The Harris Center for Mental Health and IDD
9401 Southwest Freeway Houston, TX 77074
Board Room #109

Program Committee Meeting
March 21, 2023
11:30 am

I. **DECLARATION OF QUORUM**

II. **PUBLIC COMMENTS**

III. **APPROVAL OF MINUTES**

A. Approve Minutes of the Board of Trustees Program Committee Held on Tuesday, February 21, 2023
(EXHIBIT P-1)

IV. **REVIEW AND COMMENT**

A. Behavioral Health Services Mid-Year Update
(EXHIBIT P-2 Lance Britt)

B. Integrated Care
(EXHIBIT P-3 Stanley Williams)

V. **EXECUTIVE SESSION – As authorized by §551.071 of the Texas Government Code, the Board of Trustees reserves the right to adjourn into Executive Session at any time during the course of this meeting to seek legal advice from its attorney about any matters listed on the agenda.**

VI. **RECONVENE INTO OPEN SESSION**

VII. **CONSIDER AND TAKE ACTION AS A RESULT OF THE EXECUTIVE SESSION**

VIII. **ADJOURN**

Veronica Franco

Veronica Franco, Board Liaison
Bonnie Hellums, MED, LMFT, LCDC, AAC, JD Chairperson
Program Committee
The Harris Center for Mental Health and IDD
Board of Trustees

EXHIBIT P-1

BOARD OF TRUSTEES
The HARRIS CENTER *for*
Mental Health *and* IDD
PROGRAM COMMITTEE MEETING
TUESDAY, FEBRUARY 21, 2023
MINUTES

Mrs. Bonnie Hellums, Board of Trustees Chair, called the meeting to order at 11:45 a.m. in Room 109 of the 9401 Southwest Freeway location, noting a quorum of the Committee was present.

RECORD OF ATTENDANCE

Committee Members in Attendance: Mrs. Bonnie Hellums, Dr. Robin Gearing, Dr. Lois Moore, Dr. M. Miller (videoconference) Mr. S. Zakaria,

Committee Member in Absence: J. Lykes, Mrs. N. Hurtado

Other Board Members in Attendance: Dr. G. Santos

1. **CALL TO ORDER**
   The meeting was called to order at 11:45 a.m.

2. **DESIGNATION OF BOARD MEMBERS AS VOTING COMMITTEE MEMBERS**
   Mrs. Bonnie Hellums designated Dr. G. Santos as a voting member of the committee.

2. **DECLARATION OF QUORUM**
   Mrs. Hellums declared a quorum of the committee was present.

3. **PUBLIC COMMENTS**
   There were no Public Comments.

4. **Approve the Minutes of the Board of Trustees Program Committee Meeting Held on Tuesday, January 17, 2023.**

   MOTION BY: MOORE **SECOND BY: ZAKARIA**
   With unanimous affirmative votes

   BE IT RESOLVED that the Minutes of the Board of Trustees Program Committee meeting held on Tuesday, January 17, 2023 under Exhibit P-1, are approved and recommended to the Full Board for acceptance.

5. **REVIEW AND TAKE ACTION**

   A. Application for Beverly Lively to serve on Pasadena Cottages Board

MOTION BY: SANTOS **SECOND BY: ZAKARIA**
With unanimous affirmative votes

BE IT RESOLVED Application for Beverly Lively to serve on Pasadena Cottages Board under Exhibit P-4, are approved and recommended to the Full Board for acceptance.

6. REVIEW AND COMMENT

A. **Comprehensive Psychiatric Emergency Program (CPEP) Quarterly Report-** Kim Kornmayer and Dr. Amber Pastusek presented to the Program Committee.
B. **Jail Based Competency Restoration Expansion (JBCR)-** Mona Jiles and Krystin Holmes presented to the Program Committee.

7. EXECUTIVE SESSION

There was no Executive Session during the Program Committee Meeting.

8. ADJOURN

MOTION: ZAKARIA **SECOND: SANTOS**

There being no further business, the meeting adjourned at 12:32 pm.

