Several committees have been formed to address several significant tasks, such as ensuring appropriate furniture is ordered, technology is in place, and that the clinic flow is optimal, among others. These committees will meet regularly to make decisions impacting specific areas and ensure that all necessary steps are completed to allow for the building to open on time and on budget.

Agenda Item: 1st Quarter FY 2025 Corporate Compliance and Quality Management Report **Committee:** Program	**Board Meeting Date** January 30, 2025

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 2025 are included in this Board packet.

Supporting Documentation:

1st Quarter FY 2025 Corporate Compliance and Quality Management Report

Recommended Action:

For Information Only

Corporate Compliance and Quality Management Report
1st Quarter, FY 2025

Corporate Compliance Activities

A. Key Statistics:

No compliance concerns were reported in the 1st Quarter of FY25. We will continue closely monitoring and encouraging staff to report concerns as needed.

B. Committee Activities:

The Corporate Compliance Committee convened on November 5, 2024, to review and discuss several key topics, including:

1. A final summary of FY24 investigations.
2. Recommendation to make minor modifications to Tri-County Behavioral Healthcare's internal Authorization form to streamline information sharing; and
3. A review of the Corporate Compliance Action Plan (CCAP) that resulted in two minor updates to the Plan.

Quality Management Initiatives

A. Key Statistics:

1. In response to legislation increasing the oversight of Community Centers along with increased need for focus on Continuous Quality Improvement, outcome measures and risk stratification, Tri-County has increased staffing in the Quality Management (QM) Department to include an additional Utilization Management position. Vacant positions have been filled at the time of this report and staff are currently undergoing training in new areas of supervision while continuing ongoing quality reviews in areas of established competence.
2. Staff participated in one (1) clinical desk review by a Managed Care Organization.
3. Staff conducted several ongoing internal audits including, but not limited to, documentation reviews, authorization override requests for clinically complex individuals, satisfaction survey reviews, discharge audits and use of the Co-Occurring Psychiatric and Substance Use Modifier as well as the Mobile Crisis Outreach Team Modifier.
4. Staff reviewed and submitted nine (9) record requests from six (6) different insurance companies, totaling 61 charts.
5. The Continuous Quality Improvement Committee met on October 11, 2024 to review final 2025 CQI goals and discussed next steps toward reaching these goals. The Quality and Utilization Management Committee met on October 16,

2024 and the Regional Utilization Management Committee met on October 17, 2024 both reviewing performance measures, ongoing quality improvement efforts along with key program and utilization management reports and information.

B. Reviews/Audits:

1. The QM Department, in coordination with the COO and Project Director, conducted a comprehensive review of the MH Performance Contract and associated rules and guidelines, to develop audit tools to be used for targeted program reviews that will facilitate quality improvement.
2. Staff participated in the Superior Health Plan clinical audit held on November 6, 2024 with four charts were reviewed for rule compliance and quality care. While results were primarily positive, one chart did score under 90% which resulted in a follow up audit being scheduled for April 2025.
3. Staff reviewed 62 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 staff utilizing this code are using it correctly the majority of the time. Follow up was made with supervisors as needed for quality improvement purposes.
4. Staff reviewed 50 notes which used the MCOT Modifier for quality assurance purposes. Feedback was provided to staff and supervisors as needed to ensure proper use of the code.
5. Staff reviewed 78 discharges that occurred in Q1 and communicated areas that were needing improvement to supervisory staff.
6. Staff reviewed 56 MH Adult and Child and Youth progress notes, outside of those reviewed for record requests, for quality assurance purposes. Follow up was provided to supervisors as needed for any re-training purposes.
7. Staff continue to collect and review monthly quality assurance audits from Supervisors of clinical programs and review satisfaction surveys requested from program managers throughout the Center to include discharge surveys from contract hospitals.
8. Staff prepared and submitted two record requests totaling 10 charts to WellPoint dating back to January 2023.
9. Staff prepared and submitted one record request totaling 25 charts to United Healthcare dating back to January 2024.
10. Staff prepared and submitted three record requests totaling 21 charts to Superior dating back to January 2024.
11. Staff prepared and submitted one record request totaling one chart to Cigna dating back to January 2023.
12. Staff prepared and submitted one record request totaling three charts to Aetna dating back to January 2024.
13. Staff prepared and submitted one record request totaling one chart to WellCare dating back to January 2023.

12. Staff prepared and submitted one record request totaling three charts to Aetna dating back to January 2024.
13. Staff prepared and submitted one record request totaling one chart to WellCare dating back to January 2023.

Agenda Item: 2nd Quarter FY 2025 Corporate Compliance Training **Committee:** Program	**Board Meeting Date** January 30, 2025
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 2025 Corporate Compliance Training	
Recommended Action: **For Information Only**	

COMPLIANCE NEWSLETTER

FY25, Quarter 2

Tri-County Behavioral Healthcare
Healthy Minds. Meaningful Lives.

NEWSLETTER HIGHLIGHTS

Avoiding Time Inflation

Accurate time tracking is a cornerstone of ethical billing and compliance. Inflating time—whether intentional or accidental—can lead to serious consequences, including audits, fines, and damage to our reputation.

To ensure compliance:

- Be Precise: Record only the actual time spent on services or tasks. Rounding up can misrepresent the care provided.
- Use Documentation Tools: Leverage time-tracking systems to maintain accuracy and transparency.
- Double-Check Before Submission: Review time entries for accuracy before submitting to catch potential errors or inconsistencies.

Honest time reporting protects our organization and reinforces trust with those we serve. Let's work together to uphold these standards!

YOUR CORPORATE COMPLIANCE TEAM:

Now Hiring
Administrator of Compliance

Amy Foerster
Chief Compliance Officer
amyf@tcbhc.org

Ashley Bare
HR Manager
ashleyba@tcbhc.org

If you have questions or concerns, you can also contact the Corporate Compliance team at **CorporateCompliance@tcbhc.org**

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.

Compliance Concerns Hotline:
866-243-9252

Agenda Item: Personnel Report through December 2024 **Committee:** Executive	**Board Meeting Date:** January 30, 2025
Background Information: None	
Supporting Documentation: Personnel Report through December 2024	
Recommended Action: **For Information Only**	

Personnel Report

FY25 | November - December 2024

Tri-County Behavioral Healthcare
Healthy Minds. Meaningful Lives.

OVERVIEW

NEW HIRES
Nov - Dec
17 POSITIONS
YTD
40 POSITIONS

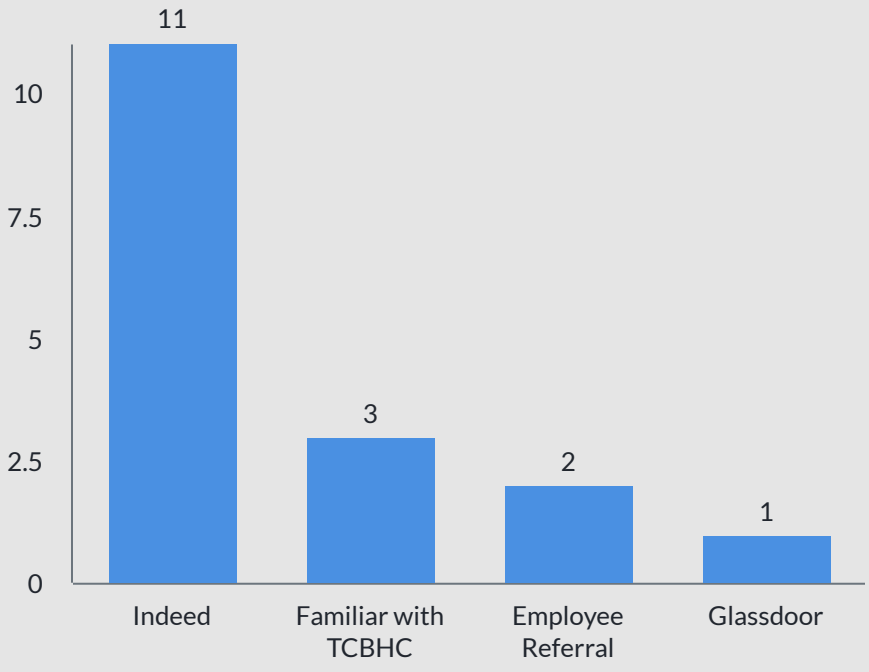
SEPARATIONS
Nov - Dec
14 POSITIONS
YTD
31 POSITIONS

Vacant Positions
56
Frozen Positions
15

Newly Created Positions
3
Total Budgeted Positions
453

RECRUITING

How did November & December new hires hear about TCBHC?



RECRUITING EVENTS

Texas A&M College of Nursing Career Fair	11/4/2024

APPLICANTS

Nov & Dec Total Applicants	368
YTD Applicants	765

CURRENT OPENINGS

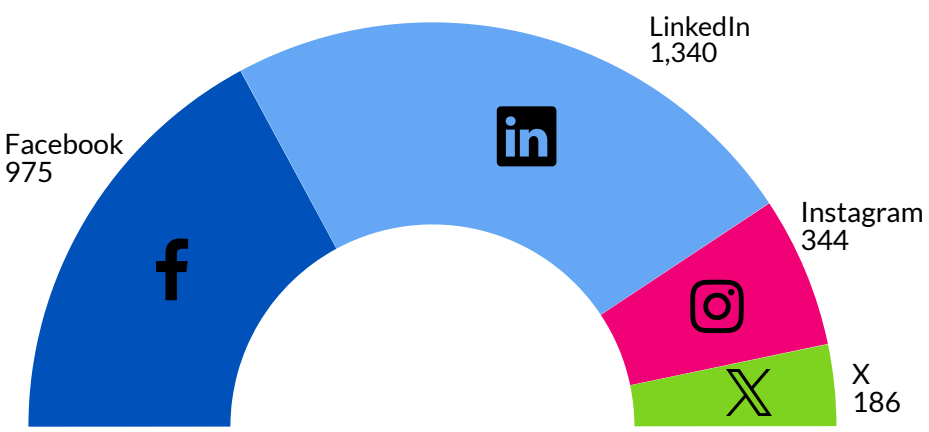
VACANCIES BY LOCATION

CONROE	38
PETC	9
CLEVELAND	3
PORTER	2
LIBERTY	2
HUNTSVILLE	2

TOP 5 VACANCIES

Mental Health Specialist/Case Manager (Adult, IDD, Crisis and C&Y)	30
Direct Care Provider	7
Licensed Clinician	5
Supervisor	4
Paraprofessional	2

SOCIAL MEDIA FOLLOWERS



Tri-County Behavioral Healthcare
Healthy Minds. Meaningful Lives.

Exit Data

FY25 | November & December 2024

Exit Stats at a Glance

12 November & December Voluntary Separations

0 November & December Neutral Terminations

8% YTD Turnover

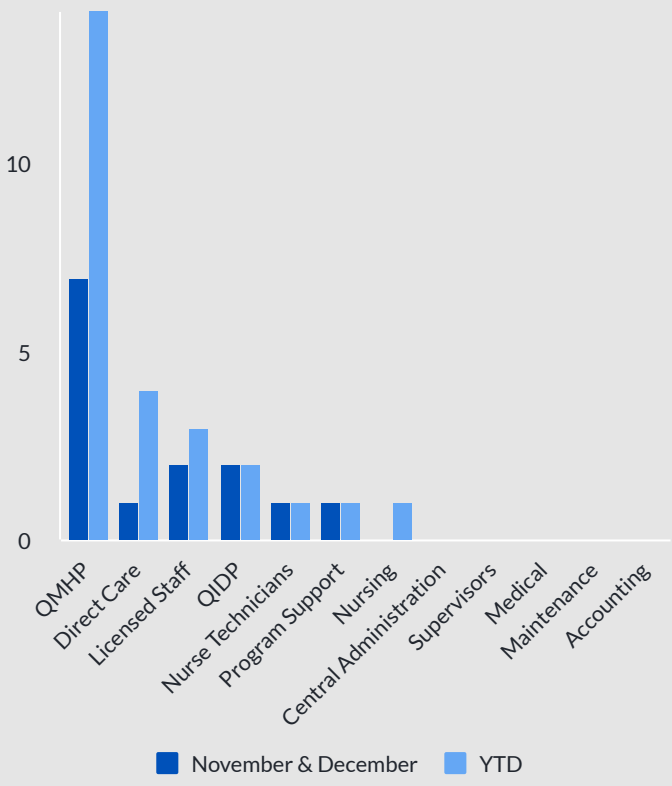
0 November & December Reduction in Force (RIF)

2 November & December Involuntary Terminations

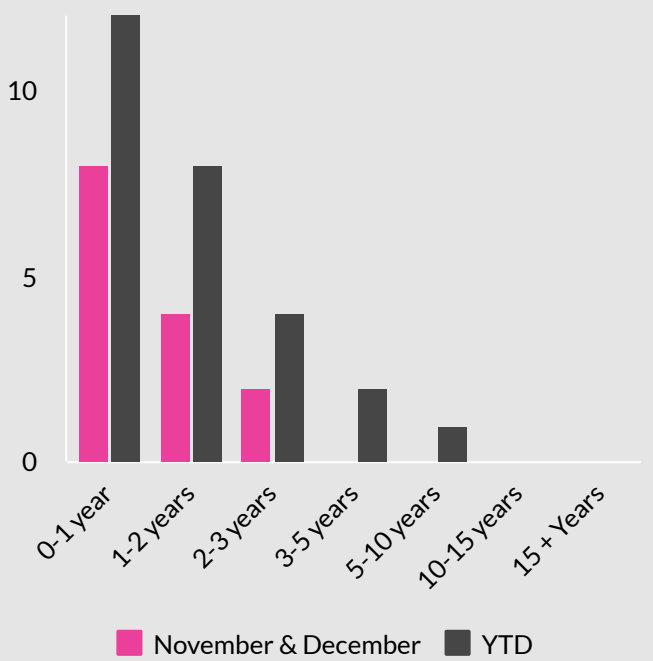
YTD Top Reasons for Separations

1. Another Job
2. Personal/Family, includes Relocating
3. Health
4. Dissatisfaction with Job/Work Environment
5. Commute

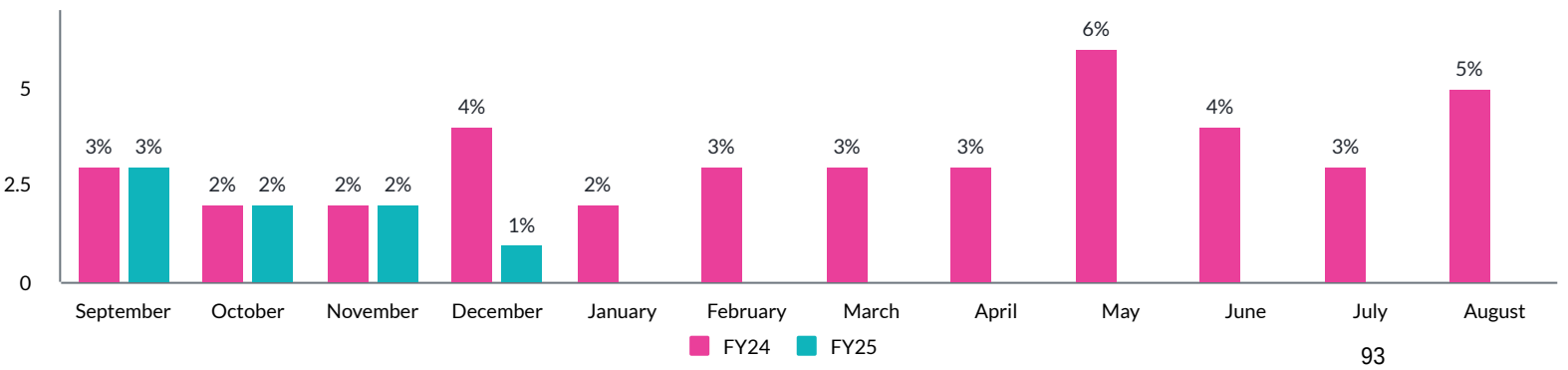
Separations by Category



Separations by Tenure

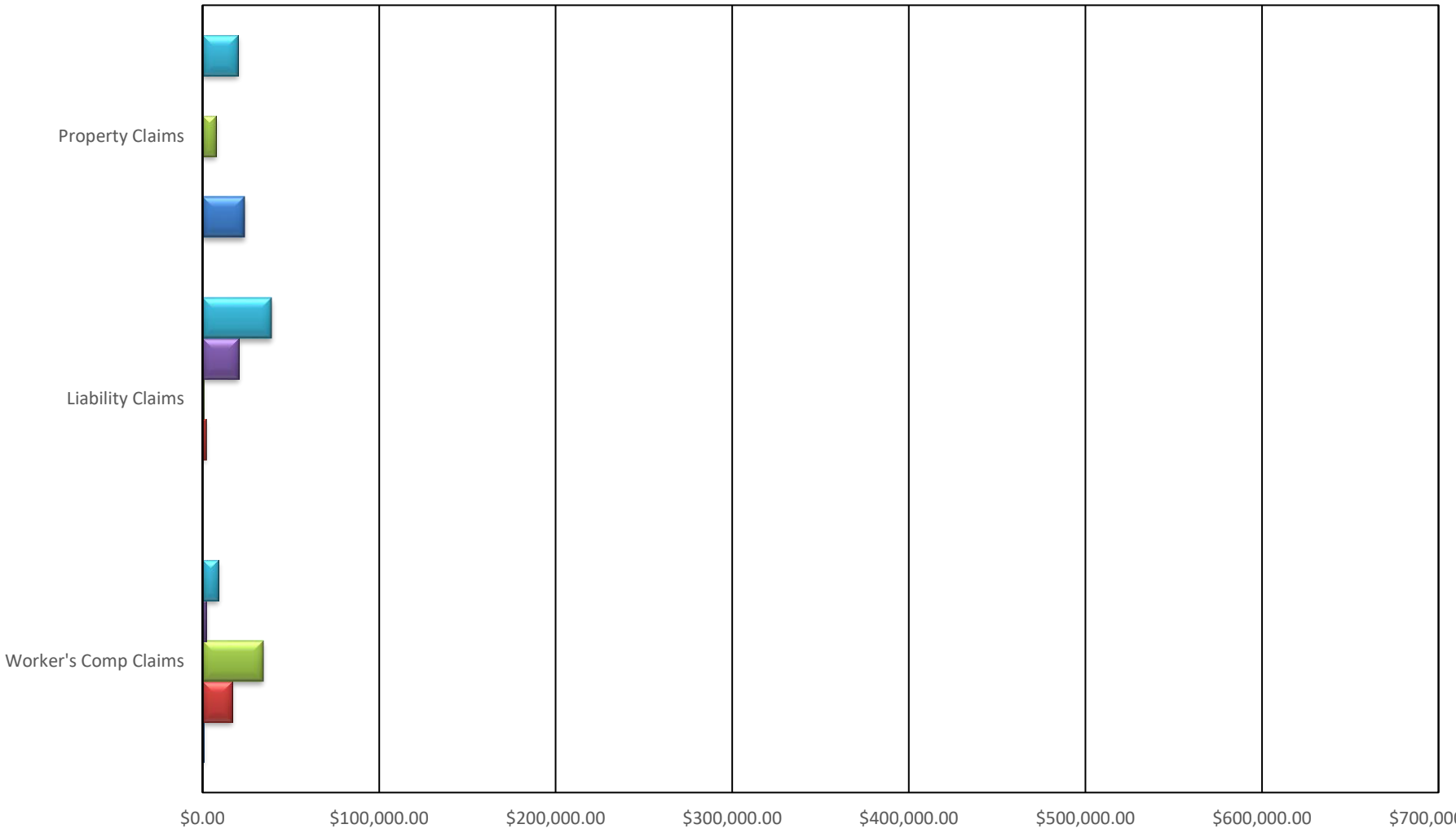


Turnover Rate by Month



Agenda Item: Texas Council Risk Management Fund Claims Summary as of December 2024 **Committee:** Executive	**Board Meeting Date:** January 30, 2025
Background Information: None	
Supporting Documentation: Texas Council Risk Management Fund Claims Summary as of December 2024	
Recommended Action: **For Information Only**	

