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

Full Board Meeting
October 24, 2023
9:30 am

I. **DECLARATION OF QUORUM**

II. **PUBLIC COMMENTS**

III. **APPROVAL OF MINUTES**

A. Approve Minutes of the Board of Trustees Meeting Held on Tuesday, September 26, 2023
(EXHIBIT F-1)

IV. **CHIEF EXECUTIVE OFFICER'S REPORT**

V. **COMMITTEE REPORTS AND ACTIONS**

A. Resource Committee Report and/or Action
(G. Womack, Chair)

B. Quality Committee Report and/or Action
(G. Santos, Chair)

C. Governance Committee Report and/or Action
(J. Lykes, Chair)

D. Audit Committee Report and/or Action
(L. Moore, Chair)

E. Foundation Report and/or Action
(J. Lykes, Chair)

VI. **CONSENT AGENDA**

A. FY'22 Year-to-Date Budget Report-September
(EXHIBIT F-2)

B. October 2023 New Amendments Over 250K
(EXHIBIT F-3 Belinda Stude)

C. October 2023 Interlocal Agreements Over 250K
(EXHIBIT F-4 Belinda Stude)

D. Foreign and Sign Language Translation Interpretation Services
(EXHIBIT F-5 Vanessa McKeown)

E. Root Cause Analysis Policy
(EXHIBIT F-6)

F. Adding and Receiving Equipment
(EXHIBIT F-7)

G. Agency Abbreviations
(EXHIBIT F-8)

H. Asset Tracking and Depreciation
(EXHIBIT F-9)

I. Breach Notification
(EXHIBIT F-10)

J. Business Associate and Subcontractor
(EXHIBIT F-11)

K. Communication with the Media and Other Entities
(EXHIBIT F-12)

L. Consents and Authorizations
(EXHIBIT F-13)

M. Content of Patient/Individual Records
(EXHIBIT F-14)

N. Declaration of Mental Health Treatment
(EXHIBIT F-15)

O. Emergency Codes, Alerts, and Response
(EXHIBIT F-16)

P. Faxing & Emailing Patient Identifying Information
(EXHIBIT F-17)

Q. Harris Center Advisory Committee
(EXHIBIT F-18)

R. IDD-PAC Bylaws
(EXHIBIT F-19)

S. Medication Administration
(EXHIBIT F-20)

T. Nepotism HR SOP
(EXHIBIT F-21)

U. Overtime Compensation
(EXHIBIT F-22)

V. Patient/ Individual Access to Medical Records
(EXHIBIT F-23)

W. Performance Improvement Plan
(EXHIBIT F-24)

X. Retention of Patient/Individual Records
(EXHIBIT F-25)

Y. Return to In-Patient Care of Furloughed Patient
(EXHIBIT F-26)

Z. Security of Patient/ Individual Identifying Information
(EXHIBIT F-27)

AA. Standardized Patient Record Form
(EXHIBIT F-28)

AB. Subpoenas
(EXHIBIT F-29)

VII. **REVIEW AND COMMENT**

A. HR Update
(EXHIBIT F-30 Joseph Gorczyca)

B. FY2022-FY2024 Strategic Plan
(EXHIBIT F-31 Wayne Young)

C. Facilities Year End
(EXHIBIT F-32 Carrie Rys/Todd McCorquodale)

VIII. **BOARD CHAIR'S REPORT**

IX. **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 anytime during the course of this meeting to seek legal advice from its attorney about any matters listed on the agenda.

• As authorized by § 551.074 of the Texas Government Code, performance evaluation of CEO. Mr. James Lykes, Chair of Governance Committee; S. Zakaria, Chair of the Harris Center Board of Trustees

• In accordance with §551.074 of the Texas Government Code, Discussion of Personnel Matters related to the Nomination of Individual Board members as Board Officers and the 2024 Slate of Officers. Mr. James Lykes, Chair of Governance Committee; S. Zakaria, Chair of the Harris Center Board of Trustees

X. **RECONVENE INTO OPEN SESSION**

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

XII. **INFORMATION ONLY**

A. Harris County Bond Reform
(EXHIBIT F-33)

B. Evolution of the Assisted Outpatient Treatment (AOT) Program Through the Application of a Social Work Lens
(EXHIBIT F-34)

C. Treatment outcomes for children with chronic food refusal in a community behavioral health center
(EXHIBIT F-35)

D. Competency Restoration Guide – Texas Behavioral Health and Justice Technical Assistance Center
(EXHIBIT F-36)

E. Role of Board-Certified Psychiatric Pharmacists in child and adolescent psychiatry
(EXHIBIT F-37)

F. Community Initiated Care: A blue-print for the practical realization of contextual behavioral science
(EXHIBIT F-38)

G. Integrated Health Home & Value Based Care, Key Lessons and Outcomes-Dartmouth University Psychiatry Grand Rounds
(EXHIBIT F-39)

H. Improving Mental and Behavioral Health Equity-MH Management Summit
(EXHIBIT F-40)

I. Abbreviations List
(EXHIBIT F-41)

XIII. **ADJOURN**

Veronica Franco, Board Liaison
Shaukat Zakaria, Chair, Board of Trustees
The Harris Center for Mental Health and IDD

EXHIBIT F-1

THE HARRIS CENTER *for*
Mental Health and IDD

MINUTES OF THE BOARD OF TRUSTEES MEETING

This is an official record of the Board of Trustees, The Harris Center for Mental Health and IDD, an Agency of the State, established by the Harris County Commissioners Court under provisions of Chapter 534 of the Health and Safety Code of the State of Texas.

PLACE OF MEETING:	Conference Room 109 9401 Southwest Freeway Houston, Texas 77074
TYPE OF MEETING:	Regular
DATE:	September 26, 2023
TRUSTEES IN ATTENDANCE:	Mr. Shaukat Zakaria-Chair Dr. L. Moore, Vice Chairperson Dr. Robin Gearing PhD, Vice Chairperson Mr. Gerald Womack Mr. Jim Lykes Dr. Max Miller, Jr. Mrs. Natali Hurtado (virtual) Sheriff Ed Gonzalez
TRUSTEES ABSENT:	Mrs. B. Hellums, Dr. George Santos, Secretary

I. Declaration of Quorum

Mr. S. Zakaria, Chair, called the meeting to order at 9:33 a.m. noting that a quorum of the Board was in attendance.

II. Public Comments

A member of the public commented on her experience with The Harris Center. Mr. Womack motioned to extend the member's time for public comment for an additional two (2) minutes. Mr. Zakaria seconded the motion.

III. Approval of Minutes

MOTION BY: MOORE SECOND: MILLER

With unanimous affirmative votes
BE IT RESOLVED the Minutes of the Regular Board of Trustees meeting held on Tuesday, August 22, 2023 as presented under Exhibit F-1, are approved.

IV. Chief Executive Officer's Report was provided by CEO Wayne Young

Mr. Young provided a Chief Executive Officer report to the Board.

V. Committee Reports and Action were presented by the respective chairs:

A. Resource Committee Report and/or Action- G. Womack, Chair
Mr. Womack provided an overview of the topics discussed and the decisions made at the Resource Committee meeting on September 19, 2023

B. Quality Committee Report and/or Action-G. Santos, Chair
Dr. Santos provided an overview of the topics discussed and the decisions made at the Quality Committee meeting on September 19, 2023.

C. Program Committee Report and/or Action-G. Santos, Secretary
Dr. Santos provided an overview of the topics discussed and the decisions made at the Program Committee meeting on September 19, 2023.

D. Governance Committee Report and/or Action-J. Lykes, Chair
Mr. Lykes provided an overview of the topics discussed and the decisions made at the Governance Committee meeting on September 26, 2023.

E. Foundation Report and/or Action-J. Lykes, Chair
Mr. Lykes provided the Board of Trustees with an update about the Foundation.

VI. Consent Agenda

A. Approve FY'22 Year-to-Date Budget Report-August

B. September 2023 Contract Amendments Over 250K

C. September 2023 Interlocal Agreements

D. Behavioral Crisis and Intervention Policy

E. Code of Ethics Policy

F. Confidentiality and Disclosure of Patient/Individual Health Information Policy

G. Correcting Documentation and Coding Errors Policy

H. Cultural Competency and Diversity Plan Policy

I. Employee Counseling, Supervision, Progressive Discipline and Termination-Policy

J. Incident Response Policy

K. Information Security Policy

L. Patient Records Administration Policy

M. Patient Records Administration Policy

N. Sanctions for Breach of Security and/or Privacy Violations of Health Information Policy

O. Sexual Harassment Policy

P. System Quality, Safety and Experience Committee Policy

Q. Temporary Personnel Services

R. The Use of Service and Assistance Animals in the Harris Center Facilities Pertaining to Patients and Visitors Policy

S. Volunteer Program

T. Workforce Member Network Internet Use

MOTION: Dr. Moore moved to approve Consent Agenda item A-T
SECOND: Mr. Lykes seconded the motion
BE IT RESOLVED, with unanimous affirmative vote, Consent Agenda items A-T are approved.

VII. Consider and Take Action

A. Update and Consideration of FQHC Look-Alike- The Board of Trustees decided to convene into Executive Session to consult with their attorney about the legal requirements associated with the Harris Center applying for FQHC Look-Alike status.

VIII. Executive Session-Mr. Zakaria announced the Board would convene into Executive Session at 11:34 am for the following purpose:

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

- In accordance with §551.071 of the Texas Government Code, consultation with attorney on a matter related to the financing of capital improvement projects and lines of credit or bond sales in which the duty of the attorney to the governmental body under the Texas Disciplinary Rules of Professional Conduct to the State Bar of Texas clearly conflicts with the Open Meetings Act. Vanessa McKeown, Chief Financial Officer and Kendra Thomas, General Counsel

- As authorized by §§551.071 and 551.074 of the Texas Government Code, consultation with attorney to seek legal advice about an employee relations matter. Kendra Thomas, General Counsel

- As authorized by §§551.071 and 551.074 of the Texas Government Code, discussion of Personnel Matters related to Board members' fiduciary duties. Shaukat Zakaria, Board Chair and Kendra Thomas, General Counsel

IX. Reconvene into Open Session – The Board reconvened into Open Session at 12:22 pm.

FQHC Look Alike

MOTION: Mr. Womack moved the Board of Trustees authorizes the Chief Executive Officer to develop and manage an implementation plan to establish FQHC Look-Alike status for the Harris Center to include creating the necessary document and establishing the governance to demonstrate the Harris Center's eligibility to apply for the FQHC Look-Alike status; and authorize the Chief Executive Officer to submit an application, along with all other required documents, to Health Resources and Services Administration (HRSA) to determine the Harris Center's compliance and eligibility for FQHC Look Alike status.

SECOND: MOORE

BE IT RESOLVED, with majority affirmative vote, the motion is approved.

X. ADJOURN

MOTION: WOMACK SECOND: LYKES

Motion passed with unanimous affirmative votes.

The meeting was adjourned at 12:23 P.M.