Veronica Franco, Board Liaison
Bonnie Hellums, Chairman
Program Committee
THE HARRIS CENTER *for* Mental Health *and* IDD
Board of Trustees

EXHIBIT P-2

Behavioral Health Services

Program Committee Mid-Year Update

Presented By: Lance Britt, MHA, LPC, FACHE, Vice President – Behavioral Health Services

Behavioral Health Services

Adult Mental Health (AMH)

- NW, NE, SE, SW clinics
- Early Onset (EO)
- New Start
- Assisted Outpatient Treatment (AOT)
- Assertive Community Treatment (ACT)

Children and Adolescent Services (CAS)

- SW, SE, Airline clinics
- Co-Locations
- NE Youth and Wellness
- Community Unit Probation Services/Juvenile Justice (CUPS/JJ)
- Early Childhood Intervention (ECI)
- YES Waiver
- Peer services

Integrated Care

- PCP Services
- Optum
- Mobile Wellness (coming soon)

Continuity of Care (COC)

- HCPC/West Oaks contracted beds
- State Hospital
- Forensic Single Portal/Court services
- Community referrals
- Utilization Management

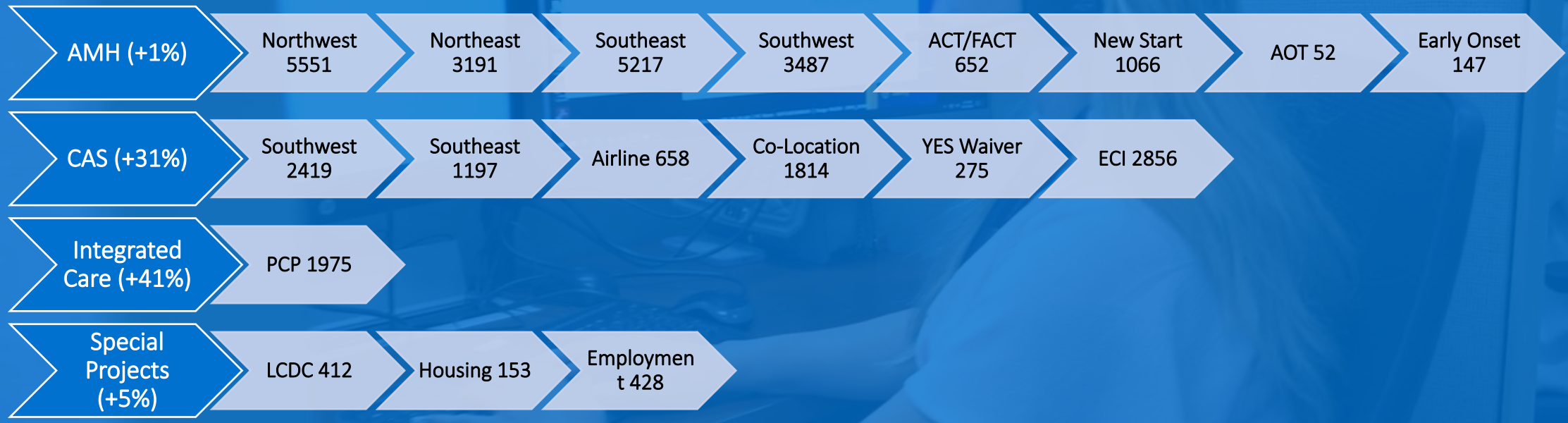
Special Projects

- LCDC clinic services
- Outreach Screening Assessment and Referral (OSAR)
- Housing
- Employment
- HCBS screening

Business Office

- Front Desk Services
- Insurance Verification
- Financial services
- Central Business Office
- SSI Outreach Access and Recovery (SOAR)
- Translation Services

Behavioral Health Services



Note: percentages are comparing 2022 to 2023

Accomplishments

AMH

- Initiated planning meetings for new NE building design
- Launched Engaged in Excellence recognition program
- Initiated multiple new access points including Memorial Hermann, Ibn Sina, Precinct 1, and the Smartpod in Precinct 2
- AOT was spotlighted and presented at October National Conference
- Helped to launch Risk Assessment tool
- MyChart push initiated

CAS

- Peers awarded new Youth led wellness grant
- New provider hired for Airline
- Five community outreach events
- Initiated no show survey to increase show rate
- Intake LPHA redesign to improve access

Accomplishments

COC

- Expanded coordination at HCPC Dunn Center with 4 restoration competency and 2 civil/private units
- TANF ended successfully with all funds distributed
- Pilot project to increase access for clients at CRU

Business Office

- CBO SOAR certified
- BO retrained in customer service
- Implemented process for identifying Charity Care cases

