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

Program Committee Meeting
September 19, 2023
11:00 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, August 15, 2023
(EXHIBIT P-1)

IV. **REVIEW AND COMMENT**

A. Comprehensive Psychiatric Emergency Programs (CPEP)
(EXHIBIT P-2)

B. Behavioral Health FY23 Year in Review
(EXHIBIT P-3)

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, AUGUST 15, 2023
MINUTES

Mrs. Hellums, Board of Trustees Vice Chairman, called the meeting to order at 12:25 p.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: Dr. R. Gearing, Dr. L. Moore, B. Hellums

Committee Member in Absence: None

Other Board Members in Attendance: None

1. **CALL TO ORDER**
   The meeting was called to order at 12:25 p.m.

2. **DESIGNATION OF BOARD MEMBERS AS VOTING COMMITTEE MEMBERS**

3. **DECLARATION OF QUORUM**
   Dr. Gearing declared a quorum of the committee was present.

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

5. **Approve the Minutes of the Board of Trustees Program Committee Meeting Held on Tuesday, July 18, 2023.**

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

   BE IT RESOLVED that the Minutes of the Board of Trustees Program Committee meeting held on Tuesday, July 18, 2023 under Exhibit P-1, are approved and recommended to the Full Board for acceptance.

6. **REVIEW AND COMMENT**
   A. IDD Update—Dr. Evanthe Collins presented to the Program Committee the IDD Update.

7. EXECUTIVE SESSION

There was no Executive Session during the Program Committee Meeting.

8. ADJOURN

MOTION: GEARING SECOND: MOORE

There being no further business, the meeting adjourned at 12:56 pm.

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

EXHIBIT P-2

Comprehensive Psychiatric Emergency Programs (CPEP)

Presented by: Kim Kornmayer, LCSW
Vice President, Crisis Services
September 18, 2023

FY23 - YTD

Emergency & Residential Programs		YTD through 06/2023
Psychiatric Emergency Services	(PES)	11,543
Crisis Stabilization Unit	(CSU)	948
Crisis Residential Program Caroline	(CRU Caroline)	291
Crisis Residential Program Southmore	(CRU Southmore)	491
P.E.E.R.S. for Hope House	(PEERS House)	271
Independent Living		23
The Respite, Rehabilitation and Re-Entry Center (6160)		
Hospital to Home	(H2H)	120
Jail Re-Entry	(JRE)	352
Outpatient Competency Restoration	(OCR)	36
Substance Use Disorder & Recovery	(Detox)	115
Step Down	(Step Down)	3
Law Enforcement Collaborations		
Crisis Intervention Response Team	(CIRT)	4,454
Clinician Officer Remote Evaluation	(CORE)	852
Chronic Consumer Stabilization Initiative	(CCSI)	30
Homeless Outreach Team	(HOT)	2,009
Jail Diversion	(JD)	1,560
Jail Diversion Aftercare	(JDA)	521
Crisis Call Diversion	(CCD)	5,718
Mobile Crisis Outreach Team Rapid Response	(MCOT RR)	908
Homeless, Field Based & Long Term Care Programs		
Project for Assistance in Transition from Homelessness	(PATH)	3,142
Substance Use Disorder Outreach Program	(SUDOP)	4,815
Mobile Crisis Outreach Team	(MCOT)	1,708
Behavioral Health Response Team	(BHRT)	400
	Total	**40,310**

The HARRIS CENTER for Mental Health and IDD

CPEP Program Accomplishments

- Admitted the first individual into the Crisis Residential Out of Home Respite program for IDD individuals. He is doing well in the program
- The Harris Center Resiliency Team developed a team of 25 volunteers and all have received Crisis Intervention training. Designated staff are currently participating in EMDR training
- Rainbow Health Dispatch Application officially launched on May 1, 2023. This new software will enable Crisis Call Diversion to dispatch crisis calls directly to MCOT Rapid Response teams through a mobile application with GPS tracking capabilities improving response times to crisis calls in the community
- Eight MCOT Clinicians and MCOT MD received training in the Commercial Sexual Exploitation Identification Tool for ages 10-17 and the Adult Human Trafficking Screening Tool. These tools will be incorporated into the crisis assessment and consumers scoring at risk for trafficking will be provided referrals to community partners specializing in human trafficking
- Jail Diversion admitted a record number of 277 clients in June, followed by 240 in July. The number admitted usually approximates 160 in any given month
- Director of MCOT, Sarah Strang was recognized as the Community Service Employee of the Year at the International Critical Intervention Stress Management (CISM) Conference in Baltimore in May 2023

CPEP Spotlight Program
Hospital to Home History

2020: Program began as a partnership with the Open Door Mission and was housed at their location at 5803 Harrisburg (Funded by: Healthy Communitive Collaborative Grant through HHSC)

2021: Program moved to 6160 with 24 beds and changed the name to Hospital to Home

2022: Received an Expansion grant to fund 10 additional beds (Funded by: HR 133 Homeless and Housing grant from HHSC)

Currently, Hospital to Home functions as a successful program providing psychosocial training and mental health and substance abuse treatment to 34 individuals at a time in a safe, comfortable residential setting to aid in their recovery.

Hospital to Home

Hospital to Home has 34 beds available to provide rehabilitation services to people who are homeless and have a serious mental illness. Participants receive comprehensive rehabilitation services intended to help them successfully transition to more permanent housing options.

Services Provided:

- Temporary Housing
- Healthy Meals
- Therapeutic Life Skills Groups
- Clothing
- Peer Support
- Assistance with Social Services
- Skills Training
- Individual Counseling
- Employment Readiness (3 Residents are currently working)

Projected Length of Stay: 90-180 days

Average Daily Census: 33.89

Referral Sources to H2H:

- Harris County Psychiatric Center/Dunn Center
- The Neuropsychiatric Center
- Ben Taub General Hospital
- West Oaks Hospital
- Any Area Hospital

Hospital to Home Activities

Activities for Clients

- Groups: Up to 4 a day; Topics include:
  - Trauma informed Care, Life Skills, Budgeting, “Ask the Nurse”, Health and Wellness, Creative Expressions, Coping Skills

- Availability of Paint Supplies, Piano and Guitar, Video Games, Board Games, Outside Activities, Gardening, Movie Night, Bingo Types: Coping Skills, Mental Health & Recovery Bingo

- Celebrations observed by Hospital to Home clients:
  - July 4th
  - Juneteenth
  - Valentine’s day
  - Black History Month
  - Host Two Talent Shows per year