Respectfully submitted,

Veronica Franco, Board Liaison
Shaukat Zakaria, Chair, Board of Trustees
***The* HARRIS CENTER *for* Mental Health *and* IDD**

EXHIBIT F-2

The Harris Center for Mental Health and IDD

Results of Financial Operations and Comparison to Budget
As of September 30, 2023

Fiscal year 2024

The Harris Center for Mental Health and IDD

Resource Committee
Board of Trustees
The Harris Center for Mental Health and IDD (The Center)

The Results of Financial Operations and Comparison to Budget submitted herewith was prepared by The Center's Accounting Department.
Responsibility for the accuracy, completeness and fairness of presentaiton of the presented data rests with the Center, the Chief Financial Officer and the Accounting Department. We believe the data, as presented, is materially accurate and is presented in a manner designed to fairly set forth the financial position and results of operations of The Center.

The Center's accounting records for its general fund are maintained on a modified accrual basis. Under this method, revenues are recognized in the period when they become measurable and available, and expenditures are recognized when the related fund liability is incurred, if measurable.
The financial report submitted herewith has not been audited by an independent auditor.

Vanessa McKeown
Chief Financial Officer

The Harris Center for Mental Health and IDD
Results of Financial Operations and Comparison to Original Budget
As of September 30, 2023
unaudited/budget-basis reporting

For the Month

	Original budget	Actual	Variance
Revenues	$ 28,547,902	$ 28,717,701	$ 169,800
Expenditures	28,250,533	27,635,586	614,946
Change in net assets	**$ 297,369**	**$ 1,082,115**	**$ 784,746**
Use of prior year balances	$ -	$ -	$
Capital, net		(5,120)	(5,120)
Bond payment	(83,333)	-	83,333
	$ 214,036	$ 1,076,995	$ 862,960

Fiscal Year to Date

	Original budget	Actual	Variance
Revenues	$ 28,547,902	$ 28,717,701	$ 169,800
Expenditures	28,250,533	27,635,586	614,946
Change in net assets, operations	**$ 297,369**	**$ 1,082,115**	**$ 784,746**
Use of prior year balances	$ -	$ -	$
Capital, net		(5,120)	(5,120)
Bond payment	(83,333)	-	83,333
	$ 214,036	$ 1,076,995	$ 862,960

The Harris Center for Mental Health and IDD
Results of Financial Operations and Comparison to Original Budget
As of September 30, 2023
unaudited/budget-basis reporting

		For the Month				Fiscal Year to Date				
		ORGBUD	Actual	Variance $	Variance %	orgbud	Actual	Variance $	Variance %	
*	**Operating Revenue**									
	State General Revenue	$ 9,663,399	$ 9,712,849	$ 49,450	1%	$ 9,663,399	$ 9,712,849	$ 49,450	1%	
	Harris County and Local	5,439,058	4,771,969	(667,089)	-12%	5,439,058	4,771,969	(667,089)	-12%	A
	Federal Contracts and Grants	4,040,370	5,050,414	1,010,045	25%	4,040,370	5,050,414	1,010,045	25%	B
	State Contract and Grants	1,513,271	1,196,476	(316,795)	-21%	1,513,271	1,196,476	(316,795)	-21%	C
	Third Party Billing	2,766,557	2,771,153	4,596	0%	2,766,557	2,771,153	4,596	0%	
	Charity Care Pool	3,340,351	3,340,351		0%	3,340,351	3,340,351		0%	
	Directed Payment Programs	726,251	767,943	41,692	6%	726,251	767,943	41,692	6%	
	PAP	833,578	805,116	(28,463)	-3%	833,578	805,116	(28,463)	-3%	
	Interest Income	225,066	301,430	76,364	34%	225,066	301,430	76,364	34%	
	Operating Revenue, total	**$ 28,547,902**	**$ 28,717,701**	**$ 169,800**	**1%**	**$ 28,547,902**	**$ 28,717,701**	**$ 169,800**	**1%**	
	Operating expenditures									
	Salaries and Fringe Benefits	$ 19,902,816	$ 19,666,500	$ 236,315	1%	$ 19,902,816	$ 19,666,500	$ 236,315	1%	
	Contracts and Consultants	2,103,444	1,948,042	155,402	7%	2,103,444	1,948,042	155,402	7%	
	HCPC Contract	2,322,734	2,568,784	(246,050)	-11%	2,322,734	2,568,784	(246,050)	-11%	
	Supplies and Drugs	1,526,528	1,872,172	(345,644)	-23%	1,526,528	1,872,172	(345,644)	-23%	J
	Purchases, Repairs and Maintenance of:									
	Equipment	560,797	85,465	475,332	85%	560,797	85,465	475,332	85%	K
	Building	302,062	242,134	59,928	20%	302,062	242,134	59,928	20%	
	Vehicle	86,370	73,079	13,291	15%	86,370	73,079	13,291	15%	
	Telephone and Utilities	311,949	282,907	29,042	9%	311,949	282,907	29,042	9%	
	Insurance, Legal and Audit	179,467	159,931	19,536	11%	179,467	159,931	19,536	11%	
	Travel	192,524	164,609	27,915	14%	192,524	164,609	27,915	14%	
	Other	761,842	571,963	189,879	25%	761,842	571,963	189,879	25%	
	Operating Expenditures, total	**$ 28,250,533**	**$ 27,635,586**	**$ 614,946**	**2%**	**$ 28,250,533**	**$ 27,635,586**	**$ 614,946**	**2%**	
	Change in Net Assets, before Other Sources	**$ 297,369**	**$ 1,082,115**	**$ 784,746**	**264%**	**$ 297,369**	**$ 1,082,115**	**$ 784,746**	**264%**	
	Other Sources									
401001	Use of Net Assets, capital	$	$ 63,593	$ 63,593		$	$ 63,593	63,593		
	Capital Outlay		68,713	(68,713)			68,713	(68,713)		
	Capital Expenditures, net		(5,120)	(5,120)			(5,120)	(5,120)		
454005	Insurance proceeds		-	-			-	-		
	Bond payment	(83,333)		83,333		(83,333)		83,333		
454015	Proceeds from Sale of Assets						-	-		
	Change in Net Assets, all Sources	**$ 214,036**	**$ 1,076,995**	**$ 862,960**		**$ 214,036**	**$ 1,076,995**	**$ 862,960**		

The Harris Center for Mental Health and IDD
Balance Sheet
As of September 30, 2023
unaudited/budget-basis reporting

	period 12 August-23	September-23	Change	
ASSETS				
Current Assets				
Cash and Petty Cash	$ 10,485,753	$ 13,854,853	$ 3,369,100	AA
Investments	64,953,497	57,922,316	(7,031,181)	AA
Inventory and Prepaid	5,069,274	4,847,801	(221,473)	
Accounts Receivable				
Other	26,335,730	37,082,225	8,768,263	CC
Patient, net of allowance	5,919,600	6,159,697	240,097	
Current Assets, Total	**$ 112,763,854**	**$ 119,866,892**	**$ 5,124,807**	
Capital Assets				
Land	$ 12,693,783	$ 12,693,783	$ -	
Building and Building Improvements	46,595,256	46,595,256	-	
Furniture, Equipment and Vehicles	9,912,523	9,912,523	-	
Construction in Progress	26,090,643	26,154,236	63,593	DD
Capital Assets, Total	**$ 95,292,205**	**$ 95,355,798**	**$ 63,593**	
Total Assets	**$ 208,056,058**	**$ 215,222,690**	**$ 5,188,400**	
LIABILITIES AND NET ASSETS				
Unearned Income	$ 2,724,850	$ 3,964,847	$ 1,239,997	
Accounts Payable and Accrued Liabilities	22,815,441	31,266,469	8,451,028	FF
Long term Liabilities	910,315	910,315	-	
Liabilities, Total	**$ 26,450,606**	**$ 36,141,631**	**$ 9,691,025**	
NET POSITION				
Inventory and Capital Assets	95,669,052	95,728,208	59,155	
Assigned (see notes for designated balances)	85,462,484	82,275,290	(3,187,194)	
Change in net assets, *budgetary basis*	495,331	1,076,995	581,664	
Net Assets, Total	**$ 181,626,867**	**$ 179,080,493**	**$ 640,819**	

The Harris Center for Mental Health and IDD
Notes to Statements Presented
As of September 30, 2023

Results of Financial Operations and Comparison to Budget

A Harris County and Local Revenue

The primary driver of the net unfavorable variance in Harris County and Local Revenue is the lack of revenue recorded in the following contract:

	Original Budget	Actual	Variance	Net revenues less expense
DDRP Dual Diagnosis Resident Program	$ 455,957	$ -	$ (455,957)	$ (417,306)
			$ (455,957)	

B Federal Contract and grants

The primary driver of the net favorable variance in Federal Contract and grants is related to the timing and fluctuation of accruals vs. amounts billed that cross periods.

C State Contract and Grants

The primary driver of the net unfavorable variance in State Contract and Grants is related to lack of revenue recorded in grants due to timing of contract finalizations.

The Harris Center for Mental Health and IDD
Notes to Statements Presented
As of September 30, 2023

J Supplies

The primary driver of the net unfavorable variance in supplies is the increase in retail drug pharmacy purchases. However, revenue earned exceeds the original budget as well.

	Expenses			Revenue		
	Original Budget	Actual	Variance	Original Budget	Actual	Variance
Drug purchases	140,583	248,642	(108,059)			
Drug purchases retail pharmacy	279,035	733,942	(454,907)	303,990	766,692	462,702
PAP drug program	833,579	833,579	-			
All other supplies	273,331	56,009	217,322			
	1,526,528	1,872,172	(345,644)			

K Equipment

Equipment costs have a favorable variance due to the timing of payment of annual epic software costs.

Balance sheet

AA Cash and Investments

We typically see our Cash and Investment balances increase in the first month of a quarter based on the receipt of our quarterly appropriations. As of October 10, 2023 we have yet to receive the ~$20m typically received the first few weeks of the first month of each quarter. The Harris Center staff have made several attempts to determine why these receipts are behind without success to date.

The Harris Center for Mental Health and IDD
Notes to Statements Presented
As of September 30, 2023

CC **Accounts receivable, other**

Accounts receivable, other, balances fluctuated primarily due to the receipt of amounts owed from the Harris County Sheriff's Office for services provided back to November 2022, $4.4M, and the recognition of amounts owed from the State of Texas, $11.5M.

DD **Construction in Progress**

The correction needed for Construction in Progress is being address by the external auditors and corrected as part of the audit work that is in progress.