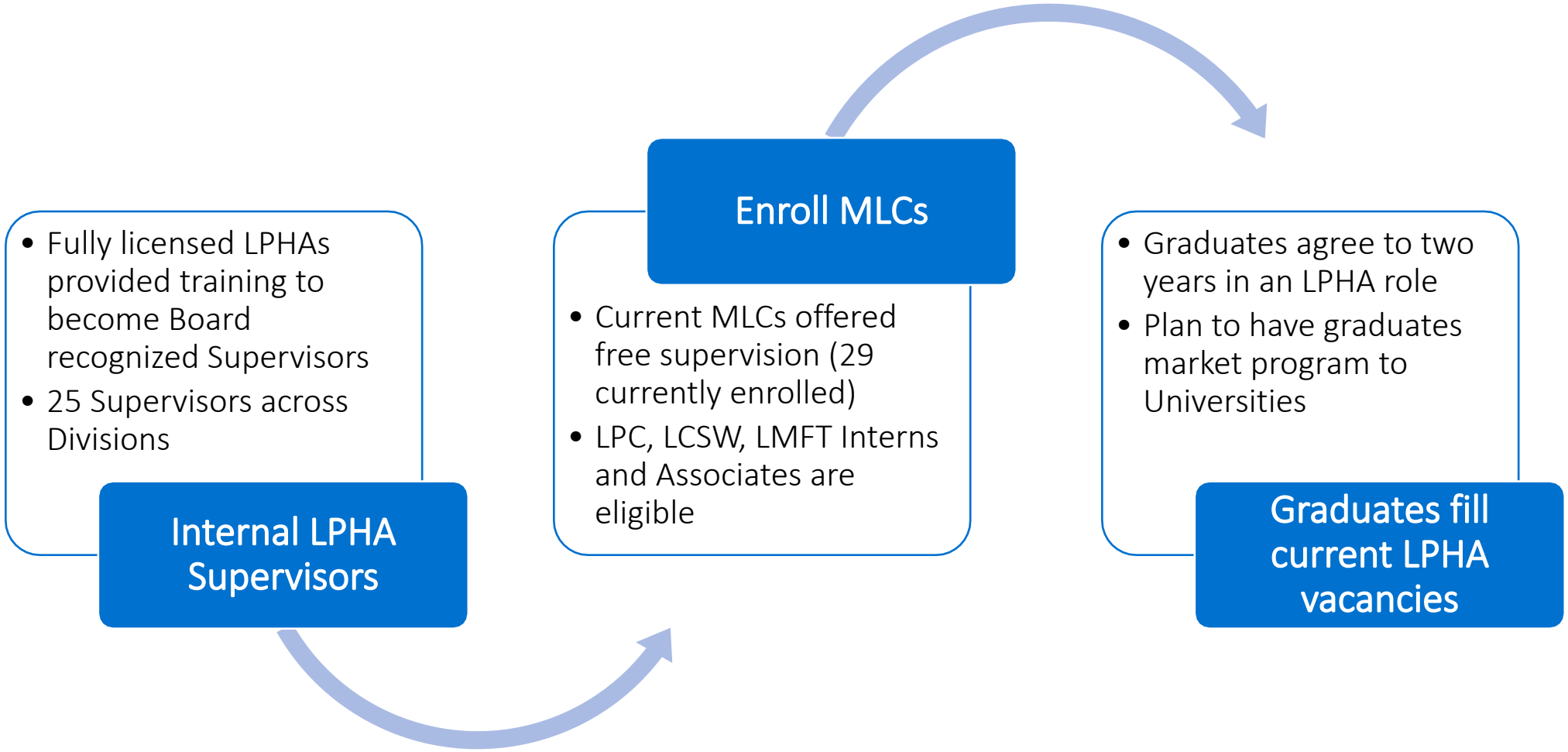
Integrated Care

- Development of mobile van concept with community partners
- Completed client vaccine project

Special Projects

- New multipurpose room on SW 3rd floor
- Provided housing assistance to 138 clients
- SUD Care Pathway collabortion

Program Spotlight: Clinician Advancement Program



Thank you.

EXHIBIT P-3

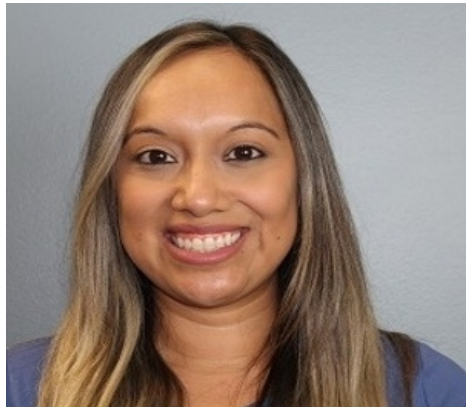
The HARRIS CENTER for Mental Health and IDD
Transforming Lives