- Representatives come in to meet with clients to assess their need for :
  - Government phones, HIV testing, Haircuts, SNAP Benefits, Free Wheels Houston, (free bikes)

CPEP Spotlight Program
Hospital to Home Success Stories

H2H: Danielle is a 24-year-old woman who arrived at Hospital to Home on 12/16/2021. Danielle was part of the foster care system from a very young age as a child. She was later able to obtain housing assistance in Utah. Danielle arrived in Houston from Utah after deciding to be closer to her family. Danielle decided to leave her supported housing behind to be with her family. Unfortunately, due to her mental health, Danielle's family was not able to assist her with a place to live and encouraged her to seek help. Danielle was self-admitted to the hospital and after stabilization, she was referred to the Hospital to Home program. Danielle's process of housing was longer than usual, she had conflicts with her housing voucher in Utah. After deciding to start from zero with Coalition for the Homeless, she was able to start working with a housing navigator. Danielle faced different obstacles that tested her patience and hopes, from debt to the passing of loved ones. Danielle was able to work on building resilience during her stay at Hospital to Home, she adopted coping strategies that helped her become more patient and understanding. Danielle was able to find housing and successfully discharge from Hospital to Home on 02/01/2023. Danielle expressed great feelings of appreciation toward Hospital to Home, she took with her tools and knowledge that have the potential to help her prevent a future crisis.

H2H Expansion: Mr. Shelby arrived at Hospital to Home on October 6th, 2021. Upon arrival, Mr. Shelby shared he was unaware of what community resources were available to provide the assistance he was seeking. Mr. Shelby shared he was previously living with his brother but was unable to live with him anymore due to personal circumstances. Mr. Shelby was not fully capable of searching for the necessary resources on his own due to his mental health and difficulties with memory.

While at Hospital to Home, Mr. Shelby was educated on and connected to community resources that could assist him with obtaining SNAP benefits, receiving optical and dental services, managing his mental and physical health, and overall preparing him for a smooth transition back into society after successfully discharging from the program. Mr. Shelby worked alongside his care coordinators at H2H and with the NW ACT Team to ensure he was linked to the necessary community resources to meet his needs. While waiting to hear back regarding his housing, Mr. Shelby was also able to obtain a variety of life skills as he continued to attend and participate in groups. Mr. Shelby acquired knowledge of coping skills, effective communication skills, healthy living, self-care, medication management, budgeting, and anger management.

After many months of actively working on improving s mental and physical health, receiving linkage to community resources, and leaning key life skills in groups, Mr. Shelby was able to achieve his main goal of obtaining a new place to call his home. Mr. Shelby has been living at a personal care home since November 1st, 2022, and is looking forward to continuing managing his psychiatric and physical health using the knowledge and resources he acquired while at Hospital to Home. Mr. Shelby continues to work with the NW ACT Team and has been using the skills he learned in the program to maintain his overall well-being.

***** The names of the clients above were changed to protect their confidentiality *****

Thank you.