FF **Accounts Payable and Accrued Liabilities**

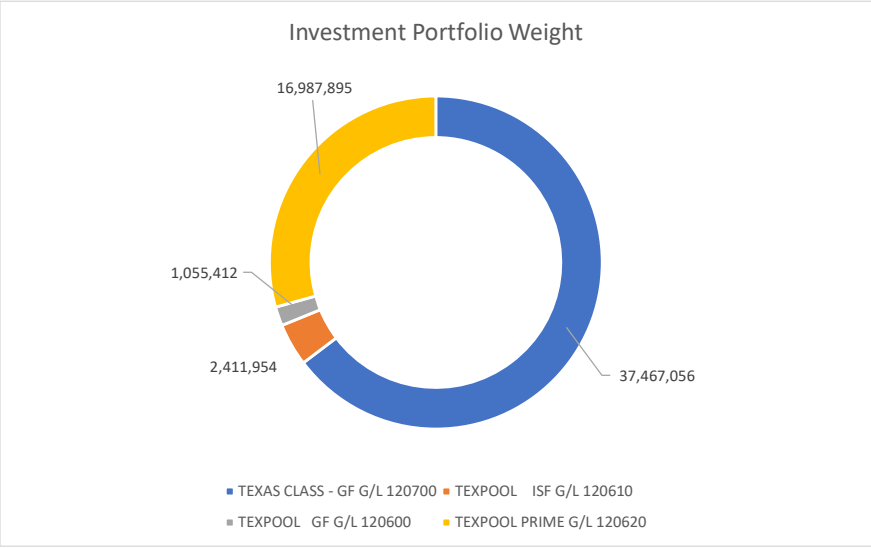
There are multiple factors leading to the increase in Accounts Payable and Accrued Liabilities

	Fluctuation
Medical premiums not remitted in September	$ 2,364,578
Amounts owed to HCPC	2,972,323
Fluctuations in accrued salaries payable	993,190
	$ 6,330,091

The Harris Center for Mental Health and IDD
Investment Portfolio
As of September 30, 2023

Local Government Investment Pools (LGIPs)

	Beginning Balance	Transfer In	Transfer Out	Interest Income	Ending Value	Portfolio %	Monthly Interest Rate	Monthly Yield
Texas CLASS								
Texas CLASS General Fund	$ 44,590,495	$ -	$ (7,300,000)	$ 176,561	$ 37,467,056	64.7%	5.52%	5.551%
TexPool								
TexPool Prime	16,910,737	-	-	77,158	16,987,895	29.3%	5.55%	4.801%
TexPool General Fund	1,050,816	-	-	4,596	1,055,412	1.8%	5.32%	4.611%
TexPool Internal Service Fund	2,401,450	-	-	10,504	2,411,954	4.2%	5.32%	4.611%
TexPool Sub-Total	*20,363,002*	-	-	*92,259*	*20,455,261*	*35.3%*		4.768%
Total Investments	$ 64,953,497	$ -	$ (7,300,000)	$ 268,819	$ 57,922,316	100%		5.275%
Additional Interest-Checking Accounts				32,611				
Total Interest Earned				$ 301,430				



3 Month Weighted Average Maturity (Days)	**1.00**
3 Month Weighted Average Yield	**5.52%**
3 Month Rolling Weighted Average Daily Treasury Bill Rate (4 weeks)	**5.28%**
Interest Rate - Chase Hybrid Checking	**3.15%**
ECR - Chase	**3.25%**

This Investment Portfolio Report of The Harris Center for Mental Health and IDD As of September 30, 2023 is in compliance with the Public Funds Investment Act (PFIA), Chapter 2256 of the Texas Government Code and the Investment Strategy approved by the Board of Trustees.

Approved:

Hayden Hernandez, Accounting and Treasury Manager

The Harris Center for Mental Health and IDD
Monthly Report of Financial Transactions Related to Payments of Liabilities for Employee Benefits
As of September 30, 2023

Vendor	Description	Monthly Not-To-Exceed*	September	YTD Total Through September
Lincoln Financial Group	Retirement Funds (401a, 403b, 457)	$3,500,000	$935,377	$935,377
Blue Cross Blue Shield of TX	Health and Dental Insurance	$3,200,000	$0	$0
UNUM	Life Insurance	$300,000	$0	$0

** As established by the Board Resolution: Harris Center Board of Trustees Signature Authorization and Delegation Authority for Certain Items* effective May 23, 2023.

Notes:

Non-employee portion of September payments of Liabilities for Employee Benefits = 2.1% of Expenditures.

EXHIBIT F-3

OCTOBER 2023

AMENDMENTS OVER 250k

THE HARRIS CENTER FOR MENTAL HEALTH AND IDD

SNAPSHOT SUMMARY
CONTRACT AMENDMENTS
MORE THAN $250,000

OCTOBER 2023
FISCAL YEAR 2024

	CONTRACTOR	PRODUCT/SERVICE DESCRIPTION	PREVIOUS AMOUNT	INCREASE AMOUNT	NTE AMOUNT	CONTRACT PERIOD	FUNDING	BID/TAG-ON	COMMENTS
	ADMINISTRATION								
1	Aptean, Inc.	Software License, Support & Maintenance for On-Line Requisition & Approval System (Formerly Ross)	$406,084.64	$57,449.00	$463,533.64	9/1/2023 - 8/31/2024	General Revenue (GR)	Request for Proposal	Amendment to increase the NTE for continued IT Capital Projects from FY23.
2	Enterprise Fleet Management	Vehicle Lease and Maintenance Agreements for Agency-Wide Transportation Services. Vehicle Procurement Services (Lease and Ownership) through a single entity.	$758,833.08	$89,928.78	$848,761.86	1/31/2021 - 12/1/2025	General Revenue (GR)	Tag-On	Amendment to increase the NTE to add new units (departments) and owned vehicles to be leased. [Tag-On through Choice Partners, TIPS].
	FORENSICS								
	INTELLECTUAL DEVELOPMENTAL DISABILITY SERVICES								
	MENTAL HEALTH								
	CPEP/CRISIS SERVICES								
	LEASES								
	INTELLECTUAL DEVELOPMENTAL DISABILITY SERVICES-ECI								

Executive Contract Summary

Contract Section

Select Header For This Contract *
Administration

Contractor *
Aptean, Inc.

Contract ID # *
6115

Presented To *
- (•) Resource Committee
- ( ) Full Board

Date Presented *
10/17/2023

Parties * (?)
Aptean & The Harris Center for Mental Health and IDD

Agenda Item Submitted For: * (?)
- [ ] Information Only (Total NTE Amount is Less than $250,000.00)
- [x] Board Approval (Total NTE Amount is $250,000.00 or more)
- [ ] Grant Proposal
- [ ] Revenue
- [ ] SOW-Change Order-Amendment#
- [ ] Other

Procurement Method(s) *
Check all that Apply

- [ ] Competitive Bid
- [x] Request for Proposal
- [ ] Request for Application
- [ ] Request for Quote
- [ ] Interlocal
- [ ] Not Applicable (If there are no funds required)
- [ ] Competitive Proposal
- [ ] Sole Source
- [ ] Request for Qualification
- [ ] Tag-On
- [ ] Consumer Driven
- [ ] Other

Funding Information *
( ) New Contract (•) Amendment

Contract Term Start Date * (?)
9/1/2023

Contract Term End Date * (?)
8/31/2024

If contract is off-cycle, specify the contract term (?)

Current Contract Amount *
$ 406,084.64

Increase Not to Exceed *
$ 57,449.00

Revised Total Not to Exceed (NTE)*

$ 463,533.64

Fiscal Year* (?)

2024

Amount* (?)

$ 57,449.00

Funding Source*

General Revenue (GR)

Contract Description / Type* (?)

- [ ] Personal/Professional Services
- [ ] Consumer Driven Contract
- [ ] Memorandum of Understanding
- [ ] Affiliation or Preceptor
- [ ] BAA/DUA
- [ ] Pooled Contract
- [ ] Renewal of Existing Contract
- [ ] Consultant
- [ ] New Contract/Agreement
- [x] Amendment to Existing Contract
- [ ] Service/Maintenance
- [ ] IT/Software License Agreement
- [ ] Lease
- [ ] Other

Contract Owner*

Mustafa Cochinwala

Previous History of Contracting with Vendor/Contractor*

( ) Yes ( ) No (•) Unknown

Vendor/Contractor a Historically Underutilized Business (HUB)* (?)

( ) Yes ( ) No (•) Unknown

Community Partnership* (?)

( ) Yes ( ) No (•) Unknown

Supporting Documentation Upload (?)

Vendor/Contractor Contact Person

Name*

Rylee Dawson

Address*

Street Address

4325 Alexander Drive

Address Line 2

Suite 100

City

Alpharetta

State / Province / Region

GA

Postal / Zip Code

30022-3740

Country

US

Phone Number*

512-431-6709

Email*

RyleeDawson@aptean.com

Budget Section

Budget Units and Amounts Charged to each Budget Unit

Budget Unit Number *
1147

Amount Charged to Unit *
$ 57,449.00

Expense/GL Code No. *
900022

Budget Manager
Brown, Erica

Secondary Budget Manager
Campbell, Ricardo

Provide Rate and Rate Descriptions if applicable * (?)
ROSS/DocuSign Integration Services.
Rate: 244.212 hours @ $250 per hour

Project WBS (Work Breakdown Structure) * (?)
WBS: IT21.1147.06

Requester Name
Jones, Anthony

Submission Date
9/27/2023

Budget Manager Approval(s)

Approved by
Erica Brown

Approval Date
9/28/2023

Procurement Approval

File Upload (?)

Approved by
Sign

Approval Date

Contract Owner Approval

Approved by

Approval Date
9/29/2023

Contracts Approval

Approved by
Belinda Stude

Approval Date
9/29/2023

Final Board Report Comments

Justification / Purpose of Contract / Description of Services Being Provided (?)
This is an IT capital project roll over funds from FY23. Contract ID 6115 FY23

Product/Service Description

Software License, Support & Maintenance for On-Line Requisition & Approval System
(Formerly Ross)

Revised Comments For Board Report*

Amendment to increase the NTE for continued IT Capital Projects from FY23.

Exclude this ECS from Board Report?*

○ Yes ◉ No

Executive Contract Summary

Contract Section

Contractor *
Enterprise Fleet Management

Contract ID # *
7287

Presented To *
- (•) Resource Committee
- ( ) Full Board

Date Presented *
10/17/2023

Parties * (?)
Enterprise Fleet Management and The Harris Center for Mental Health and IDD

Agenda Item Submitted For: * (?)
- [ ] Information Only (Total NTE Amount is Less than $100,000.00)
- [x] Board Approval (Total NTE Amount is $100,000.00+)
- [ ] Grant Proposal
- [ ] Revenue
- [ ] SOW-Change Order-Amendment#
- [ ] Other

Procurement Method(s) *
Check all that Apply

- [ ] Competitive Bid
- [ ] Request for Proposal
- [ ] Request for Application
- [ ] Request for Quote
- [ ] Interlocal
- [ ] Not Applicable (If there are no funds required)
- [ ] Competitive Proposal
- [ ] Sole Source
- [ ] Request for Qualification
- [x] Tag-On
- [ ] Consumer Driven
- [ ] Other

Funding Information *
( ) New Contract (•) Amendment

Contract Term Start Date * (?)
1/31/2021

Contract Term End Date * (?)
12/1/2025

If contract is off-cycle, specify the contract term (?)
1/31/2021-12/1/2025

Current Contract Amount *
$ 758,833.08

Increase Not to Exceed *
$ 89,928.78

Revised Total Not to Exceed (NTE) *
$ 848,761.86

Fiscal Year* (?)
2024

Amount* (?)
$ 848,761.86

Funding Source*
General Revenue (GR)

Contract Description / Type* (?)

