

**Tri-County
Behavioral Healthcare
Board of Trustees
Meeting**

November 30, 2017



Notice is hereby given that a regular meeting of the Board of Trustees of Tri-County Behavioral Healthcare will be held on Thursday, November 30, 2017. The Business Committee will convene at 9:30 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.

AGENDA

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

- II. **Program Presentation - Huntsville Life Skills Christmas Carolers**

- III. **Presentation of Awards to Consumer Christmas Card Contest Winners**

- IV. **Approve Minutes - October 26, 2017**

- V. **Executive Director's Report - Evan Roberson**
 - A. IDD Waiver MCO Pilot Cancellation Update
 - B. PASRR Rate Hearing
 - C. Senate Bill 292 Program Proposal
 - D. ETBHN Update

- VI. **Chief Financial Officer's Report - Millie McDuffey**
 - A. FY 2017 Audit
 - B. Cost Accounting Methodology (CAM)
 - C. 2017 HCS, TxHmL & ICF and MEI Cost Reports
 - D. Budget Revision
 - E. Surplus Sale Update

- VII. **Program Committee**
 - Information Items
 - A. Community Resources Report *Pages 7-9*
 - B. Consumer Services Report for October 2017 *Pages 10-11*
 - C. Program Updates *Pages 12-16*
 - D. Mental Health Quality Management and Utilization Management Plan *Pages 17-51*

- VIII. **Executive Committee**
 - Action Items
 - A. Approve Revisions to Program Administration Board Policy *Pages 52-53*
 - Information Items
 - B. Personnel Report for October 2017 *Pages 54-56*
 - C. Texas Council Risk Management Fund Claims Summary for October 2017 *Pages 57-58*
 - D. Texas Council Quarterly Board Meeting Update *Page 59*

IX. Business Committee

Action Items

- A. Approve October 2017 Financial Statements..... *Pages 60-72*
- B. Reappoint Independence Communities, Inc. Board of Directors..... *Page 73*
- C. Reappoint Montgomery Supported Housing, Inc. Board of Directors..... *Page 74*
- D. Reappoint Cleveland Supported Housing, Inc. Board of Directors..... *Page 75*

Information Items

- E. Board of Trustees Unit Financial Statement for October 2017..... *Pages 76-77*

X. Executive Session in compliance with Texas Government Code Section 551.071, Consultation with Attorney and Section 551.074, Personnel.

Posted By:

Ava Green
Executive Assistant

Tri-County Behavioral Healthcare

P.O. Box 3067
Conroe, TX 77305

BOARD OF TRUSTEES MEETING

October 26, 2017

Board Members Present:

Patti Atkins
Richard Duren
Gail Page
Morris Johnson
Janet Qureshi
Sharon Walker
Tracy Sorensen
Jacob Paschal

Board Members Absent:

Tri-County Staff Present:

Evan Roberson, Executive Director
Millie McDuffey, Chief Financial Officer
Kathy Foster, Director of IDD Provider Services
Tanya Bryant, Director of Quality Management and Support
Amy Foerster, Chief Compliance Officer
Kenneth Barfield, Director of Management Info Systems
Breanna Robertson, Director of Crisis Services
Kelly Shropshire, Director of IDD Authority Services
Tabatha Abbott, Cost Accountant
Ava Green, Executive Assistant
David Deaton, Legal Counsel

Call to Order: Board Chair, Patti Atkins, called the meeting to order at 10:01 a.m. at 233 Sgt. Ed Holcomb Blvd. S., Conroe, TX.

Public Comment: There was no public comment.

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

Resolution #10-17-01

Motion Made By: Morris Johnson

Seconded By: Sharon Walker, with affirmative votes by Patti Atkins, Richard Duren, Gail Page, Tracy Sorensen, Jacob Paschal and Janet Qureshi that it be...

Resolved:

That the Board approve the minutes of the September 28, 2017 meeting of the Board of Trustees.

Program Presentations:

Longevity Recognitions

Executive Director's Report:

The Executive Director's report is on file.

Chief Financial Officer's Report:

The Chief Financial Officer's report is on file.

PROGRAM COMMITTEE:

The Community Resources Report was reviewed for information purposes only.

The Consumer Services Report for September 2017 was reviewed for information purposes only.

The Program Updates Report was reviewed for information purposes only.

The Medicaid 1115 Transformation Waiver report were reviewed for information purposes only.

The From the Heart Update was reviewed for information purposes only.

EXECUTIVE COMMITTEE:

Resolution #10-17-02

Motion Made By: Tracy Sorensen

Seconded By: Gail Page, with affirmative votes by Patti Atkins, Richard Duren, Morris Johnson, Sharon Walker, Janet Qureshi and Jacob Paschal that it be...

Resolved:

That the Board cast the election ballot for the Texas Council Risk Management Fund Board of Trustees as follows:

- Place 4: Mr. Gus Harris (Incumbent)
- Place 5: Mr. John Jackson (Incumbent)
- Place 6: Judge Van L. York (Incumbent)

Oaths of Office were recited by Gail Page and Tracy Sorensen for two year terms ending in August 2019.

The Personnel Report for September 2017 was reviewed for information purposes only.

The Texas Council Risk Management Fund Claims Summary for September 2017 was reviewed for information purposes only.

BUSINESS COMMITTEE:

Resolution #10-17-03

Motion Made By: Morris Johnson

Seconded By: Gail Page, with affirmative votes by Patti Atkins, Janet Qureshi, Tracy Sorensen, Jacob Paschal, Richard Duren and Sharon Walker that it be...

Resolved:

That the Board approve the September 2017 Financial Statements.

Resolution #10-17-04

Motion Made By: Morris Johnson

Seconded By: Jacob Paschal, with affirmative votes by Patti Atkins, Janet Qureshi, Sharon Walker, Tracy Sorensen, Gail Page and Richard Duren that it be...

Resolved:

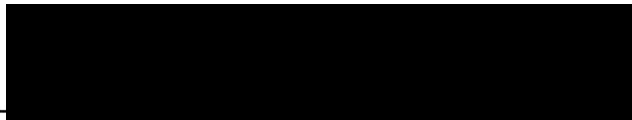
That the Board approve a \$1,500,000.00 Revolving Line of Credit.

The Board of Trustees Unit Financial Statements for August 2017 were reviewed for information purposes only.

There was no need for Executive Session.

The regular meeting of the Board of Trustees adjourned at 11:16 a.m.

Adjournment:



Patti Atkins
Chair

Date

Attest:



Gail Page
Secretary

Date



Executive Director's Report

November 30, 2017

Announcements

- The next regularly scheduled Board meeting is on January 25, 2018. As a reminder, this is the Board meeting where we review the annual financial audit for the Center. I wish each of you a wonderful Christmas.
- I wanted to let you know that we began remodeling the PETC lobby and Triage area on Monday. The flooring in the front of the PETC will be changed from carpet to tile and the walls in the lobby will be changed from sheet rock to medium density fiber board (MDF) covered by a durable Formica covering. While the initial finishes at the PETC looked nice, they have not held up well. These surfaces should be much more durable. November and December tend to be slower months, so hopefully the work can be done without major disruption to their work-flow. The work will be done in two phases and is estimated to take 3 weeks to complete.
- Reminder: The National Council Conference will be held on April 23-25th in Washington D.C. This year, the National Council required us to pay for our registration before we could reserve rooms in the hotel. We have reserved five (5) slots for the conference, which are refundable if we don't use them. If you are interested in attending, please let Ms. Patti Atkins or me know.
- Don't forget to collect your Board gifts today before you leave. The Huntsville Lifeskills folks made tote bags with the first initial of your last name, the Cleveland Lifeskills folks made ornaments and the Liberty Lifeskills folks made the Christmas ladder decoration.
- Today's cake is in honor of Ms. Gail Page who will have a birthday on December 27th.

Intellectual and Developmental Disabilities Managed Care Pilot Update

As we discussed in October, the Health and Human Services Commission has decided to cancel the IDD Managed Care Pilot that was supposed to inform the roll-out of Long Term Services and Supports (e.g. IDD Home and Community-based Services, Texas Home Living) into managed care.

The Director of Intellectual and Developmental Disability Services with the Texas Council, Erin Lawler, J.D., provided information to HHSC about required tests of the MCO roll-out which are

listed in Senate Bill 7. Dubbed 'The Letter' at the capital, the document (attached) was signed by Disability Rights Texas, the Private Provider Association of Texas, Providers Alliance for Community Services of Texas, Texas Advocates, Texas Council of Community Centers and The ARC of Texas. In addition Ms. Lawler provided HHSC staff with a 'Senate Bill 7 Requirements' spreadsheet which explained each requirement in the bill and where it was cited in the law. She also researched and provided HHSC with references to recorded testimony from the author of Senate Bill 7, Senator Jane Nelson, so that they were sure of her intent. The key message in both documents was for HHSC to conduct legitimate tests of areas required in Senate Bill 7 prior to moving IDD LTSS services into Managed care.

HHSC staff has indicated that they have no plans to change the movement of Long Term Services and Supports to Managed Care. They have not provided any further information on how they will meet the intent of the law. I will provide you additional details as they become available.

PreAdmission Services and Resident Review (PASRR) Rate Hearing

As the Board knows, the PreAdmission Screening and Resident Review (PASRR) process is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. The responsibility for compliance with this requirement has been assigned to Local Intellectual and Developmental Disability Authorities like Tri-County. Recently the state held rate hearings for PASRR services and several of the rates, if approved, will present challenges for our system of care much like the recent rates to Personal Attendant/Habilitation Services which resulted in our closure of the Texas Home Living (TxHmL) program. However, unlike TxHmL, the Center is mandated to provide these services either directly or under contract with another provider. Testimony on behalf of LIDAAs was provided by the Texas Council.

It obviously becomes problematic for us to have responsibility for this service if the rate is not adequate. I will provide more information to you as it becomes available.

Senate Bill 292 Program Proposals

Staff and I have been working on a grant submission in response to Senate Bill 292 which provides for 'Mental Health Grant Program for Justice-Involved Individuals.' As a reminder, Senate Bill 292 provides 12.5 million dollars in matching funds for counties of 250,000 or more in population in FY 2018 and will provide 25 million dollars for all counties in FY 2019. To qualify for the grant, we must have dollar for dollar grant match and must have the support of the county and any hospital districts in the county. I have narrowed seven (7) ideas down to two, an East County Crisis Extension Center and an Intensive Outpatient Services program, and will meet with the Public Health District about potential cash match for the programs on the afternoon of the 29th of November.

The East County Crisis Extension was originally the idea expressed at a meeting of the Montgomery County Sheriff's Captains in September. The Captains expressed that they

appreciated the work at the Psychiatric Emergency Treatment Center in Conroe, but needed an additional facility like that in East Montgomery County and West Montgomery County if they were going to divert more persons from the jails or emergency rooms. After meeting with the Captains, I was able to obtain information from the Montgomery County Hospital District's Ambulance service which, when combined with our data, does seem to support the need for additional facilities in east and west county. Staff and I determined that an East County expansion would be more operationally feasible because of our relationships with Kingwood Regional Medical Center (which is in Montgomery County) and Kingwood Pines Hospital in North Harris County.

Our proposal is for a 12 hour a day crisis drop-off location in Eastern Montgomery County which will serve as a place to screen and arrange placement for persons in behavioral health crisis. The facility, which would be rented, will be staffed by a Licensed Counselor or Social Worker, a bachelor's level staff, a Licensed Vocational Tech and a Psychiatric Nursing Assistant. In addition to staff, we would contract with an off-duty peace officer to handle peace-officer detentions as we do in Conroe. The cost of the program, with start-up expenses, is just under \$750,000 in the first year (includes facility remodel), and just under \$650,000 a year after that. The Public Health District has expressed some interest in funding cash match for the program.

The Intensive Outpatient Services program would provide care to up to 20 individuals who have been placed on Outpatient Commitments in Montgomery County. Often, persons with chronic mental illnesses choose not to participate in outpatient treatment and recidivate back into jails, ERs or in our crisis services. We have had some success keeping 5 individuals stable in Montgomery County who have been placed on Outpatient Commitments, but the cost of the pilot program is significant. The cost of the program is \$225,000 a year. We are still struggling to secure match for this program.

ETBHN Update

This has been an unusual year for the East Texas Behavioral Health Network and the services which are provided to member centers. Historically, ETBHN has finished the Fiscal Year with revenue over expenses of \$500,000 or more, largely driven by pharmacy revenue. This revenue is used to fund many of the services that are provided to member centers. This year, the pharmacy actually finished \$92,000 in the red and overall ETBHN finished with a revenue over expenses of \$135,161. Primary factors in the Pharmacy loss are: 1) many centers moving away from name brand medications where the mark-up is higher; 2) reduced productivity by staff; 3) problems with actively adjusting pharmaceutical prices; and, 4) increased use of Pharmacy Assistance Program scripts where ETBHN only gets a fee to fill the script (\$5). ETBHN has begun a pharmacy analysis and will be considering a variety of changes. It should be noted that the pharmacy is operating in the black (\$11,500) in FY 2018 thus far.

Senate Bill 1326 Handout

As mentioned at the last Board meeting, staff and I have developed a handout for jail staff to use for the screening of persons with mental illnesses in the jail. The form (attached) is, we

believe, a simpler explanation of the process that we believe is in compliance with the new legislation. We will be visiting with jail staff in our three counties in the coming weeks and may modify the document as needed.

October 12, 2017

Ms. Jami Snyder
Associate Commissioner, Medicaid and CHIP Services
Health and Human Services Commission
P.O. Box 13247
Austin, Texas 78711-3247

Dear Ms. Snyder:

We represent a coalition of diverse stakeholders with a strong interest in the well-being of Texans with intellectual and developmental disabilities (IDD). Collectively, we urge HHSC to adhere to the requirements of law and move with deliberate care in implementing the significant redesign of long-term services and supports (LTSS) for individuals with IDD.

In this letter, we reflect on two significant expectations of Senate Bill 7 (83rd Legislature, Regular Session) (SB 7): first, the careful, evaluative process required by law and second, the protective provisions Senator Nelson amended into SB 7, with deliberate action, when she laid the bill out to the full Senate on March 25, 2013. Additionally, we describe our concerns about the haste with which the agency is currently pursuing a potential transition of IDD LTSS to a managed care model and how this haste may place the Health and Human Services Commission (HHSC) out of compliance with statute and its own procurement and contracting protocols. Finally, we offer our recommendation for a path forward that affords an opportunity to redesign our system in a way that ensures quality and cost-effective services for Texans with IDD.

STATUTORY REQUIREMENTS

SB 7 directs HHSC to implement a system of acute care services and LTSS for individuals with IDD "in the manner and in the stages" described in statute.¹ The manner and stages of implementation require:

- measured, incremental change;
- evaluations and analyses of system changes;
- determinations by HHSC regarding certain transitions;
- substantial stakeholder involvement;
- protective provisions designed to acknowledge distinct, lifelong needs of people with IDD.

Generally, the system change directed by SB 7 is separated into two stages:

- **Stage One: Programs to Improve Service Delivery Models**
- **Stage Two: Transition of Long-term Care Medicaid Waiver Recipients to Integrated Managed Care System**

¹ Government Code Sec. 534.052.

The stages and required actions are described below, along with current status of each action. A more detailed summary, including requirements of each action and statutory citations, is included in Appendix 1.