Integrated Care Initiatives March 2023

- Update on Integrated Health Initiatives
- Review Harris Center Health Home Services and Outcomes

Presented By: Dr. Stanley Williams, PhD

Integrative Health Care Team



Janeth Martinez, MA, LPC
Project Director
Integrated Health Certified Community Behavioral Health Clinic (CCBHC) Expansion Program

Dr. Stanley Williams, PhD
Director of Integrated Health

Theresa Pettigrew -Beason, LPC-S
Practice Manager Optum Project Integrated Care Health Home

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Continuum of Physical and Behavioral Health Integration

Traditional Specialty MH Care

Outpatient mental health/substance abuse counseling, residential, crisis services, case management

Certified Community Behavioral Health Clinic

Established standardized approaches to care and a new provider type for Medicaid as a result of standardized & required set of services (MH/SA services). Evaluations and measurements that include primary health screenings for chronic health – BP/BMI, and care coordination

Co-located Care MH & Primary Care - Separate EHR Provider

Level 4
Close collaboration onsite with some system integration - same space, same facility, consultation, referral to health provider

Level 5
Close collaboration-seek integrated systems together, daily huddles, care teams, defined rolls

Behavioral Health Home

- **Known as Patient Centered Medical Home, recognized as a payor model by CMS and MCOs**
- **Care Management: Addresses social determinants of health, barriers to care, improves health status**
- **Population-based and client-based cost-effective outcomes – through risk stratification, services directed based upon risk stratification results and analytics, reduce over utilization of preventable high-cost care, includes levels of primary care**

Integrated Care Behavioral Health Home - Plus

System Level Integration
System wide data integrated, one EHR, incorporates CCBHC, primary health, and behavioral services under one roof,

Note: Integrated Care is not a recognized payor model, however, under the patent centered medical home model, it is recognized by CMS and MCOs

Rationale for Integrative Behavioral Health Home Approach

People with serious mental illness (SMI) are dying 25 years earlier than the general population.

2/3 of premature deaths are due to preventable/treatable medical conditions such as cardiovascular, pulmonary, and infectious diseases.

44% of all cigarettes consumed nationally are smoked by people with SMI.

See www.nasmhpd.org for Morbidity And Mortality In People With Serious Mental Illness report (2006)

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Transforming Lives

Trends and Data Associated with Mental Health and Chronic Diseases

Annual Per Person Cost of Care

Common Chronic Medical Illnesses with Comorbid Mental Condition

"Value Opportunities"

Patient Groups	Annual Cost of Care	Illness Prevalence	% with Comorbid Mental Condition*	Annual Cost with Mental Condition
Arthritis	$5,220	6.6%	36%	$10,710
Asthma	$3,730	5.9%	35%	$10,030
Cancer	$11,650	4.3%	37%	$18,870
Diabetes	$5,480	8.9%	30%	$12,280
CHF	$9,770	1.3%	40%	$17,200
Migraine	$4,340	8.2%	43%	$10,810
COPD	$3,840	8.2%	38%	$10,980

Cartesian Solutions, Inc.™--consolidated health plan claims data

Integrated Behavioral Health Home Approach

By building an infrastructure around integrative health to improve outcomes we can…

Redefine specialty mental health and consider the whole person – not just mental illness

Remove barriers that limit access to care and address health disparities

Improve overall health and well being of all vulnerable and at-risk behavioral health populations for preventable hospital and ER Admissions

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What is a Behavioral Health/Medical Home?

Behavioral Health/Medical Homes Provide:

- Comprehensive and coordinated care in the context of individual, cultural, and community needs
- Medical, behavioral, and related social service needs and supports are coordinated and provided by provider and/or arranged
- Emphasize education, activation, and empowerment through interpersonal interactions and system-level protocols
- At the center of the health/medical home are the patient and their relationship with their behavioral health and primary What is a Behavioral Health/Medical Home? care teams and Social Determinants of Health Community Resources and Partners

What Authority Established Behavioral Health/Medical Home?