- [ ] Personal/Professional Services
- [ ] Consumer Driven Contract
- [ ] Memorandum of Understanding
- [ ] Affiliation or Preceptor
- [ ] BAA/DUA
- [ ] Pooled Contract
- [ ] Renewal of Existing Contract
- [ ] Consultant
- [ ] New Contract/Agreement
- [x] Amendment to Existing Contract
- [ ] Service/Maintenance
- [ ] IT/Software License Agreement
- [ ] Lease
- [ ] Other

Justification/Purpose of Contract/Description of Services Being Provided* (?)

To amend FY 2024 NTE by $89,928.78 to add new units and owned vehicles to become leased.

New FY 2024 is $848,761.86.

Contract Owner*
Todd McCorquodale

Previous History of Contracting with Vendor/Contractor*

(•) Yes ( ) No ( ) Unknown

Please add previous contract dates and what services were provided*
2021 to present

Vendor/Contractor a Historically Underutilized Business (HUB)* (?)

( ) Yes (•) No ( ) Unknown

Please provide an explanation*
Does not meet requirement

Community Partnership* (?)

( ) Yes (•) No ( ) Unknown

Supporting Documentation Upload (?)
ID 7827 - Enterprise - FY24 REQ_Revised8.29.2023.xlsx 15.06KB

Vendor/Contractor Contact Person

Name*
Cindy Fiegel

Address *

Street Address

10401 Centrepark Drive

Address Line 2

City

Houston

State / Province / Region

TX

Postal / Zip Code

77043-1251

Country

United States

Phone Number *

7138759614

Email *

cindy.s.fiegel@efleets.com

Budget Section

Budget Units and Amounts Charged to each Budget Unit

Budget Unit Number *	Amount Charged to Unit *	Expense/GL Code No. *
1117	$ 6,739.56	560500
Budget Manager	**Secondary Budget Manager**	
Campbell, Ricardo	Brown, Erica	

Budget Unit Number *	Amount Charged to Unit *	Expense/GL Code No. *
1117	$ 888.12	559000
Budget Manager	**Secondary Budget Manager**	
Campbell, Ricardo	Brown, Erica	

Budget Unit Number *	Amount Charged to Unit *	Expense/GL Code No. *
1124	$ 80,071.32	560500
Budget Manager	**Secondary Budget Manager**	
Brown, Erica	Campbell, Ricardo	

Budget Unit Number *	Amount Charged to Unit *	Expense/GL Code No. *
1124	$ 19,546.56	559000
Budget Manager	**Secondary Budget Manager**	
Brown, Erica	Campbell, Ricardo	

Budget Unit Number *	Amount Charged to Unit *	Expense/GL Code No. *
1130	$ 10,088.16	560500
Budget Manager	**Secondary Budget Manager**	
Campbell, Ricardo	Brown, Erica	

Budget Unit Number *	Amount Charged to Unit *	Expense/GL Code No. *
1130	$ 1,091.76	559000
Budget Manager	**Secondary Budget Manager**	
Campbell, Ricardo	Brown, Erica	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
1150	$ 33,077.42	560500
Budget Manager	**Secondary Budget Manager**	
Campbell, Ricardo	Brown, Erica	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
1150	$ 2,177.28	559000
Budget Manager	**Secondary Budget Manager**	
Campbell, Ricardo	Brown, Erica	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
2200	$ 12,972.75	560500
Budget Manager	**Secondary Budget Manager**	
Shelby, Debbie	Hooper Jr., Michael	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
2200	$ 3,532.44	559000
Budget Manager	**Secondary Budget Manager**	
Shelby, Debbie	Hooper Jr., Michael	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
2214	$ 12,972.75	560500
Budget Manager	**Secondary Budget Manager**	
Shelby, Debbie	Hooper Jr., Michael	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
2214	$ 5,875.56	559000
Budget Manager	**Secondary Budget Manager**	
Shelby, Debbie	Hooper Jr., Michael	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
2250	$ 38,727.21	560500
Budget Manager	**Secondary Budget Manager**	
Oshman, Jodel	Ramirez, Priscilla	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
2250	$ 8,514.12	559000
Budget Manager	**Secondary Budget Manager**	
Oshman, Jodel	Ramirez, Priscilla	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
2301	$ 86,052.66	560500
Budget Manager	**Secondary Budget Manager**	
Shelby, Debbie	Hooper Jr., Michael	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
2301	$ 16,315.68	559000
Budget Manager	**Secondary Budget Manager**	
Shelby, Debbie	Hooper Jr., Michael	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
3550	$ 12,972.75	560500
Budget Manager	**Secondary Budget Manager**	
Adams-Austin, Mamie	Kerlegon, Charles	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
3550	$ 2,413.56	559000
Budget Manager	**Secondary Budget Manager**	
Adams-Austin, Mamie	Kerlegon, Charles	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
3579	$ 7,618.68	560500
Budget Manager	**Secondary Budget Manager**	
Adams-Austin, Mamie	Kerlegon, Charles	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
3579	$ 888.12	559000
Budget Manager	**Secondary Budget Manager**	
Adams-Austin, Mamie	Kerlegon, Charles	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
3585	$ 12,642.24	56000
Budget Manager	**Secondary Budget Manager**	
Adams-Austin, Mamie	Kerlegon, Charles	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
3585	$ 1,833.72	559000
Budget Manager	**Secondary Budget Manager**	
Adams-Austin, Mamie	Kerlegon, Charles	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
3609	$ 13,558.68	560500
Budget Manager	**Secondary Budget Manager**	
Adams-Austin, Mamie	Kerlegon, Charles	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
3609	$ 1,833.72	559000
Budget Manager	**Secondary Budget Manager**	
Adams-Austin, Mamie	Kerlegon, Charles	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
3611	$ 26,161.02	560500
Budget Manager	**Secondary Budget Manager**	
Adams-Austin, Mamie	Kerlegon, Charles	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
3611	$ 4,961.88	559000
Budget Manager	**Secondary Budget Manager**	
Adams-Austin, Mamie	Kerlegon, Charles	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
3636	$ 5,752.32	560500
Budget Manager	**Secondary Budget Manager**	
Adams-Austin, Mamie	Kerlegon, Charles	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
3636	$ 945.60	559000
Budget Manager	**Secondary Budget Manager**	
Adams-Austin, Mamie	Kerlegon, Charles	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
3692	$ 5,727.00	560500
Budget Manager	**Secondary Budget Manager**	
Adams-Austin, Mamie	Kerlegon, Charles	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
3692	$ 945.60	559000
Budget Manager	**Secondary Budget Manager**	
Adams-Austin, Mamie	Kerlegon, Charles	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9206	$ 19,173.36	560500
Budget Manager	**Secondary Budget Manager**	
Oshman, Jodel	Ramirez, Priscilla	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9206	$ 3,445.20	5590000
Budget Manager	**Secondary Budget Manager**	
Oshman, Jodel	Ramirez, Priscilla	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9208	$ 110,885.35	560500
Budget Manager	**Secondary Budget Manager**	
Oshman, Jodel	Ramirez, Priscilla	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9208	$ 28,029.48	559000
Budget Manager	**Secondary Budget Manager**	
Oshman, Jodel	Ramirez, Priscilla	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9210	$ 15,243.96	560500
Budget Manager	**Secondary Budget Manager**	
Oshman, Jodel	Ramirez, Priscilla	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9210	$ 2,761.20	559000
Budget Manager	**Secondary Budget Manager**	
Oshman, Jodel	Ramirez, Priscilla	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9211	$ 4,778.28	560500
Budget Manager	**Secondary Budget Manager**	
Oshman, Jodel	Ramirez, Priscilla	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9211	$ 907.80	559000
Budget Manager	**Secondary Budget Manager**	
Oshman, Jodel	Ramirez, Priscilla	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9243	$ 5,318.40	560500
Budget Manager	**Secondary Budget Manager**	
Ramirez, Priscilla	Puente, Giovanni	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9243	$ 907.80	559000
Budget Manager	**Secondary Budget Manager**	
Ramirez, Priscilla	Puente, Giovanni	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9247	$ 7,570.32	560500
Budget Manager	**Secondary Budget Manager**	
Oshman, Jodel	Ramirez, Priscilla	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9247	$ 2,269.68	559000
Budget Manager	**Secondary Budget Manager**	
Oshman, Jodel	Ramirez, Priscilla	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9248	$ 125,773.92	560500
Budget Manager	**Secondary Budget Manager**	
Oshman, Jodel	Ramirez, Priscilla	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9248	$ 15,973.20	559000
Budget Manager	**Secondary Budget Manager**	
Oshman, Jodel	Ramirez, Priscilla	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9261	$ 10,636.80	560500
Budget Manager	**Secondary Budget Manager**	
Ramirez, Priscilla	Puente, Giovanni	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9261	$ 2,323.80	559000
Budget Manager	**Secondary Budget Manager**	
Ramirez, Priscilla	Puente, Giovanni	

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9263	$ 8,063.76	560500

Budget Manager	Secondary Budget Manager
Oshman, Jodel	Ramirez, Priscilla

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9263	$ 12,168.60	559000

Budget Manager	Secondary Budget Manager
Oshman, Jodel	Ramirez, Priscilla

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9278	$ 8,000.04	560500

Budget Manager	Secondary Budget Manager
Oshman, Jodel	Ramirez, Priscilla

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9278	$ 1,909.68	559000

Budget Manager	Secondary Budget Manager
Oshman, Jodel	Ramirez, Priscilla

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9403	$ 5,802.00	559000

Budget Manager	Secondary Budget Manager
Ramirez, Priscilla	Puente, Giovanni

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9810	$ 16,924.47	560500

Budget Manager	Secondary Budget Manager
Oshman, Jodel	Ramirez, Priscilla

Budget Unit Number*	Amount Charged to Unit*	Expense/GL Code No.*
9810	$ 2,996.52	559000

Budget Manager	Secondary Budget Manager
Oshman, Jodel	Ramirez, Priscilla

Provide Rate and Rate Descriptions if applicable* (?)

N/A

Project WBS (Work Breakdown Structure)* (?)

N/A

Requester Name	Submission Date
Soto, Jessica	8/30/2023

Budget Manager Approval(s)

Approved by

Erica Brown

Approval Date

8/31/2023

Approved by

Erica Brown

Approval Date

8/31/2023

Approved by

Debbie Chambers-Shelby

Approval Date

9/6/2023

Approved by

Jodel Oshman

Approval Date

9/6/2023

Approved by

Mamie Adams-Austin

Approval Date

9/6/2023

Approved by

Priscilla M. Ramirez

Approval Date

9/7/2023

Procurement Approval

File Upload (?)