STAGE ONE: PROGRAMS TO IMPROVE SERVICE DELIVERY MODELS

1. Develop and Implement Pilot Programs to Test Managed Care Strategies: **Cancelled²**
2. Deliver Acute Care Services for Individuals with IDD through Managed Care: **Implemented**
3. Analyze Acute Care Outcomes: **Incomplete**
4. Implement Attendant and Habilitation Services [Community First Choice]: **Implemented**

STAGE TWO: TRANSITION OF LONG-TERM CARE MEDICAID WAIVER RECIPIENTS TO INTEGRATED MANAGED CARE SYSTEM REQUIRED BEFORE POTENTIAL TRANSITION OF TXHML:

1. Evaluate Cost-effectiveness of Potential TxHmL Transition: **Status unknown**
2. Evaluate Experience of Providing Community First Choice: **Status unknown**
3. Determine Whether to Provide All or a Portion of TxHmL LTSS through Managed Care: **Status unknown**
4. Determine Whether the STAR+PLUS Medicaid Managed Care Program Delivery Model or a Different Integrated, Capitated Managed Care Delivery Model is Most Appropriate (based on 1 and 2 above) **Status unknown**

REQUIRED UPON POTENTIAL TRANSITION OF TXHML:

5. Develop Stakeholder Process re: Implementation of TxHmL Transition: **Status unknown**
6. Develop TxHmL Transition Plan to Ensure Continuity of Care: **Status unknown**
7. Develop MCO Contract Requirements: **Started**

REQUIRED PRIOR TO TRANSITION OF CLASS, DBMD, AND HCS WAIVER PROGRAMS AND ICF-IID PROGRAM

8. Evaluate Cost-effectiveness of Potential Transition of CLASS, DBMD, and HCS Waiver Programs and ICF-IID Program: **Status unknown**
9. Analyze TxHmL Transition: **Status unknown**
10. Evaluate MCO Provider Network Experience and Expertise: Children's Services: **Status unknown**
11. Evaluate MCO Provider Network Experience and Expertise: Adult Services: **Status unknown**
12. Determine Whether to Transition Services: **Status unknown**
13. Determine Whether to Provide All or a Portion of Services in Managed Care: **Status unknown**
14. Determine Whether the STAR+PLUS Medicaid Managed Care Program Delivery Model or a Different Integrated, Capitated Managed Care Delivery Model is Most Appropriate (based on 8 and 9 above) **Status unknown**

REQUIRED UPON TRANSITION OF CLASS, DBMD, AND HCS WAIVER PROGRAMS AND ICF-IID PROGRAM

15. Develop Stakeholder Process re: Implementation of CLASS, DBMD, HCS, and ICF-IID Transition: **Status unknown**
16. Develop Transition Plan to Ensure Continuity of Care: **Status unknown**
17. Establish Process for Voluntary Enrollment: **Status unknown**
18. Develop MCO Contract Requirements: **Started**

² Implementation of the pilots described by SB 7 was permissive, not mandatory. Government Code Sec. 534.102. All other actions outlined here are mandatory.

As you can see, in passing SB 7 the Legislature included comprehensive requirements to ensure a deliberate decision-making approach to the potential transition, of part or all of IDD waiver services and the ICF-IID program, to managed care.

HHSC must, in consultation and collaboration with the IDD SRAC, develop a realistic timeline for completing each required element of the two stages identified in law.

LEGISLATIVE HISTORY

When SB 7 was filed and initially heard in the Senate Health and Human Services Committee, there was an intensive backlash from individuals, families, providers, and other stakeholders. The backlash was driven primarily by fear of what could happen if insurance companies, without experience in providing LTSS for people with IDD, were legislatively mandated to control funds and manage services designed to improve quality of life and diminish risk of institutional care for people with IDD.

On March 25, 2013, from the floor of the Texas Senate, Senator Jane Nelson, as author of SB 7, introduced a Committee Substitute and a substantial amendment to SB 7. Senator Nelson stated that countless hours and endless meetings were held with stakeholders to reach agreement on the proposed amendment. The agreement captured by the amending language substantially alleviated fears of losing valued services in an uncertain managed care environment and ensured the agency would take deliberate steps in making decisions about any future transition into managed care.

The amendment was endorsed unanimously by the Senate and ultimately became law. Among other things, the statutory provisions of the amendment:

- allow individuals with IDD receiving LTSS through the Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), and Home and Community-based Services (HCS) Waiver Programs and the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) program to remain in their waiver or ICF-IID program or transition to a managed care model *if* IDD LTSS services are carved-in to managed care;
- clarify that IDD system redesign goals include promotion of independent case management and prevention of inappropriate institutionalization; and
- clarify that HCS and TxHml Waiver providers may provide Community First Choice (CFC) services through STAR+PLUS.

The provisions of the amendment underscore common principles of the IDD system redesign and remind us of specific legislative action taken to honor these principles: choice, conflict-free case management, community integration, and continuity of care from quality service providers with experience and expertise in IDD services.

CONCERNS

Substantial stakeholder concerns about recent developments in the IDD system redesign implementation can be summarized as: (1) divergence from the measured, incremental change and evaluation points mandated by SB 7, and (2) undue, detrimental haste in attempting to assess system readiness through the STAR+PLUS reprocurement RFP that is already underway.

On September 17, 2017 informal reports from individual stakeholders indicated the agency was planning to cancel a keystone of the IDD system redesign directed by SB 7, the pilot program to test one or more service delivery models involving a managed care strategy to deliver LTSS to individuals with IDD (the IDD Managed Care Pilot).

The first known official announcement of the decision to cancel the pilot was released on September 18, 2017 in a written statement to the IDD System Redesign Advisory Committee (IDD SRAC). Subsequently, the Texas Medicaid Director personally announced the decision to cancel the pilot to a new workgroup comprised of former members of the Promoting Independence Advisory Committee (PIAC) and other stakeholders.

The IDD Managed Care Pilot was anticipated to allow for meaningful evaluation of the merits of a transition of IDD LTSS from a traditional Medicaid model to a managed care model through comparisons of the following measurable data points:

- average monthly cost per person for acute care and LTSS;
- utilization of non-residential settings and non-provider-owned housing (community integration and prevention of institutionalization);
- average total Medicaid cost, by level of need, in various residential settings;
- percentage of individuals employed in meaningful, integrated settings;
- impact on behavioral, medical, life-activity and other personal outcomes; and
- overall client satisfaction.³

We acknowledge that a pilot to test one or more service delivery models involving a managed care strategy was a permissive, not mandatory, element of IDD system redesign under SB 7 and we recognize that the opportunity for a pilot was foreclosed by the implementation risks and barriers HHSC encountered. The absence of a pilot creates a need for alternate mechanisms for a meaningful evaluation of the merits of a transition of IDD LTSS to managed care before a determination on the TxHmL transition can be made, including the statutorily required analysis of the acute care carve-in, evaluation of cost-effectiveness, and evaluation of the CFC experience. During the meeting with former PIAC members and other stakeholders on September 19, 2017, HHSC officials described intent to embark on a fast-paced effort to include questions in the final version of the STAR+PLUS reprocurement RFP that would allow the agency to move forward with the “required transition” of TxHmL Waiver services to managed care on September 1, 2020 and other waiver services and ICF-IID on September 1, 2021 without a subsequent procurement.

The convened stakeholder workgroup expressed substantial concern about the reference to “required transition” and a rushed process to include IDD elements in the procurement already well underway, with public comments due October 14, 2017, and a tight timeline for final release on November 17, 2017 (estimated). Various members of the stakeholder workgroup pointed out the obligations of the agency to evaluate cost-effectiveness and determine whether to provide all or a portion of IDD waiver services in managed care, prior to any transition. HHSC representatives present expressed they were not aware of these statutory obligations.

We believe the rush to include questions assessing MCO readiness for an IDD LTSS carve-in during the term of the upcoming STAR+PLUS contract places HHSC at risk of not complying with its own contracting protocols. The draft RFP does not include requirements specific to the CLASS, DBMD, HCS, ICF-IID, and TxHmL populations or their home and community-based services (HCBS). More specifically, the RFP lacks requirements for HCBS network development and adequacy, use of a functional assessment tool, care coordination, member and provider education, claims processing, and other critical components needed to care for these members. HHSC will not have a complete picture when awarding contracts, and risks selecting vendors that do not offer best value to the state for these vulnerable populations. Requiring selected MCOs to complete readiness reviews before placing these populations in STAR+PLUS does not address this concern, and does not meet the requirements of SB 7.

³ Government Code Sec. 534.108(a)(1)-(7).

GOING FORWARD

If HHSC does not adhere to the provisions set forth in law, high numbers of individuals and families currently in CLASS, DBMD, HCS, and ICF-IID programs will undoubtedly choose to remain in current services rather than choose a managed care environment that they are fearful will result in a loss of vital community-based services. This path will not only fail to yield an effective transition to managed care, but will set the stage for a substantial lack of trust in HHSC and lost opportunity to redesign a system in a way that ensures the highest quality and most cost-effective service system for Texans with IDD.

At this time, individuals, families, service providers, advocates, and other stakeholders speak with one voice in raising substantial concerns about the impact of managed care on access to acute care services. The united voice is heard at the Capitol, at HHSC rate hearings, and in stakeholder forums. Until an assessment of acute care services delivered through a managed care model is complete, as required by SB 7, stakeholders will be highly concerned about any further managed care carve-ins.

Additionally, since June 2015, the IDD system in Texas has tested the provision of LTSS through a managed care model in the Community First Choice benefit. Stakeholders describe, and we believe data will bear out, that the CFC implementation has many rough edges, including insufficient reimbursement rates for providers, provider network adequacy issues, and lack of communication among involved parties, including the agency.

For these reasons, we urge HHSC to halt use of the STAR+PLUS repurchase RFP as a vehicle for assessing MCO readiness for a potential transition of IDD LTSS, re-commit itself to the measured changes, evaluations, and determinations required by law, and continue to involve IDD stakeholders in the evaluative process.

CLOSING

Ms. Snyder, we are grateful to you and your team for your commitment to IDD system redesign in Texas. We look forward to continuing our work with HHSC to ensure individuals with IDD benefit from quality acute care services and LTSS that promote independence, community integration, and quality of life.

SIGNATORIES:

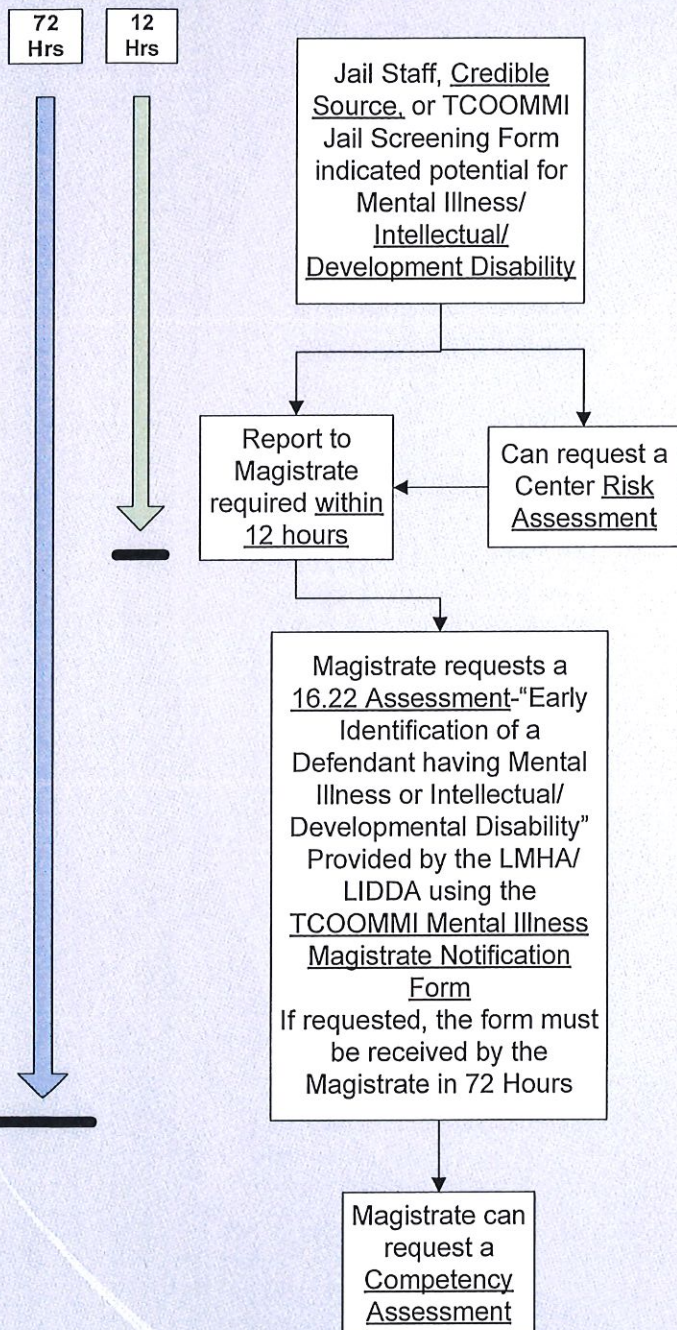
DISABILITY RIGHTS TEXAS
PRIVATE PROVIDER ASSOCIATION OF TEXAS
PROVIDERS ALLIANCE FOR COMMUNITY SERVICES OF TEXAS
TEXAS ADVOCATES
TEXAS COUNCIL OF COMMUNITY CENTERS
THE ARC OF TEXAS

cc: Charles Smith, Executive Commissioner, HHSC
Enrique Marquez, Deputy Executive Commissioner for Medical and Social Services, HHSC
Sonja Gaines, Associate Commissioner for IDD and Behavioral Health Services, HHSC

Revised Jail Screening Process

Contact Information

Contact the Center via the 24/7 Hotline
Number: **800-659-6994**



Defined Terms

Credible Source-Defined in law as one who is trustworthy and entitled to be believed; one who is entitled to have his oath or affidavit accepted as reliable. Often this will be a family member.

Intellectual and Developmental Disability-Formerly known as Mental Retardation. Intellectual/Development Disability is a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability must have originated before the age of 18.

LMHA-Local Mental Health Authority. In this case Tri-County Behavioral Healthcare.

LIDDA-Local Intellectual and Developmental Disability Authority. In this case Tri-County Behavioral Healthcare.

QMHP/QIDP-A designation by the state for bachelors level staff with required training as a Qualified Mental Health or Intellectual Disability Professionals. These are non-licensed staff working under the supervision of licensed staff.

Risk Assessment-A face to face assessment provided by LMHA/LIDDA QMHP/QIDP staff at the jail, to assess for the need to put someone on suicide precautions and/or to assess the symptoms of mental illness/Intellectual/Developmental Disability. Can include assistance with civil commitment if charges are to be dropped. May also include recommendation for the forensic waiting list. May also include information about current diagnosis/medications if person assessed is a current consumer.

Suicide Precautions-Recommendation of placing someone that shows signs of mental illness or risk behaviors that could result in self-injurious behavior into a lower risk jail environment.

16.22 Assessment -Early Identification of Defendant Suspected of having Mental Illness or Intellectual/Developmental Disability. The 16.22 Assessment is to be documented on the state required form, developed by TCOOMMI-the TCOOMMI Mental Illness Magistrate Notification Form- which is used to capture information about an inmates previous mental health or Intellectual Disability treatment history.

Competency Assessment-An assessment provided by a physician or psychologist licensed in the state of Texas with the added or special qualifications in Forensic psychiatry/psychology and certain other training. The Court may appoint as experts qualified employees of the LMHA/LIDDA, but the LMHA/LIDDA is entitled to separate compensation and reimbursement.

CHIEF FINANCIAL OFFICER'S REPORT

November 30, 2017

FY 2017 Audit – We are continuing to work on the audit with the Scott, Singleton, Fincher and Company and should be in the final stages of completing the audit schedules. The auditors were on site the week of November 1st through the 4th. This visit was focused on our financial statements and fixed assets. We have not received information of areas of concern, so we are hoping to have a clean audit again this year.

Below are a few of the items that were discussed in more detail:

- **Sale of Fixed Assets – Buildings** - A significant amount of time was spent discussing all the final sales of the properties sold during fiscal year 2017. This included the ICF Contracts and the vacant properties. We were able to reconcile all sales and the auditor was able to track the activity.
- **Managed Care** – We discuss this almost every year - the allowance for doubtful accounts. As the Managed Care reimbursement continues to increase, we will have to ensure that this amount is analyzed and is still adequate based on the amounts that we are collecting.

Cost Accounting Methodology (CAM) – We started pulling the service data for the FY 2017 CAM report. The requirements have not changed over the last few years and we are only required to submit the CAM for mental health services. The due date for the preliminary report is January 29, 2018 and the final report is due on February 27, 2018. Over the next couple of weeks, we will be spending time reviewing service data, consolidating payroll data and then producing the preliminary CAM for the period. Prior to submission, we will analyze the cost data and research any costs that have significant variances as compared with prior year's data.

FY 2017 HCS, TxHmL & ICF and MEI Cost Reports – We are also starting to work on the HCS, Texas Home Living, ICF and MEI cost reports for FY 2017. These are due in the spring of each year. This year will be the last for the ICF portion of the report since we sold the contracts.

Budget Revision – We predict the first budget revision will come to the Board for approval in February. This revision will have a contract revision on the mental health services contract and will also reflect additional programs such as the Hurricane Harvey FEMA contracts.

Surplus Sale of Excess Furniture and Equipment – We did conduct a surplus sale on November 10th. We made \$347 from the sale of our furniture and \$115 for taking the leftover filing cabinets to the scrap yard. Some of the better furniture was set aside in anticipation of an expansion clinic in Cleveland. We have disposed of the remaining items so the Maintenance facility can be ready for From the Heart gift sorting in the coming weeks.