•Section 2703 of the Affordable Care Act Allows states to amend their Medicaid state plans to provide **Health Home Services** for enrollees with qualifying chronic conditions

CMS Expectations:

•Lower rates of emergency room use
•Reduce in-hospital admissions and re-admissions
•Reduce healthcare costs
•Decrease reliance on long-term care facilities
•Improve experience of care, quality of life and consumer satisfaction
•Manage health conditions & Improve health outcomes

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Expectations from the Federal Level

The Centers for Medicare and Medicaid Services (CMS) expect healthcare homes to:

- Lower rates of emergency room use
- Reduce in-hospital admissions and re-admissions
- Reduce healthcare costs
- Decrease reliance on long-term care facilities
- Improve experience of care, quality of life and
- consumer satisfaction
- Manage health conditions
- Improve health outcomes
  - HEDIS indicators (Healthcare Effectiveness Data and Information Set)
  - http://www.ncqa.org/tabid/187/default.aspx

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

The Harris Center Health Home

Goals

Improve overall wellness of members to include their self-management of conditions

Increased member participation in the health home program based upon enrollment rates for attributed members (target goal is 50% enrollment for all attributed members within a 12 month period)

- Reductions in avoidable hospital admissions and emergency room use
- Reductions in overall hospital readmission rates
- Reduced lengths of stay in the hospital when hospitalizations are necessary
- Improved rates for follow up after hospitalization (FUH) for behavioral and medical inpatient and ER visits • Improved adherence to recommended treatments (including medications and specialty care)
- Improved access to primary care, based on key metrics related (e.g., diabetes care)

Opportunity

One of Four behavioral Health Organizations participating in the National Pilot

Target 1500 of the highest risk Optum Members (costing approximately $100K in claims per member)

Only about 25% Harris Center clients

Six Core Services

1

Comprehensive Care Management

The initial and ongoing assessment and delivery of care management services to integrate physical, behavioral health, long-term services and supports, and community services.

2

Care Coordination

Organizing and facilitating access to care and monitoring progress toward goals through face-to-face and collateral contacts with the member, family, caregivers, physical care, specialty care, and other providers, and the secure sharing of information to promote safe and effective care.

3

Health Promotion

The facilitation of activities and services that educate the member and his/her supports about various health matters that can aid in disease prevention, wellness, improved condition management, and reductions in avoidable emergency room visits and hospitalizations.

4

Comprehensive Transitional Care

The facilitation of services for the member, family, and caregivers when the member is transitioning between levels of care.

5

Individual and Family Support Services

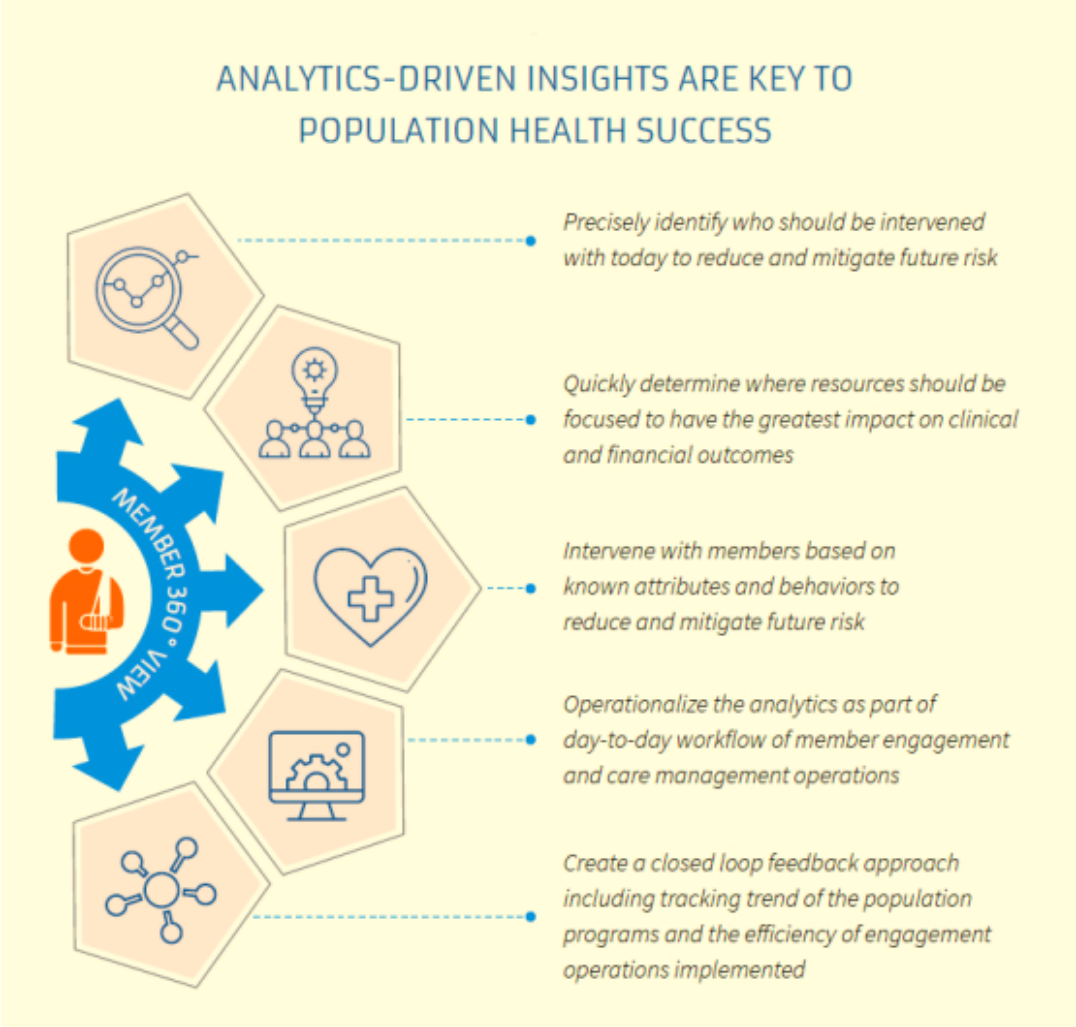
The coordination of information and services to support the member and their family or caregivers to maintain and promote quality of life, with particular focus on community living options – social determinants of health.