TCRMF Claims Summary December 2024



	Worker's Comp Claims	Liability Claims	Property Claims
2021	$9,040.00	$39,234.00	$20,074.00
2022	$2,215.00	$20,538.00	$0.00
2023	$34,369.00	$592.00	$7,743.00
2024	$16,982.00	$1,820.00	$0.00
2025	$855.00	$0.00	$23,854.00

Agenda Item: Texas Council Quarterly Board Meeting Update **Committee:** Executive	**Board Meeting Date** January 30, 2025
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 of Trustees Reappointment and Oath of Office **Committee:** Executive	**Board Meeting Date** January 30, 2025

Background Information:

Listed below is the Board member who was reappointed by the Commissioner's Court of their respective county for an additional two-year term expiring August 31, 2026.

Reappointments:

- Jacob Paschal, Walker County

Oath of Office will be recited at the Board meeting.

Supporting Documentation:

Walker County Trustees – Copy of Minutes from Walker County Commissioner's Court Meeting dated June 17, 2024.

Oath of Office Recitation.

Recommended Action:

Recite Oaths of Office

MINUTES for Walker County Commissioners Court
REGULAR SESSION
Monday, June 17, 2024, 9:00 a.m.

CALL TO ORDER

Be it remembered, Commissioners Court of Walker County was called to order by County Judge, Colt Christian at 9:00 a.m. in Commissioners Courtroom, 1st Floor, 1100 University Avenue, Huntsville Texas.

County Judge	**Colt Christian**	**Present**
Precinct 1, Commissioner	**Danny Kuykendall**	**Present**
Precinct 2, Commissioner	**Ronnie White**	**Present**
Precinct 3, Commissioner	**Bill Daugette**	**Present**
Precinct 4, Commissioner	**Brandon Decker**	**Present**

County Judge, Colt Christian stated a quorum was present.
County Clerk, Kari French, certified the notice of the meeting was given in accordance with Section 551.001 of the Texas Government Code.

GENERAL ITEMS

Pledge of Allegiance and Texas Pledge were performed.
Prayer was led by Pastor, James Ray Necker.

CONSENT AGENDA

1. Approve minutes from Commissioners Court Regular Session held on June 3, 2024.
2. Approve Disbursement Report for the period of 06/03/2024 – 06/17/2024.
3. Receive financial information as of June 12, 2024 for the fiscal year ending September 30, 2024.
4. Approve claims and invoices submitted for payment.
5. Approve transfer of fixed asset # 11502, iPad, from R&B 1 to R&B 2.
6. Approve transfer of fixed asset # 11898, 2015 Chevrolet Equinox from Sheriff's Office to the Jail.
7. Approve the transfer of fixed asset # 10172, 1992 Motor Grader from Surplus to R&B 1.
8. Approve GLO and HUD reports, GrantWorks/CDBG GLO Hurricane Harvey Grant Contract 20-065-104-C279 for May 2024.
9. Receive Walker County Appraisal District monthly tax collection report for May 2024.
10. Receive Huntsville Fire Department Reports for May 2024.
11. Receive Planning and Development Monthly Report for May 2024.

Commissioner Kuykendall asked to pull item 1.
Commissioner White asked to pull item 4.
Commissioner Daugette asked to pull item 8.

MOTION: **Made by Commissioner Daugette to APPROVE Consent Agenda with items 1, 4 and 8 pulled for discussion.**
SECOND: **Made by Commissioner White**
VOTE: **Motion carried unanimously.**

(1) Approve minutes from Commissioners Court Regular Session held on June 3, 2024.
Commissioner Kuykendall questioned the amount on item 13. There was discussion. Will approve with corrections after Clerk goes to back to verify.

MOTION: **Made by Commissioner Kuykendall to APPROVE minutes from Commissioners Court Regular Session held on June 3, 2024.**
SECOND: **Made by Commissioner Decker.**
VOTE: **Motion carried unanimously.**

(4) Approve claims and invoices submitted for payment.
Commissioner White had questions on a few items.

MOTION: **Made by Commissioner White to APPROVE invoices submitted for payment.**
SECOND: **Made by Commissioner Kuykendall.**
VOTE: **Motion carried unanimously.**

18. Discuss and take action on the reappointment of Jacob Paschal to the Tri-County Behavioral Healthcare Board of Trustees for a two-year term.
Judge Christian presented information.

MOTION: **Made by Judge Christian to APPROVE the reappointment of Jacob Paschal to the Tri-County Behavioral Healthcare Board of Trustees for a two-year term.**
SECOND: **Made by Commissioner White.**
VOTE: **Motion carried unanimously.**

19. Discuss and take action on accepting surplus materials from Trevway construction in the form of concrete lane barriers for Pct. 3.
Commissioner Daugette presented information.

MOTION: **Made by Commissioner Daugette to APPROVE as presented.**
SECOND: **Made by Commissioner Decker.**
VOTE: **Motion carried unanimously.**

20. Discuss and take action on purchase of a single axle dump truck for Pct. 3 from auction or private seller in an amount not to exceed $50,000.
Commissioner Daugette presented information.

MOTION: **Made by Commissioner Daugette to APPROVE purchase of a single axle dump truck for Pct. 3 from auction or private seller in an amount not to exceed $50,000.**
SECOND: **Made by Commissioner White.**
VOTE: **Motion carried unanimously.**

21. Discuss and take action on obtaining a temporary easement from Anthony and Leann Hildebrandt at the bridge on Roy Webb Rd in Pct. 3 for the purpose of protecting the road and bridge from erosion.
Commissioner Daugette presented information.

MOTION: **Made by Commissioner Daugette to APPROVE obtaining a temporary easement from Anthony and Leann Hildebrandt at the bridge on Roy Webb Rd in Pct. 3 for the purpose of protecting the road and bridge from erosion.**
SECOND: **Made by Commissioner White.**
VOTE: **Motion carried unanimously.**

22. Discuss and take action on accepting donation of concrete dividers from the contractor building Highland Bridge located in Pct. 3.

ACTION: **PASS at this time.**

Planning and Development

23. Public hearing concerning Plat # 2024-007, Replat of Lot(s) 2, 3 and 4, Section 3 of Sam Houston Forest Estates Subdivision, George Robinson Survey, A-454 – Magnolia Drive – Pct. 4.

ACTION: **Public Hearing opened at 9:47 a.m.**
Andy Isbell presented information.
ACTION: **Public Hearing closed at 9:48 a.m.**

24. Discuss and take action on Plat # 2024-007, Replat of Lot(s) 2, 3 and 4, Section 3 of Sam Houston Forest Estates Subdivision, George Robinson Survey, A-454 – Magnolia Drive – Pct. 4.
Andy Isbell presented information.

MOTION: **Made by Commissioner Decker to APPROVE Plat # 2024-007.**
SECOND: **Made by Commissioner Daugette.**
VOTE: **Motion carried unanimously.**

25. Discuss and take action on Ray Twardeski request for variance to Section(s) 4.23 and B4.1 of the Walker County Subdivision Regulations regarding minimum right of way width and lot lines for Plat # 2024-006, Replat of Lot(s) 3A and 4A of the Horace N. Lewis, Jr. 50.54 Acre Tract, William Roark League, A-41 - FM 1696 W – Pct. 1.
Andy Isbell presented information.

MOTION: **Made by Commissioner Kuykendall to APPROVE the Twardeski request for variance to Section(s) 4.23 and B4.1 of the Walker County Subdivision Regulations regarding minimum right of way width and lot lines for Plat # 2024-006. Motion includes that it will not be dedicated.**
SECOND: **Made by Commissioner White.**
VOTE: **Motion carried unanimously.**

33. Workshop to discuss Section 3.36 of the Walker County Subdivision Regulations regarding TCEQ groundwater certification requirement for subdivision of land in Walker County.

ACTION: **Workshop opened at 10:05 a.m.**
Andy Isbell presented information. Mike Namken also spoke regarding new changes effective January 1, 2024, with the ground water survey and rules and regulations. There was discussion with the Court.

ACTION: **Workshop closed at 10:17 a.m.**

ACTION: *County Judge, Colt Christian adjourned the meeting at 10:22 a.m.*

I, Kari A. French, County Clerk of Walker County, Texas, do hereby certify that these Commissioners Court Minutes are a true and correct record of the proceedings from the Meeting on June 17, 2024.

Kari A French 7/19/24

Walker County Clerk, Kari A. French **Walker County Judge, Colt Christian**

Date Minutes Approved by Commissioners Court

COMMISSIONERS COURT * WALKER COUNTY, TEXAS *

FILED FOR RECORD
At 9:05 o'clock a M

JUL 01 2024

KARI FRENCH, COUNTY CLERK
WALKER COUNTY, TEXAS
By K French Deputy

ADMINISTERING THE OATH OF OFFICE

Please raise your right hand and repeat after me…

I, STATE YOUR NAME,

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.

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.

Agenda Item: Approve November 2024 Financial Statements **Committee:** Business	**Board Meeting Date** January 30, 2025
Background Information: None	
Supporting Documentation: November 2024 Financial Statements	
Recommended Action: **Approve November 2024 Financial Statements**	

November 2024 Financial Summary

Revenues for November 2024 were $4,223,389 and operating expenses were $4,161,533 resulting in a gain in operations of $71,856. Capital Expenditures and Extraordinary Expenses for November were $150,263 resulting in a loss of $78,406. Total revenues were 97.79% of the monthly budgeted revenues and total expenses were 99.81% of the monthly budgeted expenses (difference of -2.02%).

Year to date revenues are $11,516,940 and operating expenses are $11,135,325 leaving excess operating revenues of $381,615. YTD Capital Expenditures and Extraordinary Expenses are $443,691 resulting in a loss YTD of $62,076. Total revenues are 97.70% of the YTD budgeted revenues and total expenses are 98.50% of the YTD budgeted expenses (difference of -.80%).

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 – MH	116,081	166,219	69.84%	50,137
Title XIX Case Management – IDD	317,556	370,388	85.74%	52,831
Directed Payment Program – DPP	479,449	550,016	87.17%	70,567
Title XIX – Medicaid Regular	115,989	145,297	79.83%	29,308
Title XIX – Rehab	437,762	490,730	89.21%	52,969

Title XIX Case Management MH and Title XIX Case Management IDD – These are two of our two earned revenue categories that continue to be below the projected budget for this fiscal year. We do still have vacancies, and do not expect to see these positions to be filled until after the holiday season.

Directed Payment Program (DPP) – This is the Directed Payment Program for the Behavioral Health Services. The DPP program in the past was made up of two components, but for this fiscal year they have changed to a process of modeling based on FY 2023 services provided for Medicaid enrollment in Star, Star+Plus, and STARKIDS and will be variable as they continue to work through the issues created from Medicaid unwinding. This line is going to need to be adjusted in a budget

revision coming soon to match their modeling which came out in September after the budget year started.

Medicaid – Regular – This line item is for Medicaid Card (physician and therapy) Services. We continue to have variances in historical trends for all Medicaid lines, some of which is based on the Medicaid unwinding and client's coverage changes. We will continue to monitor and will have to adjust this line during the first budget revision.

Title XIX Rehab – This line item is where we have the most staff vacancies that provide direct services to our clients. The variances with the budgeted amounts are less than in the past years due to conservative budgeting. We still see some improvement this year as compared to last year through the first three months, with an increase of 10% for the same time period last year.

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
Building Repairs & Maintenance	92,081	56,709	162.37%	35,372
Fixed Assets – Construction in Progress	22,339	0	0%	22,339
Payroll Fringe – Health	459,141	433,660	105.87%	25,481
Payroll Fringe – Retirement	594,282	574,960	103.36%	19,322

Building Repairs and Maintenance – This line item continues to have increases of building repairs mainly at the PETC and the Conroe facility. Most of these expenses have been reported at prior board meetings such as the PETC blowers and compressors being replaced, the Conroe facility having plumbing repairs and pressure tank replacement and Porter having to install a French Drain to improve the drainage around the front of the building during the heavy rains. One of the challenges in this area is that cost of the repairs continues to increase. We hope these will slow down now for a few months and fall back in line with the proposed budget.

Fixed Assets – Construction in Progress – This line item has costs associated with the generator for the Cleveland facility. We anticipate that these expenses may be able to be reimbursed with the contingency funds that are available in the Cleveland financing calculations.

Payroll Fringe – Health and Retirement – These two lines in our employee fringe category have been trending up the first three months of this fiscal year. We have seen a higher number of new employees enroll in our Health insurance than we have estimated, as compared to prior years data. We have also seen an increase in the number of employees are contributing to their retirement and therefore taking advantage of the employer match.

TRI-COUNTY BEHAVIORAL HEALTHCARE
GENERAL FUND BALANCE SHEET
For the Month Ended November 2024

ASSETS	GENERAL FUND November 2024	GENERAL FUND October 2024	Increase (Decrease)
CURRENT ASSETS			
Imprest Cash Funds	2,412	2,412	-
Cash on Deposit - General Fund	8,519,078	11,487,826	(2,968,748)
Accounts Receivable	6,031,671	5,337,396	694,275
Inventory	321	613	(292)
TOTAL CURRENT ASSETS	14,553,482	16,828,247	(2,274,765)
FIXED ASSETS	23,982,540	23,982,540	-
OTHER ASSETS	256,984	221,945	35,039
TOTAL ASSETS	**$ 38,793,006**	**$ 41,032,732**	**$ (2,239,726)**
LIABILITIES, DEFERRED REVENUE, FUND BALANCES			
CURRENT LIABILITIES	1,450,108	1,720,577	(270,469)
NOTES PAYABLE	785,852	785,852	-
DEFERRED REVENUE	5,718,530	7,590,362	(1,871,832)
LONG-TERM LIABILITIES FOR			
First Financial Conroe Building Loan	9,003,492	9,049,000	(45,508)
Guaranty Bank & Trust Loan	1,644,492	1,650,402	(5,910)
First Financial Huntsville Land Loan	780,318	783,344	(3,026)
Lease Liability	352,281	352,281	-
SBITA Liability	1,308,818	1,308,818	-
EXCESS(DEFICIENCY) OF REVENUES OVER EXPENSES FOR			
General Fund	(62,076)	16,330	(78,406)
Debt Service Fund			
Capital Projects Fund			
FUND EQUITY			
RESTRICTED			
Net Assets Reserved for Debt Service	(11,780,584)	(11,835,027)	54,443
Reserved for Debt Retirement			-
COMMITTED			
Net Assets - Property and Equipment	22,673,722	22,673,722	-
Reserved for Vehicles & Equipment Replacement	613,712	613,712	-
Reserved for Facility Improvement & Acquisitions	2,500,000	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	274,409	274,409	-
Reserved for Current Year Budgeted Reserve	92,498	86,332	6,166
Reserved for Insurance Deductibles	100,000	100,000	-
Reserved for Accrued Paid Time Off	(785,852)	(785,852)	-
UNASSIGNED			
Unrestricted and Undesignated	2,120,609	2,145,793	(25,184)
TOTAL LIABILITIES/FUND BALANCE	**$ 38,793,006**	**$ 41,032,732**	**$ (2,239,729)**

TRI-COUNTY BEHAVIORAL HEALTHCARE
CONSOLIDATED BALANCE SHEET
For the Month Ended November 2024