Agenda Item: Community Resources Report Committee: Program	Board Meeting Date: November 30, 2017
Background Information: None	
Supporting Documentation: Community Resources Report	
Recommended Action: For Information Only	

Community Resources Report

October 27, 2017 – November 30, 2017

Volunteer Hours:

Location	October
Conroe	211.75
Cleveland	2
Liberty	25
Huntsville	17.5
Total	256.25

COMMUNITY ACTIVITIES:

10/27/17	Walker County Juvenile Justice Meeting	Huntsville
11/1/17	Liberty County Veteran Service Officer Planning Meeting	Liberty
11/1/17	Presentation to the Leadership Montgomery County Board	Conroe
11/1/17	The Woodlands Community Relations Team Meeting	The Woodlands
11/1/17	Conroe Noon Lions Club Luncheon	Conroe
11/1/17	Liberty County Mental Health Initiative Services Probation Meeting	Liberty
11/2/17	2 nd Annual Veterans of Foreign War Campaign to Change Direction	Conroe
11/2/17	Leadership Montgomery County Education Day	The Woodlands
11/2/17	American Addiction Centers Meeting	Conroe
11/2/17	Office of Emergency Management Community Meeting	Conroe
11/2/17	Cleveland Chamber of Commerce Luncheon	Cleveland
11/2/17	Senator Nichols Fish Fry Event	Conroe
11/4/17	Cleveland Health Fair	Cleveland
11/6/17	Veteran 101	Conroe
11/6/17	Homeless Coalition Board Meeting	Conroe
11/7/17	E3 Steering Committee	The Woodlands
11/7/17	Conroe ISD Mentor Lunch	Conroe
11/7/17	MCCARES	The Woodlands
11/8/17	Conroe Noon Lions Club Luncheon	Conroe
11/8/17	Liberty County Community Resource Coordination Group	Liberty
11/9/17	Huntsville Chamber of Commerce Breakfast	Huntsville
11/9/17	Mindfulness Presentation for Conroe ISD School Counselors	Conroe
11/11/17	First Baptist Church FEMA Outreach Fair	Cleveland
11/14/17	Conroe Chamber Luncheon	Conroe
11/14/17	Empty Bowls Luncheon	Conroe
11/14/17	Conroe ISD Mentor Luncheon	Conroe
11/14/17	Veterans Treatment Court	Conroe
11/14/17	Montgomery County Community Resource Coordination Group	Conroe
11/15/17	Coffee and Connections Community Network Meeting	The Woodlands
11/15/17	Conroe Noon Lions Luncheon	Conroe
11/15/17	Liberty County Senior Home Fishing Event	Liberty

11/15/17	Liberty Chamber of Commerce Luncheon	Liberty
11/15/17	Multidisciplinary Behavioral Health Team Quarterly Meeting	Huntsville
11/16/17	Veteran 101 and Mini Resource Fair	New Caney
11/16/17	Homeless Coalition Meeting	Conroe
11/20/17	KSHN Party Line Radio Show	Liberty
11/20/17	Spiritual Care Networking Meeting	The Woodlands
11/21/17	North Houston Networking Group	The Woodlands
11/21/17	Conroe ISD Mentor Lunch	Conroe
11/22/17	Conroe Noon Lions Club Luncheon	Conroe
11/28/17	Montgomery County Business Women's Luncheon	Conroe
11/28/17	Conroe ISD Mentor Lunch	Conroe
11/29/17	Conroe Noon Lions Luncheon	Conroe
11/28/17	Veterans Treatment Court	Conroe

UPCOMING ACTIVITIES:

12/7/17	Cleveland Chamber of Commerce Luncheon	Cleveland
12/13/17	Outreach, Screening, Assessment and Referral to Treatment Meeting	League City
12/13/17	Liberty County Community Resource Coordination Group	Liberty
12/14/17	Huntsville Chamber of Commerce Breakfast	Huntsville
12/19/17	Montgomery County Community Resource Coordination Group	Conroe
12/20/17	Liberty Chamber of Commerce Luncheon	Liberty
1/4/18	Cleveland Chamber of Commerce Luncheon	Cleveland
1/10/18	Liberty County Community Resource Coordination Group	Liberty
1/11/18	Huntsville Chamber of Commerce Breakfast	Huntsville
1/16/18	Montgomery County Community Resource Coordination Group	Conroe
1/17/18	Liberty Chamber of Commerce Luncheon	Liberty
1/18/18	Homeless Coalition Meeting	Conroe
1/20/18	Conroe ISD Employee Health Fair	Conroe
2/1/18	Cleveland Chamber of Commerce Luncheon	Cleveland
2/1/18	Homeless Coalition Meeting	Conroe
2/10/18	Liberty Chamber of Commerce Luncheon	Liberty
2/14/18	Liberty County Community Resource Coordination Group	Liberty
2/15/18	Huntsville Chamber of Commerce Breakfast	Huntsville
2/21/18	Liberty Chamber of Commerce Luncheon	Liberty

Agenda Item: Consumer Services Report for October 2017 Committee: Program	Board Meeting Date: November 30, 2017
Background Information: None	
Supporting Documentation: Consumer Services Report for October 2017	
Recommended Action: For Information Only	

Consumer Services Report October 2017

Consumer Services	Montgomery County	Cleveland	Liberty	Walker County	Total
Crisis Services, MH Adults/Children					
Persons Screened, Intakes, Other Crisis Services	648	49	27	50	774
Crisis and Transitional Services (LOC 0, LOC 5)	44	2	0	1	47
Psychiatric Emergency Treatment Center (PETC) Served	71	8	4	7	90
Psychiatric Emergency Treatment Center (PETC) Bed Days	286	40	16	22	364
Contract Hospital Admissions	10	1	0	0	11
Diversion Admits	10	1	0	1	12
Total State Hospital Admissions	0	0	0	0	0
Routine Services, MH Adults/Children					
Adult Service Packages (LOC 1m,1s,2,3,4)	1302	143	123	103	1671
Adult Medication Services	856	91	87	95	1129
Child Service Packages (LOC 1-4 and YC)	537	55	16	65	673
Child Medication Services	263	17	6	29	315
TCOOMMI (Adult Only)	132	17	20	9	178
Adult Jail Diversions	5	0	0	0	5
Persons Served by Program, IDD					
Number of New Enrollments for IDD Services	3	0	0	0	3
Service Coordination	638	38	46	64	786
Persons Enrolled in Programs, IDD					
Center Waiver Services (HCS, Supervised Living, TxHmL)	39	5	17	21	82
Substance Abuse Services					
Children and Youth Prevention Services	59	99	0	36	194
Youth Substance Abuse Treatment Services/COPSD	11	0	0	0	11
Adult Substance Abuse Treatment Services/COPSD	28	0	0	0	28
Waiting/Interest Lists as of Month End					
Adult Mental Health Waiting List	6	0	0	0	6
Home and Community Based Services Interest List	1565	127	131	147	1970
October Served by County					
Adult Mental Health Services	1694	171	136	183	2184
Child Mental Health Services	671	60	19	70	820
Intellectual and Developmental Disabilities Services	669	44	53	74	840
Total Served by County	3034	275	208	327	3844
September Served by County					
Adult Mental Health Services	1695	153	110	184	2142
Child Mental Health Services	586	51	18	65	720
Intellectual and Developmental Disabilities Services	638	45	51	67	801
Total Served by County	2919	249	179	316	3663
August Served by County					
Adult Mental Health Services	1619	162	128	196	2105
Child Mental Health Services	581	56	19	58	714
Intellectual and Developmental Disabilities Services	648	46	48	70	812
Total Served by County	2848	264	195	324	3631

Agenda Item: Program Updates	Board Meeting Date: November 30, 2017
Committee: Program	
Background Information: None	
Supporting Documentation: Program Updates	
Recommended Action: For Information Only	

Program Updates

October 27, 2017 – November 30, 2017

Crisis Services

1. The Crisis Department assisted in getting two individuals placed at Rusk State Hospital the last week of October. One of the individuals had been at St. Luke's since early October due to complex medical and mental health issues.
2. Recently Cypress Creek and Kingwood Pines Hospitals have had problems with the current language in Montgomery County Emergency Detention Orders. This has caused some barriers in getting Tri-County clients admitted to their facility unless the individual is under an Order of Protective Custody. Montgomery County Sherriff's Office Precinct 1 and JD Lambright's Office are working with the hospital CEO's to help resolve the issue.

MH Adult Services

1. The Rural Adult Outpatient programs are fully staffed, with four new hires completing training and assuming independent case management duties.
2. Adult Outpatient is developing a policy defining medication refill protocols and the scheduling of brief office visits.

MH Child Services

1. We continue to experience significant turnover in staff due to promotions and life events (i.e. child birth, family illnesses, relocations).
2. C&Y supervisors are interviewing applicants and training new hires to keep caseloads manageable.
3. C&Y supervisors are diligently providing more clinical supervision to staff due to the increasing demand for services for child and youth with more complex needs.
4. The C&Y team continues to offer and provide learning opportunities to school counselors to assist with behavioral health responses in the schools.

Criminal Justice Services

1. TCOOMMI adult caseloads are within contracted numbers and that revenue has remained steady. The Montgomery County Jail Liaison assessed 41 individuals and coordinated the treatment of 7 others in October. In addition, we provided discharge planning assistance for 88 individuals before leaving the jail in October.
2. The Outpatient Competency Restoration program has admitted 3 individuals in FY18 and is currently serving 4 and the Jail Diversion clinician assessed 13 individuals at the jail and was able to divert 1 in October.

Substance Abuse Services

1. Adult Substance Abuse Treatment is currently reviewing models for COPSD services that integrate mental health and substance abuse treatment in an effort to enhance service offerings for individuals with comorbid substance use and mental health. Further, the program is reviewing the processes and training needed to implement the evidenced based practice for addressing post-traumatic stress disorder, Seeking Safety. This therapeutic model focuses on the behaviors, moods, and thoughts around trauma that perpetuate substance use and seeks to provide education and training on the development of healthy coping strategies as well as challenging maladaptive thinking patterns.
2. Referrals to our Youth Substance Abuse Treatment program from Montgomery County Juvenile Justice continue to increase due to regular meetings with Juvenile Services. However, the challenge for this program continues to be engagement of youth and families referred for treatment as most are in denial of the need.
3. We are providing prevention services in schools in all three counties this school year and are on target for meeting our contracted service targets. The requests for prevention services continue to exceed our funding under the current grant, so we are working closely with our region's Prevention Resource Center to prepare for a larger request during the next grant cycle.

IDD Services

1. IDD Authority continues to wait on the response from HHSC concerning the Autism Program application that has been submitted.
2. The annual IDD Authority survey has been delayed until March 26th through 29th due to Harvey recovery.
3. The Centers TxHmL contract ends November 30th. Authority and Provider teams have been busy completing required paperwork and preparing consumers for transition to private providers.
4. Provider revenue and expenses are being analyzed to develop plan to address another 21% cut pending for PASRR services that will go into effect December 1st.

Support Services

1. **Quality Management:**
 - a. Staff completed the Program Survey for Child and Youth Services, Levels of Care 1, 2, and 3.
 - b. Staff is currently conducting a Program Survey of Criminal Justice Services.
 - c. Telemedicine surveys were completed for Q1 of FY 18. All but 1 had very positive reviews of the service.
2. **Utilization Management:**
 - a. Staff is beginning to make contact with the 6 (six) individuals on the wait list.
 - b. The Clinical Trainer is now certified as a Child Needs and Strengths (CANS)/ Adult Needs and Strengths (ANSA) Assessment Superuser.

3. **Training:**
 - a. Staff began providing Trauma Informed Care to all new employees beginning on November 13th and has continued to provide additional trainings to existing employees as needed.
 - b. The Clinical Trainer is now trained as a trainer in Psychological First Aid (PFA), Satori Alternatives to Managing Aggression (SAMA), Cardiopulmonary Resuscitation CPR, and has obtained training in Person Centered Recovery Planning (PCRP) through the State.

4. **Veteran Affairs:**
 - a. Staff hosted the 2nd Annual Veterans of Foreign Wars (VFW) Campaign to Change Direction on the dialogue on mental health for American's Veterans. Six (6) veterans attended the movie screening and discussion.
 - b. On November 15th Staff took 10 veterans out for a day of fishing at the Champions Lake Pier on the Trinity River Wildlife Refuge.
 - c. Staff held a Veterans 101 Training and Mini Resource Fair at the New Caney Library on November 16th. This event was designed to provide resources and information to veterans in the community that have been affected by Hurricane Harvey.

Community Activities

1. From the Heart is in full swing – we currently have 82 families adopted, we've received \$2800 in cash, and have had 30 brand new bicycles donated.
2. The Christmas Party at Main Event has been scheduled for December 1st from 1-5pm.
3. Crisis Counseling Program Staff are very involved in all 3 counties providing information, support, and referrals for individuals affected by Hurricane Harvey.
4. Crisis Counseling Program Team Lead, Director of Strategic Development, and the Executive Director will be guests on the local Liberty Radio Station KSHN Party Line to provide information on the CCP program and how to request help.

Community Activities

1. From the Heart is in full swing – we currently have 77 families adopted, we've received \$2800 in cash, and have had 30 brand new bicycles donated.
2. The Christmas Party at Main Event has been scheduled for December 1st from 1-5pm.
3. Crisis Counseling Program Staff are very involved in all 3 counties providing information, support, and referrals for individuals affected by Hurricane Harvey.
4. Crisis Counseling Program Team Lead, Director of Strategic Development, and the Executive Director will be guests on the local Liberty Radio Station to provide information on the CCP program and how to request help.

Agenda Item: Mental Health Quality Management and Utilization Management (MH QM/UM) Plan

Board Meeting Date

November 30, 2017

Committee: Program

In 2006, Tri-County split the Center's Quality Management Plan into a plan for mental health services and a plan for intellectual and developmental disability services due to increasingly different expectations for quality management activities in the contracts for Department of State Health Services (DSHS) and Department of Aging and Disability Services (DADS). While the Health and Human Services Commission (HHSC) now oversees both IDD and MH services, we continue to need both plans to ensure compliance with HHSC contract requirements.

The MH QM/UM Plan describes the administrative structures that the Center has in place to evaluate service provision and ensure contract compliance. The MH QM/UM Plan was reviewed and updated as necessary to ensure compliance with current HHSC contract requirements and Texas Administrative Code (TAC).

Typically the Board has approved the QM/UM Plan at the same time as the Mental Health Local Plan and Local Planning Network Development Plan. However, the Local and LPND plans have been delayed and are currently due at the end of April. Staff thought that it was appropriate to update the MH QM/UM plan at this time, but recognize that it may need to be reevaluated later this year if contract changes are significant.

The changes were relatively minor and include updates to references to the Department of State Health Services, updated references to our new name for the program evaluation called 'program survey' and a series of updates to staff duties and community activities.

Supporting Documentation:

Mental Health QM/UM Plan for Fiscal Years 2018-2019

Recommended Action:

Approve the Mental Health Quality Management and Utilization Management Plan for Fiscal Years 2018-2019



Tri-County Behavioral Healthcare

Mental Health Quality Management and Utilization Management Plan For Fiscal Years 2018-2019

Evan Roberson, Executive Director

Date

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INTRODUCTION

The Mental Health Quality Management and Utilization Management (MH QM/UM) Plan is a document written to provide a framework of activities designed to ensure that individuals, who are receiving assistance through Tri-County Behavioral Healthcare (Tri-County), are receiving quality services provided by culturally competent and adequately trained staff in a manner that is financially viable.

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

The Quality Management and Utilization Management Departments work closely with program managers and direct service staff to ensure that they are compliant with contract requirements and State regulations. We are constantly measuring, assessing and striving to improve our local authority functions 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 provided to HHSC are key focuses of our Quality Management and Utilization Management programs.

MISSION, VISION AND PHILOSOPHY STATEMENT

Mission

Our mission is to ensure the provision of quality services for individuals with mental illness, substance abuse disorders and intellectual/developmental disabilities to enhance the quality of life in our community.

Vision

Our vision is to develop a mental health and developmental disabilities care system with adequate resources that ensures the provision of effective and efficient services to meet the needs of our community.

To achieve our vision, we will partner with the community to:

- Expand the availability of new and existing resources; and
- Assure the availability of technically and culturally competent staff

Philosophy/Values

The CORE Values of Tri-County Behavioral Healthcare are:

<i>Commitment</i>	We are committed to honesty and integrity
<i>Optimism</i>	We are optimistic about the future of those we serve and for Tri-County
<i>Respect</i>	Everyone deserves to be treated with dignity and respect
<i>Excellence</i>	We will strive for excellence in all that we do

MISSION OF THE QUALITY/UTILIZATION MANAGEMENT DEPARTMENTS

The mission of the Quality/Utilization Management Departments is to ensure that the highest possible quality of services is provided to our stakeholders while also ensuring the provision of cost effective and timely services provided in the most appropriate settings.