EXHIBIT P-3

Behavioral Health

FY23 Year in Review

Lance Britt, MHA, LPC, FACHE
VP Behavioral Health

September 19, 2023

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

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

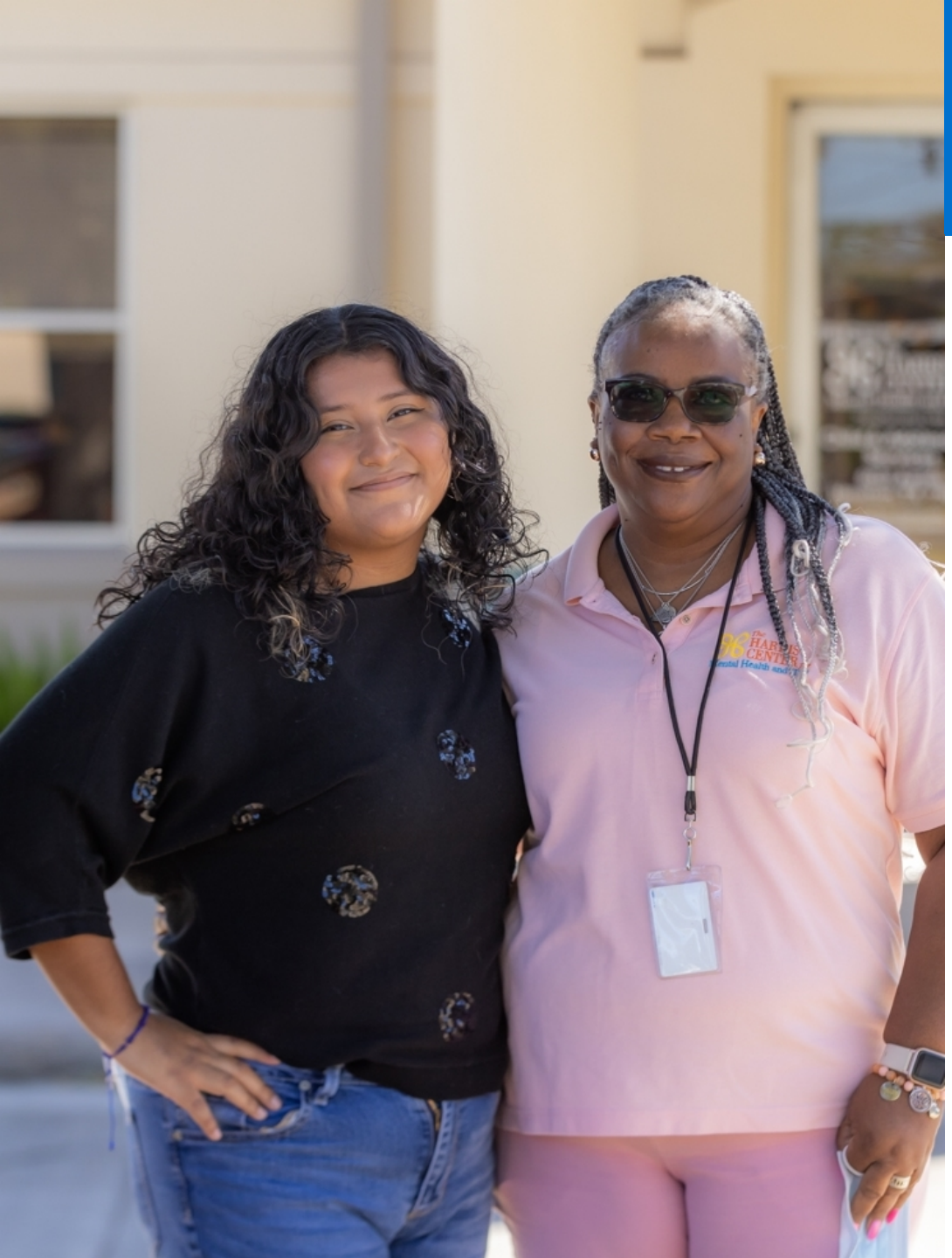
Business Office

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

Behavioral Health Services FY23 Numbers Served

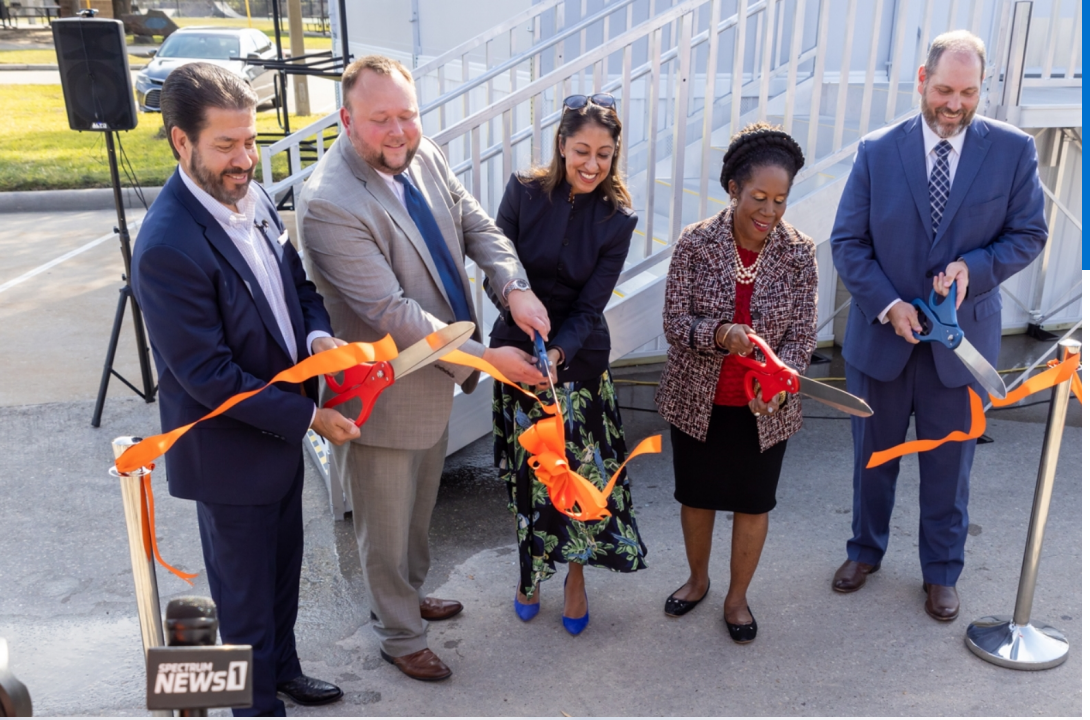
AMH	Northwest 7192	Northeast 4518	Southeast 6837	Southwest 4674	ACT/FACT 868	New Start 2228	AOT 81	Early Onset 290
CAS	Southwest 3445	Southeast 1466	Airline 968	Co-Location 2250	YES Waiver 381	ECI 4229		
Integrated Care	PCP 3317	Optum 704						
Special Projects	LCDC 896	Housing 544	Employment 1332					

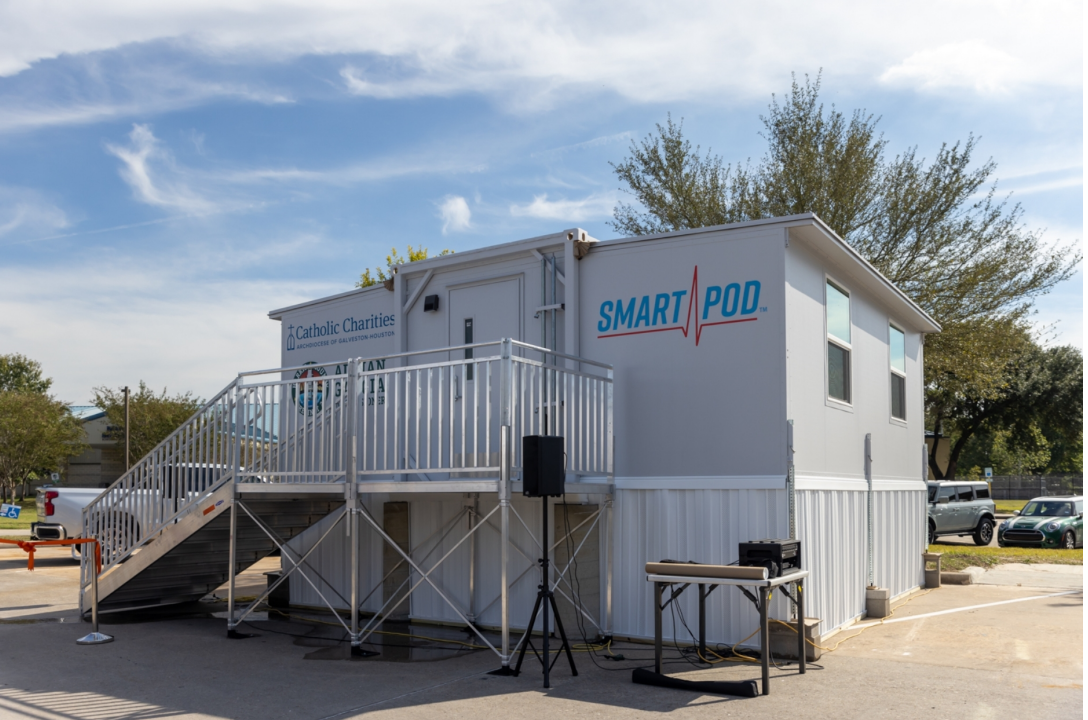
Behavioral Health Services Accomplishments