6

Community and Social Support Referrals

Providing information and assistance to refer the member and their family or caregivers to community-based resources that are needed to improve member wellness.

Utilizing Optum Portal – Data



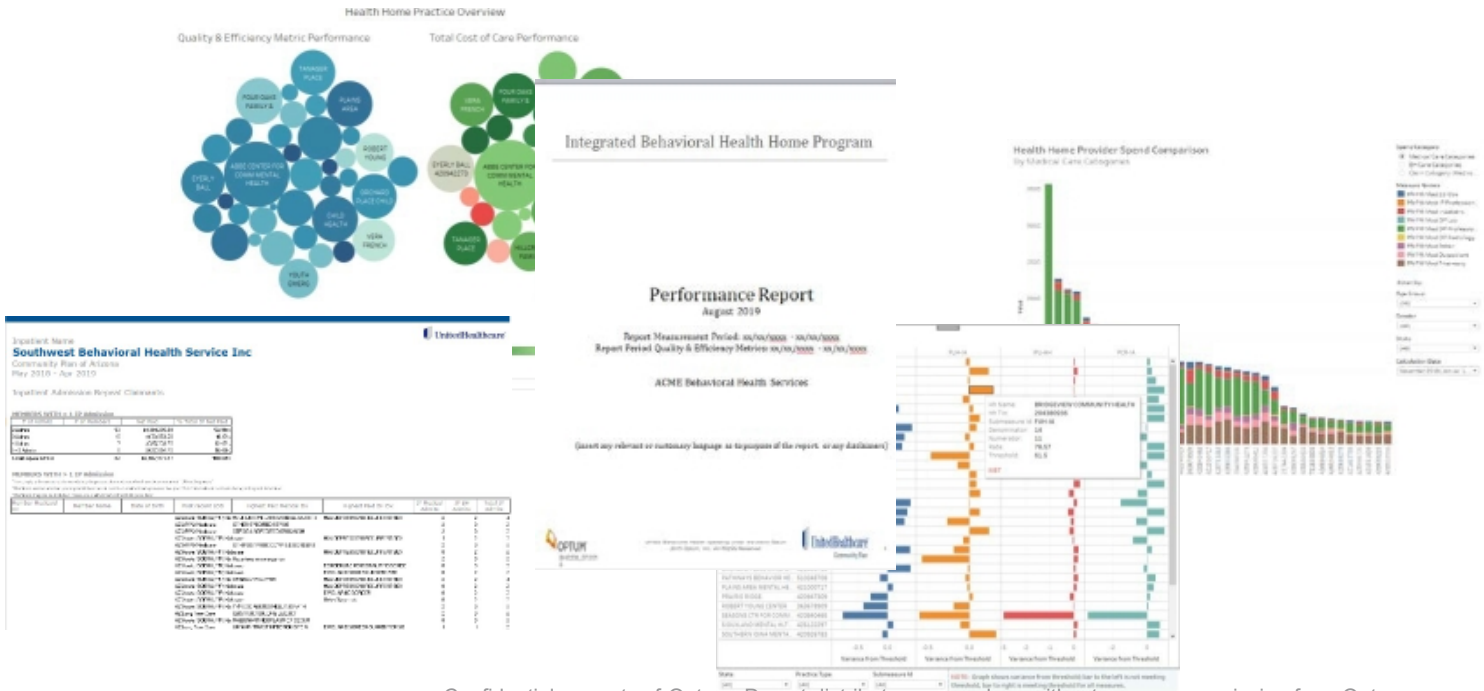
1. Data-driven decisions
2. Identification of high-utilizer and assignments
3. Care coordination and collaborative contacts with patient care team
4. Gaps in Care and Social Determinants of Health