DIRECTION OF THE QUALITY/UTILIZATION MANAGEMENT PROGRAMS

The Quality/Utilization Management Programs focus on a systematic, objective, and continuous process for monitoring, evaluating, and improving the quality, cost effectiveness, appropriateness, and timeliness of service delivery systems within our organization. The QM/UM Program assists Tri-County in assuring existing standards of care are met, accurate information is reported to DSHS as requested, and provides the framework to obtain feedback from stakeholders on the manner in which the Center conducts its business.

MENTAL HEALTH AUTHORITY RESPONSIBILITIES

Tri-County continues to ensure that we are developing and managing 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. The East Texas Behavioral Healthcare Network, our local Mental Health Planning Network Advisory Committee, and the Regional Planning Network Advisory Committee provide best value analysis for Center services. In addition, we analyze Cost Accounting Methodology data and Medicaid Administrative Claiming results to identify areas where improvements are needed.

To expand our service capacity, Tri-County is actively writing grants and pursuing service contracts. We are also actively pursuing fundraising opportunities and soliciting donations. Additionally, Tri-County is constantly analyzing and improving productivity so that more services can be provided with existing resources.

ACCREDITATION

Tri-County is currently in the preparation phase toward achieving accreditation with a nationally recognized accreditation organization. Tri-County is pursuing accreditation as we feel that this will help us align our standards with national best practice standards and will provide us with ongoing up-to-date information on national changes to these standards. Once accreditation is achieved, the goals listed in accredited program areas of this plan will be adjusted to incorporate accreditation standards and monitoring activities. During this transition phase, it may be necessary to adjust the goals, however Tri-County is committed to providing continuous quality monitoring, assessment, feedback and improvements during this transition. The Quality Management Department will continue to ensure that frequent quality assurance reviews continue to be conducted by managers in lieu of a formal review process and that these reviews continue to be submitted to the quality management department for review. Quality Management staff continue review records from varying departments on a regular basis and look to provide feedback to managers and staff related to fidelity to evidence based practice, medical necessity including appropriateness of level of care, fidelity to State assessments, follow up, referrals, safety, and other general quality care issues. Quality staff are also involved in an ongoing process to ensure that appropriate trainings are filed in staff HR files and there is a continued focus on assisting our Center make enhancements to provide person centered recovery focused services for those we serve. Additionally, Quality staff work closely with Utilization Management staff to continue to monitor performance measures and other quality data that can help us monitor outcomes, identify patterns and make needed improvements to our system.

GOALS 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 the key elements of the Center's mental health 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.

GOALS OF THE QUALITY MANAGEMENT PROGRAM

Goal 1: Direct the internal MH program survey process to consistently, effectively and efficiently monitor and evaluate the provision of mental health services.

Performance Standards:

Participate in internal program surveys throughout the year and produce reports for programs reviewed.

Measurable Activities:

1. Update, as necessary, all program review tools to be in compliance with the Texas Administrative Code (TAC), fidelity to the current evidenced based practice model, Medicaid rules, state performance contracts, and other applicable guidelines.
2. Complete program survey for selected service programs annually.
3. Provide feedback to reviewed programs that include department strengths, weaknesses and recommendations for improvement.
4. Provide the MH program survey report to program managers and the Management Team upon completion.
5. Follow up with program managers regarding plans of correction as needed.
6. Provide updates from program surveys to the Mental Health Quality Management/Utilization Management Committee (MH QM/UM), for evaluation.
7. Continually review the MH program review process and make modifications as needed to ensure that the process is measuring critical program elements.

Outcomes:

1. All tools used in program survey are being reviewed and updated, as necessary, prior to each survey.
2. Reports are completed for each surveyed program and are shared with program managers for their input before being presented to the Management Team.
3. Reports have been provided upon completion.
4. The QM Department has followed up with program managers regarding their plan of correction as needed.

5. Program managers have provided training to program staff when weaknesses are noted during the program survey.
6. Program managers continue to conduct frequent chart reviews, enabling them to better identify and assess the strengths or weaknesses of their staff in completing treatment plans, progress notes and other areas of concern.
7. The QM Department has presented program results for evaluation, as necessary, at the MH QM/UM meetings.

Goal 2: Successfully coordinate the Center’s organizational self-assessment activities as a part of the ongoing evaluation and monitoring process of Tri-County Behavioral Healthcare.

Performance Standards:

1. At intervals designated by HHSC, ensure that organizational self-assessment activities are completed and submitted.
2. At intervals designated by HHSC, ensure that applicable improvement plans are completed, submitted, and reviewed.

Measurable activities:

1. Track required plans of improvement.
2. Involve non-program staff in monitoring activities.

Outcomes:

1. Plans of improvement are monitored as required.
2. Non-program staff continue to be involved in monitoring activities.

Goal 3: Support Tri-County in meeting or exceeding all applicable requirements and standards.

Performance standards:

1. Review all new Texas Administrative Codes (TAC) that apply to services to persons with mental health disorders.
2. Assure that appropriate staff are notified of changes to the TAC and understand how to access it online.
3. Review Tri-County’s Policies and Procedures on a regular basis.

Measurable results:

1. Review all new TAC that comes into the agency within two (2) weeks of receipt.
2. Copy and distribute relevant TAC to programs within two (2) weeks of review.

3. Look at training materials for each program, as part of program reviews, to ensure programs have included the most current TAC, contract requirements and related memorandum of understanding (MOU).

Outcomes:

1. The QM Department reviews all new TAC within two (2) weeks of receipt.
2. The QM Department continues to copy and distribute all new TAC to appropriate programs within two (2) weeks.
3. The QM Department will review personnel files of staff to ensure initial and on-going trainings are complete and the personnel files contain the appropriate certificate when necessary. The QM Department reviews Policies and Procedures and makes revisions and/or recommendations for revisions when necessary.

Goal 4: To ensure individuals served are treated with dignity and respect.

Measurable activities:

1. Monitor all allegations of abuse, neglect and exploitation.
2. Ensure relevant training is provided to staff when trends are noted.
3. Ensure all individuals are provided with a copy of the rights handbook and that it is explained to them in a way they understand, and is documented in the individual's clinical record.
4. Ensure that all staff know who to contact in the event of an allegation of abuse, neglect or exploitation.
5. Investigate all rights complaints in a timely manner and ensure that these complaints are handled with confidentiality.
6. Make reasonable improvements to programs resulting from complaints.

Outcomes:

1. The Rights Protection Officer monitors, reports on, and makes recommendations regarding abuse, neglect and exploitation allegations and investigation results; including to the Executive Management Team quarterly.
2. Training sessions continue to be provided to TCBHC program staff and select contract staff at least annually, and in response to allegations of abuse, neglect and exploitation, as needed.
3. Individuals are provided with rights booklets upon admission, as well as annually, and documentation of this provision continues to be monitored.
4. During internal review audits staff are asked questions related to how, where and when to report events of abuse, neglect and exploitation. The ability of staff to answer these questions correctly assists the Quality Management Department identify areas to target for additional training/education.
5. All complaints continue to be handled with confidentiality and in a timely manner.

6. The Rights Protection Officer and the program managers have worked well together in ensuring complaints are taken seriously and reasonable changes are made as a result of complaints, when necessary.

GOAL OF THE UTILIZATION MANAGEMENT PROGRAM

Goal 1: To ensure that Tri-County is in compliance with HHSC approved Utilization Management Guidelines and contract requirements.

Performance Standards

1. Assure that appropriate individuals are provided with notice of their right to appeal.
2. Assure that service delivery outcomes for both children and adults are meeting targets specified by HHSC.
3. Assure effective management of clinical and financial resources and ongoing improvement of the UM process.
4. 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.
5. Assure that continuity and coordination of services among mental health community service providers is monitored according to the HHSC approved UM guidelines.
6. Assure that the MH QM/UM committee meets at least quarterly.
7. Assure compliance with the HHSC Submission Calendar.

Measurable Activities

1. Monitor and review Center appeals information.
2. Ensure that service delivery outcomes for both children and adults are meeting targets specified by HHSC.
3. Maintain contact with program managers to provide feedback on performance measures.
4. Monitor services that are authorized and reauthorized to ensure that these services are provided in a timely manner and are deemed medically necessary and appropriate to the individual's level of care and/or level of need.
5. Ensure that individuals served are appropriately linked to outside community and mental health services when such needs arise.
6. Ensure that contract requirement information is provided to the Junior Utilization Management Committee (JUM) and the Mental Health Quality Management/Utilization Management (MH QM/UM) Committee for review on a consistent basis.
7. Monitor the HHSC Submission Calendar and notify staff of upcoming submission dates to ensure timely entry to the State.

Outcomes

1. The UM Department continues to review and monitor all Center appeals as specified by the UM guidelines and maintains proper communication with individuals when necessary.
2. The UM Department continues to review and monitor service delivery outcomes for both children and adults to ensure targets identified by HHSC are being met.
3. The UM Department continues to maintain contact with program managers to provide feedback on performance measures on a regular basis.
4. The UM Department continues to monitor authorizations and reauthorizations to ensure that services are being provided in a timely manner, are medically necessary and are appropriate to the individual served.
5. The UM Department continues to monitor continuity and coordination of services among community service providers.
6. The UM Department continues to provide the Center's progress with performance measures at the JUM and MH QM/UM committee meetings for review on a regular basis.
7. The UM Department continues to monitor the HHSC Submission Calendar and notifies the staff of entries due on a routine basis.

QUALITY RELATED RESPONSIBILITIES - MANAGEMENT AND COMMITTEES

Tri-County is dedicated to promoting a team approach to serving persons with mental illness. Tri-County continues to work diligently at increasing the lines of communication between levels of management, quality-related committees and all staff. We continue to strive to enrich the lives of individuals served and their families. Although we adhere to the team philosophy, there must also be individuals and groups of people identified to focus on specific aspects of the Center. Individual, group and committee responsibilities at Tri-County are:

The Board of Trustees:

- Responsible for the provision of a comprehensive program of services related to mental health and intellectual and developmental disabilities in its service area.
- Strives to obtain the highest quality of service for the lowest cost.
- Establishes services for mental health and intellectual and developmental disabilities directly, and/or through contractual arrangements stressing accessibility, availability, acceptability, and continuity of care, based on the financial capability of the Center.
- Develops and executes plans for the continued financial stability and the acquisition of adequate resources to accomplish the purposes and objectives of the Center.
- Establishes an on-going quality management program that provides for appropriate review systems which monitor client care.

- Reviews monthly reports of programmatic and fiscal activities.
- Promotes the goals and objectives of the Center to the community by utilizing the media and other forms of communication.

The Executive Director:

- Ensures the Executive Management Team (Management Team) implements, oversees and reviews Quality Management activities.
- Ensures the Management Team receives and evaluates internal and external reports for Quality Management activities.
- Ensures that program operations and Policies and Procedures are in compliance with local, state and federal statutes and regulations.
- Evaluates and monitors Quality Management performance outcomes to ensure compliance with the QM plan.
- Appoints members to agency committees.
- Ensures that Center goals and objectives are developed annually and that progress toward goals is monitored on at least a quarterly basis.
- Implements Board Policies through the development of operational procedures.
- Responsible for overall operations of the Center and compliance with the Performance Contract.

The Management Team:

The Management Team consists of the Executive Director, Chief Financial Officer, Medical Director, Director of Quality Management and Support, Chief Compliance Officer, Director of Crisis Services, Director of IDD Authority Services, Director of IDD Provider Services, the Director of Management Information Systems, and the Director of Strategic Development. The Management Team meets regularly and is responsible for:

- Implementing, overseeing and reviewing Quality Management activities.
- Reviewing and evaluating internal and external reports for Quality Management activities.
- Reviewing committee reports to ensure that issues related to individual's needs are properly addressed.
- Monitoring and assuring compliance to all contract requirements, standards and codes.
- Ensuring that changes in contract and standards are provided to the relevant program staff.
- Serving as liaisons to all agency committees.
- Reviewing key service indicators and outcomes at least quarterly.
- Reviewing financial reports on a monthly basis.
- Monitoring quarterly risk data related to employees and individuals served.
- Monitoring results of internal program review audits as well as plans of improvement.

The Administrator of Quality Management:

The Administrator of Quality Management's duty, in cooperation with the Management Team, is to ensure oversight of a quality management plan that describes the on-going method for assessing, coordinating, communicating, and improving the quality management functions, processes and outcomes of the Center. The Administrator of Quality Management:

- Co-chairs the Mental Health Quality Management/Utilization Management Committee.
- Serves as a member of the Junior Utilization Management Committee.
- Serves as a member of the Corporate Compliance 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 on the Safety Committee.
- Coordinates activities and information between the Quality Management and Utilization Management programs.
- Works closely with utilization management staff and program managers to measure, analyze and improve service capacity and access to services.
- Provides the Management Team with reports so they can oversee and review Quality Management activities.
- Completes all program survey audits for a representative sample of programs at least annually.
- Assists the Rights Protection Officer 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 at least an annual basis and monitors results of program specific surveys.
- Monitors the Performance Contract for compliance.
- Assists the Management Team in accreditation preparation activities.

Utilization Manager/Director:

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

- Co-chairs the Mental Health Quality Management/Utilization Management Committee.
- Serves as a member of the Junior Utilization Management Committee.
- Serves as a member of the Regional Utilization Management Committee.
- Monitors and tracks the performance targets for our Center.

- Works closely with the Administrator of Quality Management and mental health program managers to assure cost effective, timely and appropriate service provisions.
- Monitors the Performance Contract for compliance.

Rights Protection Officer:

- Receives and follows up on complaints until there is resolution.
- Assists utilization management staff with various appeal processes and discharge reviews, as needed.
- Chairs the Rights Review Team.
- Monitors rights, abuse, safety, and health data for trends, and provides information to the Management Team on at least a quarterly basis.
- Assists with the completion of internal audits, as needed.

Risk Manager:

- Reviews aggregate critical incident data for mental health services and ensures it is reported to HHSC in a timely manner.
- Ensures a 24 hour/7 day a week on call process for reporting incidents
- Oversees Center Risk Data and reports trends to program managers through the QM/UM Committee and Management Team on a regular basis.
- Chairs the Center’s Safety Committees
- Serves as a member on the Infection Control Committee

Rights Review Team (RRT):

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

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

Recommendations from the RRT are submitted to the Management Team when adverse trends, patterns or barriers are identified.

Safety Committee:

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

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.

Risk Management Team:

The Comprehensive Risk Management Team is responsible for the development, implementation, support, monitoring, and evaluation of the comprehensive Risk Management Program. Executive management staff serve as permanent members of this team, with additional staff serving on an as needed basis. Information on rights and abuse is presented to the Risk Management Team on a regular basis. This team meets regularly or as often as is necessary to conduct its business.

Mental Health Quality Management/Utilization Management Committee (MH QM/UM):

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

- Review data for MH services, complaints from individuals served, deaths of individuals served, abuse/neglect allegations, incident reports, safety committee recommendations, program satisfaction surveys, and any other data or reports that reflect compliance with quality standards.
- Review clinical records from MH programs as part of a more comprehensive record review to ensure that all required documentation is present in the chart and is up to quality standards
- Provide program information about the types of problems found in charts that were reviewed so that process/performance issues can be corrected.

- Review any recommendations of the local Mental Health Planning Network Advisory Committee (MHPNAC) and participate in and submit information to the Regional Planning Network Advisory Committee (RPNAC) as needed.
- Review results of internal audits and program surveys as indicated.

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 Management Team for review and approval.

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

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

Junior Utilization Management Committee (JUM):

The Director of Quality Management Support chairs this committee. The Junior Utilization Management Committee (JUM) consists of the Administrator of Utilization and Risk Management, the Administrator of Quality Management, the Manager of Management Information Services, Reimbursement and Service Analyst and other agency staff as needed. The JUM meets multiple times a month (usually 3) to analyze factors that might be affecting Tri-County's ability to meet contract performance expectations. To fulfill its responsibilities, the JUM Committee:

- Reviews a list of contract expectations and performance up to the date of the meeting.
- Updates the JUM Log (a document that is accessible to all managers, that reflects agency performance on target measures).
- Sends emails to managers of programs that are below contract expectations informing them of program areas that are not in compliance with contract expectations.