Children and Adolescent Services **Accomplishments**

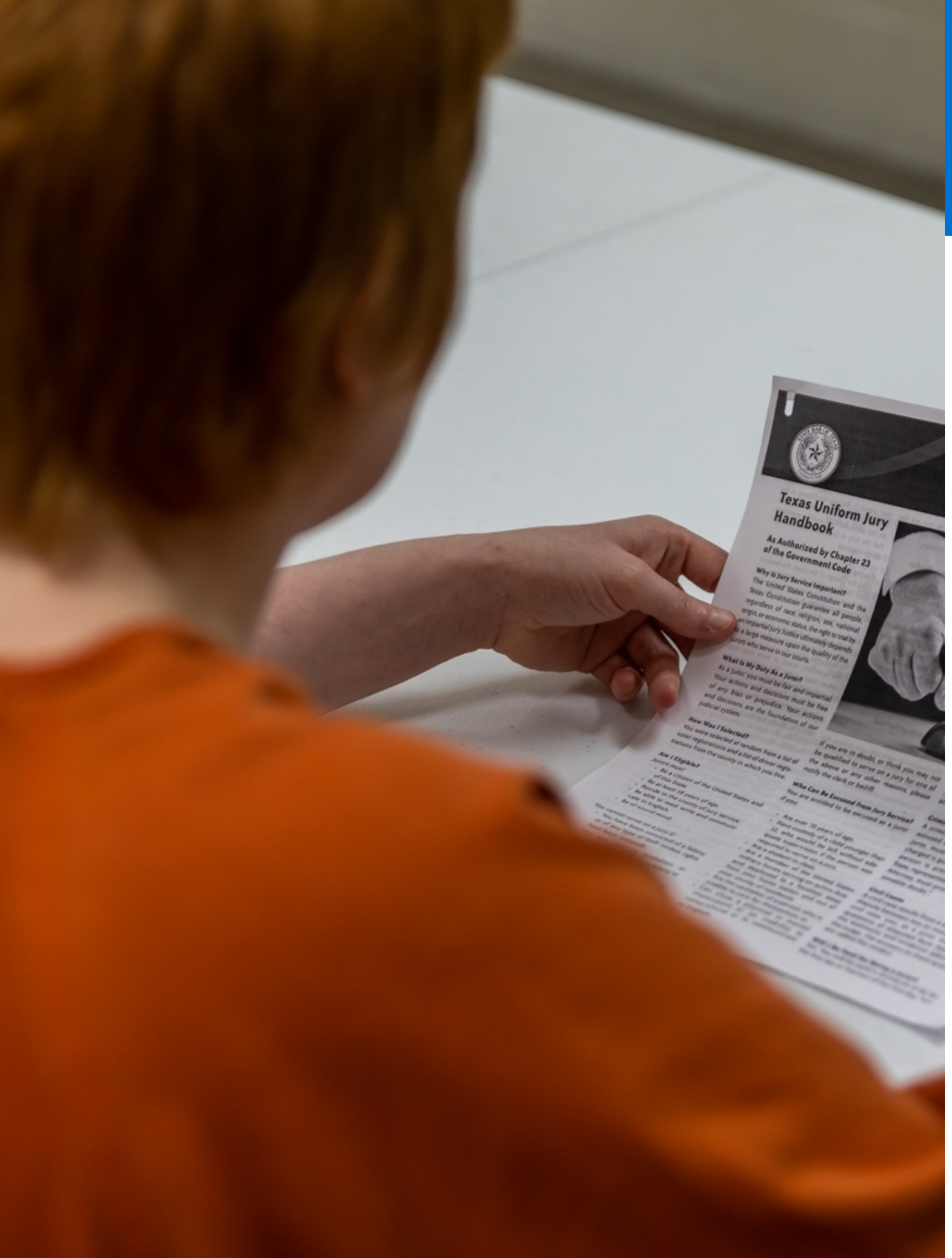
- A Youth Peer Support Specialist was hired for the YES Waiver Program
- YES Waiver was awarded ARPA funding to purchase IT equipment for both client and families and the clinicians
- The outpatient clinics hosted 2 externs for the Harris Center's Externship Program
- A Child Psychiatrist was hired
- The ECI program was approved for the Personnel Incentive Program
- ECI continues to serve over the contract number
- New MOU's added: Huffman ISD & Children's Museum
- The NE Multiservice Center Lease is being signed to expand services for NE Youth and Wellness and ECI
- *CAS 1st contact to an LPHA Assessment is less than 2 days*
- Peer Services was awarded a $2,000.00 grant for the Youth Lead Mental Wellness Project
- All MST Teams exceeded the target of 85% in completing treatment
- *The CAS team represented the agency in Austin at the Mental Health Acceptance Day*
- The NE Youth and Family Wellness team represented the agency at the Mayor's Back-Pack giveaway
- CAS representative joined Sheldon ISD Student Health Advisory Council for quarterly meetings
- 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*





Adult Mental Health **Accomplishments**

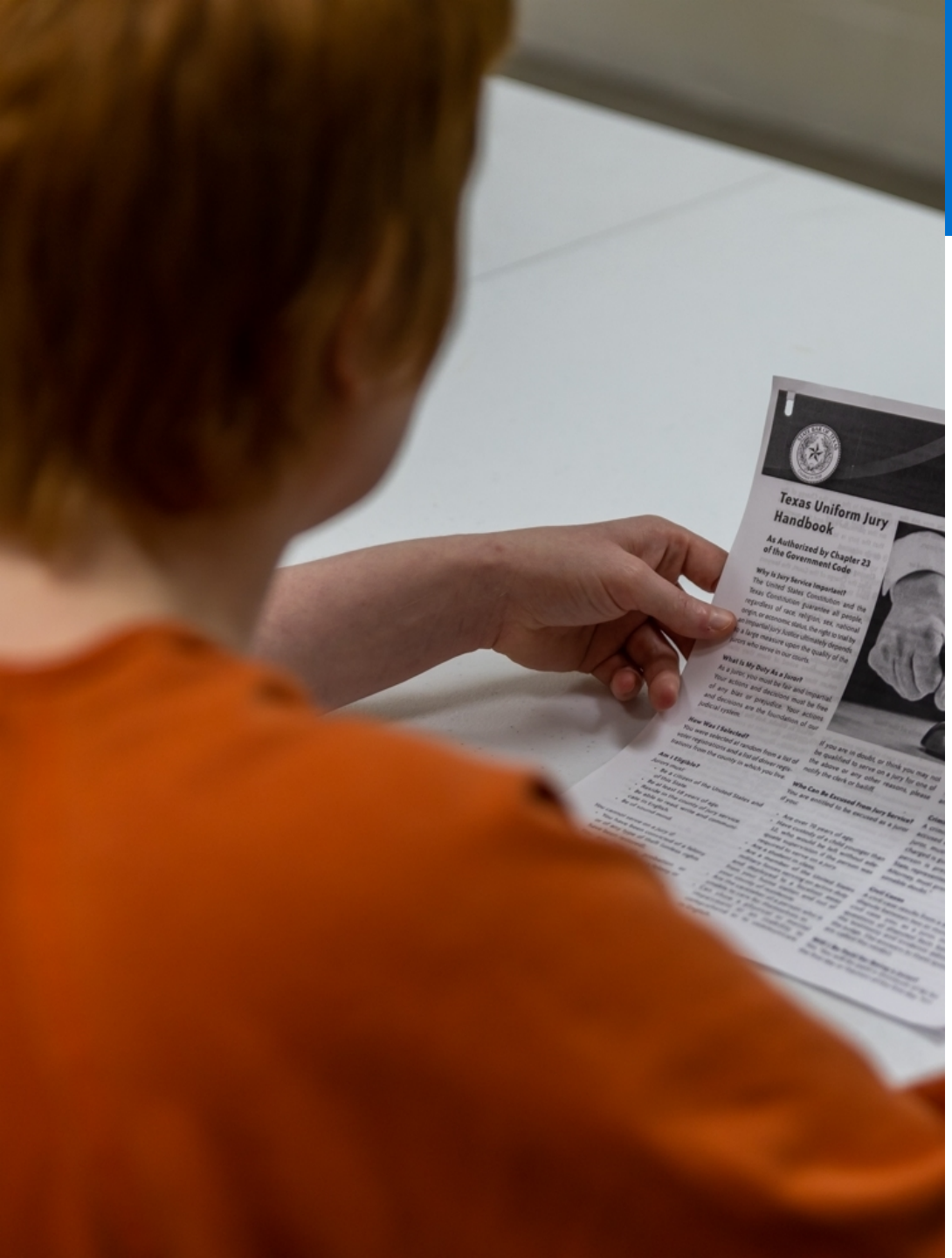
- Opened and maintained Precinct 2 Mental Health Smartpod
- Increased number of psychiatry providers
- Developed EPIC training manual for Behavioral Health Division
- Increased number of eligibility intakes
- Began year 2 of the Resident Clinic with 4 residents and a full-time attending to provide oversight
- Clinician Advancement Program increased to 28 supervisees with 3 clinicians becoming fully licensed
- Participated in community outreach events to engage community in mental health resources and access
- 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