ASSETS	General Operating Fund	Debt Service Fund	Capital Projects Fund	Government Wide 2024	Memorandum Only Final August 2023
CURRENT ASSETS					
Imprest Cash Funds	2,412			2,412	2,100
Cash on Deposit - General Fund	8,519,078			8,519,078	7,455,394
Bond Reserve 2024		362,027		362,027	
Bond Fund 2024		341,983		341,983	-
Bank of New York - Capital Project Fund			7,030,206	7,030,206	
Accounts Receivable	6,031,671			6,031,671	4,917,356
Inventory	321			321	1,205
TOTAL CURRENT ASSETS	14,553,482	704,010	7,030,206	22,287,698	12,376,055
FIXED ASSETS	23,982,540			23,982,540	24,400,583
OTHER ASSETS	256,984			256,984	223,016
Bond 2024 - Amount to retire bond			11,535,925	11,535,925	
Bond Discount 2024			384,075	384,075	-
Total Assets	**$ 38,793,006**	**$ 704,010**	**$ 18,950,206**	**$ 58,447,221**	**$ 36,999,654**
LIABILITIES, DEFERRED REVENUE, FUND BALANCES					
CURRENT LIABILITIES	1,450,108			1,450,108	2,165,154
BOND LIABILITIES			11,920,000	11,920,000	
NOTES PAYABLE	785,852			785,852	802,466
DEFERRED REVENUE	5,718,530			5,718,530	407,578
LONG-TERM LIABILITIES FOR					
First Financial Conroe Building Loan	9,003,492			9,003,492	9,679,420
Guaranty Bank & Trust Loan	1,644,492			1,644,492	1,732,496
First Financial Huntsville Land Loan	780,318			780,318	828,926
Lease Liability	352,281			352,281	352,281
SBITA Liability	1,308,818			1,308,818	1,308,818
EXCESS(DEFICIENCY) OF REVENUES OVER EXPENSES FOR					
General Fund	(62,076)			(62,076)	129,506
Debt Service Fund				-	
Capital Projects Fund				-	
FUND EQUITY					
RESTRICTED					
Net Assets Reserved for Debt Service - Restricted	(11,780,584)			(11,780,584)	(12,593,123)
Cleveland New Build - Bond	-	704,010	7,030,206	7,734,216	-
Reserved for Debt Retirement					
COMMITTED					-
Net Assets - Property and Equipment - Committed	22,673,722			22,673,722	23,091,764
Reserved for Vehicles & Equipment Replacement	613,712			613,712	613,712
Reserved for Facility Improvement & Acquisitions	2,500,000			2,500,000	2,500,000
Reserved for Board Initiatives	1,500,000			1,500,000	1,500,000
Reserved for 1115 Waiver Programs	502,677			502,677	502,677
ASSIGNED					-
Reserved for Workers' Compensation - Assigned	274,409			274,409	274,409
Reserved for Current Year Budgeted Reserve - Assigned	92,498			92,498	-
Reserved for Insurance Deductibles - Assigned	100,000			100,000	100,000
Reserved for Accrued Paid Time Off	(785,852)			(785,852)	(802,466)
UNASSIGNED					
Unrestricted and Undesignated	2,120,609	-	-	2,120,609	4,406,035
TOTAL LIABILITIES/FUND BALANCE	**$ 38,793,006**	**$ 704,010**	**$ 18,950,206**	**$ 58,447,221**	**$ 36,999,654**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
For the Month Ended November 2024
and Year To Date as of November 2024

INCOME:	MONTH OF November 2024	YTD November 2024
Local Revenue Sources	110,875	305,829
Earned Income	2,199,177	6,185,690
General Revenue - Contract	1,923,337	5,025,421
TOTAL INCOME	**$ 4,233,389**	**$ 11,516,940**
EXPENSES:		
Salaries	2,518,196	6,553,351
Employee Benefits	437,649	1,208,243
Medication Expense	44,194	136,548
Travel - Board/Staff	37,034	112,257
Building Rent/Maintenance	28,456	103,183
Consultants/Contracts	857,380	2,293,532
Other Operating Expenses	238,624	728,211
TOTAL EXPENSES	**$ 4,161,533**	**$ 11,135,325**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 71,856**	**$ 381,615**
CAPITAL EXPENDITURES		
Capital Outlay - FF&E, Automobiles, Building	21,724	58,073
Capital Outlay - Debt Service	128,539	385,618
TOTAL CAPITAL EXPENDITURES	**$ 150,263**	**$ 443,691**
GRAND TOTAL EXPENDITURES	**$ 4,311,796**	**$ 11,579,016**
Excess (Deficiency) of Revenues and Expenses	**$ (78,406)**	**$ (62,076)**

Debt Service and Fixed Asset Fund:		
Debt Service	128,539	385,618
Excess (Deficiency) of Revenues over Expenses	**128,539**	**385,618**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
Compared to Budget
Year to Date as of November 2024

	YTD November 2024	APPROVED BUDGET	Increase (Decrease)
INCOME:			
Local Revenue Sources	305,829	270,372	35,457
Earned Income	6,185,690	6,474,870	(289,180)
General Revenue	5,025,421	5,043,421	(18,000)
TOTAL INCOME	**$ 11,516,940**	**$ 11,788,663**	**$ (271,723)**
EXPENSES:			
Salaries	6,553,351	6,725,233	(171,882)
Employee Benefits	1,208,243	1,165,703	42,540
Medication Expense	136,548	144,558	(8,010)
Travel - Board/Staff	112,257	99,217	13,040
Building Rent/Maintenance	103,183	72,951	30,232
Consultants/Contracts	2,293,532	2,328,594	(35,062)
Other Operating Expenses	728,211	799,480	(71,269)
TOTAL EXPENSES	**$ 11,135,325**	**$ 11,335,736**	**$ (200,411)**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 381,615**	**$ 452,927**	**$ (71,312)**
CAPITAL EXPENDITURES			
Capital Outlay - FF&E, Automobiles, Building	58,073	34,001	24,071
Capital Outlay - Debt Service	385,618	385,619	(1)
TOTAL CAPITAL EXPENDITURES	**$ 443,691**	**$ 419,620**	**$ 24,070**
GRAND TOTAL EXPENDITURES	**$ 11,579,016**	**$ 11,755,356**	**$ (176,341)**
Excess (Deficiency) of Revenues and Expenses	**$ (62,076)**	**$ 33,307**	**$ (95,383)**

Debt Service and Fixed Asset Fund:			
Debt Service	385,618	385,619	**(1)**
Excess(Deficiency) of Revenues over Expenses	**385,618**	**385,619**	**(1)**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
Compared to Budget
For the Month Ended November 2024

INCOME:	MONTH OF November 2024	APPROVED BUDGET	Increase (Decrease)
Local Revenue Sources	110,875	107,222	3,653
Earned Income	2,199,177	2,316,832	(117,655)
General Revenue-Contract	1,923,337	1,904,992	18,345
TOTAL INCOME	**$ 4,233,389**	**$ 4,329,046**	**$ (95,657)**
EXPENSES:			
Salaries	2,518,196	2,580,544	(62,348)
Employee Benefits	437,649	414,004	23,645
Medication Expense	44,194	48,186	(3,992)
Travel - Board/Staff	37,034	33,070	3,964
Building Rent/Maintenance	28,456	24,317	4,139
Consultants/Contracts	857,380	848,600	8,780
Other Operating Expenses	238,624	242,079	(3,455)
TOTAL EXPENSES	**$ 4,161,533**	**$ 4,190,800**	**$ (29,267)**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 71,856**	**$ 138,246**	**$ (66,390)**
CAPITAL EXPENDITURES			
Capital Outlay - FF&E, Automobiles, Building	21,724	667	21,056
Capital Outlay - Debt Service	128,539	128,539	-
TOTAL CAPITAL EXPENDITURES	**$ 150,263**	**$ 129,206**	**$ 21,056**
GRAND TOTAL EXPENDITURES	**$ 4,311,796**	**$ 4,320,006**	**$ (8,210)**
Excess (Deficiency) of Revenues and Expenses	**$ (78,407)**	**$ 9,039**	**$ (87,446)**
Debt Service and Fixed Asset Fund:			
Debt Service	128,539	128,539	-
Excess (Deficiency) of Revenues over Expenses	**128,539**	**128,539**	**-**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
With YTD November 2023 Comparative Data
Year to Date as of November 2024

INCOME:	YTD November 2024	YTD November 2023	Increase (Decrease)
Local Revenue Sources	305,829	649,690	(343,861)
Earned Income	6,185,690	6,283,283	(97,593)
General Revenue-Contract	5,025,421	5,208,809	(183,388)
TOTAL INCOME	**$ 11,516,940**	**$ 12,141,782**	**$ (624,842)**
EXPENSES:			
Salaries	6,553,351	6,597,511	(44,160)
Employee Benefits	1,208,243	1,181,497	26,746
Medication Expense	136,548	142,731	(6,183)
Travel - Board/Staff	112,257	111,406	851
Building Rent/Maintenance	103,183	167,273	(64,090)
Consultants/Contracts	2,293,532	2,585,540	(292,008)
Other Operating Expenses	728,211	836,113	(107,902)
TOTAL EXPENSES	**$ 11,135,325**	**$ 11,622,071**	**$ (486,746)**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 381,615**	**$ 519,711**	**$ (138,096)**
CAPITAL EXPENDITURES			
Capital Outlay - FF&E, Automobiles, Building	58,073	387,386	(329,313)
Capital Outlay - Debt Service	385,618	261,094	124,524
TOTAL CAPITAL EXPENDITURES	**$ 443,691**	**$ 648,480**	**$ (204,789)**
GRAND TOTAL EXPENDITURES	**$ 11,579,016**	**$ 12,270,551**	**$ (691,535)**
Excess (Deficiency) of Revenues and Expenses	**$ (62,076)**	**$ (128,769)**	**$ 66,693**

Debt Service and Fixed Asset Fund:			
Debt Service	385,618	261,094	124,524
			-
Excess (Deficiency) of Revenues over Expenses	**385,618**	**261,094**	**124,524**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
With November 2023 Comparative Data
For the Month ending November 2024

INCOME:	MONTH OF November 2024	MONTH OF November 2023	Increase (Decrease)
Local Revenue Sources	110,875	338,857	(227,982)
Earned Income	2,199,177	1,930,224	268,953
General Revenue-Contract	1,923,337	1,729,777	193,560
TOTAL INCOME	**$ 4,233,389**	**$ 3,998,858**	**$ 234,531**
Salaries	2,518,196	2,031,116	487,080
Employee Benefits	437,649	377,528	60,121
Medication Expense	44,194	47,948	(3,754)
Travel - Board/Staff	37,034	37,292	(258)
Building Rent/Maintenance	28,456	113,107	(84,651)
Consultants/Contracts	857,380	881,664	(24,284)
Other Operating Expenses	238,624	260,474	(21,850)
TOTAL EXPENSES	**$ 4,161,533**	**$ 3,749,130**	**$ 412,404**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 71,856**	**$ 249,728**	**$ (177,873)**
CAPITAL EXPENDITURES			
Capital Outlay - FF&E, Automobiles, Building	21,724	242,270	(220,546)
Capital Outlay - Debt Service	128,539	87,031	41,508
TOTAL CAPITAL EXPENDITURES	**$ 150,263**	**$ 329,301**	**$ (179,038)**
GRAND TOTAL EXPENDITURES	**$ 4,311,796**	**$ 4,078,431**	**$ 233,365**
Excess (Deficiency) of Revenues and Expenses	**$ (78,407)**	**$ (79,574)**	**$ 1,165**

Debt Service and Fixed Asset Fund:			
Debt Service	128,539	87,031	41,508
			-
Excess (Deficiency) of Revenues over Expenses	**128,539**	**87,031**	**41,508**

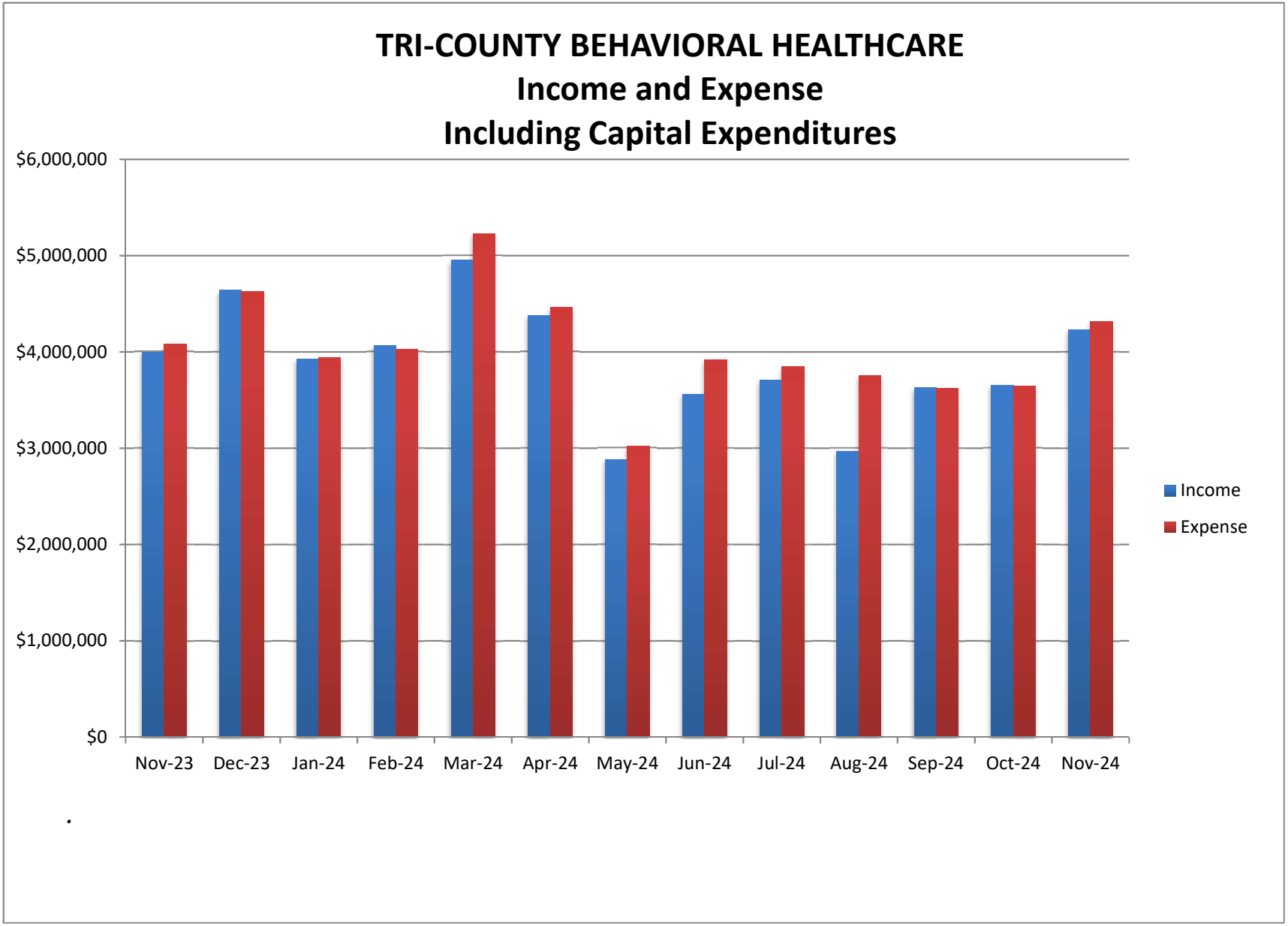
TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
With October 2024 Comparative Data
For the Month Ended November 2024

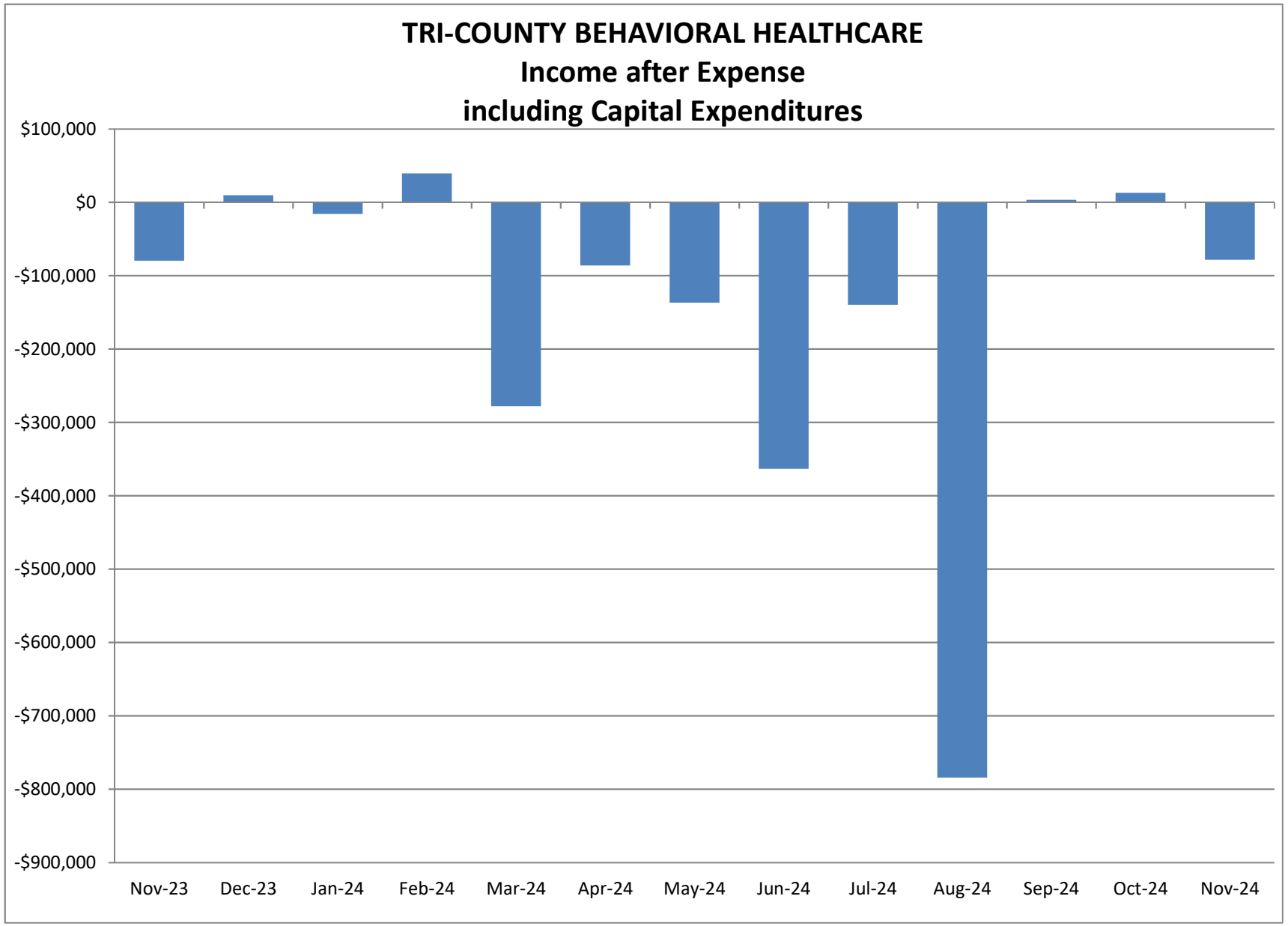
INCOME:	**MONTH OF November 2024**	**MONTH OF October 2024**	**Increase (Decrease)**
Local Revenue Sources	110,875	80,268	30,607
Earned Income	2,199,177	2,062,735	136,442
General Revenue-Contract	1,923,337	1,513,098	410,239
TOTAL INCOME	**$ 4,233,389**	**$ 3,656,101**	**$ 577,288**
EXPENSES:			
Salaries	2,518,196	2,015,852	502,344
Employee Benefits	437,649	383,586	54,063
Medication Expense	44,194	44,670	(476)
Travel - Board/Staff	37,034	43,283	(6,249)
Building Rent/Maintenance	28,456	55,920	(27,464)
Consultants/Contracts	857,380	705,324	152,056
Other Operating Expenses	238,624	254,829	(16,205)
TOTAL EXPENSES	**$ 4,161,533**	**$ 3,503,465**	**$ 658,069**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 71,856**	**$ 152,636**	**$ (80,781)**
CAPITAL EXPENDITURES			
Capital Outlay - FF&E, Automobiles, Building	21,724	11,055	10,669
Capital Outlay - Debt Service	128,539	128,539	-
TOTAL CAPITAL EXPENDITURES	**$ 150,263**	**$ 139,594**	**$ 10,669**
GRAND TOTAL EXPENDITURES	**$ 4,311,796**	**$ 3,643,059**	**$ 668,737**
Excess (Deficiency) of Revenues and Expenses	**$ (78,407)**	**$ 13,042**	**$ (91,450)**