Approved by

Sign

Approval Date

Contract Owner Approval

Approved by

Todd McCorquodale

Approval Date

9/7/2023

Contracts Approval

Approve *

- (•) Yes
- ( ) No, reject entire submission
- ( ) Return for correction

Approved by *

Approval Date *

9/8/2023

EXHIBIT F-4

OCTOBER 2023

INTERLOCAL AGREEMENTS

THE HARRIS CENTER FOR MENTAL HEALTH AND IDD
9/6/2023

SNAPSHOT SUMMARY
INTERLOCALS

OCTOBER 2023
FISCAL YEAR 2024

	CONTRACTOR	PRODUCT/SERVICE DESCRIPTION	Action Type	CONTRACT PERIOD	FUNDING	COMMENTS
1	Aldine Independent School District	New MOU	New Contract	9/1/2023 - 8/31/2024	General Revenue (GR)	New MOU with Aldine ISD for the Harris Center to provide remote school based qualified mental health practitioners (YES Waiver) who will provide wraparound services, case management, and social and emotional support to prevent and reduce mental illness, symptoms, conditions, or disorders.
2	Harris County Hospital District d/b/a Harris Health System	EPIC Software	New Contract	9/1/2023 - 8/31/2024	General Revenue (GR)	Annual maintenance and support fee to Harris Health System for the EPIC EMR System. [FY24 NTE: $2,327,727.00]
3	Harris County Juvenile Board	New ILA Revenue	New Contract	9/28/2023 - 8/31/2024	General Revenue (GR)	New Interlocal between the Harris County Juvenile Probation Board and the Harris Center for the Multi-Systemic Therapy (MST) Program to provide intensive in-home family therapy to prevent youth from further penetrating the juvenile justice system. [Revenue: $367,000.00].
4	Houston Housing Authority	New MOU	New Contract	9/1/2023 - 9/1/2025	State	New MOU with Houston Housing Authority to outline the referral process, coordination of services and responsibilities of both Parties in relation to a collaboration of services to ensure that consumers receive prompt housing, social and mental health services.
5	PRAIRIE VIEW A&M UNIVERSITY	New Affiliation Agreement	New Contract	8/1/2023 - 8/31/2028	General Revenue (GR)	New Affiliation agreement will allow students enrolled in PRAIRIE VIEW A&M UNIVERSITY College of Education to complete clinical field placements as part of their degree requirements.
6	Texas Tech University Health Science Center	New Affiliation Agreement	New Contract	9/1/2023 - 9/30/2028	General Revenue (GR)	New Affiliation Agreement to allow students enrolled in Texas Tech University Health Science Center to complete their APRN's preceptorship in clinical field placements as part of their degree requirements.
7	Texas Woman's University School of Physical Therapy	New Affiliation Agreement	New Contract	9/1/2023 - 9/30/2028	General Revenue (GR)	New Affiliation Agreement to allow students enrolled in Texas Woman's University School of Physical Therapy to complete their clinical field placements as part of their degree requirements.
8	University of Houston Social Work (MH-RITES)	Amendment	Amendment	2/1/2022 - 9/30/2024	County	Amendment to increase the NTE due to revised budget for FY24. External Evaluation of the Program is part of the required ARPA project deliverables. Unexpended dollars in year 1 and 2 are being rolled forward. Evaluation needs of the program increases as the program grows. [$636,294.00]
9	University of Houston-Clear Lake	New Affiliation Agreement	New Contract	9/1/2023 - 9/30/2028	General Revenue (GR)	New Affiliation Agreement with the University of Houston-Clear Lake College of Human Sciences and Humanities to complete clinical field placements as part of their degree requirements.
10	University of Texas Medical Branch - School of Nursing	New Affiliation Agreement	New Contract	9/1/2023 - 8/31/2028	General Revenue (GR)	New Affiliation Agreement will allow students enrolled in the University of Texas Medical Branch - School of Nursing to complete clinical field placements as part of their degree requirements.

Executive Contract Summary

Contract Section

Contractor *
Aldine Independent School District

Contract ID # *
N/A

Presented To *
- (•) Resource Committee
- ( ) Full Board

Date Presented *
10/17/2023

Parties * (?)
Aldine Independent School District and The Harris Center for Mental Health and IDD.

Agenda Item Submitted For: * (?)
- [x] Information Only (Total NTE Amount is Less than $100,000.00)
- [ ] Board Approval (Total NTE Amount is $100,000.00+)
- [ ] Grant Proposal
- [ ] Revenue
- [ ] SOW-Change Order-Amendment#
- [ ] Other

Procurement Method(s) *
Check all that Apply

- [ ] Competitive Bid
- [ ] Request for Proposal
- [ ] Request for Application
- [ ] Request for Quote
- [ ] Interlocal
- [x] Not Applicable (If there are no funds required)
- [ ] Competitive Proposal
- [ ] Sole Source
- [ ] Request for Qualification
- [ ] Tag-On
- [ ] Consumer Driven
- [ ] Other

Funding Information *
(•) New Contract ( ) Amendment

Contract Term Start Date * (?)
9/1/2023

Contract Term End Date * (?)
8/31/2024

If contract is off-cycle, specify the contract term (?)

Fiscal Year * (?)
2024

Amount * (?)
$ 0.00

Funding Source *
General Revenue (GR)

Contract Description / Type* (?)

- [ ] Personal/Professional Services
- [ ] Consumer Driven Contract
- [x] Memorandum of Understanding
- [ ] Affiliation or Preceptor
- [ ] BAA/DUA
- [ ] Pooled Contract
- [ ] Renewal of Existing Contract
- [ ] Consultant
- [ ] New Contract/Agreement
- [ ] Amendment to Existing Contract
- [ ] Service/Maintenance
- [ ] IT/Software License Agreement
- [ ] Lease
- [ ] Other

Justification/Purpose of Contract/Description of Services Being Provided* (?)

The Harris Center for Mental Health and IDD will provide remote school based qualified mental health practitioners (YES Waiver) who will provide wraparound services, case management, and social and emotional support to prevent and reduce mental illness, symptoms, conditions, or disorders.

Contract Owner*

Tiffanie Williams-Brooks

Previous History of Contracting with Vendor/Contractor*

( ) Yes ( ) No (•) Unknown

Vendor/Contractor a Historically Underutilized Business (HUB)* (?)

( ) Yes ( ) No (•) Unknown

Community Partnership* (?)

(•) Yes ( ) No ( ) Unknown

Specify Name*

Aldine Independent School District

Supporting Documentation Upload (?)

Copy of Aldine ISD MoU - Force Copy.docx 24.93KB

Vendor/Contractor Contact Person

Name*

Dr. Marcie Strahan

Address*

Street Address

14909 Aldine Westfield

Address Line 2

City

Houston

State / Province / Region

TX

Postal / Zip Code

77032

Country

USA

Phone Number*

2819856280

Email*

MDStrahan@aldineisd.org

Budget Section

Budget Units and Amounts Charged to each Budget Unit

Budget Unit Number *
4913

Amount Charged to Unit *
$ 0.00

Expense/GL Code No. *
000000

Budget Manager
Smith, Janai

Secondary Budget Manager
Hooper Jr., Michael

Provide Rate and Rate Descriptions if applicable * (?)
0.00

Project WBS (Work Breakdown Structure) * (?)
0.00

Requester Name
Bowser, Mohagony

Submission Date
9/8/2023

Budget Manager Approval(s)

Approved by
Janai Lynnette Smith

Approval Date
9/8/2023

Procurement Approval

File Upload (?)

Approved by
Sign

Approval Date

Contract Owner Approval

Approved by
Tiffanie Ann Williams-Brooks

Approval Date
9/11/2023

Contracts Approval

Approve *
- (•) Yes
- ( ) No, reject entire submission
- ( ) Return for correction

Approved by *
Belinda Stude

Approval Date *
9/13/2023

Executive Contract Summary

Contract Section

Contractor *
Harris County Hospital District d/b/a Harris Health System

Contract ID # *
7731

Presented To *
- (•) Resource Committee
- ( ) Full Board

Date Presented *
10/17/2023

Parties * (?)
Harris Health and The Harris Center - EPIC Yearly Payment

Agenda Item Submitted For: * (?)
- [ ] Information Only (Total NTE Amount is Less than $100,000.00)
- [x] Board Approval (Total NTE Amount is $100,000.00+)
- [ ] Grant Proposal
- [ ] Revenue
- [ ] SOW-Change Order-Amendment#
- [ ] Other

Procurement Method(s) *
Check all that Apply

- [ ] Competitive Bid
- [ ] Request for Proposal
- [ ] Request for Application
- [ ] Request for Quote
- [x] Interlocal
- [ ] Not Applicable (If there are no funds required)
- [ ] Competitive Proposal
- [ ] Sole Source
- [ ] Request for Qualification
- [ ] Tag-On
- [ ] Consumer Driven
- [ ] Other

Funding Information *
(•) New Contract ( ) Amendment

Contract Term Start Date * (?)
9/1/2023

Contract Term End Date * (?)
8/31/2024

If contract is off-cycle, specify the contract term (?)

Fiscal Year * (?)
2024

Amount * (?)
$ 2,327,727.00

Funding Source *
General Revenue (GR)

Contract Description / Type* (?)

- [ ] Personal/Professional Services
- [ ] Consumer Driven Contract
- [ ] Memorandum of Understanding
- [ ] Affiliation or Preceptor
- [ ] BAA/DUA
- [ ] Pooled Contract
- [x] Renewal of Existing Contract
- [ ] Consultant
- [ ] New Contract/Agreement
- [ ] Amendment to Existing Contract
- [ ] Service/Maintenance
- [ ] IT/Software License Agreement
- [ ] Lease
- [ ] Other

Justification/Purpose of Contract/Description of Services Being Provided* (?)

Interlocal agreement between Harris County Hospital District dba Harris Health System and the Harris Center for Epic
annual maintenance and support fee for the term of 7/10/2023 to 7/9/2024.

Contract Owner*

Mustafa Cochinwala

Previous History of Contracting with Vendor/Contractor*

(•) Yes ( ) No ( ) Unknown

Please add previous contract dates and what services were provided*

FY21, FY22, FY23
EPIC Annual Maintenance

Vendor/Contractor a Historically Underutilized Business (HUB)* (?)

( ) Yes ( ) No (•) Unknown

Community Partnership* (?)

( ) Yes ( ) No (•) Unknown

Supporting Documentation Upload (?)

MS457 - Harris Center EPIC Maint 2023-24.pdf 387.53KB

Vendor/Contractor Contact Person

Name*

Kari McMichael

Address*

Street Address

4800 Fournace Place

Address Line 2

City

Bellaire

State / Province / Region

TX

Postal / Zip Code

77401-2324

Country

US

Phone Number*

713-526-4243

Email*

invoices@harrishealth.org

Budget Section

Budget Units and Amounts Charged to each Budget Unit

Budget Unit Number* 1130

Amount Charged to Unit* $ 2,327,727.00

Expense/GL Code No.* 574000

Budget Manager Campbell, Ricardo

Secondary Budget Manager Brown, Erica

Provide Rate and Rate Descriptions if applicable* (?) N/A

Project WBS (Work Breakdown Structure)* (?) N/A

Requester Name Hurst, Richard

Submission Date 9/20/2023

Budget Manager Approval(s)

Approved by Ricardo Campbell

Approval Date 9/20/2023

Procurement Approval

File Upload (?)