Continuity of Care **Accomplishments**

Jail and Mental Health Courts

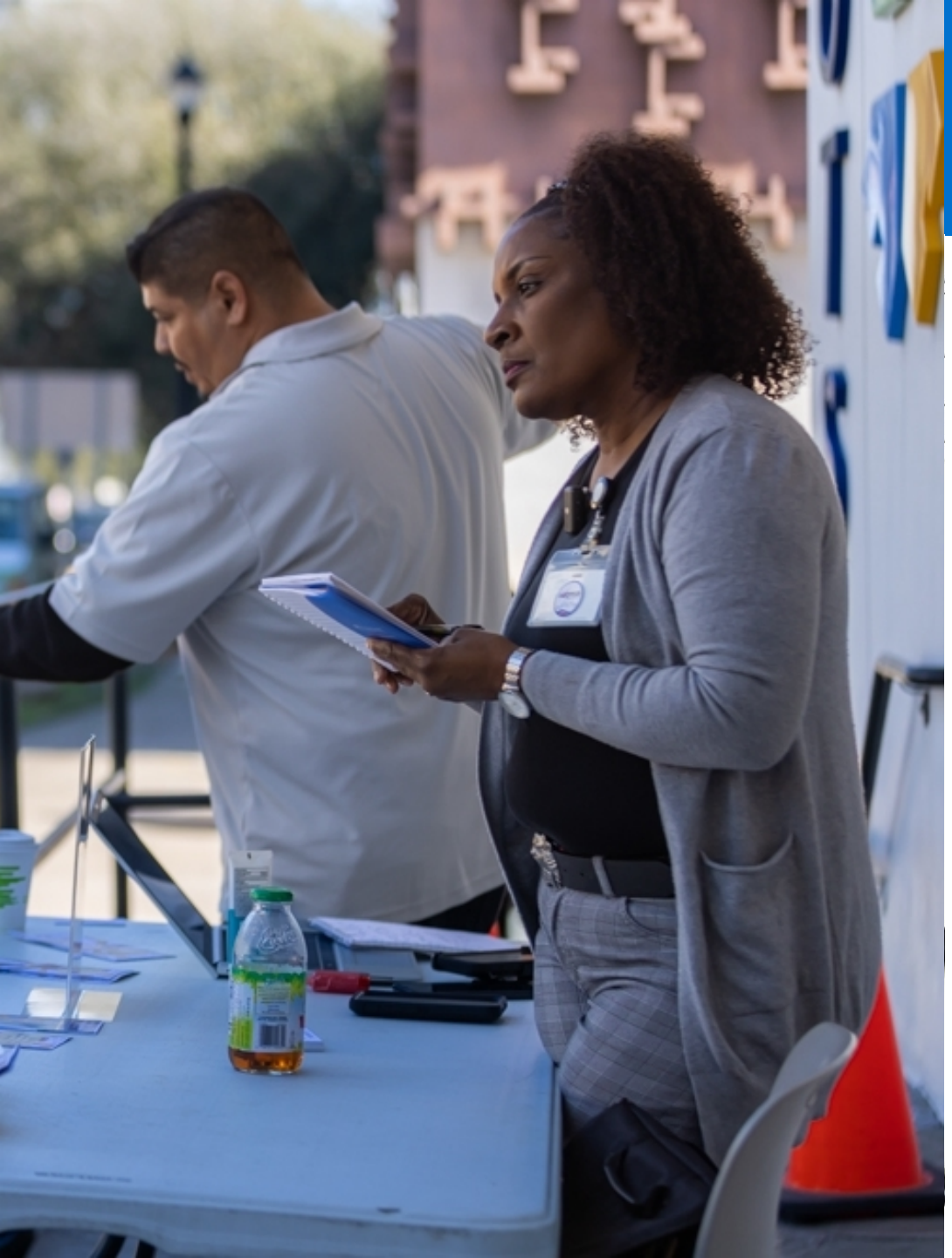
- Fiscal Year 23 Discharges from HHSC funded inpatient beds offered appointments at The Harris Center:
  - *HCPC Discharges= 3757*
  - *West Oaks Discharges= 370*
  - *State Hospital Discharges= 61*
- Forensic Single Portal- COC team inside Courts & Jail assisting with HCPC & State Hospital transitions to & from the jail
- State hospital wait listers in jail/out on bond waiting
  - 406 patients added to SHWL (avg of 33 new forensic commitments to CR programming a month)
  - 160 court ordered med petitions granted through the Probate court
- State hospital returnees to jail
  - 180 patients returned to custody (average of 15 per month)
  - 393 discharge plans presented Competency Restoration Docket
  - Mental Health Court-Judges Gray, Judge Ellis, and Judge Cornelio
- Responsive Integrations for Change (RIC) Court
  - 7826 cases with MH history on docket in Fy23 (average of 50% of total docket cases)
  - 1454 contacts/engagements made with patients in the RIC court
  - Judge Brock Thomas