Debt Service and Fixed Asset Fund:			
Debt Service	128,539	128,539	-
Excess (Deficiency) of Revenues over Expenses	**128,539**	**128,539**	**-**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary by Service Type
Compared to Budget
Year To Date as of November 2024

INCOME:	YTD Mental Health November 2024	YTD IDD November 2024	YTD Other Services November 2024	YTD Agency Total November 2024	YTD Approved Budget November 2024	Increase (Decrease)
Local Revenue Sources	287,084	(25,002)	43,746	305,828	270,372	35,456
Earned Income	2,367,951	1,083,202	2,734,537	6,185,690	6,474,870	(289,180)
General Revenue-Contract	4,451,235	365,707	208,479	5,025,421	5,043,422	(18,000)
TOTAL INCOME	**$ 7,106,270**	**$ 1,423,907**	**$ 2,986,762**	**$ 11,516,940**	**$ 11,788,663**	**$ (271,723)**
EXPENSES:						
Salaries	4,276,938	894,151	1,382,262	6,553,351	6,725,233	(171,882)
Employee Benefits	793,101	182,443	232,699	1,208,243	1,165,703	42,540
Medication Expense	116,011		20,537	136,548	144,558	(8,010)
Travel - Board/Staff	65,053	30,851	16,353	112,256	99,217	13,039
Building Rent/Maintenance	101,140	845	1,197	103,182	72,951	30,231
Consultants/Contracts	838,466	308,373	1,146,694	2,293,533	2,328,594	(35,061)
Other Operating Expenses	461,333	132,776	134,102	728,211	799,480	(71,270)
TOTAL EXPENSES	**$ 6,652,042**	**$ 1,549,439**	**$ 2,933,844**	**$ 11,135,324**	**$ 11,335,736**	**$ (200,411)**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 454,228**	**$ (125,532)**	**$ 52,918**	**$ 381,616**	**$ 452,927**	**$ (71,312)**
CAPITAL EXPENDITURES						
Capital Outlay - FF&E, Automobiles, Building	26,778	7,281	24,013	58,073	34,001	24,072
Capital Outlay - Debt Service	154,046	36,553	195,020	385,618	385,618	-
TOTAL CAPITAL EXPENDITURES	**$ 180,824**	**$ 43,834**	**$ 219,033**	**$ 443,691**	**$ 419,619**	**$ 24,072**
GRAND TOTAL EXPENDITURES	**$ 6,832,866**	**$ 1,593,273**	**$ 3,152,877**	**$ 11,579,015**	**$ 11,755,355**	**$ (176,339)**
Excess (Deficiency) of Revenues and Expenses	**$ 273,404**	**$ (169,366)**	**$ (166,115)**	**$ (62,075)**	**$ 33,308**	**$ (95,384)**
Debt Service and Fixed Asset Fund:						
Debt Service	180,824	43,834	219,033	443,691	419,619	24,072
		-	-	-		-
Excess (Deficiency) of Revenues over Expenses	**$ 180,824**	**$ 43,834**	**$ 219,033**	**$ 443,691**	**$ 419,619**	**$ 24,072**


TRI-COUNTY BEHAVIORAL HEALTHCARE
Income and Expense
Including Capital Expenditures
$6,000,000
$5,000,000
$4,000,000
$3,000,000
$2,000,000
$1,000,000
$0
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Income
Expense


TRI-COUNTY BEHAVIORAL HEALTHCARE
Income after Expense
including Capital Expenditures
$100,000
$0
-$100,000
-$200,000
-$300,000
-$400,000
-$500,000
-$600,000
-$700,000
-$800,000
-$900,000
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24

Agenda Item: Approve December 2024 Financial Statements **Committee:** Business	**Board Meeting Date** January 30, 2025
Background Information: None	
Supporting Documentation: December 2024 Financial Statements	
Recommended Action: **Approve December 2024 Financial Statements**	

December 2024 Financial Summary

Revenues for December 2024 were $3,440,980 and operating expenses were $3,343,574 resulting in a gain in operations of $97,406. Capital Expenditures and Extraordinary Expenses for December were $128,539 resulting in a loss of $31,134. Total revenues were 98.70% of the monthly budgeted revenues and total expenses were 100.01% of the monthly budgeted expenses (difference of -1.31%).

Year to date revenues are $14,957,920 and operating expenses are $14,478,899 leaving excess operating revenues of $479,021. YTD Capital Expenditures and Extraordinary Expenses are $572,231 resulting in a loss YTD of $93,210. Total revenues are 98.05% of the YTD budgeted revenues and total expenses are 98.97% of the YTD budgeted expenses (difference of -.92%).

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 – MH	148,127	219,838	67.38%	71,711
Title XIX Case Management – IDD	412,429	489,868	84.19%	77,439
Directed Payment Program – DPP	626,399	734,032	85.34%	107,633
Title XIX – Medicaid Regular	122,377	192,168	63.68%	69,791
Title XIX – Rehab	573,193	649,031	88.31%	75,837

Title XIX Case Management MH and Title XIX Case Management IDD – These lines are two of the earned revenue categories that continue to be below our budgeted amounts for this fiscal year. We continue to have vacancies in these program areas that are required to hire the QMHP level of direct care providers. Case Management IDD is coming in 5% higher in providing services compared to this same time period last year, but Case Management MH is 20% less as compared to the same time period last fiscal year. Now that we are through the holiday months, we hope to see improvement in the revenue in the coming months.

Directed Payment Program (DPP) – This line item is the Directed Payment Program for Behavioral Health Services. The DPP program in the past was made up of two component parts, but for this fiscal year they have gone to a process of modeling based on the FY 2023 services provided for Medicaid enrollment in STAR, STAR+Plus, and STARKIDS and will continue to have variances as they work through the issues created from Medicaid unwinding and kids who have lost Medicaid coverage. This line is going to need to be adjusted in the budget revision that should be coming to the Board at the March meeting.

Medicaid – Regular – This line item is for Medicaid Card (physician and therapy) Services. We continue to have variances in historical trends for all Medicaid lines, some of which is based on the Medicaid unwinding and client's coverage changes. We will continue to monitor and will have to adjust this line during the first budget revision.

Rehab - Title XIX –This line item is where we have the most staff vacancies that provide direct services to our clients. The positive news is the amount of revenue earned for Rehab services for the first four months this fiscal year as compared to last fiscal year is up by 19%. This is a good trend to watch and with the holidays being over we should continue to see revenues improve.

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
Building Repairs & Maintenance	95,278	75,612	126.00%	19,666
Fixed Assets – Construction in Progress	22,339	0	0%	22,339
Payroll Fringe – Health	610,171	572,558	106.57%	37,612
Payroll Fringe – Retirement	779,519	752,312	103.62%	27,206

Building Repairs and Maintenance – As we have talked about in the narrative since the beginning of the fiscal year, we have had many different repairs that have been at the Conroe facility and the PETC as well as the Porter location. Some of these repairs were caused by weather and drainage issues, but most of the expenses have been related to A/C repairs and some plumbing problems. One of the challenges

in this area is that cost of the repairs continues to increase. As we continue to work towards getting our earned revenue back to pre-COVID levels, we will have to also make it a priority to develop a building maintenance and replacement plan for the areas that continue to cause us to spend excessive amount of funds on repairs. This month we did have a slowdown of repairs.

Fixed Assets – Construction in Progress – This line item has costs associated with the generator for the Cleveland facility. We anticipate that these expenses may be able to be reimbursed with the contingency funds that are available in the Cleveland financing calculations.

Payroll Fringe – Health and Retirement – These two lines in our employee fringe category have been trending up the first three months of this fiscal year. We have seen a higher number of new employees enroll in our Health insurance than we have estimated, as compared to prior years data. We have also seen an increase in the number of employees are contributing to their retirement and therefore taking advantage of the employer match.

TRI-COUNTY BEHAVIORAL HEALTHCARE
GENERAL FUND BALANCE SHEET
For the Month Ended December 2024

ASSETS	GENERAL FUND December 2024	GENERAL FUND November 2024	Increase (Decrease)
CURRENT ASSETS			
Imprest Cash Funds	2,412	2,412	-
Cash on Deposit - General Fund	12,782,186	8,519,078	4,263,108
Accounts Receivable	6,063,616	6,031,671	31,945
Inventory	175	321	(146)
TOTAL CURRENT ASSETS	18,848,390	14,553,482	4,294,907
FIXED ASSETS	23,982,540	23,982,540	-
OTHER ASSETS	203,204	256,984	(53,780)
TOTAL ASSETS	**$ 43,034,134**	**$ 38,793,006**	**$ 4,241,127**
LIABILITIES, DEFERRED REVENUE, FUND BALANCES			
CURRENT LIABILITIES	1,358,813	1,450,108	(91,295)
NOTES PAYABLE	785,852	785,852	-
DEFERRED REVENUE	10,075,920	5,718,530	4,357,390
LONG-TERM LIABILITIES FOR			
First Financial Conroe Building Loan	8,957,056	9,003,492	(46,436)
Guaranty Bank & Trust Loan	1,638,423	1,644,492	(6,069)
First Financial Huntsville Land Loan	777,513	780,318	(2,805)
Lease Liability	352,281	352,281	-
SBITA Liability	1,308,818	1,308,818	-
EXCESS(DEFICIENCY) OF REVENUES OVER EXPENSES FOR			
General Fund	(93,210)	(62,076)	(31,134)
Debt Service Fund			
Capital Projects Fund			
FUND EQUITY			
RESTRICTED			
Net Assets Reserved for Debt Service	(11,725,273)	(11,780,584)	55,311
Reserved for Debt Retirement			-
COMMITTED			
Net Assets - Property and Equipment	22,673,722	22,673,722	-
Reserved for Vehicles & Equipment Replacement	613,712	613,712	-
Reserved for Facility Improvement & Acquisitions	2,500,000	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	274,409	274,409	-
Reserved for Current Year Budgeted Reserve	98,664	92,498	6,166
Reserved for Insurance Deductibles	100,000	100,000	-
Reserved for Accrued Paid Time Off	(785,852)	(785,852)	-
UNASSIGNED			
Unrestricted and Undesignated	2,120,609	2,120,609	-
TOTAL LIABILITIES/FUND BALANCE	**$ 43,034,134**	**$ 38,793,006**	**$ 4,241,125**

TRI-COUNTY BEHAVIORAL HEALTHCARE
CONSOLIDATED BALANCE SHEET
For the Month Ended December 2024

ASSETS	General Operating Fund	Debt Service Fund	Capital Projects Fund	Government Wide 2024	Memorandum Only Final August 2023
CURRENT ASSETS					
Imprest Cash Funds	2,412			2,412	2,100
Cash on Deposit - General Fund	12,782,186			12,782,186	7,455,394
Bond Reserve 2024		362,027		362,027	
Bond Fund 2024		341,983		341,983	-
Bank of New York - Capital Project Fund			7,030,206	7,030,206	
Accounts Receivable	6,063,616			6,063,616	4,917,356
Inventory	175			175	1,205
TOTAL CURRENT ASSETS	18,848,389	704,010	7,030,206	26,582,605	12,376,055
FIXED ASSETS	23,982,540			23,982,540	24,400,583
OTHER ASSETS	203,204			203,204	223,016
Bond 2024 - Amount to retire bond			11,535,925	11,535,925	
Bond Discount 2024			384,075	384,075	-
Total Assets	**$ 43,034,133**	**$ 704,010**	**$ 18,950,206**	**$ 62,688,348**	**$ 36,999,654**
LIABILITIES, DEFERRED REVENUE, FUND BALANCES					
CURRENT LIABILITIES	1,358,813			1,358,813	2,165,154
BOND LIABILITIES			11,920,000	11,920,000	
NOTES PAYABLE	785,852			785,852	802,466
DEFERRED REVENUE	10,075,920			10,075,920	407,578
LONG-TERM LIABILITIES FOR					
First Financial Conroe Building Loan	8,957,056			8,957,056	9,679,420
Guaranty Bank & Trust Loan	1,638,423			1,638,423	1,732,496
First Financial Huntsville Land Loan	777,513			777,513	828,926
Lease Liability	352,281			352,281	352,281
SBITA Liability	1,308,818			1,308,818	1,308,818
EXCESS(DEFICIENCY) OF REVENUES OVER EXPENSES FOR					
General Fund	(93,210)			(93,210)	129,506
Debt Service Fund				-	
Capital Projects Fund				-	
FUND EQUITY					
RESTRICTED					
Net Assets Reserved for Debt Service - Restricted	(11,725,273)			(11,725,273)	(12,593,123)
Cleveland New Build - Bond	-	704,010	7,030,206	7,734,216	-
Reserved for Debt Retirement					
COMMITTED					-
Net Assets - Property and Equipment - Committed	22,673,722			22,673,722	23,091,764
Reserved for Vehicles & Equipment Replacement	613,712			613,712	613,712
Reserved for Facility Improvement & Acquisitions	2,500,000			2,500,000	2,500,000
Reserved for Board Initiatives	1,500,000			1,500,000	1,500,000
Reserved for 1115 Waiver Programs	502,677			502,677	502,677
ASSIGNED					-
Reserved for Workers' Compensation - Assigned	274,409			274,409	274,409
Reserved for Current Year Budgeted Reserve - Assigned	98,664			98,664	-
Reserved for Insurance Deductibles - Assigned	100,000			100,000	100,000
Reserved for Accrued Paid Time Off	(785,852)			(785,852)	(802,466)
UNASSIGNED					
Unrestricted and Undesignated	2,120,609	-	-	2,120,609	4,406,035
TOTAL LIABILITIES/FUND BALANCE	**$ 43,034,134**	**$ 704,010**	**$ 18,950,206**	**$ 62,688,349**	**$ 36,999,654**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
For the Month Ended December 2024
and Year To Date as of December 2024

INCOME:	MONTH OF December 2024	YTD December 2024
Local Revenue Sources	189,070	494,899
Earned Income	1,641,738	7,827,428
General Revenue - Contract	1,610,172	6,635,593
TOTAL INCOME	**$ 3,440,980**	**$ 14,957,920**
EXPENSES:		
Salaries	2,049,069	8,602,420
Employee Benefits	390,049	1,598,292
Medication Expense	41,754	178,303
Travel - Board/Staff	35,479	147,736
Building Rent/Maintenance	7,145	110,328
Consultants/Contracts	598,633	2,892,165
Other Operating Expenses	221,445	949,655
TOTAL EXPENSES	**$ 3,343,574**	**$ 14,478,899**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 97,406**	**$ 479,021**
CAPITAL EXPENDITURES		
Capital Outlay - FF&E, Automobiles, Building	-	58,073
Capital Outlay - Debt Service	128,539	514,158
TOTAL CAPITAL EXPENDITURES	**$ 128,539**	**$ 572,231**
GRAND TOTAL EXPENDITURES	**$ 3,472,114**	**$ 15,051,130**
Excess (Deficiency) of Revenues and Expenses	**$ (31,134)**	**$ (93,210)**

Debt Service and Fixed Asset Fund:		
Debt Service	128,539	514,158
Excess (Deficiency) of Revenues over Expenses	**128,539**	**514,158**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
Compared to Budget
Year to Date as of December 2024