- Reviews contract due dates and sends reminders to staff about upcoming contract deadlines.
- Creates custom reports for problem areas so staff can be more knowledgeable about factors that are affecting contract compliance.
- Scrutinizes data that is submitted to determine possible data problems that might be affecting performance.
- Invites program managers to present compliance concerns to the committee so that the JUM can assist with problem-solving activities.

Software Management Team (SMT):

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

Grid Review Team (GRT):

- Sets up encounter data modalities to ensure correct submission to DSHS.
- Reviews the Chagemaster 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 and the Performance Contract.
- Meets annually and/or as needed.

Corporate Compliance Committee:

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

The Corporate Compliance Committee is responsible for reviewing corporate compliance issues on both a systems level and an individual provider level to determine whether there are changes that the Center needs to make to ensure compliance with rules and laws related to ethics, service and/or billing. To fulfill its responsibility, the Corporate Compliance Committee will:

- Provide oversight of the Center’s Corporate Compliance Plan.
- Review results of internal and external audits and make recommendations for corrective actions (i.e. changes to policies and procedures, staff training) as necessary to assure compliance with federal funding rules.
- Coordinate information and actions with the Mental Health Quality and Utilization Management Committee.
- Review findings of any Corporate Compliance investigations.
- Assure that staff are provided education regarding corporate compliance issues at least quarterly.
- Evaluate the Chargemaster Report which is completed by the Grid Review Team at least annually.
- 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.

Mental Health Planning Network Advisory Committee (MHPNAC):

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

- Advising the Board of Trustees on planning, budgeting, and contract issues, as well as the needs and priorities in Tri-County’s service area.
- Obtaining stakeholder input on service needs and delivery and presenting this information to the Board of Trustees and the Executive Director.
- Assisting with advocacy projects related to individuals served and/or the Center.
- Reviewing and providing input on the Local Plan.
- Assisting in promoting Tri-County in the community through education efforts, presentations and contact with key community and political leaders.
- Meeting at least 6 times a year.

- Providing an annual report to the Board of Trustees.

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 quarterly 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 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.

SUBSTANCE ABUSE SERVICES

Selective, Preventative Youth Substance Abuse Services (YPS)

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

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

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

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

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

Substance Abuse Treatment Program (SATP)

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

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

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

The Substance Abuse Treatment Program manager will provide updates to the Center's MH QM/UM Committee regularly. The program staff will report SATP performance target numbers to the JUM and MH QM/UM Committees and these committees will

monitor quarterly performance as required by HHSC. If a waiting list has to be started for the program, this information will also be shared with these committees who will review the information to ensure fairness and equity in the access of services.

Tri-County's Utilization Management staff will assist program staff with the completion of these activities and results will be reported to the Tri-County Management Team for review. Additional audit requests will be completed by Tri-County Quality Management staff in cooperation with program staff. Plans of improvement and supporting documentation will be submitted to HHSC as required. Plans of improvement will be monitored by the Utilization Management and/or Quality Management Departments. If HHSC 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 SUBSTANCE ABUSE TREATMENT AND SUBSTANCE ABUSE PREVENTION PROGRAMS

Goal 1: The Quality Management Department will implement a process to monitor Substance Abuse Treatment Program (SATP) services and Youth Substance Abuse Prevention Program (YPS) services for appropriateness, review progress toward goals, monitor compliance with the HHSC Substance Abuse Performance Contract, and ensure a documented process to implement improvements.

Performance Standard:

Conduct an internal review of Substance Abuse Treatment services and/or Youth Substance Abuse Prevention services on an annual basis 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 Abuse Performance Contract, The Texas Administrative Code, applicable Memorandums of understanding, and current evidence – based practices (i.e. The Matrix Model, Cannabis Youth Treatment (CYT), Rainbow days, Kids and Youth Connections)
2. Evaluate and assess these programs in the following domains: Documentation, Satisfaction, Financial, Human Resources, HIPAA Compliance, Performance Outcomes, and Rights, Abuse, Safety, and Health.
3. Provide feedback to reviewed programs that include department strengths, weaknesses and recommendations for improvement.
4. Provide the findings report to program managers and the Management Team upon completion.
5. Follow up with program managers regarding plans of correction as needed.

6. Provide updates from internal reviews to the Mental Health Quality Management/Utilization Management Committee (MHQM/UM), for evaluation.
7. Continually review the program review process for Substance Abuse Services and make modifications as needed to ensure that the process is measuring critical program elements.

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

Performance Standard:

Review written procedures applicable to Substance Abuse Treatment and/or Youth Substance Abuse Prevention programs on an annual basis and ensure that all staff review these procedures.

Measurable Activities:

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

Note: The structures explained in this Quality Management Plan are used for monitoring, assessing, and improving substance abuse services provided at Tri-County Behavioral Healthcare and should be taken into account when reviewing quality management of substance abuse services. These include 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 Survey Process
- Satisfaction Survey
- Stakeholder Involvement and Input
- Staff Development

- Rights, Abuse/Neglect, Safety, and Health Data
- Plan for reducing Confirmed Instances of Abuse and Neglect

Youth Empowerment Services (YES) Waiver

In FY 2016, under direction from the 83rd Legislature, Tri-County Behavioral Healthcare began providing comprehensive and community-based mental health services to children and youth at risk of institutionalization and/or out-of-home placement due to their serious emotional disturbances. The population served includes children and youth ages three (3) to eighteen (18) that reside in Montgomery, Walker and Liberty Counties. In addition to providing Wraparound services (including Intensive Case Management and Individual Skills Training) children and youth enrolled in the YES Waiver can receive contracted services including; Respite, Adaptive Aids and Supports, Community Living Supports (CLS), Employment Assistance, Family Supports, Minor Home Modifications, Non-Medical Transportation, Paraprofessional Services, Supportive Employment, Transitional Services and Specialized Therapies including Animal-Assisted Therapy, Art Therapy, Music Therapy, Recreational therapy and Nutritional Counseling.

The program manager for the YES Waiver is a Licensed Professional Counselor with over 15 years of experience in the mental health and social services setting. As required by the Department of State Health Services contract, all Tri-County policy and procedure that governs security of confidential information, discrimination, individual rights, use of tobacco, and the participant's right to file a grievance will be followed by the YES Waiver program.

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

GOALS FOR PROVIDING QUALITY MANAGEMENT OF YOUTH EMPOWERMENT SERVICES

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

- a. Timeliness of Services**

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

Performance Standard:

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

Measurable Activities:

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

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

Performance Standard:

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

Measurable Activities:

1. Ensure that written procedures are developed and 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 survey process for YES Waiver services.
4. Provide feedback to program managers when there are indications that changes may be warranted.

Note: The structures explained in this Quality Management Plan are used for monitoring, assessing and improving YES Waiver services provided at Tri-County Behavioral Healthcare and should be taken into account when reviewing quality management of YES Waiver services. These include 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 Survey Process
- Satisfaction Survey
- Stakeholder Involvement and Input
- Staff Development
- Rights, Abuse/Neglect, Safety, and Health Data
- Plan for reducing Confirmed Instances of Abuse and Neglect

ORGANIZATIONAL MEASUREMENT, ASSESSMENT AND IMPROVEMENT**The Use of the MH QM/UM Committee:**

The Administrator of Quality Management is a member of the MH QM/UM, JUM, and Corporate Compliance committees. The Administrator of Quality Management helps ensure 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 SA services to individuals, standards, compliance, and financial resources. Through these initiatives, outliers can be determined and improvement plans written. Any needed plans of improvement will be presented to the Management Team and acted upon in a timely manner. The MH QM/UM Committee will ensure implementation and oversight of improvement initiatives.

Measuring, Assessing and Improving the Accuracy of Data Reported by the Local Authority:

Tri-County continues to work on perfecting the data that are 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 HHCS Data Warehouse can be used daily for monitoring our progress toward meeting performance measures. Each day select staff review encounter data warnings so that corrections can be made in Tri-County's clinical system that might affect batching accuracy. Additionally, Tri-County staff are doing the following activities:

- CARE reports used for monitoring performance are sent to JUM members as well as program managers for review.
- The billing department has begun monitoring weekly service reports. In this review, the staff review billing for possible billing errors.
- The billing department looks for diagnosis errors as a part of their weekly billing review.
- Monthly billing suspense reports are provided to clinical staff to correct billing errors. These reports are reviewed by the Software Management Team (SMT) as needed.
- Substance Abuse Prevention and Treatment Data:

Data for persons in the Substance Abuse Prevention and Treatment Programs is captured in the Center's local data system (Anasazi), and in the Clinical Management for Behavioral Health Services system (CMBHS) as required by our contracts with HHSC. Reports from these systems will be monitored by Tri-County staff to determine accuracy and consistency. Data issues will be addressed as they are found and monthly reports will be provided to the Center's Quality Management and Utilization Management Committee.

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 Staff complete this process. Continuously redeveloped to be in line with the current evidence based practice model, and other acceptable guidelines, this internal auditing process looks at each program's compliance with the MH and/or SA Contracts and applicable standards. Program outcomes, quality and satisfaction endeavors, financial reports, personnel development, and compliance with the Health Insurance Portability Accountability Act (HIPAA) are some of the items surveyed in this process. Chart audits, interviews with program staff, interviews with the program manager, interviews with individuals served, inspection of the facilities, review of satisfaction surveys, and review of training materials are all a part of this process. A summary of findings from the survey is presented including identified program strengths, weaknesses, and recommendations for improvement.

Each documentation/chart review conducted by quality management staff takes into account applicable evidenced based practices, appropriateness of placement, adequacy of services provided, and quality of individual continuum of care (continuity of care). Documentation and chart review tools used in this audit are developed from State manuals, current Fidelity Guidelines, HHSC Performance Contract and/or HHSC SA Contracts, relevant Texas Administrative Code and other applicable evidenced based practices. 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 who makes a plan of correction, if necessary, and submits it to the Administrator of Quality Management. A final report is generated and presented to the Management Team. The Center's MH QM/UM Committee also reviews the results of each program review audit and makes recommendations as needed.

Satisfaction Survey:

The Quality Management Department conducts phone surveys with individuals served during each internal program survey in order to monitor and assess satisfaction. Recommendations are made to program managers when indicated. In addition, satisfaction surveys are completed as part of the Center's self-assessment process. Each program has developed its own questionnaire and distributes it to individuals they serve. The results are used to make reasonable changes/improvements to the program. In addition, the Administrator of Quality Management facilitates the distribution of additional satisfaction survey, on an intermittent schedule and/or as indicated, to further evaluate services.

Stakeholder Involvement and Input:

Area organizations in which Tri-County participates include the Community Resource Coordinating Group (CRCG), Montgomery County Homeless Coalition, United Way of Greater Houston, Lone Star College Human Services Advisory Committee, Montgomery County Mental Health Treatment Court Advisory Board, the local Mental Health Planning Network Advisory Committee (MHPNAC), Regional Planning Network Advisory Committee (RPNAC), Leadership Montgomery County (Conroe/Greater Conroe Chamber of Commerce), Montgomery County Veteran's Treatment Court, Child Fatality Review Teams from each represented county and Partnership with the Cooperative Extension office. Participating in these groups enables Tri-County staff to network and collaborate with representatives from other area agencies.

We continue to strive to engage individuals we serve, families, providers, advocates, local officials, volunteers, staff, and the general public in planning initiatives. Information needed to ensure Tri-County identifies community values, service needs, and priorities for the persons in the HHSC priority population is obtained in many different ways. Networking and collaborating with community agencies, as well as surveys for obtaining stakeholder input, has helped us to identify service gaps and priorities.

Corporate Compliance:

Tri-County continues to implement and monitor initiatives that are outlined in the Center's Corporate Compliance Policy and Procedures. 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 be the Corporate Compliance Officer and the Corporate Compliance Committee meets at least quarterly.

To ensure compliance with the Deficit Reduction Act of 2005 (DRA), Tri-County has modified our Corporate Compliance program to include the following:

- The Corporate Compliance Policy has been revised to include:
 - Reference to the Corporate Compliance Action Plan as the guide for Corporate Compliance activities in the Center.
 - Requirement that that training includes information on:
 - The Federal False Claims Act
 - The State Medicaid False Claims Act
 - Qui Tam
- The Corporate Compliance Action Plan was developed to guide the activities of the Corporate Compliance Program at Tri-County.
- The Community Based Services Agreement was modified to specify that contractors with Tri-County had to either:
 - Participate in the Tri-County Compliance program, or
 - Provide their Corporate Compliance information to our committee for review and approval.
- The Corporate Compliance Training was revised to reflect all changes.
- The Agency Employee Handbook was revised to reflect all Corporate Compliance Program changes.

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 has developed specific CBT modules as well as provided face-to-face specific training to the program staff.

Tri-County staff may also receive training from the Texas Council Risk Management Fund and other regional and statewide conferences. The Training Department ensures that all staff are current on their training and no lapse occurs. The Human Resource Department, in coordination with the Billing Department, ensures that professional clinical staff licensing and credentials are current. Tri-County is committed to on-going professional training and provides a variety of experts to provide training on such topics as cultural diversity, customer service, responsible care, best practices, and teaching strategies for persons with mental illness and/or substance abuse diagnoses.

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 the on-going monitoring and reporting of critical incidents, medication errors, infection control events, maintenance, and safety reports. The MH QM/UM Committee reviews the Critical Incident Reporting (CIR) data quarterly looking for trends in all aspects of the data. If trends are found, improvement plans are requested from the appropriate program. The Safety Committee reviews those incidents involving maintenance and safety issues. The Management Team reviews these reports at least quarterly and takes remedial action as appropriate. 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 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.

Plan for reducing Confirmed Instances of Abuse and Neglect:

On a quarterly basis, the Rights Protection Officer presents information relevant to abuse and neglect of persons served. This data includes not only confirmed allegations, but also unconfirmed and inconclusive allegations. The data are reviewed and analyzed by the

Quality and Utilization Management Committee for trends or patterns involving particular programs, certain staff or persons served. If trends or patterns are identified, recommendations for improvements are made and improvement plans are requested if necessary. Tri-County Quality Management Department staff have worked closely with the providers to assist with increased staff training to include documented annual updates in all training areas for new employees as well as current employees. The Safety Committee also reviews the data to determine any trends or patterns related to safety and makes necessary recommendations.

Tri-County continues its efforts to safe guard 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 her 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 will 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 have face-to-face interviews with program staff during the program survey process of each department to ensure that staff members are knowledgeable in all areas concerning rights, abuse, neglect, and exploitation issues and how 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 employees. Significant efforts to retain staff have been taken in the last few years including a cost of living pay increases and establishment of an education fund. The Center continues in its commitment to explore new ways to provide quality services to the individuals we serve with our available resources.

UTILIZATION REVIEW ACTIVITIES

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.

Process for Level of Care Assignment:

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

Process for Authorizations and Reauthorizations:

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

Process of Outlier Review:

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

Exception/ Clinical Override Process:

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

Appeal Process:

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

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 review process.

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

Tri-County shall provide written notification in a language and/or method understood by the individual and/or their legally authorized representative (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 persons and legally authorized representatives to request a review of their concerns or dissatisfaction by Tri-County;
2. How the person may receive assistance in requesting the review;
3. The timeframe for the review; and
4. The method by which the person is informed of the outcome of that review.

Tri-County shall notify persons and legally authorized representatives in writing in a language and/or method understood by the individual of the following decisions and of the process to appeal by requesting a review of:

1. A decision to change, reduce, or deny the individual services/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/supports and follow-along from Tri-County or its contractor, if appropriate.

The written notification referred to above must:

1. Be given or mailed to the person and the legally authorized representative within ten (10) business days of the date the decision was made;
2. State the reason for the decision;
3. Explain that the person and legally authorized representative may contact Tri-County within thirty (30) days of receipt of notification of the denial/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 legally authorized representative 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 person 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 person's dissatisfaction;
 - e. Result in a decision to uphold, reverse or modify the original decision; and
 - f. Provide the person 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 person to:
 - 1) Have a representative talk with the reviewer, or
 - 2) Submit his or her concerns in writing, on tape, or in some other fashion.

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

1. Is applicable only to services/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, Texas Health and Safety Code, Title 7, Chapter 593 (Persons with Mental Retardation Act) 42 USC 1396 (Medicaid Statute); and Texas Human Resources Code, Chapter 73 (relating to early Childhood Intervention), and Early Childhood Intervention programs as funded by the Texas Interagency Council for Early Childhood Intervention.