Approved by Sign

Approval Date

Contract Owner Approval

Approved by Mustafa Cochinwala

Approval Date 9/20/2023

Contracts Approval

Approve*

- (•) Yes
- ( ) No, reject entire submission
- ( ) Return for correction

Approved by* Belinda Strude

Approval Date* 9/20/2023

Executive Contract Summary

Contract Section

Contractor *
Harris County Juvenile Board

Contract ID # *
N/A

Presented To *
- (•) Resource Committee
- ( ) Full Board

Date Presented *
10/17/2023

Parties * (?)
Harris County Juvenile Board and The Harris Center for Health and IDD.

Agenda Item Submitted For: * (?)
- [ ] Information Only (Total NTE Amount is Less than $250,000.00)
- [x] Board Approval (Total NTE Amount is $250,000.00 or more)
- [ ] Grant Proposal
- [ ] Revenue
- [ ] SOW-Change Order-Amendment#
- [ ] Other

Procurement Method(s) *
Check all that Apply

- [ ] Competitive Bid
- [ ] Request for Proposal
- [ ] Request for Application
- [ ] Request for Quote
- [x] Interlocal
- [ ] Not Applicable (If there are no funds required)
- [ ] Competitive Proposal
- [ ] Sole Source
- [ ] Request for Qualification
- [ ] Tag-On
- [ ] Consumer Driven
- [x] Other Revenue

Funding Information *
(•) New Contract ( ) Amendment

Contract Term Start Date * (?)
9/28/2023

Contract Term End Date * (?)
8/31/2024

If contract is off-cycle, specify the contract term (?)

Fiscal Year * (?)
2024

Amount * (?)
$ 367,000.00

Funding Source *
General Revenue (GR)

Contract Description / Type* (?)

- [ ] Personal/Professional Services
- [ ] Consumer Driven Contract
- [ ] Memorandum of Understanding
- [ ] Affiliation or Preceptor
- [ ] BAA/DUA
- [ ] Pooled Contract
- [ ] Renewal of Existing Contract
- [ ] Consultant
- [x] New Contract/Agreement
- [ ] Amendment to Existing Contract
- [ ] Service/Maintenance
- [ ] IT/Software License Agreement
- [ ] Lease
- [ ] Other

Justification/Purpose of Contract/Description of Services Being Provided* (?)

Multi-Systemic Therapy (MST) Program to provide intensive in-home family therapy to prevent youth from further penetrating the juvenile justice system.

Contract Owner*

Tiffanie Williams-Brooks

Previous History of Contracting with Vendor/Contractor*

(•) Yes ( ) No ( ) Unknown

Please add previous contract dates and what services were provided*

01/21/2020- Increase continuity of services for juveniles leaving the Juvenile Detention Center and MST services in the community.

03/01/2022-Multi-Systemic Therapy (MST) Program to provide intensive in-home family therapy to prevent youth from further penetrating the juvenile justice system.

Vendor/Contractor a Historically Underutilized Business (HUB)* (?)

( ) Yes ( ) No (•) Unknown

Community Partnership* (?)

(•) Yes ( ) No ( ) Unknown

Specify Name*

Harris Co Juvenile Probation

Supporting Documentation Upload (?)

FY24 MST Team Contract 2 Budget Proposal - revised.pdf 48.52KB

Vendor/Contractor Contact Person

Name*

Farrah Simon

Address*

Street Address

1200 Congress,

Address Line 2

City

Houston

State / Province / Region

TX

Postal / Zip Code

713-274-4425

Country

USA

Phone Number *
713-274-4425

Email *
Farrah.simon@pur.hctx.net

Budget Section

Budget Units and Amounts Charged to each Budget Unit

Budget Unit Number *	Amount Charged to Unit *	Expense/GL Code No. *
6622	$ 0.00	403010

Budget Manager	Secondary Budget Manager
Smith, Janai	Hooper Jr., Michael

Provide Rate and Rate Descriptions if applicable * (?)
0.00

Project WBS (Work Breakdown Structure) * (?)
0.00

Requester Name	Submission Date
Bowser, Mohagony	9/28/2023

Budget Manager Approval(s)

Approved by
Janai Lynnette Smith

Approval Date
9/28/2023

Procurement Approval

File Upload (?)

Approved by
Sign

Approval Date

Contract Owner Approval

Approved by
Tiffanie Ann Williams-Brooks

Approval Date
9/28/2023

Contracts Approval

Approve *
- (•) Yes
- ( ) No, reject entire submission
- ( ) Return for correction

Approved by *

Approval Date *

9/28/2023

Executive Contract Summary

Contract Section

Contractor *
Houston Housing Authority

Contract ID # *
7313

Presented To *
- (•) Resource Committee
- ( ) Full Board

Date Presented *
10/17/2023

Parties * (?)
The Harris Center for Mental Health & IDD
Houston Housing Authority

Agenda Item Submitted For: * (?)
- [ ] Information Only (Total NTE Amount is Less than $100,000.00)
- [ ] Board Approval (Total NTE Amount is $100,000.00+)
- [ ] Grant Proposal
- [ ] Revenue
- [ ] SOW-Change Order-Amendment#
- [x] Other MOU Only

Procurement Method(s) *
Check all that Apply

- [ ] Competitive Bid
- [ ] Request for Proposal
- [ ] Request for Application
- [ ] Request for Quote
- [ ] Interlocal
- [x] Not Applicable (If there are no funds required)
- [ ] Competitive Proposal
- [ ] Sole Source
- [ ] Request for Qualification
- [ ] Tag-On
- [ ] Consumer Driven
- [ ] Other

Funding Information *
(•) New Contract ( ) Amendment

Contract Term Start Date * (?)
9/1/2023

Contract Term End Date * (?)
9/1/2025

If contract is off-cycle, specify the contract term (?)

Fiscal Year * (?)
2024

Amount * (?)
$ 0.00

Funding Source *
State

Contract Description / Type* (?)

- [ ] Personal/Professional Services
- [ ] Consumer Driven Contract
- [x] Memorandum of Understanding
- [ ] Affiliation or Preceptor
- [ ] BAA/DUA
- [ ] Pooled Contract
- [ ] Renewal of Existing Contract
- [ ] Consultant
- [ ] New Contract/Agreement
- [ ] Amendment to Existing Contract
- [ ] Service/Maintenance
- [ ] IT/Software License Agreement
- [ ] Lease
- [ ] Other

Justification/Purpose of Contract/Description of Services Being Provided* (?)

To outline the referral process, coordination of services and responsibilities of both Parties in relation to a collaboration of services to ensure that consumers receive prompt housing, social and mental health services.

Contract Owner*

Sandra Brock

Previous History of Contracting with Vendor/Contractor*

(•) Yes ( ) No ( ) Unknown

Please add previous contract dates and what services were provided*

September 01, 2018 through September 30, 2020
Section 8 housing and mental health services

Vendor/Contractor a Historically Underutilized Business (HUB)* (?)

( ) Yes ( ) No (•) Unknown

Community Partnership* (?)

(•) Yes ( ) No ( ) Unknown

Specify Name*

Houston Housing Authority

Supporting Documentation Upload (?)

MOU between HHA and The Harris Center.pdf 310.36KB

Vendor/Contractor Contact Person

Name*

Sandra Brock

Address*

Street Address

9401 Southwest Fwy.

Address Line 2

City

Houston

State / Province / Region

Texas

Postal / Zip Code

77074

Country

USA

Phone Number*

7139703307

Email*

sandra.brock@theharriscenter.org

Budget Section

Budget Units and Amounts Charged to each Budget Unit

Budget Unit Number *
2200

Amount Charged to Unit *
$ 0.00

Expense/GL Code No. *
0

Budget Manager
Shelby, Debbie

Secondary Budget Manager
Hooper Jr., Michael

Provide Rate and Rate Descriptions if applicable * (?)
NA

Project WBS (Work Breakdown Structure) * (?)
NA

Requester Name
Brock, Sandra

Submission Date
9/6/2023

Budget Manager Approval(s)

Approved by
Debbie Chambers Shelby

Approval Date
9/6/2023

Procurement Approval

File Upload (?)

Approved by
Sign

Approval Date

Contract Owner Approval

Approved by
Sandra Brock

Approval Date
9/12/2023

Contracts Approval

Approve *
- (•) Yes
- ( ) No, reject entire submission
- ( ) Return for correction

Approved by *
Belinda Stude

Approval Date *
9/13/2023

Executive Contract Summary

Contract Section

Contractor *
PRAIRIE VIEW A&M UNIVERSITY

Contract ID # *
NA

Presented To *
- (•) Resource Committee
- ( ) Full Board

Date Presented *
10/17/2023

Parties * (?)
PRAIRIE VIEW A&M UNIVERSITY College of Education and The Harris Center for Mental Health and IDD

Agenda Item Submitted For: * (?)
- [x] Information Only (Total NTE Amount is Less than $100,000.00)
- [ ] Board Approval (Total NTE Amount is $100,000.00+)
- [ ] Grant Proposal
- [ ] Revenue
- [ ] SOW-Change Order-Amendment#
- [ ] Other

Procurement Method(s) *
Check all that Apply

- [ ] Competitive Bid
- [ ] Request for Proposal
- [ ] Request for Application
- [ ] Request for Quote
- [ ] Interlocal
- [x] Not Applicable (If there are no funds required)
- [ ] Competitive Proposal
- [ ] Sole Source
- [ ] Request for Qualification
- [ ] Tag-On
- [ ] Consumer Driven
- [ ] Other

Funding Information *
(•) New Contract ( ) Amendment

Contract Term Start Date * (?)
8/1/2023

Contract Term End Date * (?)
8/31/2028

If contract is off-cycle, specify the contract term (?)

Fiscal Year * (?)
2023

Amount * (?)
$ 0.00

Funding Source *
General Revenue (GR)

Contract Description / Type* (?)

- [ ] Personal/Professional Services
- [ ] Consumer Driven Contract
- [ ] Memorandum of Understanding
- [x] Affiliation or Preceptor
- [ ] BAA/DUA
- [ ] Pooled Contract
- [ ] Renewal of Existing Contract
- [ ] Consultant
- [x] New Contract/Agreement
- [ ] Amendment to Existing Contract
- [ ] Service/Maintenance
- [ ] IT/Software License Agreement
- [ ] Lease
- [ ] Other

Justification/Purpose of Contract/Description of Services Being Provided* (?)

This agreement will allow students enrolled in PRAIRIE VIEW A&M UNIVERSITY College of Education to complete clinical field placements as part of their degree requirements. The students will utilize the skills gained through education while adhering to agency policy and procedures.

Contract Owner*

Ninfa Escobar

Previous History of Contracting with Vendor/Contractor*

- ( ) Yes (•) No ( ) Unknown

Vendor/Contractor a Historically Underutilized Business (HUB)* (?)

- ( ) Yes ( ) No (•) Unknown

Community Partnership* (?)