	YTD December 2024	APPROVED BUDGET	Increase (Decrease)
INCOME:			
Local Revenue Sources	494,899	424,752	70,147
Earned Income	7,827,428	8,193,619	(366,191)
General Revenue	6,635,593	6,637,748	(2,155)
TOTAL INCOME	**$ 14,957,920**	**$ 15,256,119**	**$ (298,199)**
EXPENSES:			
Salaries	8,602,420	8,768,098	(165,678)
Employee Benefits	1,598,292	1,530,059	68,233
Medication Expense	178,303	192,744	(14,441)
Travel - Board/Staff	147,736	138,287	9,449
Building Rent/Maintenance	110,328	97,268	13,060
Consultants/Contracts	2,892,165	2,911,305	(19,140)
Other Operating Expenses	949,655	1,020,648	(70,993)
TOTAL EXPENSES	**$ 14,478,899**	**$ 14,658,409**	**$ (179,510)**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 479,021**	**$ 597,710**	**$ (118,689)**
CAPITAL EXPENDITURES			
Capital Outlay - FF&E, Automobiles, Building	58,073	35,668	22,404
Capital Outlay - Debt Service	514,158	514,158	-
TOTAL CAPITAL EXPENDITURES	**$ 572,231**	**$ 549,826**	**$ 22,404**
GRAND TOTAL EXPENDITURES	**$ 15,051,130**	**$ 15,208,236**	**$ (157,106)**
Excess (Deficiency) of Revenues and Expenses	**$ (93,210)**	**$ 47,883**	**$ (141,093)**

Debt Service and Fixed Asset Fund:			
Debt Service	514,158	514,158	**-**
Excess(Deficiency) of Revenues over Expenses	**514,158**	**514,158**	**-**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
Compared to Budget
For the Month Ended December 2024

INCOME:	MONTH OF December 2024	APPROVED BUDGET	Increase (Decrease)
Local Revenue Sources	189,070	154,380	34,690
Earned Income	1,641,738	1,737,649	(95,911)
General Revenue-Contract	1,610,172	1,594,327	15,845
TOTAL INCOME	**$ 3,440,980**	**$ 3,486,356**	**$ (45,376)**
EXPENSES:			
Salaries	2,049,069	2,042,865	6,204
Employee Benefits	390,049	364,356	25,693
Medication Expense	41,754	48,186	(6,432)
Travel - Board/Staff	35,479	39,070	(3,591)
Building Rent/Maintenance	7,145	24,317	(17,172)
Consultants/Contracts	598,633	601,611	(2,978)
Other Operating Expenses	221,445	221,168	277
TOTAL EXPENSES	**$ 3,343,574**	**$ 3,341,573**	**$ 2,001**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 97,406**	**$ 144,783**	**$ (47,377)**
CAPITAL EXPENDITURES			
Capital Outlay - FF&E, Automobiles, Building	-	1,667	(1,668)
Capital Outlay - Debt Service	128,539	128,539	-
TOTAL CAPITAL EXPENDITURES	**$ 128,539**	**$ 130,206**	**$ (1,668)**
GRAND TOTAL EXPENDITURES	**$ 3,472,114**	**$ 3,471,780**	**$ 334**
Excess (Deficiency) of Revenues and Expenses	**$ (31,134)**	**$ 14,576**	**$ (45,710)**
Debt Service and Fixed Asset Fund:			
Debt Service	128,539	128,539	-
Excess (Deficiency) of Revenues over Expenses	**128,539**	**128,539**	**-**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
With YTD December 2023 Comparative Data
Year to Date as of December 2024

INCOME:	YTD December 2024	YTD December 2023	Increase (Decrease)
Local Revenue Sources	494,899	826,072	(331,173)
Earned Income	7,827,428	8,573,498	(746,070)
General Revenue-Contract	6,635,593	7,382,220	(746,627)
TOTAL INCOME	**$ 14,957,920**	**$ 16,781,790**	**$ (1,823,870)**
EXPENSES:			
Salaries	8,602,420	9,306,465	(704,045)
Employee Benefits	1,598,292	1,643,722	(45,430)
Medication Expense	178,303	184,803	(6,500)
Travel - Board/Staff	147,736	145,082	2,654
Building Rent/Maintenance	110,328	205,336	(95,008)
Consultants/Contracts	2,892,165	3,394,320	(502,155)
Other Operating Expenses	949,655	1,149,203	(199,548)
TOTAL EXPENSES	**$ 14,478,899**	**$ 16,028,932**	**$ (1,550,032)**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 479,021**	**$ 752,858**	**$ (273,838)**
CAPITAL EXPENDITURES			
Capital Outlay - FF&E, Automobiles, Building	58,073	523,899	(465,826)
Capital Outlay - Debt Service	514,158	348,126	166,032
TOTAL CAPITAL EXPENDITURES	**$ 572,231**	**$ 872,025**	**$ (299,794)**
GRAND TOTAL EXPENDITURES	**$ 15,051,130**	**$ 16,900,957**	**$ (1,849,827)**
Excess (Deficiency) of Revenues and Expenses	**$ (93,210)**	**$ (119,166)**	**$ 25,956**

Debt Service and Fixed Asset Fund:			
Debt Service	514,158	348,126	166,032
Excess (Deficiency) of Revenues over Expenses	**514,158**	**348,126**	**166,032**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
With December 2023 Comparative Data
For the Month ending December 2024

INCOME:	MONTH OF December 2024	MONTH OF December 2023	Increase (Decrease)
Local Revenue Sources	189,070	176,382	12,688
Earned Income	1,641,738	2,290,214	(648,476)
General Revenue-Contract	1,610,172	2,173,411	(563,239)
TOTAL INCOME	**$ 3,440,980**	**$ 4,640,007**	**$ (1,199,027)**
Salaries	2,049,069	2,708,954	(659,885)
Employee Benefits	390,049	462,225	(72,176)
Medication Expense	41,754	42,072	(318)
Travel - Board/Staff	35,479	33,676	1,803
Building Rent/Maintenance	7,145	38,063	(30,918)
Consultants/Contracts	598,633	808,779	(210,146)
Other Operating Expenses	221,445	313,090	(91,645)
TOTAL EXPENSES	**$ 3,343,574**	**$ 4,406,860**	**$ (1,063,285)**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 97,406**	**$ 233,147**	**$ (135,742)**
CAPITAL EXPENDITURES			
Capital Outlay - FF&E, Automobiles, Building	-	136,513	(136,513)
Capital Outlay - Debt Service	128,539	87,031	41,508
TOTAL CAPITAL EXPENDITURES	**$ 128,539**	**$ 223,544**	**$ (95,005)**
GRAND TOTAL EXPENDITURES	**$ 3,472,114**	**$ 4,630,404**	**$ (1,158,290)**
Excess (Deficiency) of Revenues and Expenses	**$ (31,134)**	**$ 9,602**	**$ (40,737)**

Debt Service and Fixed Asset Fund:			
Debt Service	128,539	87,031	41,508
Excess (Deficiency) of Revenues over Expenses	**128,539**	**87,031**	**41,508**

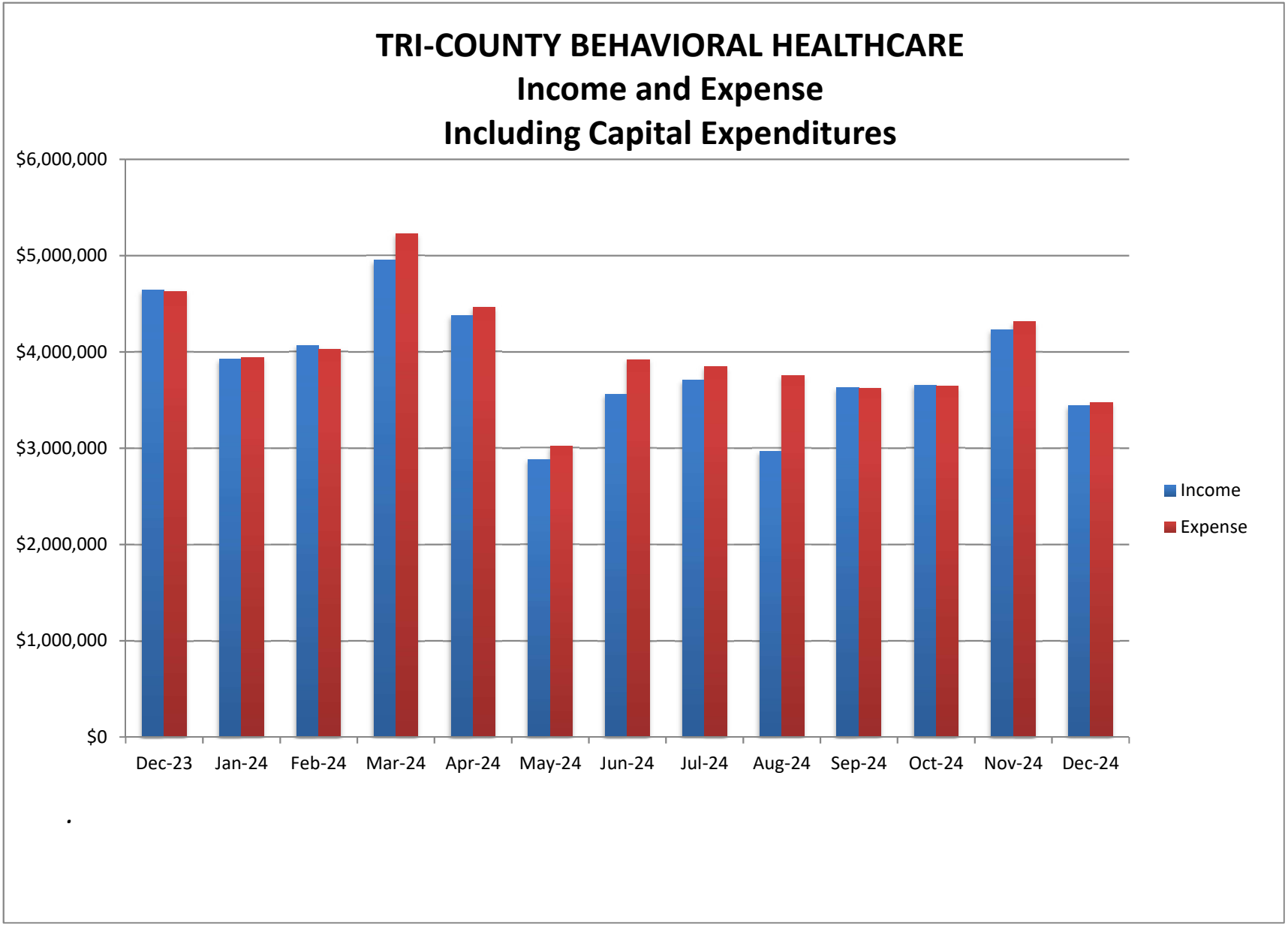
TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
With November 2024 Comparative Data
For the Month Ended December 2024

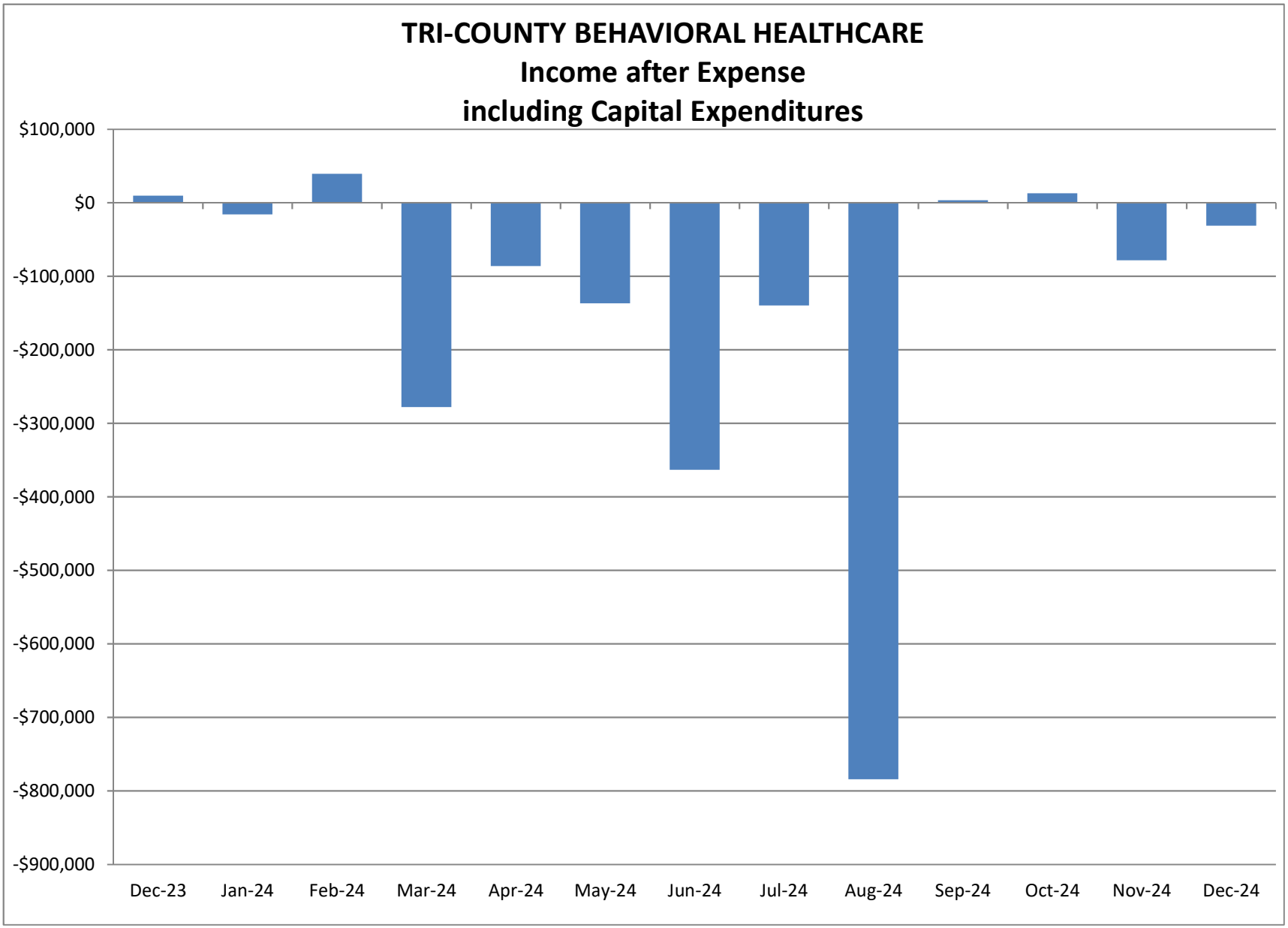
INCOME:	**MONTH OF December 2024**	**MONTH OF November 2024**	**Increase (Decrease)**
Local Revenue Sources	189,070	110,875	78,195
Earned Income	1,641,738	2,199,177	(557,439)
General Revenue-Contract	1,610,172	1,923,337	(313,165)
TOTAL INCOME	**$ 3,440,980**	**$ 4,233,389**	**$ (792,409)**
EXPENSES:			
Salaries	2,049,069	2,518,196	(469,127)
Employee Benefits	390,049	437,649	(47,600)
Medication Expense	41,754	44,194	(2,440)
Travel - Board/Staff	35,479	37,034	(1,555)
Building Rent/Maintenance	7,145	28,456	(21,311)
Consultants/Contracts	598,633	857,380	(258,747)
Other Operating Expenses	221,445	238,624	(17,179)
TOTAL EXPENSES	**$ 3,343,574**	**$ 4,161,533**	**$ (817,959)**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 97,406**	**$ 71,856**	**$ 25,550**
CAPITAL EXPENDITURES			
Capital Outlay - FF&E, Automobiles, Building	-	21,724	(21,724)
Capital Outlay - Debt Service	128,539	128,539	-
TOTAL CAPITAL EXPENDITURES	**$ 128,539**	**$ 150,263**	**$ (21,724)**
GRAND TOTAL EXPENDITURES	**$ 3,472,114**	**$ 4,311,796**	**$ (839,682)**
Excess (Deficiency) of Revenues and Expenses	**$ (31,134)**	**$ (78,407)**	**$ 47,274**

Debt Service and Fixed Asset Fund:			
Debt Service	128,539	128,539	-
Excess (Deficiency) of Revenues over Expenses	**128,539**	**128,539**	**-**

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary by Service Type
Compared to Budget
Year To Date as of December 2024

INCOME:	YTD Mental Health December 2024	YTD IDD December 2024	YTD Other Services December 2024	YTD Agency Total December 2024	YTD Approved Budget December 2024	Increase (Decrease)
Local Revenue Sources	426,800	(17,402)	85,500	494,898	424,752	70,146
Earned Income	3,050,572	1,437,599	3,339,258	7,827,429	8,193,619	(366,190)
General Revenue-Contract	5,903,878	474,129	257,586	6,635,593	6,637,748	(2,154)
TOTAL INCOME	**$ 9,381,250**	**$ 1,894,326**	**$ 3,682,344**	**$ 14,957,920**	**$ 15,256,119**	**$ (298,199)**
EXPENSES:						
Salaries	5,648,509	1,172,661	1,781,250	8,602,420	**8,768,098**	**(165,678)**
Employee Benefits	1,056,227	241,607	300,457	1,598,291	**1,530,059**	**68,232**
Medication Expense	151,783		26,520	178,303	**192,744**	**(14,441)**
Travel - Board/Staff	87,187	41,035	19,514	147,735	**138,287**	**9,448**
Building Rent/Maintenance	108,082	915	1,331	110,328	**97,268**	**13,060**
Consultants/Contracts	1,195,632	413,402	1,283,131	2,892,165	**2,911,305**	**(19,140)**
Other Operating Expenses	609,053	175,525	165,077	949,655	**1,020,648**	**(70,993)**
TOTAL EXPENSES	**$ 8,856,473**	**$ 2,045,145**	**$ 3,577,280**	**$ 14,478,898**	**$ 14,658,409**	**$ (179,510)**
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	**$ 524,777**	**$ (150,819)**	**$ 105,064**	**$ 479,022**	**$ 597,710**	**$ (118,689)**
CAPITAL EXPENDITURES						
Capital Outlay - FF&E, Automobiles, Building	27,211	7,281	23,580	58,073	35,668	22,405
Capital Outlay - Debt Service	208,876	48,738	256,545	514,158	514,158	-
TOTAL CAPITAL EXPENDITURES	**$ 236,087**	**$ 56,019**	**$ 280,125**	**$ 572,231**	**$ 549,826**	**$ 22,405**
GRAND TOTAL EXPENDITURES	**$ 9,092,560**	**$ 2,101,164**	**$ 3,857,405**	**$ 15,051,130**	**$ 15,208,236**	**$ (157,106)**
Excess (Deficiency) of Revenues and Expenses	**$ 288,690**	**$ (206,838)**	**$ (175,061)**	**$ (93,210)**	**$ 47,883**	**$ (141,093)**
Debt Service and Fixed Asset Fund:						
Debt Service	208,876	48,738	256,545	514,158	514,158	-
		-	-	-		-
Excess (Deficiency) of Revenues over Expenses	**$ 208,876**	**$ 48,738**	**$ 256,545**	**$ 514,158**	**$ 514,158**	**$ -**


TRI-COUNTY BEHAVIORAL HEALTHCARE
Income and Expense
Including Capital Expenditures
$6,000,000
$5,000,000
$4,000,000
$3,000,000
$2,000,000
$1,000,000
$0
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Income
Expense


TRI-COUNTY BEHAVIORAL HEALTHCARE
Income after Expense
including Capital Expenditures
$100,000
$0
-$100,000
-$200,000
-$300,000
-$400,000
-$500,000
-$600,000
-$700,000
-$800,000
-$900,000
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24

Agenda Item: Ratify PreAdmission Screening and Resident Review (PASRR) Assisted Technology Contract HHSC No. HHS001574000001 **Committee:** Business	**Board Meeting Date** January 30, 2025

Background Information:

The Health and Human Services Commission has provided $8500 for a pilot to purchase assistive technology for Preadmission Screening and Resident Review (PASRR) recipients with intellectual and/or developmental disabilities (IDD) living in Texas nursing facilities who desire to transition to the community.