Continuity of Care **Accomplishments**

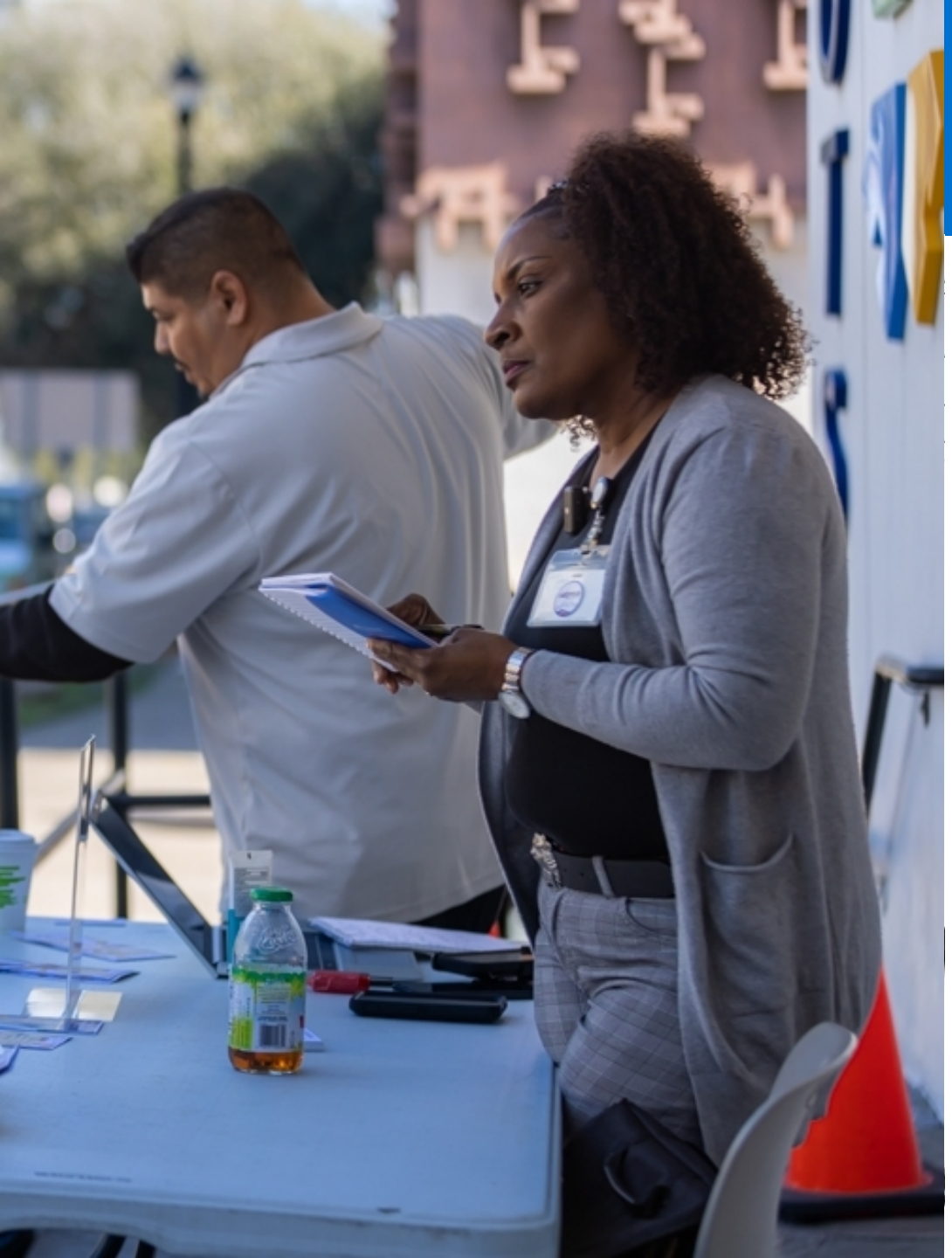
COC/Utilization Management

- Supportive Housing
  - *Served 335 patients*
  - $1,161,093.20
- Furniture Bank
  - ~374 patients served with furniture vouchers
- Access Point:
  - 42 Eligibility assessments completed at Memorial Hermann community service centers and 42 THC MD intake appointments scheduled
    - 60% attended the intake (3 still pending)
  - Current MH locations are MH Community Resource Center Southwest, Community Resource Center Greater Heights, and Community Resource Center Northeast
- HCCOC Referrals (Community/THC COC in reach):
  - 790 clinic appointments scheduled from outside agency transfers
- ANSA/CANS: 55,000 Authorizations completed by UM team
- LPND (Local Planning and Network Development) submission to HHSC submission on time 12/31/22
- 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*