- (•) Yes ( ) No ( ) Unknown

Specify Name*

PRAIRIE VIEW A&M UNIVERSITY College of Education

Supporting Documentation Upload (?)

Ina Ashley Praticum.pdf	76.29KB

Vendor/Contractor Contact Person

Name*

Dr. Bernadine Duncan

Address*

Street Address

700 University Drive

Address Line 2

City	State / Province / Region
Prairie View	TX
Postal / Zip Code	**Country**
77446	US

Phone Number*

(936)261-3564

Email*

bduncan@pvamu.edu

Budget Section

Budget Units and Amounts Charged to each Budget Unit

Budget Unit Number *
1108

Amount Charged to Unit *
$ 0.00

Expense/GL Code No. *
NA

Budget Manager
Brown, Erica

Secondary Budget Manager
Campbell, Ricardo

Provide Rate and Rate Descriptions if applicable * (?)
NA

Project WBS (Work Breakdown Structure) * (?)
NA

Requester Name
Daswani, Bianca

Submission Date
8/25/2023

Budget Manager Approval(s)

Approved by
Erica Brown

Approval Date
8/25/2023

Procurement Approval

File Upload (?)

Approved by
Sign

Approval Date

Contract Owner Approval

Approved by
Ninfa Escobar

Approval Date
9/6/2023

Contracts Approval

Approve *
- (•) Yes
- ( ) No, reject entire submission
- ( ) Return for correction

Approved by *
Belinda Stude

Approval Date *
9/6/2023

Executive Contract Summary

Contract Section

Contractor *
Texas Tech University Health Science Center

Contract ID # *
NA

Presented To *
- (•) Resource Committee
- ( ) Full Board

Date Presented *
10/17/2023

Parties * (?)
Texas Tech University Health Science Center & The Harris Center for Mental Health and IDD

Agenda Item Submitted For: * (?)
- [x] Information Only (Total NTE Amount is Less than $100,000.00)
- [ ] Board Approval (Total NTE Amount is $100,000.00+)
- [ ] Grant Proposal
- [ ] Revenue
- [ ] SOW-Change Order-Amendment#
- [ ] Other

Procurement Method(s) *
Check all that Apply

- [ ] Competitive Bid
- [ ] Request for Proposal
- [ ] Request for Application
- [ ] Request for Quote
- [ ] Interlocal
- [x] Not Applicable (If there are no funds required)
- [ ] Competitive Proposal
- [ ] Sole Source
- [ ] Request for Qualification
- [ ] Tag-On
- [ ] Consumer Driven
- [ ] Other

Funding Information *
(•) New Contract ( ) Amendment

Contract Term Start Date * (?)
9/1/2023

Contract Term End Date * (?)
9/30/2028

If contract is off-cycle, specify the contract term (?)

Fiscal Year * (?)
2024

Amount * (?)
$ 0.00

Funding Source *
General Revenue (GR)

Contract Description / Type* (?)

- [ ] Personal/Professional Services
- [ ] Consumer Driven Contract
- [ ] Memorandum of Understanding
- [x] Affiliation or Preceptor
- [ ] BAA/DUA
- [ ] Pooled Contract
- [ ] Renewal of Existing Contract
- [ ] Consultant
- [x] New Contract/Agreement
- [ ] Amendment to Existing Contract
- [ ] Service/Maintenance
- [ ] IT/Software License Agreement
- [ ] Lease
- [ ] Other

Justification/Purpose of Contract/Description of Services Being Provided* (?)

This agreement will allow students enrolled in Texas Tech University Health Science Center to complete clinical field placements as part of their degree requirements. The students will utilize the skills gained through education while adhering to agency policy and procedures.

Contract Owner*

Ninfa Escobar

Previous History of Contracting with Vendor/Contractor*

- ( ) Yes (•) No ( ) Unknown

Vendor/Contractor a Historically Underutilized Business (HUB)* (?)

- ( ) Yes ( ) No (•) Unknown

Community Partnership* (?)

- (•) Yes ( ) No ( ) Unknown

Specify Name*

Texas Tech University Health Science Center

Supporting Documentation Upload (?)

N5604 description.docx 21.39KB

Vendor/Contractor Contact Person

Name*

Stephanie Jones

Address*

Street Address

3601 4th Street

Address Line 2

City

Lubbock

State / Province / Region

TX

Postal / Zip Code

79430

Country

US

Phone Number*

(806) 743-1732

Email*

stephanie.l.jones@ttuhsc.edu

Budget Section

Budget Units and Amounts Charged to each Budget Unit

Budget Unit Number* 1108

Amount Charged to Unit* $ 0.00

Expense/GL Code No.* NA

Budget Manager Brown, Erica

Secondary Budget Manager Campbell, Ricardo

Provide Rate and Rate Descriptions if applicable* (?)
NA

Project WBS (Work Breakdown Structure)* (?)
NA

Requester Name Daswani, Bianca

Submission Date 9/7/2023

Budget Manager Approval(s)

Approved by
Ricardo Campbell

Approval Date 9/8/2023

Procurement Approval

File Upload (?)

Approved by
Sign

Approval Date

Contract Owner Approval

Approved by
Ninfa Escobar

Approval Date 9/8/2023

Contracts Approval

Approve*
- (•) Yes
- ( ) No, reject entire submission
- ( ) Return for correction

Approved by*
Belinda Stude

Approval Date* 9/13/2023

Executive Contract Summary

Contract Section

Contractor *
Texas Woman's University School of Physical Therapy

Contract ID # *
NA

Presented To *
- (•) Resource Committee
- ( ) Full Board

Date Presented *
10/17/2023

Parties * (?)
Texas Woman's University School of Physical Therapy and The Harris Center for Mental Health and IDD

Agenda Item Submitted For: * (?)
- [x] Information Only (Total NTE Amount is Less than $250,000.00)
- [ ] Board Approval (Total NTE Amount is $250,000.00 or more)
- [ ] Grant Proposal
- [ ] Revenue
- [ ] SOW-Change Order-Amendment#
- [ ] Other

Procurement Method(s) *
Check all that Apply

- [ ] Competitive Bid
- [ ] Request for Proposal
- [ ] Request for Application
- [ ] Request for Quote
- [ ] Interlocal
- [x] Not Applicable (If there are no funds required)
- [ ] Competitive Proposal
- [ ] Sole Source
- [ ] Request for Qualification
- [ ] Tag-On
- [ ] Consumer Driven
- [ ] Other

Funding Information *
(•) New Contract ( ) Amendment

Contract Term Start Date * (?)
9/1/2023

Contract Term End Date * (?)
9/30/2028

If contract is off-cycle, specify the contract term (?)

Fiscal Year * (?)
2024

Amount * (?)
$ 0.00

Funding Source *
General Revenue (GR)

Contract Description / Type* (?)

- [ ] Personal/Professional Services
- [ ] Consumer Driven Contract
- [ ] Memorandum of Understanding
- [x] Affiliation or Preceptor
- [ ] BAA/DUA
- [ ] Pooled Contract
- [ ] Renewal of Existing Contract
- [ ] Consultant
- [x] New Contract/Agreement
- [ ] Amendment to Existing Contract
- [ ] Service/Maintenance
- [ ] IT/Software License Agreement
- [ ] Lease
- [ ] Other

Justification/Purpose of Contract/Description of Services Being Provided* (?)

This agreement will allow students enrolled in Texas Woman's University School of Physical Therapy to complete clinical field placements as part of their degree requirements. The students will utilize the skills gained through education while adhering to agency policy and procedures.

Contract Owner*

Ninfa Escobar

Previous History of Contracting with Vendor/Contractor*

- ( ) Yes (•) No ( ) Unknown

Vendor/Contractor a Historically Underutilized Business (HUB)* (?)

- ( ) Yes ( ) No (•) Unknown

Community Partnership* (?)

- (•) Yes ( ) No ( ) Unknown

Specify Name*

Texas Woman's University School of Physical Therapy

Supporting Documentation Upload (?)

Vendor/Contractor Contact Person

Name*

Stacy Flynn

Address*

Street Address

6700 Fannin St

Address Line 2

City

Houston

State / Province / Region

TX

Postal / Zip Code

77030-2343

Country

US

Phone Number*

713 794 2084

Email*

sflynn@twu.edu

Budget Section

Budget Units and Amounts Charged to each Budget Unit

Budget Unit Number *
1108

Amount Charged to Unit *
$ 0.00

Expense/GL Code No. *
NA

Budget Manager
Brown, Erica

Secondary Budget Manager
Campbell, Ricardo

Provide Rate and Rate Descriptions if applicable * (?)
NA

Project WBS (Work Breakdown Structure) * (?)
NA

Requester Name
Daswani, Bianca

Submission Date
9/19/2023

Budget Manager Approval(s)

Approved by
Erica Brown

Approval Date
9/20/2023

Procurement Approval

File Upload (?)

Approved by
Sign

Approval Date

Contract Owner Approval

Approved by
Ninfa Escobar

Approval Date
9/21/2023

Contracts Approval

Approve *
- (•) Yes
- ( ) No, reject entire submission
- ( ) Return for correction

Approved by *
Belinda Stude

Approval Date *
9/28/2023

Executive Contract Summary

Contract Section

Contractor *
University of Houston Social Work (MH-RITES)

Contract ID # *
2021-0280

Presented To *
- ○ Resource Committee
- ◉ Full Board

Date Presented *
10/17/2023

Parties * (?)
The Harris Center and MHRITES

Agenda Item Submitted For: * (?)
- ☐ Information Only (Total NTE Amount is Less than $100,000.00)
- ☑ Board Approval (Total NTE Amount is $100,000.00+)
- ☐ Grant Proposal
- ☐ Revenue
- ☐ SOW-Change Order-Amendment#
- ☐ Other

Procurement Method(s) *
Check all that Apply

- ☐ Competitive Bid
- ☐ Request for Proposal
- ☐ Request for Application
- ☐ Request for Quote
- ☑ Interlocal
- ☐ Not Applicable (If there are no funds required)
- ☐ Competitive Proposal
- ☐ Sole Source
- ☐ Request for Qualification
- ☐ Tag-On
- ☐ Consumer Driven
- ☐ Other

Funding Information *
○ New Contract ◉ Amendment

Contract Term Start Date * (?)
2/1/2022

Contract Term End Date * (?)
9/30/2024

If contract is off-cycle, specify the contract term (?)

Current Contract Amount *
$ 242,918.00

Increase Not to Exceed *
$ 393,376.00

Revised Total Not to Exceed (NTE) *
$ 636,294.00

Fiscal Year* (?)
2024

Amount* (?)
$ 636,294.00

Funding Source*
County

Contract Description / Type* (?)