How we Engage Clients and Provide Care

Member Identification & Attribution

Provider Attestation Portal

Reporting



The HARRIS CENTER - Behavioral Health Home

Care Management Six Steps – Team-Based Care Model

1. Member Identification & Analytics

- Real-time Utilization data
- Population Health Risk Stratification
- Utilization of Community & Health Exchanges as part of data collection and analysis

2. Integrative Health- Care Management

- Weekly & monthly team meetings
- Care –based upon analytics and health outcome improvements
- Whole care approach with integrative health care plan addressing health, behavioral health team monitoring and outcomes for both health and behavioral health outcomes and bench marks.
- Care Coordination with other health providers, PCP, law enforcement, criminal justice system, SDOH resource referral and follow-up
- Best practices (stages of change, motivational counseling) behavioral change
- Member advocacy
- Non-traditional hours and scheduling

6. Health Coaching

- Health Promotions & Wellness Strategies
- Coaching and monitoring health outcomes
- Health system navigation
- Medication education

3. Physical Health/Healthcare

- Care Coordination with Harris Center Integrated Health Clinic, Community PCPs, other providers – hospital, ED
- Health Promotions, disease & medication management

5. Social Determinants of Needs

- SDOH Assessment – include strategies in individualized care plan
- Comprehensive resource list development & resource connections – monthly monitor resources for qualifications & accuracy
- Trained in SAMHSA SOAR program -

4. Integrative Behavioral Healthcare

- In-person & televisual care
- Specialized treatment addressing mental health, substance use, criminal justice factors; SDOH; and integrative health

Preliminary Reports Are Promising: 2021 Annual Performance Report

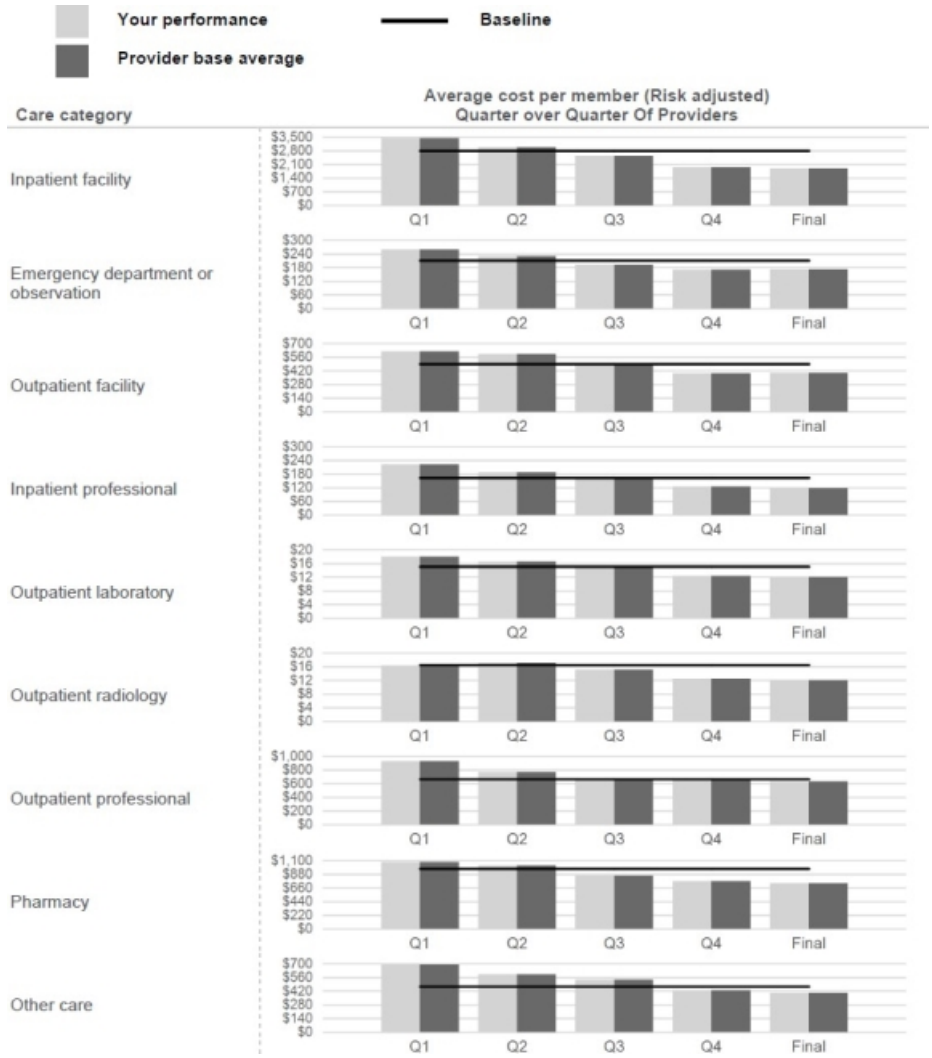
- Inpatient Facility, Pharmacy and Outpatient Specialty Professional tend to be the highest cost care categories
- Reductions in Inpatient and Pharmacy costs are the primary driver of the savings generated the first year