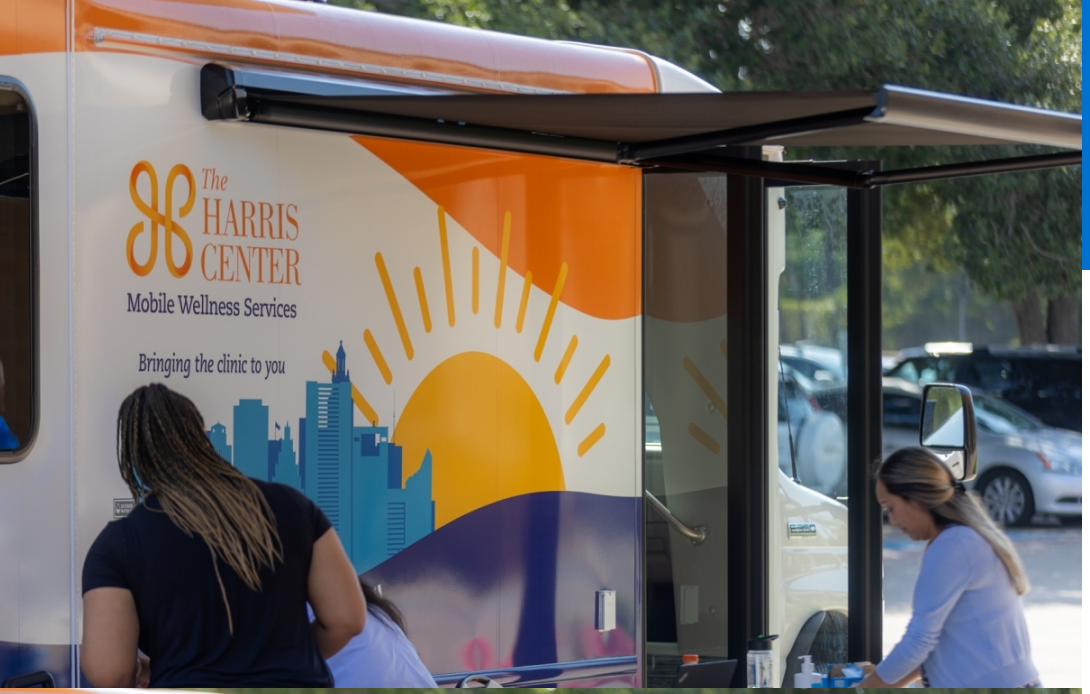
Special Projects **Accomplishments**

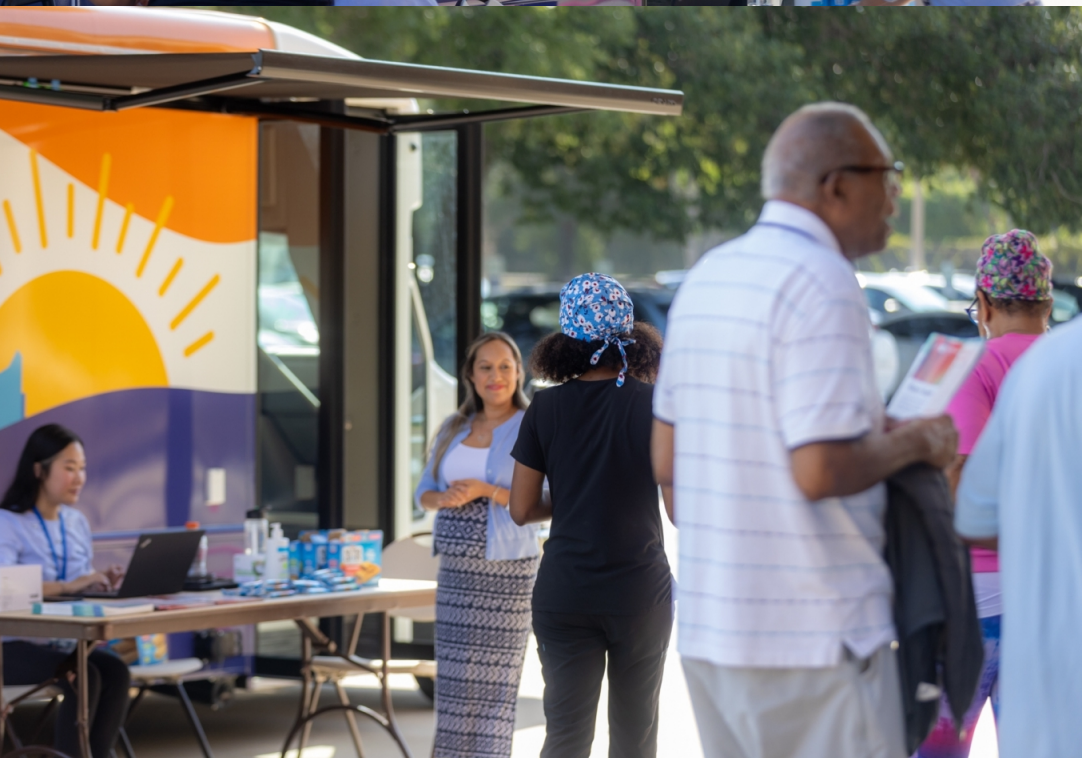
- *New multipurpose room on SW 3rd floor*
- Provided housing assistance to 138 clients
- SUD Care Pathway collaboration
- Supported Employment
  - Currently serving 800+ Harris County Residents
  - Average of 50 New Job Placements per month over the past 12 months
  - *Total of 594 Job placements over the past 12 months*
  - Harris Center Job Fair for clients scheduled for October 27, 2023
- Supported Housing
  - Section 8 Program: Received 403 Housing Vouchers since 2018
  - Section 8 Program: Housed 319 Clients since 2018
  - Flex Funds Programs: Rental and Utility Assistance to 213 clients since 2018
- Home and Community Based Services through The Harris Center
  - Processed 375 referrals since the program's inception in 2016
  - 156 current enrollees YTD FY2023 as reported July 2023
  - Met and/or exceeded state mandated quarterly pre-engagement performance measures