The virtual reality equipment will be used by persons with IDD living in a Nursing Facility who are considering moving out into the community and see what community living will be like.

Persons that have seen the demonstration of this software have indicated that the impact on persons who use it is profound.

This contract needed to be submitted shortly after arrival, so the request is to ratify this contract today.

Supporting Documentation:

Contract Available for Review

Recommended Action:

Ratify PreAdmission Screening and Resident Review (PASRR) Assisted Technology Contract HHSC No. HHS001574000001

Agenda Item: Ratify Health and Human Services Commission Contract No. HHS001333300037, Amendment No. 3, Local Intellectual and Developmental Disability Authority Services **Committee:** Business	**Board Meeting Date** January 30, 2025

Background Information:

The Health and Human Services Local Intellectual and Developmental Disability Performance Contract is the contract for all IDD Authority (LIDDA) services, including:

- Eligibility Determination;
- State Supported Living Center Admission and Continuity of Care services;
- Service Coordination;
- Maintenance of the TxHmL and HCS Interest lists;
- Permanency Planning;
- IDD Crisis Intervention and Crisis Respite;
- Enhanced Community Coordination;
- PreAdmission and Resident Review (PASRR); and
- Habilitation Coordination.

This is the third amendment to the contract that went into effect on September 1, 2023 and terminates on August 31, 2025. The total funding remains unchanged.

The main purpose of this contract revision is to reauthorize the use of American Rescue Plan Act funds for Determinations of Intellectual Disability. There are no new funds associated with the contract because these are billed to HHSC as cost reimbursement.

This contract includes a variety of small changes to contract requirements, including more clarity on required training for staff, the role of the LIDDA in a situation where a current IDD provider in the community has their contract 'decertified' and responding to notifications of potential threats to health and safety.

The Executive Director has signed this contract in advance of the Board meeting to prevent a delay in contract funding.

Supporting Documentation:

Contract will be available for review at the Board meeting.

Recommended Action:

Ratify Health and Human Services Commission Contract No. HHS001333300037, Amendment No. 3, Local Intellectual and Developmental Disability Authority Services

Agenda Item: Ratify HHSC Youth Empowerment Services (YES) Waiver Contract No. HHS001291000036, Amendment No. 1 **Committee:** Business	**Board Meeting Date** January 30, 2025

Background Information:

The Youth Empowerment Services waiver is a 1915(c) Medicaid program that helps children and youth with serious mental, emotional and behavioral difficulties. The YES Waiver provides intensive services delivered within a strengths-based team planning process called wraparound. Wraparound builds on family and community support and utilizes YES Waiver services to help build the family's natural support network and connection with the community. YES Wavier services are family-centered, coordinated and effective at preventing out-of-home placement and promoting lifelong independence and self-defined success.

HHSC has issued this new contract for YES Waiver services to extend the contract until March 31, 2027.

The contract includes changes to program requirements but none of these are thought to have a significant impact on operations.

This contract needed to be approved prior to the Board meeting so the Executive Director has signed the contract which will be need to be ratified by the Board today.

Supporting Documentation:

Contract Available for Review

Recommended Action:

Ratify HHSC Youth Empowerment Services (YES) Waiver Contract No. HHS001291000036, Amendment No. 1

Agenda Item: Approve Purchase of Fleet Vehicles

Committee: Business

Board Meeting Date

January 30, 2025

Background Information:

The Management Team has reviewed the status of existing vehicles for YCOT. It was determined that there is a need for three new vehicles for use by staff to provide direct services to clients out of the office as well as provide transportation as needed.

Staff recommends the purchase of three mid-size SUVs for direct care staff to be purchased at the dealership chosen by the Board.

Bids received:

2025 Mid-Size SUVs

Dealership	Keating Honda	Gullo Toyota, Conroe	Wiesner, Conroe
2025 Toyota RAV4- LE	N/A	$29,356.06	N/A
2025 Honda CR-V	$34,526.12	N/A	N/A
2025 Hyundai Tucson SEL	N/A	N/A	$28,800.00

These vehicles will be purchased using available YCOT program funds.

Supporting Documentation:

Copy of bids and backup information attached

Recommended Action:

Approve the Purchase of 3 Mid-Size SUV's at a price of NTE $30,000 based on availability of vehicles at time of purchase.

DEAL NO. 416167

CUST. NO. 577894

DEL. BY 01/14/2025

jenniferb@tcbhc.org

Wiesner
FOUNDATION OF EXPERIENCE

JOHN WIESNER, INC.
1645 I-45 N (P. O. BOX 2348)
CONROE TX 77304
WWW.WIESNERAUTO.COM

Customer's Name as it will appear on Title Papers TRI-COUNTY BEHAVIORAL

Vehicle License No. _____ Stock No. SC3019

Date JANUARY 14, 2025

Address 233 SGT ED HOLCOMB BLVD S Home Phone (936)521-6121 Bus. Phone (936)521-6100

City CONROE State TX Zip Code 77304

NEW [X] USED [ ] COLOR SERENITY TRIM GRY STAIN KEY #'s IGN. T0608 TRK.

YEAR	MAKE	MODEL / TYPE	ODOMETER		CASH SELLING PRICE
2025	HYUNDAI	TUCSON / 4DR FWD SE			26342.67

SERIAL NO. 3KMJA3DE0SE010253

MEMO

TITLE

P.O.A.

FINANCE DEPARTMENT

SW RE Red Alert

INSTALLED ACCESSORIES

LOJACK

A DOCUMENTARY FEE IS NOT AN OFFICIAL FEE. A DOCUMENTARY FEE IS NOT REQUIRED BY LAW, BUT MAY BE CHARGED TO BUYERS FOR HANDLING DOCUMENTS RELATING TO THE SALE. A DOCUMENTARY FEE MAY NOT EXCEED A REASONABLE AMOUNT AGREED TO BY THE PARTIES. THIS NOTICE IS REQUIRED BY LAW. 2094.00

TRADE INFORMATION

YEAR / COLOR

MAKE

MODEL

BODY STYLE

VIN #

LICENSE NO.

ODOMETER

Cash Price of Car & Accessories	$ 28436.67	
Dealer's Inventory Tax	$ 45.33	
Luxury Tax	$	N/A
Sales Tax	$	N/A
Registration, Road & Bridge Fee	$ 20.00	
License	$ 130.00	
State Inspection	$	N/A
Full Service Deputy Fee	$	N/A
DOCUMENTARY FEE	$ 135.00	
TITLE 33.00	33.00	
TOTAL CASH PRICE	$ 28800.00	
Trade-In Allowance .....$	N/A	
Less Pay-off .....$	N/A	
NET ALLOWANCE $	N/A	
Cust. Rebate .....$	N/A	
Cust. Rebate .....$	N/A	
Cust. Rebate .....$	N/A	
Cash on Delivery .....$	N/A	
TOTAL DOWN PAYMENT	$	N/A
TOTAL UNPAID BALANCE	28800.00	
	$	N/A
TOTAL UNPAID BALANCE	$ 28800.00	

PAY-OFF TO:

ADDRESS:

ADDRESS:

GOOD TILL:

Talked To:

LEGAL OWNER (Lien Holder)

ADDRESS:

ADDRESS:

ADDRESS:

Date: 01/14/25 Amount: 28800.00 Talked To:

DRAFT THRU:

ADDRESS:

DISCLAIMER OF WARRANTIES

ANY WARRANTIES ON THE PRODUCTS SOLD HEREBY ARE THOSE MADE BY THE MANUFACTURER. THE SELLER, WIESNER, HEREBY EXPRESSLY DISCLAIMS ALL WARRANTIES, EITHER EXPRESS OR IMPLIED, INCLUDING ANY IMPLIED WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, AND WIESNER NEITHER ASSUMES NOR AUTHORIZES ANY OTHER PERSON TO ASSUME FOR IT ANY LIABILITY IN CONNECTION WITH THE SALE OF SAID PRODUCTS.

The Dealer's Inventory Tax charge is intended to reimburse the dealer for ad valorem taxes on its motor vehicle inventory. The charge, which is paid by the dealer to the county tax assessor-collector, is not a tax imposed on a consumer by the government, and is not required to be charged by the dealer to the consumer.

WARNING: Your signature and deposit is our authorization to hold this vehicle for you at the above agreed upon price against any and all future offers and to put it through our service and make-ready departments for delivery to you. Any refusal to take delivery other than being unable to arrange financing will subject you to the loss of your deposit. At delivery, your trade-in must be in virtually the same condition as when it was first appraised. (Same Tires, Radio, Engine Condition, Etc.)

Customer Signature Date 01/14/2025

	VIN #	NET ALLOWANCE $ N/A		
		Cust. Rebate . . . . . $ N/A		
INSTALLED ACCESSORIES		Cust. Rebate . . . . . $ N/A		
		Cust. Rebate . . . . . $ N/A		
		Cash on Delivery . . . . . $ N/A		
	LICENSE NO.	TOTAL DOWN PAYMENT	$	N/A
LOJACK		TOTAL UNPAID BALANCE	28800	00
			$	N/A
	ODOMETER	TOTAL UNPAID BALANCE	$ 28800	00

PAY-OFF TO:
ADDRESS:
ADDRESS:
GOOD TILL:
Talked To:

LEGAL OWNER (Lien Holder)
ADDRESS:
ADDRESS:
ADDRESS:
Date: 01/14/25 Amount: 28800.00 Talked To:
DRAFT THRU:
ADDRESS:

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Customer Signature _____ Date 01/14/2025

Salesman _____ #_____

Salesman _____ #_____

Manager _____

NOT BINDING UNTIL APPROVED BY MANAGER

The Reynolds and Reynolds Company CC236154 Q (2/10)

Wiesner

FOUNDATION OF EXPERIENCE

CONROE • HUNTSVILLE

Specifications

Showing 1 of 5 trims

Help me choose a trim

Vehicle shown for illustrative purposes only. Actual model may vary.

SE

$28,605

Starting MSRP

Build >

Hide all

Return to chat

EPA Fuel Economy Estimates

EPA Fuel Economy Estimates

City/Highway/Combined (FWD)

25 / 33 / 28

City/Highway/Combined (AWD)

24 / 30 / 26

Fuel Capacity

Fuel tank capacity (gal.)

14.3

Powertrain & Handling

Engine

Type

Inline 4-cylinder

Displacement (liters)

2.5

Horsepower @ RPM

187 @ 6100

Torque @ RPM

178 @ 4000

Compression ratio

13.0:1

Valve train

DOHC 16-valve

Fuel system: Gasoline Direct Injection (GDI) with Multi-Port

Standard

Drivetrain

Front Wheel Drive (FWD)

Standard

HTRAC All Wheel Drive (HTRAC AWD)

Optional

8-speed automatic with SHIFTRONIC®

Standard

Idle Stop & Go (ISG)

Standard

Drive Mode Select (Normal, Sport, My Drive, (Snow AWD))

Standard

Column-mounted Shift-by-Wire

Not Available

Steering-wheel-mounted paddle shifters

Not Available

Towing

Towing capacity with trailer brakes (lbs.)

2000

Towing capacity without trailer brakes (lbs.)

1650

Tow hitch

Accessory

Trailer pre-wiring

Standard

Suspension & Chassis

Front suspension: Independent MacPherson strut with coil springs

Standard

Rear suspension: Independent multi-link design

Standard

Brakes

4-wheel disc brakes with Anti-lock Braking System (ABS)

Standard

Electronic Parking Brake (EPB)

Standard

Steering

Motor-Driven Power Steering (MDPS) rack-and-pinion steering, column-mounted

Standard

Exterior

Wheels

Alloy wheels

17-inch

Tires

Tires

235/65 R17

Compact temporary spare tire

Standard

Lighting

Headlights

Bi-LED

LED front turn signals

Standard

Daytime Running Lights (DRL)

LED

Taillights

Bulb-type

Automatic headlights

Standard

High Beam Assist (HBA)

Standard

Roof-mounted Center High-Mount Stop Lamp (CHMSL)

Standard

Side Mirrors

Side mirrors

Bodycolor

Heated side mirrors

Not Available

Side mirrors with LED turn-signal indicators

Not Available

Exterior Trim

XRT exclusive side cladding

Not Available

XRT liftgate badge

Not Available

Premium dark chrome accent grille

Not Available

Gloss black pillars

Not Available

Shark-fin roof antenna

Standard

Bodycolor door handles

Standard

Rear spoiler

Standard

Comfort & Convenience

Power tilt-and-slide sunroof

Not Available

Panoramic sunroof

Not Available

Rear privacy glass

Not Available

Solar control front glass

Standard

Acoustic-laminated windscreen

Standard

Acoustic-laminated front side windows

Not Available

Roof side rails

Not Available

Hands-free smart liftgate with auto open and adjustable height setting

Not Available

Interior

Seating & Trim

5-passenger seating

Standard

Seating surfaces

Cloth

6-way adjustable driver seat

Standard

8-way power driver seat

Not Available

Power driver's lumbar support

Not Available

Heated front seats (3-steps)

Not Available

8-way power front passenger seat

Not Available

Ventilated front seats

Not Available

Integrated Memory System (memory driver's seat, outside mirrors and HUD setting)

Not Available

60/40 split fold-down and reclining rear seatback with adjustable head restraint

Standard

Heated rear seats

Not Available

Leather-wrapped steering wheel

Not Available

Black headliner

Not Available

Leather-wrapped shift knob

Not Available

Infotainment & Audio

Touchscreen display

12.3-inch

Onboard navigation

Not Available

Multimedia software OTA update capability

Standard

Bose Premium Audio System

Not Available

Dynamic Voice Recognition

Not Available

Wireless Android Auto™ & Apple CarPlay®

Standard

HD Radio™ Technology

Standard

SiriusXM Satellite Radio

Standard

Comfort & Convenience

Bluelink+

Standard

Bluelink+ Basic Package

Standard

Bluelink+ Advanced Package

Standard

Fingerprint scanner (infotainment + engine start via Bluelink)

Not Available

Hyundai Pay

Not Available

Gauge cluster

4.2-inch

12-inch Head-up Display

Not Available

Wireless device quick charging (for supported devices)

Not Available

Front Dual USB Type-C ports (1 data/charge + 1 charge port (27W))

Standard

Second-row dual USB charging ports

Standard

Rear View Monitor

Standard

Dual automatic temperature control with auto defogger

Not Available

Floor console-mounted rear A/C vents

Not Available

Rear window defroster with timer

Standard

Heated steering wheel

Not Available

Steering-wheel-mounted paddle shifters

Not Available

Bluetooth® hands-free phone system

Standard

Steering-wheel-mounted audio, cruise and Bluetooth® controls

Standard

Tilt-and-telescopic steering wheel

Standard

Remote keyless entry system with alarm and panic

Standard

Hyundai Digital Key 2

Not Available

Proximity Key entry with push button start

Standard

Rear center armrest with cupholders

Standard

Front seatback map pockets

Passenger side

12-volt outlets (2) 1 front/1 cargo

Standard

Auto-dimming rearview mirror

Not Available

LED interior map lights

Standard

Expanded ambient interior lighting (64-color, upper/lower center console, door pockets)

Not Available

Power windows with driver auto-down

Standard

Power windows with front auto-down/up

Not Available

Illuminated sunvisors with sliding function

Not Available

Dual level cargo floor

Standard

Remote release folding rear seats (from cargo area)

Standard

Front 2-speed/variable intermittent windshield wipers

Standard

Intermittent rear window wiper/washer

Standard

Rain-sensing windshield wipers

Not Available

Safety/SmartSense

SmartSense

Forward Collision-Avoidance Assist with Pedestrian/Cyclist/Junction Turning Detection (FCA-JT)

Standard

Forward Attention Warning

Not Available

Blind-Spot Collision Warning (BCW)

Standard

Blind-Spot View Monitor (BVM)

Not Available

Driver Attention Warning (DAW)

Standard

Lane Keeping Assist (LKA)

Standard

Lane Following Assist (LFA)

Standard

Highway Driving Assist 1 (HDA1)

Not Available

Rear Cross-Traffic Collision-Avoidance Assist (RCCA)

Standard

Smart Cruise Control (SCC) with Stop & Go

Standard

Smart Cruise Control 2 (SCC2)

Not Available

Navigation-based Smart Cruise Control with Curve Control

Not Available

Safe Exit Warning (SEW)

Standard

Rear Occupant Alert (ROA)

Standard

Advanced Rear Occupant Alert (AROA)

Not Available

Parking Collision-Avoidance Assist – Reverse

Not Available

Parking Distance Warning – Forward/Reverse/Side

Not Available

Remote Smart Parking Assist (RSPA)

Not Available

Surround View Monitor (SVM)

Not Available

Safety

Front (2), front side (2), side-curtain (2), & rear side (2) airbags

Standard

Downhill Brake Control (DBC)

Standard

Adjustable front-seat shoulder belt anchors

Standard

Front and rear outboard seatbelt pretensioners and load limiters

Standard

LATCH lower anchors and upper tether anchors

Standard

Power window lock-out button

Standard

Rear child safety locks

Standard

Anti-lock Braking System (ABS) with 4-wheel disc brakes

Standard

Electronic Stability Control (ESC) with Traction Control System (TCS) and Brake Assist (BA)

Standard

Vehicle Stability Management (VSM)

Standard

Immobilizer

Standard

Tire Pressure Monitoring System (TPMS) with individual tire

Standard

Dimensions/Weights/Capacities

Exterior Dimensions

Wheelbase (in.)
108.5

Length (in.)
182.7

Width (in., not including side mirrors)
73.4

Height (in.)
Not Available

Overhang (front/rear)
35.2 / 38.6

Minimum Ground Clearance (2WD/AWD)
7.1 / 8.3

Turning Diameter

Turning diameter, curb-to-curb (ft.)
38.6

Weight

Curb weight (lbs., FWD/AWD)
3429 / 3572

Interior Dimensions

Head room (in., front/rear)

40.1 / 39.5

Leg room (in., front/rear)

41.4 / 41.3

Shoulder room (in., front/rear)

57.6 / 56.0

Hip room (in., front/rear)

54.5 / 53.9

Interior Volume

Total interior volume (cu. ft.)