REVIEWING AND UPDATING THE MH QM/UM PLAN

The Mental Health Quality Management and Utilization Management Plan will be reviewed semiannually by the Administrator of Quality Management and the Director of Quality Management and Support. Potential changes will be discussed with at least one Management Team staff. At least annually, the Mental Health Quality Management/Utilization Management Plan is re-evaluated for its effectiveness. If the plan is not determined to be effective, new activities including intensified monitoring efforts, re-assignment of staff, and/or the appointment of additional committees or improvement teams will be considered. The Mental Health Quality

Management/Utilization Management Plan is reviewed and approved each biennium by the Management Team. This plan will be amended, as needed, if any portion of the plan is modified or discontinued.

<p>Agenda Item: Approve Revisions to Board Policy D.12</p> <p>Committee: Executive</p>	<p>Board Meeting Date</p> <p>November 30, 2017</p>
<p>Background Information:</p> <p>As staff continue to update Board Policy statements, one (1) Policy change is recommended for approval by the Board. In addition to formatting changes, the following modifications are recommended:</p> <p>D.12-Abuse, Neglect and Exploitation—Last Revised in May, 1997—updated formatting and removal of outdated language related to the IDD quality assurance program called QAIS.</p>	
<p>Supporting Documentation:</p> <p>Revised Board Policy (Markup Versions)</p>	
<p>Recommended Action:</p> <p>Approve Revisions to Board Policy D.12</p>	

TRI-COUNTY MENTAL HEALTH MENTAL RETARDATION SERVICES

STATEMENT OF POLICY

Donald Kraemer, Chairman

Date

Subject: Abuse, Neglect and Exploitation

Original Effective Date: May 29, 1997

Revision Effective Date: November 30, 2017

It is the policy of the Board of Trustees of Tri-County Behavioral Healthcare ('Tri-County' or 'Center') that all persons receiving services from Tri-County and through any of its contracting entities, will be treated in a safe and humane manner. Therefore, any form of abuse, neglect and/or exploitation by staff, volunteers, consultants and/or contractors is prohibited.

All new employees, volunteers, clinical contractors (including contractor's employees providing services to consumers), and clinical consultants of Tri-County must receive training in the prevention and reporting of suspected abuse, neglect, and exploitation and demonstrate a thorough understanding of the relevant elements through competency-based testing which must be renewed annually. ~~All employees, volunteers, consultants, and contractors, including their employees who provide services to consumers, must annually demonstrate a thorough understanding of the relevant elements through competency based testing and when interviewed during QAIS self assessments and program certifications.~~

Documentation of the training will be maintained by Tri-County.

All programs will have legible postings of the 1-800 number for reporting suspected abuse, neglect and/or exploitation.

Procedures will be developed which address the following:

- (1) Reporting abuse/neglect
- (2) Reporting and investigating violation of rights
- (3) Requirements for training

Agenda Item: Personnel Report for October 2017	Board Meeting Date: November 30, 2017
Committee: Executive	
Background Information: None	
Supporting Documentation: Personnel Report for October 2017	
Recommended Action: For Information Only	

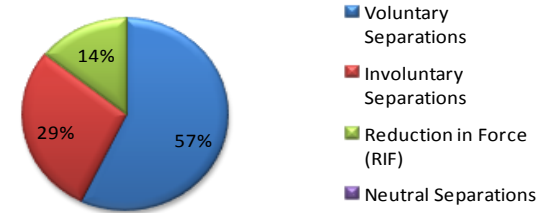
Personnel Report October 2017

Total Applications received in October = 259
Total New Hires for the month of October = 4
Total New Hires Year to Date = 18

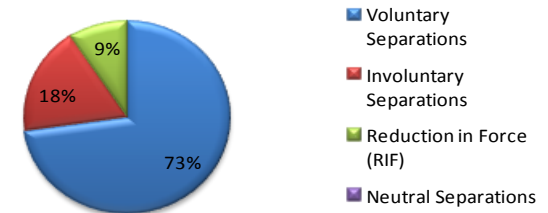
October Turnover - FY18 compared to FY17	FY18	FY17
Number of Active Employees	339	327
Number of Monthly Separations	7	8
Number of Separations YTD	11	21
Year to Date Turnover Rate	3%	6%
October Turnover Rate	2%	2%

Separations by Reason	October Separations	FY18	YTD
Retired	0	0	0
Involuntarily Terminated	2	2	2
Neutral Termination	0	0	0
Dissatisfied	0	0	0
Lack of Support from Administration	0	0	0
Micro-managing supervisor	0	0	0
Lack of growth opportunities/recognition	0	0	0
Difficulty learning new job	0	0	0
Co-workers	0	0	0
Work Related Stress/Environment	0	0	0
RIF	1	1	1
Deceased	0	0	0
Pay	1	1	1
Health	0	0	0
Family	0	1	1
Relocation	0	0	0
School	0	0	0
Personal	0	0	0
Unknown	1	1	1
New Job	2	5	5
Total Separations	7	11	

October Voluntary, Involuntary, RIF and Neutral Separations



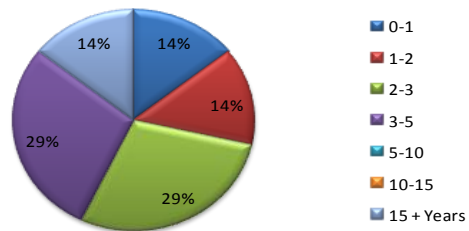
Year to Date Voluntary, Involuntary, RIF and Neutral Separations



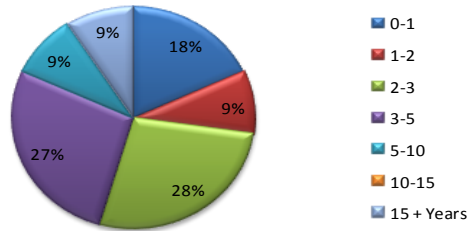
Management Team	# of Employees	Monthly Separations	Year to Date Separations	% October	% YTD
Evan Roberson	17	1	1	6%	6%
Millie McDuffey	32	1	1	3%	3%
Amy Foerster	12	0	0	0%	0%
Tanya Bryant	11	0	0	0%	0%
MH Adult	82	0	1	0%	1%
MH Child & Youth	52	1	1	2%	2%
Catherine Prestigiovanni	8	0	0	0%	0%
Breanna Robertson	55	2	4	4%	7%
Kelly Shropshire	32	2	3	6%	9%
Kathy Foster	31	0	0	0%	0%
Kenneth Barfield	7	0	0	0%	0%
Total	339	7	11		

Separation by EEO Category	# of Employees	Monthly Separations	Year to Date	% October	% Year to Date
Supervisors & Managers	24	0	0	0%	0%
Medical (MD,DO, LVN, RN, APN, PA, Psychologist)	42	1	2	2%	5%
Professionals (QMHP)	97	1	3	1%	3%
Professionals (QIDP)	27	1	2	4%	7%
Licensed Staff (LCDC, LPC...)	16	1	1	6%	6%
Business Services (Accounting)	14	1	1	7%	7%
Central Administration (HR, IT, Executive Director)	22	0	0	0%	0%
Program Support(Financial Counselors, QA, Training, Med. Records)	46	1	1	2%	2%
Nurse Technicians/Aides	16	1	1	6%	6%
Service/Maintenance	10	0	0	0%	0%
Direct Care (HCS, Respite, Life Skills)	25	0	0	0%	0%
Total	339	7	11		

October Separations by Tenure

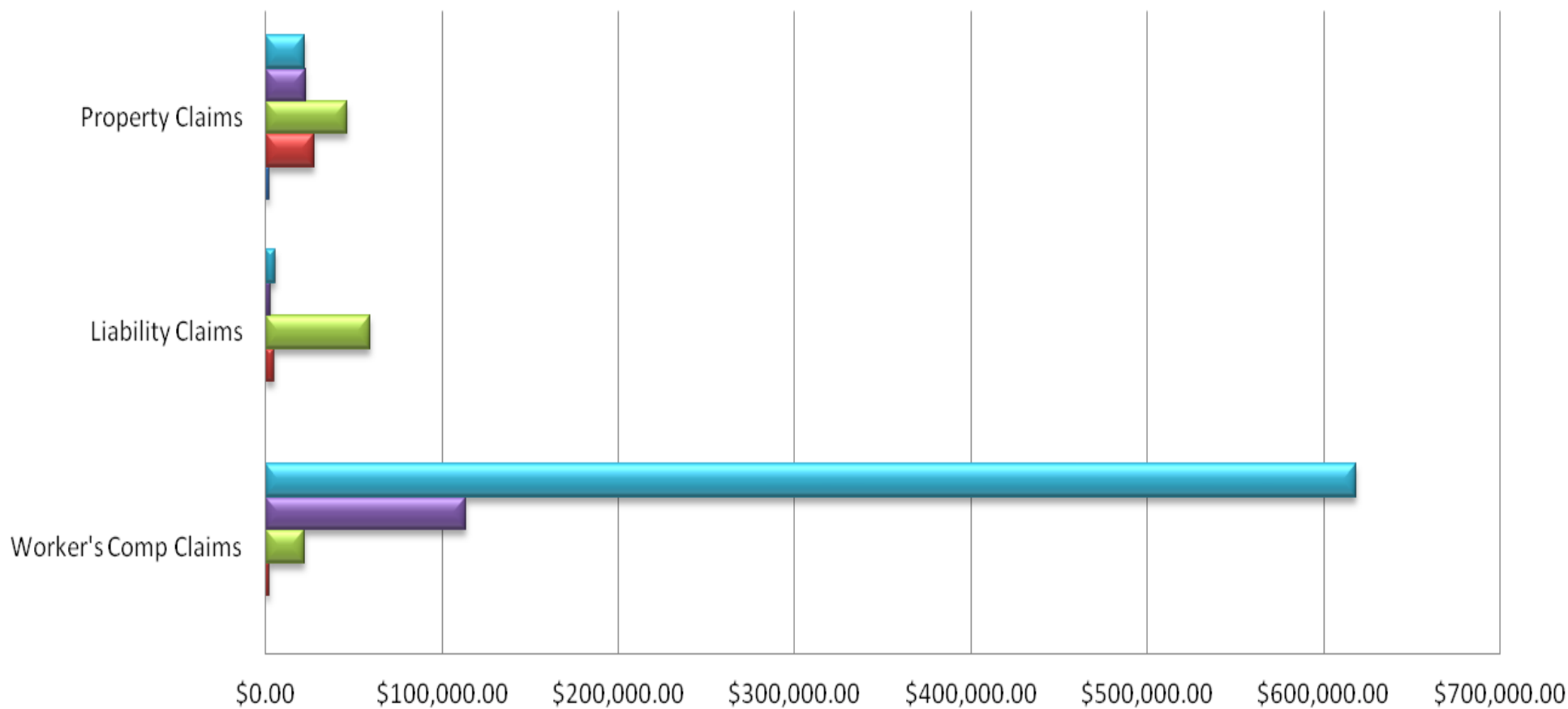


Year to Date Separations by Tenure



<p>Agenda Item: Texas Council Risk Management Fund Claims Summary as of October 2017</p> <p>Committee: Executive</p>	<p>Board Meeting Date:</p> <p>November 30, 2017</p>
<p>Background Information:</p> <p>None</p>	
<p>Supporting Documentation:</p> <p>Texas Council Risk Management Fund Claims Summary as of October 2017</p>	
<p>Recommended Action:</p> <p>For Information Only</p>	

TCRMF Claims Summary October 2017



	Worker's Comp Claims	Liability Claims	Property Claims
2014	\$618,699.00	\$5,295.00	\$21,931.00
2015	\$113,917.00	\$2,556.00	\$22,505.00
2016	\$21,879.00	\$59,491.00	\$46,114.00
2017	\$2,146.00	\$4,856.00	\$27,455.00
2018	\$0.00	\$0.00	\$2,301.00

<p>Agenda Item: Texas Council Quarterly Board Meeting Update</p> <p>Committee: Executive</p>	<p>Board Meeting Date</p> <p>November 30, 2017</p>
<p>Background Information:</p> <p>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.</p>	
<p>Supporting Documentation:</p> <p>Texas Council Staff Report</p>	
<p>Recommended Action:</p> <p>For Information Only</p>	

Agenda Item: Approve October 2017 Financial Statements Committee: Business	Board Meeting Date November 30, 2017
Background Information: None	
Supporting Documentation: October 2017 Financial Statements	
Recommended Action: Approve October 2017 Financial Statements	

October 2017 Financial Summary

Revenues for October 2017 were \$2,451,053 and operating expenses were \$2,319,040; resulting in a gain in operations of \$132,014. Capital Expenditures and Extraordinary Expenses for October were \$95,540; resulting in a gain of \$36,474. Total revenues were 100.36% of the monthly budgeted revenues and total expenses were 98.00% of the monthly budgeted expenses.

Year to date revenues are \$4,807,703 and operating expenses are \$4,598,081; leaving excess operating revenues of \$209,622. YTD Capital Expenditures and Extraordinary Expenses are \$153,067; resulting in a gain YTD of \$56,555. Total revenues are 99.27% of the YTD budgeted revenues and total expenses are 97.50% of the YTD budgeted expenses

REVENUES

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

Revenue Source	YTD Revenue	YTD Budget	% of Budget	\$ Variance
Rehab – Title XIX	320,797	340,309	94.27%	19,512

Rehab – Title XIX – We continue to see a decrease in the number of clients with Medicaid being served in the adult clinic. We have been tracking this decline over the past 3 budget years. We will continue to monitor and work toward solutions to help get clients benefits.

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
No items to report				

**TRI-COUNTY BEHAVIORAL HEALTHCARE
CONSOLIDATED BALANCE SHEET
For the Month Ended October 31, 2017**

	TOTALS COMBINED FUNDS October 2017	TOTALS COMBINED FUNDS September 2017	Increase (Decrease)
ASSETS			
CURRENT ASSETS			
Imprest Cash Funds	3,954	3,740	214
Cash on Deposit-General Fund	9,132,783	10,223,803	(1,091,020)
Cash on Deposit-Debt Fund			-
Accounts Receivable	1,846,306	2,033,521	(187,214)
Inventory	4,986	4,986	-
TOTAL CURRENT ASSETS	10,988,029	12,266,049	(1,278,021)
FIXED ASSETS	20,760,463	15,648,025	5,112,438
OTHER ASSETS	74,858	201,713	(126,855)
TOTAL ASSETS	\$ 31,823,350	\$ 28,115,788	\$ 3,707,563
LIABILITIES, DEFERRED REVENUE, FUND BALANCES			
CURRENT LIABILITIES	1,225,065	1,071,804	153,262
NOTES PAYABLE	642,552	607,292	35,260
DEFERRED REVENUE	752,808	2,309,207	(1,556,399)
LONG-TERM LIABILITIES FOR			
Line of Credit - Tradition Bank	-	-	-
Note Payable Prosperity Bank	-	-	-
First Financial loan tied to CD	939,583	962,500	(22,917)
First Financial Construction Loan	12,399,793	12,253,313	146,479
EXCESS(DEFICIENCY) OF REVENUES OVER EXPENSES FOR			
General Fund	3,578,703	3,512,608	66,095
FUND EQUITY			
RESTRICTED			
Net Assets Reserved for Debt Service	(13,339,376)	(13,215,813)	(123,563)
Reserved for Debt Retirement	-	963,631	(963,631)
COMMITTED			
Net Assets-Property and Equipment	20,760,463	15,648,025	5,112,438
Reserved for Vehicles & Equipment Replacement	678,112	678,112	-
Reserved for Facility Improvement & Acquisitions	-	-	-
Reserved for Board Initiatives	1,500,000	1,500,000	-
Reserved for 1115 Waiver Programs	516,833	516,833	-
ASSIGNED			
Reserved for Workers' Compensation	274,409	274,409	-
Reserved for Current Year Budgeted Reserve	12,332	80,166	(67,834)
Reserved for Insurance Deductibles	100,000	100,000	-
Reserved for Accrued Paid Time Off	(642,552)	(607,292)	(35,260)
UNASSIGNED			
Unrestricted and Undesignated	2,424,625	1,460,994	963,631
TOTAL LIABILITIES/FUND BALANCE	\$ 31,823,350	\$ 28,115,788	\$ 3,707,562