Special Projects **Accomplishments**

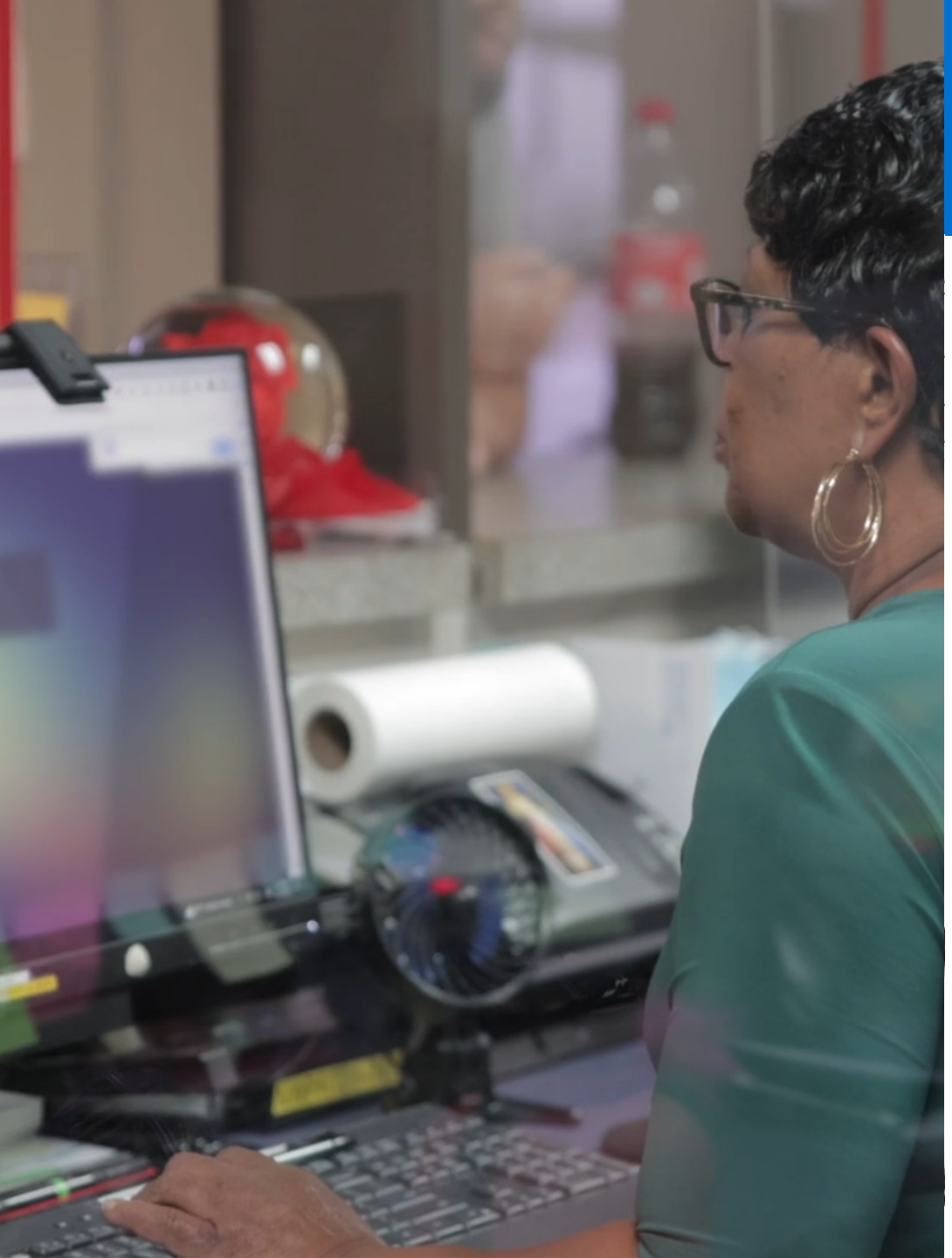
- Adult Recovery Program
  - *Served over 200 people since August 2022*
  - Over 20% of clients discharged since August 2022 have discharged successfully
  - Provided over 1400 hours of direct care since August 2022
- Co-Occurring Psychiatric Substance use Disorder Recovery Services (COPSDR)
  - Screened over 400 clients for substance use recovery services since August 2022
  - Increased collaboration amongst behavioral health providers
  - Provided over 1900 hours of direct care since August 2022
- Smoking Cessation Program
  - Monthly smoking cessation education groups available
  - Resource tables are housed in clinic lobbies to increase access to education/services
  - Over 100 hours of smoking cessation education has been provided since August 2022
- Outreach, Screening, Assessment, and Referrals (OSAR)
  - 784 total referrals FY2023 YTD as reported for July 2023
  - 706 total engaged patients (screenings) FY2023 YTD as reported for July 2023





Integrated Care **Accomplishments**

- Mental Health Awareness Month
  - As part of our Precinct 1 Partnership, our Registered Dietitian provided a Nutrition Class with a Food Demo in May 2023
- *June 2023 - We received our Mobile Wellness Vehicle that will be used to target the underserved areas of Harris County*
- Since January 2023 – August 2023 we have provided health and wellness - 47 groups to 389 people at the following Community Neighborhood Centers
  - Tom Bass Community Center, Lincoln Park Community Center, Finnigan Community Center, Cavalcade Community Center
- Since January 2023, Our Dietitians have offered our patients 28 Heart Health groups, 31 Diabetes Management groups, and 31 Weight Management groups
- NCQA Measurement of Patient Centered Outcomes/Goals launching September 202
- New Collaboration with United Healthcare and Star Kids
- Collaboration with West Oaks and Houston Behavioral for 7-Day and 30-Day Follow-Up HEDIS Measures
- New Collaborations on patient discharge plans – and 7-day Follow-up HEDIS Measures with
  - Texas West Oaks, Sun Behavioral, Behavioral Hospital of Bellaire, Houston Behavioral Hospital, Kingwood Pines, Cypresswood Hospital
- On boarded 670 members into the Health Home Program
- *Outreached and engaged 200+ clients to reduce ER admissions*
- 30 RACI rounds in collaboration with 5 major hospitals, United Healthcare and Optum to reduce in-patient admissions
- Assisted 100 clients with establishing primary care providers
- Assisted 75 clients with obtaining durable medical equipment
- Provided 50 clients with housing assistance
- Development of mobile van concept with community partners
- *Completed client vaccine project*



Business Office **Accomplishments**

- *Supported implementation of EPIC Video with therapists and identified providers*
- Implemented process to complete Financial Assessment Trackers on the day of initial screening for all walk-in clients to assist in reducing overall number of missing financials
- *Supported the initiative to enroll clients in MyChart by identifying clients who had scheduled appointments and were pending completion of enrollment*
- Expanded the use of the WQ Hub and successfully reduced the number of errors pending resolution on a daily basis
- The Interpreter Hub facilitated over 13,000 interpretation services for doctors and nurses within the outpatient clinics
- Supported initial overview and implementation of Real Time Eligibility
- Supported the implementation of Charity Care and identified clients who qualify for this discount per their Monthly Ability to Pay
- Assisted in the implementation of the center's Good Faith Estimate policy
- Successfully had every staff member of the Consumer Benefit Specialist team certified in SSI/SSDI Outreach, Access, and Recovery, (SOAR)
- CBO SOAR certified
- *BO retrained in customer service*
- Implemented process for identifying Charity Care cases

Next Steps

- Identify new opportunities to partner with school districts
- Join the Northeast Houston Pastor Roundtable discussion to promote services in the NE area
- Coordinating Primary Care with IDD population at their sites
- Enroll our PCPs in additional insurance panels
- *Develop partnership with Houston Foodbank – clients with food insecurity*
- *Deliver screenings, wellness education to underserved areas (Mobile Wellness Vehicle)*
- Build community partnerships-wellness activities (Mobile Wellness Vehicle)
- Create Events Calendar for the Mobile Wellness Clinic
- Launch NCQA Goals/Patient Outcomes Measures to track patient-centered outcomes
- Continue working to connect with FQHCs and ERs to help coordinate patient care
- *Support full implementation of Real Time Eligibility*
- *Support full implementation of Epic Video with providers across the outpatient clinics*
- Meet patient care expectations
- Increase in delivery of face-to-face services
- Increase staff engagement
- *Increase supervisor and supervisee participation in the Clinician Advancement Program*
- Participate in community outreach events and host events at AMH clinics
- Coordinate Vaccine clinics
- Prepare for upcoming CCBHC and CARF recertifications
- Launch new CEU opportunities such as substance abuse training with Council for Recovery

Thank you.