146.9

Passenger volume (cu. ft.)

108.2

Cargo volume (cu. ft.) rear seats up/rear seats folded down

41.2 (SAE 38.7) / 80.3 (SAE 74.8)

2025 TUCSON Warranty

5 years/60,000 miles
New Vehicle Limited
STANDARD

10 years/100,000 miles
Powertrain Limited
STANDARD

7 years/unlimited miles
Anti-perforation
STANDARD

5 years/unlimited miles
24/7 Roadside Assistance

Keating Honda

Date: 1/15/2025
Salesperson: Robert Dams
Manager: Nate Shaw
Customer ID #: 209024

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BUSINESS NAME	TRI-COUNTY BEHAVIORAL HEALTHCARE	Home Phone :
CONTACT		
Address :	233 SGT ED HOLCOMB BLVD S CONROE, TX 77304 MONTGOMERY	Work Phone : (936) 521-6100
E-Mail :	holliep@tcbhc.org	Cell Phone : (214) 934-8620

VEHICLE

Stock # : H450024 New / Used : New VIN : 2HKRS4H29SH450024 Mileage: 21
Vehicle : 2025 Honda CR-V Color : Crystal Black P
Type : LX (CVT) 4dr All-Wheel Drive RS4H2SEW

Market Value Selling Price	32,950.00
XPEL Ceramic Tint & PPF	1,097.00
Total Purchase	34,047.00
Doc Fee	225.00
Non Tax Fees	254.12
Balance	34,526.12

Customer Approval: _____ Management Approval: _____

By signing this authorization form, you certify that the above personal information is correct and accurate, and authorize the release of credit and employment information. By signing above, I provide to the dealership and its affiliates consent to communicate with me about my vehicle or any future vehicles using electronic, verbal and written communications including but not limited to eMail, text messaging, SMS, phone calls and direct mail. Terms and Conditions subject to credit approval. For Information Only. This is not an offer or contract for sale.

1500 Less
for 2 wheel drive

Hollie Park

From: Robert Dams <rdams@keatinghonda.com>
Sent: Wednesday, January 8, 2025 1:47 PM
To: Hollie Park
Subject: RE: Vehicle Bid Request for Tri-County Behavioral Healthcare
Attachments: 2025 CRV LX AWD.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Attached is the bid proposal for you to review. Two Wheel drive CRV LX are 1500 less than this quote. Her are the details of the CRV below.

- 1.5-liter, turbocharged and intercooled DOHC VTEC® 4-cylinder engine with direct injection
  - 190 horsepower @ 6000 rpm (SAE net)
  - 179 lb-ft of torque @ 1700-5000 rpm (SAE net)
- Continuously variable transmission (CVT)
- Idle-stop
- Available Real Time AWD with Intelligent Control System™
- 3-mode drive system (ECON/Normal/Snow)
- Drive-by-Wire throttle system
- Active Noise Cancellation™ (ANC)
- Eco Assist™ system
- Electric parking brake with automatic brake hold
- Hill Start Assist
- Hill descent control
- LEV3-SULEV30 CARB emissions rating[35] (2WD)
- LEV3-ULEV50 CARB emissions rating[35] (AWD)
- MacPherson strut front suspension
- Multi-link double wishbone rear suspension
- Front and rear stabilizer bars
- Variable-ratio electric power-assisted rack-and-pinion steering (EPS)
- Active shutter grille
- 4-wheel disc brakes
- 17-inch steel wheels with covers
- P235/65 R17 all-season tires

Safety Features

- Advanced Compatibility Engineering™ (ACE™) body structure
- Multi-angle rearview camera with guidelines[7]
- Driver's and front passenger's advanced front airbags (SRS)
- Driver's and front passenger's knee airbags
- Driver's and front passenger's front side airbags
- Rear outboard passengers' side airbags
- Side curtain airbags with rollover sensor
- Vehicle Stability Assist™ (VSA®) with traction control[5]
- Anti-lock braking system (ABS)

- Electronic Brake Distribution (EBD)
- Brake Assist
- Collision Mitigation Braking System™ (CMBS™)[8] (Honda Sensing® feature)
- Forward Collision Warning (FCW)[9] (Honda Sensing® feature)
- Lane Departure Warning (LDW)[10] (Honda Sensing® feature)
- Road Departure Mitigation System (RDM)[4] (Honda Sensing® feature)
- Tire Pressure Monitoring System (TPMS)[6]
- LED Daytime Running Lights (DRL)
- 3-point seat belts at all seating positions[49]
- Seat-belt reminder for all seating positions
- Lower Anchors and Tethers for Children (LATCH)

Robert Dams
Keating Honda
Fleet Manager
(832) 655-8792

From: Hollie Park <HollieP@tcbhc.org>
Sent: Wednesday, January 8, 2025 10:39 AM
To: Robert Dams <rdams@keatinghonda.com>
Subject: Vehicle Bid Request for Tri-County Behavioral Healthcare

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Good morning,

As we discussed on the phone earlier, here is our request for bids on up to three vehicles. I look forward to hearing back from you.

Thank you,

Hollie Park
Administrative Assistant
HollieP@tcbhc.org
936-521-6121 | Crisis Line: **1-800-659-6994**

GULLO TOYOTA

Date: *1/8/2025*
Salesperson: **Philip Sharp**
Manager: **Philip Sharp**
Customer ID #: **815700**

FOR INTERNAL USE ONLY

BUSINESS NAME *Tri-County Behavioral Healthcare* Home Phone :

CONTACT

Address : *233 SGT ED HOLCOMB BLVD S CONROE, TX 77304MONTGOMERY* Work Phone : *(936) 521-6121*

E-Mail : *evanr@tcbhc.org* Cell Phone : *(936) 494-8352*

VEHICLE

Stock # : *INC 4430* New / Used : **New** VIN : *2T3H1RFV7SC311559* Mileage: *0*

Vehicle : *2025 Toyota RAV4* Color : *MAGNETIC GRAY*

Type : *LE (A8) 4dr Front-Wheel Drive4430*

Body Size : Style : Weight : *0* Unit Class :

Market Value Selling Price	30,395.00
Discount	1,500.00
Adjusted Price	28,895.00
Doc Fee	225.00
Non Tax Fees	236.06
Balance	29,356.06

Customer Approval: _____ Management Approval: _____

By signing this authorization form, you certify that the above personal information is correct and accurate, and authorize the release of credit and employment information. By signing above, I provide to the dealership and its affiliates consent to communicate with me about my vehicle or any future vehicles using electronic, verbal and written communications including but not limited to eMail, text messaging, SMS, phone calls and direct mail. Terms and Conditions subject to credit approval. For Information Only. This is not an offer or contract for sale.

TOYOTA

Gullo Toyota of Conroe
500 I-45 South
Conroe TX 77304
936-441-4141

2025 RAV4

RAV4 LE

Model: 2025 RAV4 LE 2.5L 4-Cyl. Engine Front-Wheel Drive 4430A
VIN: 2T3H1RFV7SC311559
Stock: N/A
Engine: 2.5L 4-Cyl. Engine
Transmission: Direct Shift 8-Speed Electronically Controlled automatic Transmission with intelligence (ECT-i) and sequential shift mode

EXTERIOR
Magnetic Gray Metallic

INTERIOR
Black Fabric

PRICE

Base MSRP *	$28,850.00
Delivery Processing and Handling	$1,545.00
Total Advertised Price	**$30,395.00**

FUEL ECONOMY

30 MPG Combined City/Hwy | 27 MPG City | 35 MPG Highway

INSTALLED PACKAGES & ACCESSORIES

50 State Emissions	FIO	$0.00
Vehicle Fueling (4 Gal.)	LIO	$0.00
PDS - Pre Delivery Services	LIO	$0.00
Owner's Portfolio	LIO	$0.00
Total Optional Equipment		$0.00
Vehicle Base Model		$28,850.00
Delivery Processing and Handling		$1,545.00

FEATURES

Mechanical & Performance

- Drivetrain: Front-Wheel Drive (FWD)
- Tow Prep Equipment: 100-amp alternator
- Tow Prep Equipment: Automatic transmission fluid cooler
- Engine: Emission rating: Ultra Low Emission Vehicle (ULEV)
- Suspension: Independent MacPherson strut front suspension with stabilizer bar; multi-link rear suspension with stabilizer bar
- Steering: Electric Power Steering (EPS); power-assisted rack-and-pinion
- Brakes: Power-assisted ventilated 12.0-in. front disc brakes; ventilated 11.1-in. rear disc brakes
- Engine: Induction system: (D-4S) Dual-Injection (Direct-Injection and Port-injection) EFI with Electronic Throttle Control System with intelligence (ETCS-i)
- Engine: Stop and Start Engine System (S&S)
- Engine: 2.5-Liter Dynamic Force 4-Cylinder DOHC D-4S Injection with Dual Variable Valve Timing with intelligence (VVT-i), with SPORT, Eco, NORMAL Modes, 203 hp @ 6,600 rpm; 184 lb.-ft. @ 5,000 rpm
- Transmission: Direct Shift-8-speed Electronically Controlled automatic Transmission with intelligence (ECT-i) and sequential shift mode
- Engine: Compression ratio: 13.0:1
- Drive Modes: SPORT, Eco, and NORMAL drive modes
- Capability: Hill Start Assist Control (HAC)
- Brakes: Active Cornering Assist (ACA)
- Body Construction: Reinforced unitized steel body

- Engine: 2.5L 4-Cyl. Engine
- Weight Rating: 4610 lbs
- Direct Shift 8-Speed Electronically Controlled automatic Transmission with intelligence (ECT-i) and sequential shift mode

Steering

- Steering wheel turns (lock-to-lock) 2.76
- Turning circle diameter, curb-to-curb (ft.) 36.1
- Steering ratio 14.4:1

Exterior

- Color-keyed outside door handles
- LED projector low- and high-beam headlights with chrome accent, Automatic High Beams (AHB)
- Black power outside mirrors with folding feature
- Color-keyed upper front bumper, and black lower front bumper, overfenders and rear bumper
- LED Daytime Running Lights (DRL)
- LED taillights
- Dual chrome-tipped exhaust
- 17-in. steel wheels with silver 6-spoke wheel covers
- Intermittent windshield wipers and intermittent rear window wiper
- Aerodynamic underbody panels with vortex generators, front and rear wheel spats, and integrated rear spoiler
- Color-keyed roof-mounted shark-fin antenna
- Privacy glass on all rear side, quarter and liftgate windows
- Black hexagon-patterned bar front grille

Interior

- Climate control system with dust and pollen filter and rear-seat vents
- Remote keyless entry system with lock, unlock, panic functions and remote illuminated entry
- Sun visors with illuminated vanity mirrors
- One 12V/120W auxiliary power outlet in front instrument panel storage tray and one 12V/120W auxiliary power outlet in second row
- Soft-touch dash and armrests, with stitched dash accents
- Urethane tilt/telescopic 3-spoke steering wheel with controls for audio, Multi-Information Display (MID), Bluetooth® hands-free phone, voice-command, Dynamic Radar Cruise Control (DRCC), Lane Departure Alert (LDA) and Lane Trace Assist (LTA)
- Passenger-side lockable glove compartment
- Front-door storage pockets with bottle holders
- Black in-dash storage trays
- 60/40 split reclining fold-flat rear seat with center armrest and cup holders
- Day/night rearview mirror
- Center console with covered storage compartment, two cup holders, drive mode, Electric Parking Brake (EPB) and automatic Brake Hold controls, and front storage tray
- 2 front and 2 rear cup holders; 2 front and 2 rear bottle holders
- Electric Parking Brake (EPB) with Brake Hold
- Fabric-trimmed seats; 6-way adjustable front driver's seat; 4-way adjustable front passenger seat with seatback pocket
- Three USB ports— USB media port in front storage tray and two additional charge ports in front center console
- Black interior door handles
- Digital speedometer and instrumentation with analog tachometer, coolant temperature, and fuel gauges; 7-in. digital Multi-Information Display (MID) with customizable settings, odometer, tripmeters, clock, outside temperature, rear passenger seatbelt indicators, fuel economy information, trip timer, shift-position and scheduled maintenance indicators, and warning messages
- Overhead console with maplights, sunglasses storage and Safety Connect® button
- Shift lever with sequential mode
- Rear liftgate window defogger
- Power door locks with shift-linked automatic lock/unlock feature
- Turn signal stalk with headlight controls and one-touch 3-blink lane change turn signals
- Power windows with auto up/down and jam protection in all positions
- Height-adjustable rear cargo area deck board
- LED front-seat reading lights, dome light and cargo area light
- Black carpet flooring with driver-side footrest
- Ash Gray fabric-trimmed headliner

Audio Multimedia

- 8-in. Toyota Audio Multimedia, six speakers, with wireless Apple CarPlay® & Android Auto™ compatible, SiriusXM® with 3-month trial. See toyota.com/audio-multimedia for details. S

ToyotaCare

- No cost maintenance plan $0 (No Cost)
- 24-hour Roadside Assistance $0 (No Cost)

Safety & Convenience

- Trailer-Sway Control (TSC)
- Eight airbags — includes driver and front passenger Advanced Airbag System, driver and front passenger seat-mounted side airbags, driver's knee airbag, front passenger seat cushion airbag, and front and rear side curtain airbags
- Adjustable front shoulder anchors
- Hill Start Assist Control (HAC)
- Front and outboard second-row seatbelts with seatbelt pretensioners with force limiters
- 3-point seatbelts for all seating positions; driver-side Emergency Locking Retractor (ELR) and Automatic/Emergency Locking Retractor (ALR/ELR) on all passenger seatbelts

- LATCH (Lower Anchors and Tethers for Children) includes lower anchors on outboard rear seats and tether anchors on all rear seats
- Tire Pressure Monitor System (TPMS) with direct pressure readout and individual tire location alert
- Toyota Safety Sense™ 2.5 — Pre-Collision System w/Pedestrian Detection , Full-Speed Range Dynamic Radar Cruise Control , Lane Departure Alert w/Steering Assist , Lane Tracing Assist , Automatic High Beams , Road Sign Assist
- Backup camera with dynamic gridlines
- Anti-theft system with engine immobilizer
- Child-protector rear door locks and power window lockout control
- Star Safety System™ — includes Vehicle Stability Control (VSC), Traction Control (TRAC), Anti-lock Brake System (ABS), Electronic Brake-force Distribution (EBD), Brake Assist (BA) and Smart Stop Technology® (SST)
- Front and rear side-impact door beams

Connected Services

- Remote Connect — remotely interact with your vehicle through the Toyota app via your smartwatch. Depending on grade, allows you to lock/unlock doors, start and stop the vehicle, locate your last parked location, check vehicle status and monitor guest drivers. Subscription required after trial. 4G network dependent. Subscription required, select features only
- Service Connect — receive personalized maintenance updates and vehicle health reports. Subscription required after trial. 4G network dependent. Up to 10-year trial subscription
- Drive Connect — includes Cloud Navigation with Google Points of Interest (POI) data, Intelligent Assistant with Hey, Toyota, and Destination Assist. Subscription required after trial. 4G network dependent. Capable, subscription required
- Safety Connect® — includes Emergency Assistance Button, Enhanced Roadside Assistance, Automatic Collision Notification, and Stolen Vehicle Locator. Subscription required. 4G network dependent. Up to 10-year trial subscription
- Wi-Fi Connect — includes AT&T Wi-Fi hotspot and Integrated Streaming (Apple Music® and Amazon Music) compatibility. 1-month trial subscription for music services. Subscription required after trial. 4G network dependent. Up to 30-day/3 GB trial subscription

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* Base MSRP excludes manufacturer, distributor and dealer options, taxes, title and license and dealer fees and charges. Also excludes the Delivery, Processing and Handling of $1,135 for Cars (Corolla, Corolla HV, Corolla HB, GR Corolla, Camry, Prius, Prius Plug-in Hybrid, Toyota Crown, Mirai, GR86, GR Supra), $1,350 for Entry SUV (Corolla Cross, Corolla Cross HV), $1,395 for Small SUV (RAV4, RAV4 HV, RAV4 Plug-in Hybrid, bZ4X), $1,450 for Mid SUV/Van (4Runner, Venza, Highlander, Highlander HV, Grand Highlander, Grand Highlander HV, Sienna, Land Cruiser, Toyota Crown Signia), $1,495 for Small Pickup (Tacoma), $1,945 for Large Pickup/Large SUV (Tundra, Tundra HV, Sequoia). (Historically, vehicle manufacturers and distributors have charged a separate fee for processing, handling and delivering vehicles to dealerships. Toyota's charge for these services is called the "Delivery, Processing and Handling" and is based on the value of the processing, handling and delivery services Toyota provides as well as Toyota's overall pricing structure and may be subject to change at any time. Toyota may make a profit on the Delivery, Processing and Handling.) The Delivery, Processing and Handling in AL, AR, FL, GA, LA, MS, NC, OK, SC and TX may vary. The published prices do not apply to Puerto Rico and the U.S. Virgin Islands. Dealer price will vary.