**TRI-COUNTY BEHAVIORAL HEALTHCARE
CONSOLIDATED BALANCE SHEET
For the Month Ended October 31, 2017**

	General Operating Funds	Memorandum Only Prelim August 2017
ASSETS		
CURRENT ASSETS		
Imprest Cash Funds	3,954	3,840
Cash on Deposit-General Fund	9,132,783	5,498,537
Cash on Deposit-Debt Fund	-	-
Accounts Receivable	1,846,306	4,163,554
Inventory	4,986	4,986
TOTAL CURRENT ASSETS	10,988,029	9,670,917
FIXED ASSETS	20,760,463	15,648,025
OTHER ASSETS	74,858	212,571
	\$ 31,823,350	\$ 25,531,513
LIABILITIES, DEFERRED REVENUE, FUND BALANCES		
CURRENT LIABILITIES	1,225,065	1,078,569
NOTES PAYABLE	642,552	607,292
DEFERRED REVENUE	752,808	(380,384)
LONG-TERM LIABILITIES FOR		
Line of Credit - Tradition Bank	-	-
Note Payable Prosperity Bank	-	-
First Financial loan tied to CD	939,583	985,417
First Financial Construction Loan	12,399,793	12,253,313
EXCESS(DEFICIENCY) OF REVENUES OVER EXPENSES FOR		
General Fund	3,578,703	3,652,781
FUND EQUITY		
RESTRICTED		
Net Assets Reserved for Debt service-Restricted	(13,339,376)	(13,238,730)
Reserved for Debt Retirement	-	963,631
COMMITTED		
Net Assets-Property and Equipment-Committed	20,760,463	15,648,025
Reserved for Vehicles & Equipment Replacement	678,112	678,112
Reserved for Facility Improvement & Acquisitions	-	-
Reserved for Board Initiatives	1,500,000	1,464,542
Reserved for 1115 Waiver Programs	516,833	516,833
ASSIGNED		
Reserved for Workers' Compensation-Assigned	274,409	274,409
Reserved for Current Year Budgeted Reserve -Assigned	12,332	74,000
Reserved for Insurance Deductibles-Assigned	100,000	100,000
Reserved for Accrued Paid Time Off	(642,552)	(607,292)
UNASSIGNED		
Unrestricted and Undesignated	2,424,625	1,460,994
TOTAL LIABILITIES/FUND BALANCE	\$ 31,823,350	\$ 25,531,513

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
For the Month Ended October 2017
and Year To Date as of October 2017

INCOME:	<u>MONTH OF</u> <u>October 2017</u>	<u>YTD</u> <u>October 2017</u>
Local Revenue Sources	119,872	198,182
Earned Income	1,018,804	1,988,689
General Revenue-Contract	1,312,377	2,620,832
TOTAL INCOME	<u>\$ 2,451,053</u>	<u>\$ 4,807,703</u>
EXPENSES:		
Salaries	1,346,232	2,756,630
Employee Benefits	264,569	538,466
Medication Expense	72,475	125,331
Travel-Board/Staff	44,661	77,361
Building Rent/Maintenance	37,158	55,525
Consultants/Contracts	320,854	620,334
Other Operating Expenses	233,092	424,436
TOTAL EXPENSES	<u>\$ 2,319,040</u>	<u>\$ 4,598,081</u>
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	<u>\$ 132,014</u>	<u>\$ 209,622</u>
CAPITAL EXPENDITURES		
Capital Outlay-FF&E, Automobiles, Building	38,769	38,769
Capital Outlay-Debt Service	56,771	114,298
TOTAL CAPITAL EXPENDITURES	<u>\$ 95,540</u>	<u>\$ 153,067</u>
GRAND TOTAL EXPENDITURES	<u>\$ 2,414,580</u>	<u>\$ 4,751,148</u>
Excess (Deficiency) of Revenues and Expenses	<u>\$ 36,474</u>	<u>\$ 56,555</u>

Debt Service and Fixed Asset Fund:		
Debt Service	56,771	114,298
Excess(Deficiency) of revenues over Expenses	<u>56,771</u>	<u>114,298</u>

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
Compared to Budget
Year to Date as of October 2017

	YTD October 2017	APPROVED BUDGET	Increase (Decrease)
INCOME:			
Local Revenue Sources	198,182	193,353	4,829
Earned Income	1,988,689	2,020,945	(32,256)
General Revenue-Contract	2,620,832	2,628,978	(8,146)
TOTAL INCOME	\$ 4,807,703	\$ 4,843,276	\$ (35,573)
EXPENSES:			
Salaries	2,756,630	2,817,141	(60,511)
Employee Benefits	538,466	536,994	1,472
Medication Expense	125,331	116,271	9,060
Travel-Board/Staff	77,361	72,964	4,397
Building Rent/Maintenance	55,525	46,980	8,545
Consultants/Contracts	620,334	668,114	(47,780)
Other Operating Expenses	424,436	423,137	1,299
TOTAL EXPENSES	\$ 4,598,081	\$ 4,681,601	\$ (83,520)
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	\$ 209,622	\$ 161,675	\$ 47,947
CAPITAL EXPENDITURES			
Capital Outlay-FF&E, Automobiles	38,769	67,750	(28,981)
Capital Outlay-Debt Service	114,298	123,734	(9,436)
TOTAL CAPITAL EXPENDITURES	\$ 153,067	\$ 191,484	\$ (38,417)
GRAND TOTAL EXPENDITURES	\$ 4,751,148	\$ 4,873,085	\$ (121,937)
Excess (Deficiency) of Revenues and Expenses	\$ 56,555	\$ (29,809)	\$ 86,364

Debt Service and Fixed Asset Fund:

Debt Service	114,298	123,734	(9,436)
Excess(Deficiency) of revenues over Expenses	114,298	123,734	(9,436)

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
Compared to Budget
For the Month Ended October 2017

INCOME:	MONTH OF October 2017	APPROVED BUDGET	Increase (Decrease)
Local Revenue Sources	119,872	102,290	17,582
Earned Income	1,018,804	1,028,367	(9,563)
General Revenue-Contract	1,312,377	1,311,584	793
TOTAL INCOME	\$ 2,451,053	\$ 2,442,241	\$ 8,812
EXPENSES:			
Salaries	1,346,232	1,400,574	(54,342)
Employee Benefits	264,569	261,004	3,565
Medication Expense	72,475	62,135	10,340
Travel-Board/Staff	44,661	36,481	8,180
Building Rent/Maintenance	37,158	35,190	1,968
Consultants/Contracts	320,854	343,807	(22,953)
Other Operating Expenses	233,092	221,658	11,434
TOTAL EXPENSES	\$ 2,319,040	\$ 2,360,849	\$ (41,809)
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	\$ 132,014	\$ 81,392	\$ 50,622
CAPITAL EXPENDITURES			
Capital Outlay-FF&E, Automobiles	38,769	41,125	(2,356)
Capital Outlay-Debt Service	56,771	61,867	(5,096)
TOTAL CAPITAL EXPENDITURES	\$ 95,540	\$ 102,992	\$ (7,452)
GRAND TOTAL EXPENDITURES	\$ 2,414,580	\$ 2,463,841	\$ (49,261)
Excess (Deficiency) of Revenues and Expenses	\$ 36,474	\$ (21,600)	\$ 58,074

Debt Service and Fixed Asset Fund:

Debt Service	56,771	61,867	(5,096)
Excess(Deficiency) of revenues over Expenses	56,771	61,867	(5,096)

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
With October 2016 Comparative Data
Year to Date as of October 2017

INCOME:	<u>YTD October 2017</u>	<u>YTD October 2016</u>	<u>Increase (Decrease)</u>
Local Revenue Sources	198,182	149,020	49,162
Earned Income	1,988,689	1,192,701	795,988
General Revenue-Contract	2,620,832	1,283,100	1,337,732
TOTAL INCOME	<u>\$ 4,807,703</u>	<u>\$ 2,624,821</u>	<u>\$ 2,182,882</u>
EXPENSES:			
Salaries	2,756,630	1,321,387	1,435,243
Employee Benefits	538,466	263,407	275,059
Medication Expense	125,331	43,304	82,027
Travel-Board/Staff	77,361	47,533	29,828
Building Rent/Maintenance	55,525	19,167	36,358
Consultants/Contracts	620,334	477,282	143,052
Other Operating Expenses	424,436	222,821	201,615
TOTAL EXPENSES	<u>\$ 4,598,081</u>	<u>\$ 2,394,901</u>	<u>\$ 2,203,180</u>
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	<u>\$ 209,622</u>	<u>\$ 229,920</u>	<u>\$ (20,298)</u>
CAPITAL EXPENDITURES			
Capital Outlay-FF&E, Automobiles	38,769	174,429	(135,660)
Capital Outlay-Debt Service	114,298	49,865	64,433
TOTAL CAPITAL EXPENDITURES	<u>\$ 153,067</u>	<u>\$ 224,294</u>	<u>\$ (71,227)</u>
GRAND TOTAL EXPENDITURES	<u>\$ 4,751,148</u>	<u>\$ 2,619,195</u>	<u>\$ 2,131,953</u>
Excess (Deficiency) of Revenues and Expenses	<u>\$ 56,555</u>	<u>\$ 5,626</u>	<u>\$ 50,929</u>

Debt Service and Fixed Asset Fund:

Debt Service	114,298	49,865	64,433
Excess(Deficiency) of revenues over Expenses	<u>114,298</u>	<u>49,865</u>	<u>64,433</u>

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
With October 2016 Comparative Data
For the Month Ended October 2017

INCOME:	MONTH OF October 2017	MONTH OF October 2016	Increase (Decrease)
Local Revenue Sources	119,872	257,911	(138,039)
Earned Income	1,018,804	2,347,981	(1,329,177)
General Revenue-Contract	1,312,377	2,614,669	(1,302,292)
TOTAL INCOME	\$ 2,451,053	\$ 5,220,561	\$ (2,769,508)
Salaries	1,346,232	2,717,173	(1,370,941)
Employee Benefits	264,569	530,536	(265,967)
Medication Expense	72,475	109,636	(37,161)
Travel-Board/Staff	44,661	87,934	(43,273)
Building Rent/Maintenance	37,158	55,578	(18,420)
Consultants/Contracts	320,854	966,182	(645,328)
Other Operating Expenses	233,092	432,124	(199,032)
TOTAL EXPENSES	\$ 2,319,040	\$ 4,899,163	\$ (2,580,123)
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	\$ 132,014	\$ 321,398	\$ (189,384)
CAPITAL EXPENDITURES			
Capital Outlay-FF&E, Automobiles	38,769	174,429	(135,660)
Capital Outlay-Debt Service	56,771	95,630	(38,859)
TOTAL CAPITAL EXPENDITURES	\$ 95,540	\$ 270,059	\$ (174,519)
GRAND TOTAL EXPENDITURES	\$ 2,414,580	\$ 5,169,222	\$ (2,754,642)
Excess (Deficiency) of Revenues and Expenses	\$ 36,474	\$ 51,339	\$ (14,865)

Debt Service and Fixed Asset Fund:

Debt Service	56,771	95,630	(38,859)
Excess(Deficiency) of revenues over Expenses	56,771	95,630	(38,859)

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary
With September 2017 Comparative Data
For the Month Ended October 2017

INCOME:	MONTH OF October 2017	MONTH OF September 2017	Increase (Decrease)
Local Revenue Sources	119,872	78,310	41,562
Earned Income	1,018,804	969,885	48,919
General Revenue-Contract	1,312,377	1,308,454	3,923
TOTAL INCOME	\$ 2,451,053	\$ 2,356,649	\$ 94,404
EXPENSES:			
Salaries	1,346,232	1,410,397	(64,165)
Employee Benefits	264,569	273,897	(9,328)
Medication Expense	72,475	52,856	19,619
Travel-Board/Staff	44,661	32,700	11,961
Building Rent/Maintenance	37,158	18,367	18,791
Consultants/Contracts	320,854	299,480	21,374
Other Operating Expenses	233,092	191,344	41,748
TOTAL EXPENSES	\$ 2,319,040	\$ 2,279,041	\$ 39,999
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	\$ 132,014	\$ 77,608	\$ 54,405
CAPITAL EXPENDITURES			
Capital Outlay-FF&E, Automobiles	38,769	-	38,769
Capital Outlay-Debt Service	56,771	57,527	(756)
TOTAL CAPITAL EXPENDITURES	\$ 95,540	\$ 57,527	\$ 38,013
GRAND TOTAL EXPENDITURES	\$ 2,414,580	\$ 2,336,568	\$ 78,011
Excess (Deficiency) of Revenues and Expenses	\$ 36,474	\$ 20,081	\$ 16,393

Debt Service and Fixed Asset Fund:

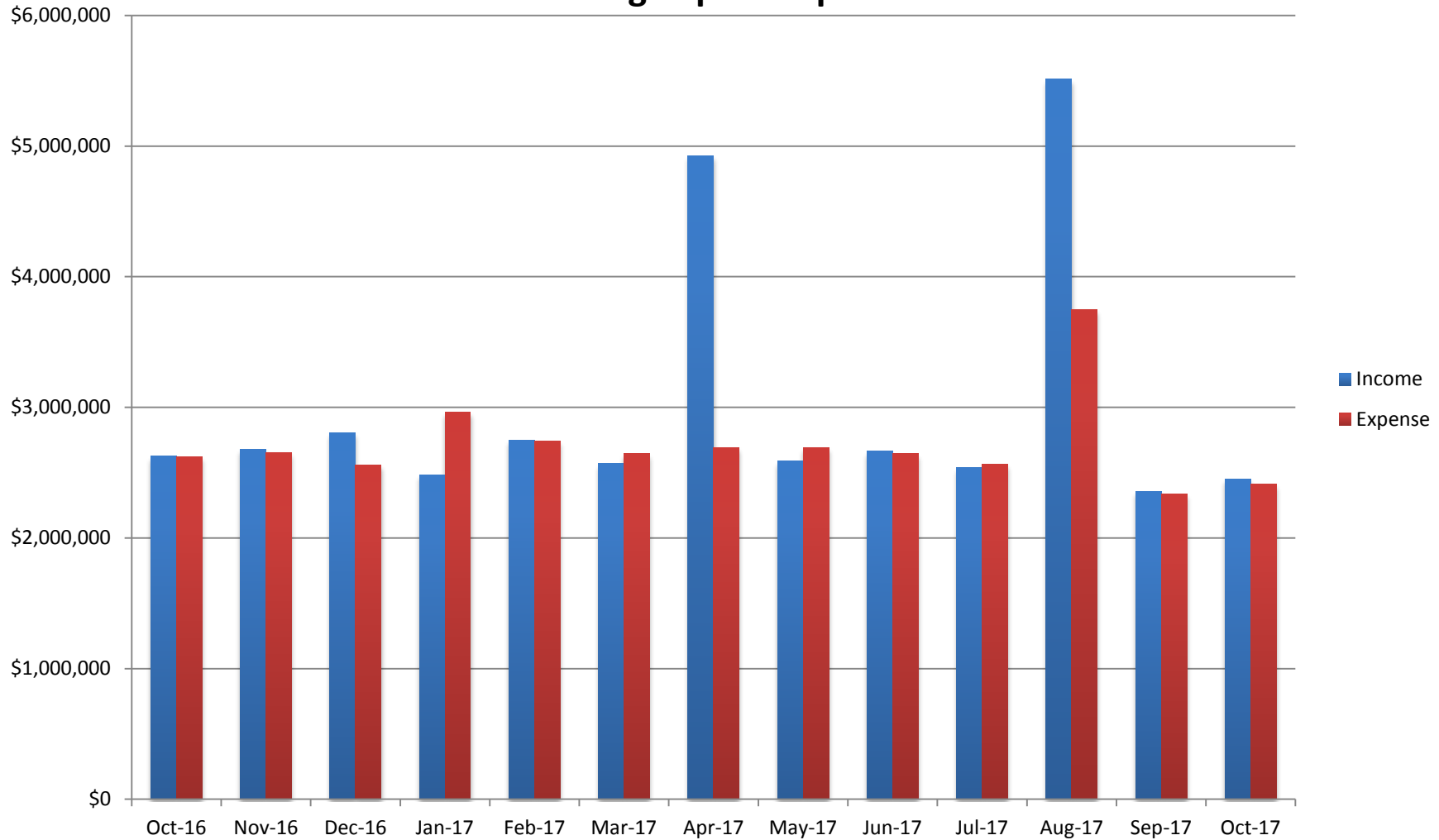
Debt Service	56,771	57,527	(756)
Excess(Deficiency) of revenues over Expenses	56,771	57,527	(756)

TRI-COUNTY BEHAVIORAL HEALTHCARE
Revenue and Expense Summary by Service Type
Compared to Budget
Year To Date as of October 2017