- **Average Total Cost of Care Per Member Prior to Program Start:** $5,077 per month

- **Reduction in total Cost of Care Per Member 1st Year:** $4,384 or Cost Savings of $693 Per Member Per Month

- **October Outcome Payment check from Optum**

  -United Healthcare **$8,545**

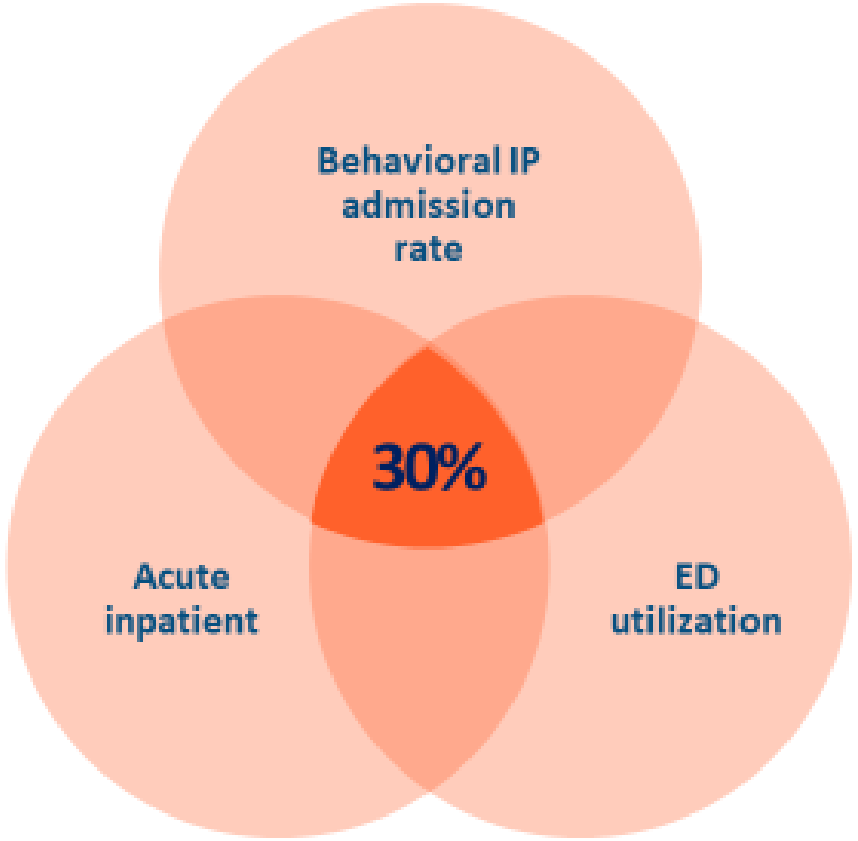


Success indicators: The Harris Center IBHH Measurement Year 1*

13.7% reduction to TCOC PMPM ($693 per attributed member)

Optum Cost Savings $6,985,440

Based on medical and behavioral claims paid through June 2022 for **840 members attributed at least 6 months**



30% enrollment rate
Represents percentage of members opting into the program

17% reduction in acute IP
Based on frequency of medical admissions to IP facility

30% reduction in ED utilization
Based on frequency of visits to an ED

42% reduction in BH IP rate
Based on frequency of admission events to a BH IP facility

Measurement Year 1 is 1/1/21 – 12/31/21

Optum

Note: over 1200 engaged and enrolled with the Harris Center within the year – some received less than 6 months of services TCOC = Total Cost of Care

The HARRIS CENTER for Mental Health and IDD

Transforming Lives

Thank You