ToyotaCare, which covers normal factory scheduled maintenance for 2 years or 25,000 miles, whichever comes first, is included as part of the sales price of the vehicle for qualifying buyers. See participating dealer for eligibility and coverage details.

Disclaimer: This document is not meant to replace or substitute the actual window sticker on the vehicle. Toyota Motor Sales, U.S.A., Inc. is not responsible and disclaims any liability for inaccuracies. Please contact your dealer with any questions or if you require additional information.

Agenda Item: Approve Sale of Four Ford Focus Vehicles **Committee:** Business	**Board Meeting Date:** January 30, 2025

Background Information:

Staff are requesting that the following vehicles with significant mechanical issues be removed from the Tri-County fleet and sold at auction. In addition to the issues below, the 2014 Focus vehicles have had transmission problems which Ford has been unable/unwilling to repair – these vehicles drive very poorly.

- 2012 Ford Focus (BCJ-9420) - 92,180 – This vehicle has had recalls on the side door latch and a faulty fuel tank. The window motor has been replaced and it has not been used in quite some time.

- 2012 Ford Focus (BCJ-9421) – 99,550 – The vehicle has past door latch and fuel tank recalls and repairs done. It was in a collision in 2022 and repaired at Gullo Ford.

- 2014 Ford Focus (DTR-9701) – 65,928 – Vehicle has received the same recalls and repairs to the side door latch and fuel tank. The ball joints and control arm have also been replaced.

- 2014 Ford Focus (DTR-9703) – 58,077 – This vehicle has not been driven in two years.

Staff recommend sale of these vehicles at auction to the highest bidder.

Supporting Documentation:

None

Recommended Action:

Approve the Sale of Four Ford Focus Vehicles at Auction to the Highest Bidder.

Agenda Item: FY 2024 Independent Financial Audit Extension **Committee**: Business	**Board Meeting Date** January 30, 2025

Background Information:

This is the 2nd year with Scott, Singleton, Fincher & Co. PC performing the FY 2024 Annual Financial & Compliance Audit. The normal due date for the audit is February 1, 2025 for Fiscal Year ending August 31, 2024.

In previous updates the Board has been made aware that this year's audit has not been proceeding as it normally does because of turnover at the audit firm. This is not just a Tri-County issue, but has impacted most of the Centers audited by Scott, Singleton, Fincher and Co.

On 1/3/25, we were asked by Jonathan Smith, Principal, from Scott, Singleton, Fincher & Co. to request a 30-day extension from the audit report deadline as a precaution.

We emailed our request on January 6th to HHSC, MH Contract Manager and IDD Contract Manager to have an extension of the audit deadline until 3/3/2025. Reason for the request was due to additional time needed by our Independent Auditors due to staff shortages, and their need for additional time for necessary review, analysis, and final completion of the audit schedules.

We did receive back approval from both our MH Contract Manager and our IDD Contract Manager to extend our deadline to 3/3/2025.

Supporting Documentation:

Copy of Letter Submitted for Audit Extension Request

Recommended Action:

Information Only - FY 2024 Independent Financial Audit Extension

Agenda Item: 1st Quarter FY 2025 Quarterly Investment Report **Committee:** Business	**Board Meeting Date** January 30, 2025

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 30th, 2024

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	$367.09	$577.32	$945.29
Accrual of Interest Income	$112,828,581.37	$102,668,044.49	$110,813,543.62
Interest and Management Fees Payable	($-128,585,557.60)	($-128,291,561.48)	($-120,944,733.93)
Payable for Investments Purchased	($-75,000,000.00)	($-1,201,868,106.75)	($-288,186,076.25)
Accrued Expense & Taxes	($-35,183.61)	($-35,369.98)	($-71,523.20)
Repurchase Agreements	$8,982,767,000.00	$8,660,668,000.00	$8,055,876,000.00
Mutual Fund Investments	$1,467,085,200.00	$1,467,085,200.00	$1,467,085,200.00
Government Securities	$11,278,347,731.17	$12,295,576,352.17	$12,870,401,879.31
U.S. Treasury Bills	$7,572,994,548.50	$8,145,393,662.59	$7,568,675,134.53
U.S. Treasury Notes	$1,673,969,716.95	$1,674,684,816.45	$1,674,901,642.35
TOTAL	**$30,884,372,403.87**	**$31,015,881,614.81**	**$31,338,552,011.72**

Book Value for the Period

Type of Asset	Beginning Balance	Ending Balance
Uninvested Balance	$980.38	$945.29
Accrual of Interest Income	$129,985,053.28	$110,813,543.62
Interest and Management Fees Payable	($141,670,304.24)	($-120,944,733.93)
Payable for Investments Purchased	($1,052,079,563.55)	($-288,186,076.25)
Accrued Expenses & Taxes	($61,475.28)	($-71,523.20)
Repurchase Agreements	$7,043,488,000.00	$8,055,876,000.00
Mutual Fund Investments	$1,467,085,200.00	$1,467,085,200.00
Government Securities	$11,977,613,453.52	$12,870,737,552.40
U.S. Treasury Bills	$9,195,869,271.22	$7,564,824,903.40
U.S. Treasury Notes	$1,674,784,791.82	$1,674,824,646.12
TOTAL	**$30,295,015,407.15**	**$31,334,960,457.45**

Portfolio by Maturity as of November 30th, 2024

1 to 7 days	8 to 90 day	91 to 180 days	181 + days
67.6 %	19.9 %	8.0 %	4.5 %

Portfolio by Type of Investments as of November 30th, 2024

Treasuries	Repurchase Agreements	Agencies	Money Market Funds
29.2 %	25.5 %	40.7 %	4.6 %

SUMMARY INFORMATION

On a simple daily basis, the monthly average yield was 5.16% for September, 4.91% for October, and 4.73% 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 30th, 2024 was 40 days.

The net asset value as of November 30th, 2024 was 1.00011.

The total amount of interest distributed to participants during the period was $120,944,555.99.

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 2,905.

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:

_____ _____
Evan Roberson Date
Executive Director / Investment Officer

_____ _____
Millie McDuffey Date
Chief Financial Officer / Investment Officer

_____ _____
Darius Tuminas Date
Controller / Investment Officer

_____ _____
Tabatha Abbott Date
Manager of Accounting / Investment Officer

TRI-COUNTY BEHAVIORAL HEALTHCARE
QUARTERLY INTEREST EARNED REPORT
FISCAL YEAR 2025
As Of November 30, 2024

BANK NAME	INTEREST EARNED				
	1st QTR.	2nd QTR.	3rd QTR.	4th QTR.	YTD TOTAL
Alliance Bank - Central Texas CD	$ -				$ -
First Liberty National Bank	$ 1.87				$ 1.87
JP Morgan Chase (HBS)	$ 27,437.62				$ 27,437.62
Prosperity Bank	$ 25.10				$ 25.10
Prosperity Bank CD (formerly Tradition)	$ 26.83				$ 26.83
TexPool Participants	$ 14,896.30				$ 14,896.30
First Financial Bank	$ 537.33				$ 537.33
Total Earned	$ 42,925.05	$ -	$ -	$ -	$ 42,925.05

Agenda Item: Board of Trustees Unit Financial Statements as of November and December 2024 **Committee:** Business	**Board Meeting Date** January 30, 2025
Background Information: None	
Supporting Documentation: November and December 2024 Board of Trustees Unit Financial Statements	
Recommended Action: **For Information Only**	

Unit Financial Statement

FY 2024

November 30, 2024

	November 2024 Budget	November 2024 Actual	Variance	YTD Budget	YTD Actual	Variance	Percent	Budget
Revenues								
Allocated Revenue	$ 1,942	$ 1,942	$ -	$ 5,826	$ 5,826	$ -	100%	$ 23,315
Total Revenue	$ 1,942	$ 1,942	$ -	$ 5,826	$ 5,826	$ -	100%	$ 23,315
Expenses								
Insurance-Worker Compensation	$ 4	$ 0	$ 4	$ 12	$ 4	$ 8	33%	$ 55
Legal Fees	$ 1,500	$ 1,500	$ -	$ 4,500	$ 3,000	$ 1,500	67%	$ 18,000
Training	$ 76	$ -	$ 76	$ 228	$ -	$ 228	0%	$ 910
Travel - Non-local mileage	$ 58	$ 206	$ (148)	$ 174	$ 206	$ (32)	119%	$ 700
Travel - Non-local Hotel	$ 258	$ 395	$ (137)	$ 774	$ 395	$ 379	51%	$ 3,100
Travel - Meals	$ 46	$ -	$ 46	$ 138	$ -	$ 138	0%	$ 550
Total Expenses	$ 1,942	$ 2,102	$ (160)	$ 5,826	$ 3,606	$ 2,220	62%	$ 23,315
Total Revenue minus Expenses	$ 0	$ (160)	$ 160	$ -	$ 2,220	$ (2,220)	38%	$ -

Unit Financial Statement

FY 2024

December 31, 2024

	December 2024 Budget	December 2024 Actual	Variance	YTD Budget	YTD Actual	Variance	Percent	Budget
Revenues								
Allocated Revenue	$ 1,942	$ 1,942	$ -	$ 7,768	$ 7,768	$ -	100%	$ 23,315
Total Revenue	$ 1,942	$ 1,942	$ -	$ 7,768	$ 7,768	$ -	100%	$ 23,315
Expenses								
Insurance-Worker Compensation	$ 4	$ 2	$ 2	$ 16	$ 6	$ 10	38%	$ 55
Legal Fees	$ 1,500	$ 1,500	$ -	$ 6,000	$ 4,500	$ 1,500	75%	$ 18,000
Training	$ 76	$ 1,750	$ (1,674)	$ 304	$ 1,750	$ (1,446)	576%	$ 910
Travel - Non-local mileage	$ 58	$ -	$ 58	$ 232	$ 206	$ 26	89%	$ 700
Travel - Non-local Hotel	$ 258	$ -	$ 258	$ 1,032	$ 395	$ 637	38%	$ 3,100
Travel - Meals	$ 46	$ -	$ 46	$ 184	$ -	$ 184	0%	$ 550
Total Expenses	$ 1,942	$ 3,252	$ (1,310)	$ 7,768	$ 6,858	$ 910	88%	$ 23,315
Total Revenue minus Expenses	$ 0	$ (1,310)	$ 1,310	$ -	$ 910	$ (910)	12%	$ -

Agenda Item: HUD 811 Update **Committee:** Business	**Board Meeting Date** January 30, 2025

Background Information:

Each of the Housing Boards is appointed by the Board of Trustees and each organization is a component unit of Tri-County Behavioral Healthcare.

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 2025 HUD 811 Report

Recommended Action:

For Information Only

1st Quarter FY 2025 HUD 811 Report

The Cleveland Supported Housing, Inc. Board (CSHI)

The CSHI Board held a meeting on December 13, 2024 where they reviewed financial statements, project status reports, and voted to accept the engagement letter from Pittsford Samuels, PLLC. The next meeting will serve as the the annual meeting and is scheduled for late March 2025. At the March Board meeting the preliminary audit will be reviewed along with regular items and elections will take place for officer positions.

The property is currently at 100% occupancy with two people on the waiting list. The property manager reports that the residents are doing well and continue to regularly participate in social activities throughout the month. Since the last report, Tri-County Staff made a visit to the property where the grounds and buildings were observed to be in good condition. Tri-County staff have been keeping the Board and Property Management up to date on the status of the new Cleveland Facility to ensure that all residents are prepared for the location change.

As of the Balance Sheet ending on September 30, 2024, the current outstanding payable to Tri-County is $19,237. The CSHI Board currently has three members and we continue to seek 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 10, 2024 where they reviewed financial statements, project status reports, and voted to accept the annual audit engagement letter from Pittsford Samuels, PLLC. The next meeting is scheduled for late March 2025 and will serve as the annual meeting.

The current outstanding payable to Tri-County is $29,718. As a reminder, these projects are not developed to make large profits. As such, MDP Management will review the financial status at the end of each year and if able, will make a payment toward the payable amount at that time.

Following consultation with the MSHI Board, MDP Management is currently exploring options for a new bank following concerns related to excess charges and customer service.

Independence Place is currently at 100% occupancy with four people on the waiting list and the property does not have any maintenance concerns at this time.

The MSHI Board currently has five board members with two new members attending the December meeting.

The Independence Communities, Inc. Board (ICI)

Following the ICI Board meeting on September 17, 2024, the Board elected to skip the December Board meeting and will reconvene at the annual meeting in late March where they will review financial statements, receive project status updates and elect officers for the next year. Staff provided an email update to the Board on January 2, 2025 following continued concerns form MDP Management related to the current bank charges and customer service. Decisions will be reviewed with the ICI Board and a special meeting may be called if deemed necessary but does not appear to be needed at this time.

Independence Village is currently at 100% occupancy with several people on the waiting list. Staff made a visit to the property in the first quarter of 2025 and the property manager reports that residents are doing well and there are no known maintenance issues at this time. The two units previously reported as being treated for bed bugs have been cleared as it is believed that the infestation has been eradicated.

The ICI Board currently has four members. We continue to accept recommendations for additional membership as they become available. Please contact Tanya with any potential leads.

Agenda Item: Tri-County's Consumer Foundation Board Update **Committee:** Business	**Board Meeting Date** January 30, 2025

Background Information:

The Tri-County Consumer Foundation Board of Directors met on January 10, 2025. The Board accepted the financial statements through December of 2024 and approved a spending limit for the 1st quarter of calendar year 2025 in the amount of $5,000.

4th Quarter Updates:

- Stephanie Luis was hired as the Community Engagement Specialist to work with the Foundation Board, among other duties.
- No fundraisers were scheduled.
- A recent parking spot auction for spots at Sgt. Ed Holcomb raised $765 total.
- A $1,000 check was received from the 'Big as Texas' concert event in the fall.
- The Board continues to seek a new President and additional Board Directors.

The Foundation currently has $40,737.87 in the bank.

The next meeting of the Foundation Board is April 11th, 2025.

Supporting Documentation:

None

Recommended Action:

For Information Only

UPCOMING MEETINGS

February 27, 2025 – Board Meeting

- Longevity Presentations
- Approve Minutes from January 30, 2025 Board Meeting
- Community Resources Report
- Consumer Services Report for January 2025
- Program Updates
- Personnel Report for January 2025
- Texas Council Risk Management Fund Claims Summary for January 2025
- Approve Financial Statements for January 2025
- Approve FY 2024 Independent Financial Audit
- FY 25 Budget Revision
- Board of Trustees Unit Financial Statement as of January 2025

March 27, 2025 – Board Meeting

- ISC Group Retirement Plan Presentation
- Approve Minutes from February 27, 2025 Board Meeting
- Community Resources Report
- Consumer Services Report for February 2025
- Program Updates
- FY 2025 Goals and Objectives Progress Report
- 2nd Quarter FY 2025 Investment Report
- 2nd Quarter FY 2025 Corporate Compliance and Quality Management Report
- 3rd Quarter FY 2025 Corporate Compliance Training
- Personnel Report for February 2025
- Texas Council Risk Management Fund Claims Summary as of February 2025
- Approve Financial Statements for February 2025
- 401(a) Retirement Plan Account Review
- Board of Trustees Unit Financial Statement as of February 2025

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
ASD	Autism Spectrum Disorder
ASH	Austin State Hospital
ATC	Attempt to Contact
BCBA	Board Certified Behavior Analyst
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
CAS	Crisis Access Services
CBT	Computer Based Training & Cognitive Based Therapy
CC	Corporate Compliance
CCBHC	Certified Community Behavioral Health Clinic
CCP	Charity Care Pool
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
CIT	Crisis Intervention Team
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

DID	Determination of Intellectual Disability
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
DUNN	Dunn Behavioral Health Science Center at UT Houston
Dx	Diagnosis
EBP	Evidence Based Practice
ECI	Early Childhood Intervention
EDO	Emergency Detention Order
EDW	Emergency Detention Warrant (Judge or Magistrate Issued)
EHR	Electronic Health Record
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.
MST	Multisystemic Therapy
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
OPC	Order for Protective Custody
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)
PCB	Private Contract Bed
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
RP	Recovery Plan
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
YCOT	Youth Crisis Outreach Team
YES	Youth Empowerment Services
YMHFA	Youth Mental Heath First Aid
YPS	Youth Prevention Services
YPU	Youth Prevention Selective

Updated January 6, 2025