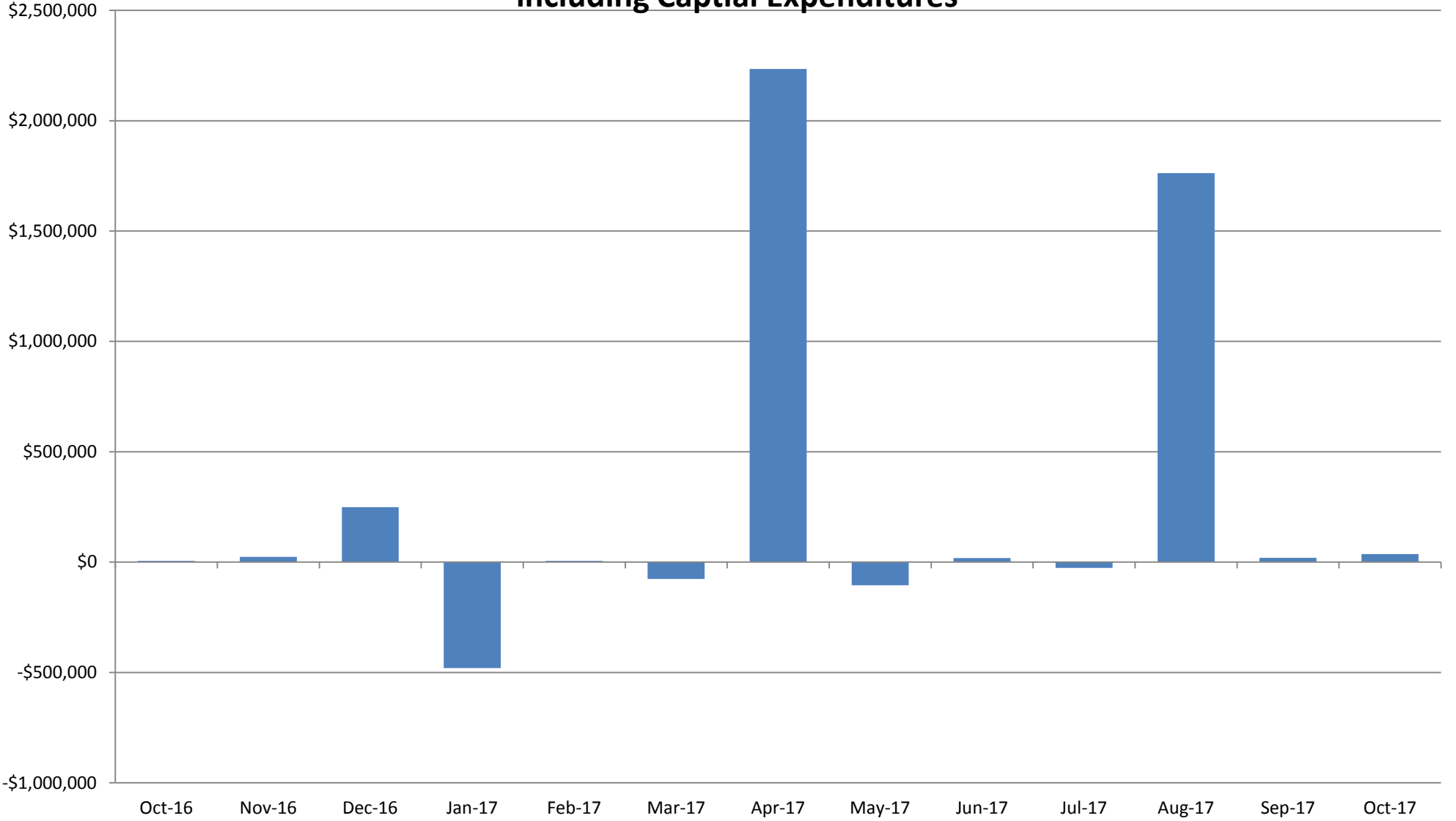
	YTD Mental Health October 2017	YTD IDD October 2017	YTD Other Services October 2017	YTD Agency Total October 2017	YTD Approved Budget October 2017	Increase (Decrease)
INCOME:						
Local Revenue Sources	338,825	16,406	(157,049)	198,182	193,353	4,829
Earned Income	696,701	617,371	674,617	1,988,689	2,020,945	(32,256)
General Revenue-Contract	2,325,061	295,772		2,620,832	2,628,978	(8,146)
TOTAL INCOME	\$ 3,360,587	\$ 929,549	\$ 517,568	\$ 4,807,703	\$ 4,843,276	\$ (35,573)
EXPENSES:						
Salaries	1,846,186	486,603	423,842	2,756,630	2,817,141	(60,511)
Employee Benefits	354,661	107,551	76,254	538,466	536,994	1,472
Medication Expense	106,835	-	18,496	125,331	116,271	9,060
Travel-Board/Staff	42,168	23,453	11,740	77,361	72,964	4,397
Building Rent/Maintenance	38,528	8,957	8,041	55,525	46,980	8,545
Consultants/Contracts	394,056	175,856	50,422	620,334	668,114	(47,780)
Other Operating Expenses	263,518	92,437	68,482	424,436	423,137	1,299
TOTAL EXPENSES	\$ 3,045,952	\$ 894,857	\$ 657,277	\$ 4,598,083	\$ 4,681,601	\$ (83,518)
Excess(Deficiency) of Revenues over Expenses before Capital Expenditures	\$ 314,635	\$ 34,692	\$ (139,709)	\$ 209,620	\$ 161,675	\$ 47,945
CAPITAL EXPENDITURES						
Capital Outlay-FF&E, Automobiles	24,169	8,434	6,167	38,769	67,750	(28,981)
Capital Outlay-Debt Service	33,366	16,108	64,825	114,298	123,734	(9,436)
TOTAL CAPITAL EXPENDITURES	\$ 57,535	\$ 24,542	\$ 70,992	\$ 153,067	\$ 191,484	\$ (38,417)
GRAND TOTAL EXPENDITURES	\$ 3,103,487	\$ 919,399	\$ 728,269	\$ 4,751,150	\$ 4,873,085	\$ (121,935)
Excess (Deficiency) of Revenues and Expenses	\$ 257,100	\$ 10,150	\$ (210,701)	\$ 56,555	\$ (29,809)	\$ 86,362
Debt Service and Fixed Asset Fund:						
Debt Service	33,366	16,108	64,825	114,298	123,734	(90,368)
		-	-	-	-	-
Excess(Deficiency) of revenues over Expenses	33,366	16,108	64,825	114,298	123,734	(90,368)

TRI-COUNTY BEHAVIORAL HEALTHCARE

Income and Expense including Capital Expenditures



TRI-COUNTY BEHAVIORAL HEALTHCARE
Income after Expense
including Capital Expenditures



<p>Agenda Item: Reappoint Independence Communities, Inc. Board of Directors</p> <p>Committee: Business</p>	<p>Board Meeting Date:</p> <p>November 30, 2017</p>
<p>Background Information:</p> <p>Mr. Morris V. Johnson and Mr. Macka Lee Murrah serve on the Independence Communities, Inc. Board and have terms expiring in January 2018.</p> <p>Mr. Johnson and Mr. Murrah have been contacted and are willing to serve an additional two-year term, which would expire in January 2020.</p>	
<p>Supporting Documentation:</p> <p>None</p>	
<p>Recommended Action:</p> <p>Reappoint Mr. Johnson and Mr. Murrah to Serve on the Independence Communities, Inc. Board of Directors for an Additional Two-Year Term Expiring in January 2020</p>	

<p>Agenda Item: Reappoint Montgomery Supported Housing, Inc. Board of Directors</p> <p>Committee: Business</p>	<p>Board Meeting Date:</p> <p>November 30, 2017</p>
<p>Background Information:</p> <p>Mr. Michael Cooley, Ms. Barbara Duren and Ms. Jane Fetterman serve on the Montgomery Supported Housing, Inc. Board and have terms expiring in January 2018.</p> <p>Mr. Cooley, Ms. Duren and Ms. Fetterman have been contacted and are willing to serve an additional two-year term, which would expire in January 2020.</p>	
<p>Supporting Documentation:</p> <p>None</p>	
<p>Recommended Action:</p> <p>Reappoint Mr. Cooley, Ms. Duren and Ms. Fetterman to Serve on the Montgomery Supported Housing, Inc. Board of Directors for an Additional Two-Year Term Expiring in January 2020</p>	

<p>Agenda Item: Reappoint Cleveland Supported Housing, Inc. Board of Directors</p> <p>Committee: Business</p>	<p>Board Meeting Date:</p> <p>November 30, 2017</p>
<p>Background Information:</p> <p>Mr. Joe Bazar serves on the Cleveland Supported Housing, Inc. Board and has a term expiring in January 2018.</p> <p>Mr. Bazar has been contacted and is willing to serve an additional two-year term, which would expire in January 2020.</p>	
<p>Supporting Documentation:</p> <p>None</p>	
<p>Recommended Action:</p> <p>Reappoint Mr. Bazar to Serve on the Cleveland Supported Housing, Inc. Board of Directors for an Additional Two-Year Term Expiring in January 2020</p>	

Agenda Item: Board of Trustees Unit Financial Statement as of October 2017 Committee: Business	Board Meeting Date November 30, 2017
Background Information: None	
Supporting Documentation: October 2017 Board of Trustees Unit Financial Statement	
Recommended Action: For Information Only	

Unit Financial Statement

FY 2018

	October 2017 Actuals	October 2017 Budgeted	Variance	YTD Actual	YTD Budget	Variance	Percent	Budget
Revenues								
Allocated Revenue	\$ 2,553.00	\$ 2,553.00	\$ -	\$ 5,106.00	\$ 5,106.00	\$ -	100.00%	\$ 30,645.00
Total Revenue	\$ 2,553.00	\$ 2,553.00	\$ -	\$ 5,106.00	\$ 5,106.00	\$ -	100.00%	\$ 30,645.00
Expenses								
Food Items	\$ -	\$ 166.00	\$ (166.00)	\$ -	\$ 332.00	\$ (332.00)	0.00%	\$ 2,000.00
Insurance-Worker Compensation	\$ 11.42	\$ 16.00	\$ (4.58)	\$ 23.72	\$ 32.00	\$ (8.28)	74.13%	\$ 200.00
Legal Fees	\$ 1,500.00	\$ 1,500.00	\$ -	\$ 3,000.00	\$ 3,000.00	\$ -	100.00%	\$ 18,000.00
Supplies-Office	\$ -	\$ 21.00	\$ (21.00)	\$ -	\$ 42.00	\$ (42.00)	0.00%	\$ 245.00
Training	\$ -	\$ 300.00	\$ (300.00)	\$ -	\$ 600.00	\$ (600.00)	0.00%	\$ 3,600.00
Travel - Local	\$ -	\$ 50.00	\$ (50.00)	\$ -	\$ 100.00	\$ (100.00)	0.00%	\$ 600.00
Travel - Non-local Mileage/Air	\$ -	\$ 150.00	\$ (150.00)	\$ -	\$ 300.00	\$ (300.00)	0.00%	\$ 1,800.00
Travel - Non-local Hotel	\$ 191.35	\$ 250.00	\$ (58.65)	\$ 191.35	\$ 500.00	\$ (308.65)	38.27%	\$ 3,000.00
Travel - Meals	\$ 131.11	\$ 100.00	\$ 31.11	\$ 131.11	\$ 200.00	\$ (68.89)	65.56%	\$ 1,200.00
Total Expenses	\$ 1,833.88	\$ 2,553.00	\$ (719.12)	\$ 3,346.18	\$ 5,106.00	\$ (1,759.82)	65.53%	\$ 30,645.00
Total Revenue minus Expenses	\$ 719.12	\$ -	\$ 719.12	\$ 1,759.82	\$ -	\$ 1,759.82	34.47%	\$ -

UPCOMING MEETINGS

January 25, 2018 – Board Meeting

- Approve Minutes from November 30, 2017 Board Meeting
- From the Heart Presentation
- Community Resources Report
- Consumer Services Report for November and December 2017
- Program Updates
- FY 2018 Goals & Objectives Progress Report
- 1st Quarter FY 2018 Corporate Compliance and Quality Management Report
- 2nd Quarter FY 2018 Corporate Compliance Training
- Medicaid 1115 Transformation Waiver Project Status Report
- Personnel Report for November and December 2017
- Texas Council Risk Management Fund Claims Summary for November and December 2017
- Texas Council Quarterly Board Meeting Update
- Approve Financial Statements for November and December 2017
- Approve FY 2017 Independent Financial Audit
- 1st Quarter FY 2018 Investment Report
- Board of Trustees Unit Financial Statement as of November and December 2017
- Foundation Board Update
- HUD 811 Updates
- Building Consolidation Update

February 22, 2018 – Board Meeting

- Approve Minutes from January 25, 2018 Board Meeting
- Longevity Recognition Presentations
- Community Resources Report
- Consumer Services Report for January 2018
- Program Updates
- Program Presentation
- Personnel Report for January 2018
- Texas Council Risk Management Fund Claims Summary as of January 2018
- Approve Financial Statements for January 2018
- 401(a) Retirement Plan Account Review
- Board of Trustees Unit Financial Statement as of January 2018
- Building Consolidation Update

Tri-County Acronyms	
1115	Medicaid 1115 Transformation Waiver
ACT	Assertive Community Treatment
APS	Adult Protective Services
ADRC	Aging and Disability Resource Center
ANSA	Adult Needs and Strengths Assessment
APRN	Advanced Practice Registered Nurse
ARDS	Assignment Registration and Dismissal Services
BJA	Bureau of Justice Administration
BMI	Body Mass Index
C&Y	Child & Youth Services
CAM	Cost Accounting Method
CANS	Child and Adolescent Needs and Strengths
CARE	Client Assignment Registration & Enrollment
CBT	Computer Based Training & Cognitive Based Therapy
CC	Corporate Compliance
CFRT	Child Fidelity Review Team
CHIP	Children's Health Insurance Program
CPS	Child Protective Service
CRCG	Community Resource Coordination Group
CSHI	Cleveland Supported Housing, Inc.
DADS	Department of Aging and Disability Service
DOB	Date of Birth
DRPS	Department of Protective and Regulatory Services
DSHS	Department of State Health Services
Dx	Diagnosis
ETBHN	East Texas Behavioral Healthcare Network
FLSA	Fair Labor Standards Act
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
ICAP	Inventory for Client and Agency Planning
ICF-IID	Intermediate Care Facility - for Individuals w/Intellectual Disabilities
ICI	Independence Communities, Inc.
IHP	Individual Habilitative Plan
IPP	Individual Program Plan
ITP	Individual Transition Planning (schools)
JUM	Junior Utilization Management Committee
LAR	Legally Authorized Representative
LCDC	Licensed Chemical Dependency Counselor
LCSW	Licensed Clinical Social Worker
LIDDA	Local Intellectual & Developmental Disabilities Authority
LMC	Leadership Montgomery County
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
LMSW	Licensed Masters Social Worker
LSFHC	Lone Star Family Health Center
LTD	Long Term Disability
MAC	Medicaid Administrative Claiming
MCHC	Montgomery County Homeless Coalition
MCHD	Montgomery County Hospital District
MCOT	Mobile Crisis Outreach Team
MD	Medical Director/Doctor
MHFA	Mental Health First Aid
MIS	Management Information Services
MOU	Memorandum of Understanding
MSHI	Montgomery Supported Housing, Inc.
MTP	Master Treatment Plan
MVPN	Military Veteran Peer Network
NAMI	National Alliance for the Mentally Ill
NEO	New Employee Orientation
NGM	New Generation Medication
NGRI	Not guilty for Reason of Insanity
PA	Physician's Assistant
PAP	Patient Assistance Program
PASRR	Pre-Admission Screening and Resident Review
PATH	Projects for Assistance in Transition from Homelessness (PATH)
PNAC	Planning Network Advisory Committee
PRS	Psychosocial Rehab Specialist
PQI	Partnership for Quality Improvement
QIDP	Qualified Intellectual Disabilities Professional
QM	Quality Management
QMHP	Qualified Mental Health Professional
RN	Registered Nurse
RPNAC	Regional Planning & Network Advisory Committee
SAMA	Satori Alternatives to Managing Aggression
TAC	Texas Administrative Code
TCBHC	Tri-County Behavioral Healthcare
TCOOMMI	Texas Correction Office on Offenders with Medical & Mental Impairments
TCO	Treatment Co-Occurring Mental Health and Substance Abuse Services
TCRMF	Texas Council Risk Management Fund
TRA	Treatment Adult Services (Substance Abuse)
TRR	Texas Resilience and Recovery
TxHML	Texas Home Living
TRY	Treatment Youth Services (Substance Abuse)
UM	Utilization Management
UW	United Way
YES	Youth Empowerment Services
YMHFA	Youth Mental Health First Aid
YPS	Youth Prevention Services

Updated 4/17/17