- [ ] Personal/Professional Services
- [ ] Consumer Driven Contract
- [ ] Memorandum of Understanding
- [ ] Affiliation or Preceptor
- [ ] BAA/DUA
- [ ] Pooled Contract
- [ ] Renewal of Existing Contract
- [ ] Consultant
- [ ] New Contract/Agreement
- [x] Amendment to Existing Contract
- [ ] Service/Maintenance
- [ ] IT/Software License Agreement
- [ ] Lease
- [ ] Other

Justification/Purpose of Contract/Description of Services Being Provided* (?)
Evaluation is part of the required ARPA project deliverables. Unexpended dollars in year 1 and 2 being rolled forward. Evaluation needs increase as the program grows.
Mental Health Research and Innovation in Treatment Engagement and Service (MHRITES)

Contract Owner*
Jennifer Battle

Previous History of Contracting with Vendor/Contractor*
(•) Yes ( ) No ( ) Unknown

Please add previous contract dates and what services were provided*
2022 - 2023 - same services

Vendor/Contractor a Historically Underutilized Business (HUB)* (?)
( ) Yes ( ) No (•) Unknown

Community Partnership* (?)
(•) Yes ( ) No ( ) Unknown

Specify Name*
University of Houston

Supporting Documentation Upload (?)

Vendor/Contractor Contact Person

Name*
Sarah Narendorf

Address *

Street Address

University of Houston School of Social Work

Address Line 2

3511 Cullen Blvd, Room 110HA

City

Houston

State / Province / Region

Texas

Postal / Zip Code

77204-4013

Country

USA

Phone Number *

713-743-8672

Email *

sanarendorf@uh.edu

Budget Section

Budget Units and Amounts Charged to each Budget Unit

Budget Unit Number *	Amount Charged to Unit *	Expense/GL Code No. *
7008	$ 636,294.00	542000

Budget Manager

Ilejay, Kevin

Secondary Budget Manager

Campbell, Ricardo

Provide Rate and Rate Descriptions if applicable * (?)

In the contract SOW

Project WBS (Work Breakdown Structure) * (?)

NA

Requester Name

Battle, Jennifer

Submission Date

9/25/2023

Budget Manager Approval(s)

Approved by

kevin ilejay

Approval Date

9/25/2023

Contract Owner Approval

Approved by

Jennifer Battle

Approval Date

9/25/2023

Contracts Approval

Approve *

- (•) Yes
- ( ) No, reject entire submission
- ( ) Return for correction

Approved by *

Approval Date *

9/26/2023

Executive Contract Summary

Contract Section

Contractor *

University of Houston-Clear Lake College of Human Sciences and Humanities

Contract ID # *

NA

Presented To *

- (•) Resource Committee
- ( ) Full Board

Date Presented *

10/17/2023

Parties * (?)

University of Houston-Clear Lake College of Human Sciences and Humanities & The Harris Center for Mental Health and IDD

Agenda Item Submitted For: * (?)

- [x] Information Only (Total NTE Amount is Less than $100,000.00)
- [ ] Board Approval (Total NTE Amount is $100,000.00+)
- [ ] Grant Proposal
- [ ] Revenue
- [ ] SOW-Change Order-Amendment#
- [ ] Other

Procurement Method(s) *

Check all that Apply

- [ ] Competitive Bid
- [ ] Request for Proposal
- [ ] Request for Application
- [ ] Request for Quote
- [ ] Interlocal
- [x] Not Applicable (If there are no funds required)
- [ ] Competitive Proposal
- [ ] Sole Source
- [ ] Request for Qualification
- [ ] Tag-On
- [ ] Consumer Driven
- [ ] Other

Funding Information *

(•) New Contract ( ) Amendment

Contract Term Start Date * (?)

9/1/2023

Contract Term End Date * (?)

9/30/2028

If contract is off-cycle, specify the contract term (?)

Fiscal Year * (?)

2024

Amount * (?)

$ 0.00

Funding Source *

General Revenue (GR)

Contract Description / Type* (?)

- [ ] Personal/Professional Services
- [ ] Consumer Driven Contract
- [ ] Memorandum of Understanding
- [x] Affiliation or Preceptor
- [ ] BAA/DUA
- [ ] Pooled Contract
- [ ] Renewal of Existing Contract
- [ ] Consultant
- [x] New Contract/Agreement
- [ ] Amendment to Existing Contract
- [ ] Service/Maintenance
- [ ] IT/Software License Agreement
- [ ] Lease
- [ ] Other

Justification/Purpose of Contract/Description of Services Being Provided* (?)

This agreement will allow students enrolled in University of Houston-Clear Lake College of Human Sciences and Humanities to complete clinical field placements as part of their degree requirements. The students will utilize the skills gained through education while adhering to agency policy and procedures.

Contract Owner*

Ninfa Escobar

Previous History of Contracting with Vendor/Contractor*

- ( ) Yes (•) No ( ) Unknown

Vendor/Contractor a Historically Underutilized Business (HUB)* (?)

- ( ) Yes ( ) No (•) Unknown

Community Partnership* (?)

- (•) Yes ( ) No ( ) Unknown

Specify Name*

University of Houston-Clear Lake College of Human Sciences and Humanities

Supporting Documentation Upload (?)

Syllabus.docx	39.98KB

Vendor/Contractor Contact Person

Name*

Hae Rim Jin

Address*

Street Address

2700 Bay Area Blvd

Address Line 2

City	State / Province / Region
Houston	TX
Postal / Zip Code	**Country**
77058	US

Phone Number*

(281)-283-3459

Email*

Jin@uhcl.edu

Budget Section

Budget Units and Amounts Charged to each Budget Unit

Budget Unit Number *
1108

Amount Charged to Unit *
$ 0.00

Expense/GL Code No. *
NA

Budget Manager
Brown, Erica

Secondary Budget Manager
Campbell, Ricardo

Provide Rate and Rate Descriptions if applicable * (?)
NA

Project WBS (Work Breakdown Structure) * (?)
NA

Requester Name
Daswani, Bianca

Submission Date
9/7/2023

Budget Manager Approval(s)

Approved by
Ricardo Campbell

Approval Date
9/8/2023

Procurement Approval

File Upload (?)

Approved by
Sign

Approval Date

Contract Owner Approval

Approved by
Ninfa Escobar

Approval Date
9/11/2023

Contracts Approval

Approve *
- (•) Yes
- ( ) No, reject entire submission
- ( ) Return for correction

Approved by *
Belinda Stude

Approval Date *
9/13/2023

Executive Contract Summary

Contract Section

Contractor *
University of Texas Medical Branch - School of Nursing

Contract ID # *
2023-002

Presented To *
- (•) Resource Committee
- ( ) Full Board

Date Presented *
10/17/2023

Parties * (?)
University of Texas Medical Branch - School of Nursing

Agenda Item Submitted For: * (?)
- [x] Information Only (Total NTE Amount is Less than $100,000.00)
- [ ] Board Approval (Total NTE Amount is $100,000.00+)
- [ ] Grant Proposal
- [ ] Revenue
- [ ] SOW-Change Order-Amendment#
- [ ] Other

Procurement Method(s) *
Check all that Apply

- [ ] Competitive Bid
- [ ] Request for Proposal
- [ ] Request for Application
- [ ] Request for Quote
- [ ] Interlocal
- [x] Not Applicable (If there are no funds required)
- [ ] Competitive Proposal
- [ ] Sole Source
- [ ] Request for Qualification
- [ ] Tag-On
- [ ] Consumer Driven
- [ ] Other

Funding Information *
(•) New Contract ( ) Amendment

Contract Term Start Date * (?)
7/19/2023

Contract Term End Date * (?)
7/31/2028

If contract is off-cycle, specify the contract term (?)

Fiscal Year * (?)
2023

Amount * (?)
$ 0.00

Funding Source *
General Revenue (GR)

Contract Description / Type* (?)

- [ ] Personal/Professional Services
- [ ] Consumer Driven Contract
- [ ] Memorandum of Understanding
- [x] Affiliation or Preceptor
- [ ] BAA/DUA
- [ ] Pooled Contract
- [ ] Renewal of Existing Contract
- [ ] Consultant
- [x] New Contract/Agreement
- [ ] Amendment to Existing Contract
- [ ] Service/Maintenance
- [ ] IT/Software License Agreement
- [ ] Lease
- [ ] Other

Justification/Purpose of Contract/Description of Services Being Provided* (?)

This agreement will allow students enrolled in University of Texas Medical Branch - School of Nursing to complete clinical field placements as part of their degree requirements. The students will utilize the skills gained through education while adhering to agency policy and procedures.

Contract Owner*

Ninfa Escobar

Previous History of Contracting with Vendor/Contractor*

○ Yes ◉ No ○ Unknown

Vendor/Contractor a Historically Underutilized Business (HUB)* (?)

○ Yes ○ No ◉ Unknown

Community Partnership* (?)

◉ Yes ○ No ○ Unknown

Specify Name*

University of Texas Medical Branch - School of Nursing

Supporting Documentation Upload (?)

Vendor/Contractor Contact Person

Name*

Elizabeth Jansen

Address*

Street Address

SON/SHP Bldg. Rm. 3.406

Address Line 2

301 University Blvd.

City

Galveston

State / Province / Region

TX

Postal / Zip Code

77555-1029

Country

US

Phone Number*

(409) 772-8310

Email*

eljansen@utmb.edu

Budget Section

Budget Units and Amounts Charged to each Budget Unit

Budget Unit Number *
1108

Amount Charged to Unit *
$ 0.00

Expense/GL Code No. *
NA

Budget Manager
Brown, Erica

Secondary Budget Manager
Campbell, Ricardo

Provide Rate and Rate Descriptions if applicable * (?)
NA

Project WBS (Work Breakdown Structure) * (?)
NA

Requester Name
Daswani, Bianca

Submission Date
7/19/2023

Budget Manager Approval(s)

Approved by
Erica Brown

Approval Date
7/19/2023

Procurement Approval

File Upload (?)

Approved by
Sign

Approval Date

Contract Owner Approval

Approved by
Ninfa Escobar

Approval Date
7/19/2023

Contracts Approval

Approve *
- (•) Yes
- ( ) No, reject entire submission
- ( ) Return for correction

Approved by *
Belinda Stude

Approval Date *
9/5/2023

EXHIBIT F-5

Foreign and Sign Language Translation / Interpretation Services RFP

Presented by: Vanessa McKeown, CPA

Request For Proposal – Evaluation Criteria

Evaluation Category	Relative Weight
Overall Program	25%
Personnel	35%
Financial Condition	10%
References	10%
Past Performance	20%
Cost	N/A
TOTAL	100%

Request for Proposal – Proposal Evaluation Scores

Evaluation Team	Vendor 1	Vendor 2	Vendor 3	Vendor 4	Vendor 5	Vendor 6	Vendor 7
Evaluator 1	80	80	62	73	80	80	78
Evaluator 2	100	98	80	91	64	67	60
Evaluator 3	87	70	70	57	73	78	73
Evaluator 4	76	73	78	67	69	60	63
Average Evaluation Score	**85.75**	**80.25**	**72.5**	**72**	**71.5**	**71.25**	**68.5**

The total possible score is 100 points.

Request for Proposal – Proposal Evaluation Scores

Evaluation Team	Vendor 8	Vendor 9	Vendor 10	Vendor 11	Vendor 12	Vendor 13	Vendor 14
Evaluator 1	80	73	64	60	80	60	54
Evaluator 2	40	80	60	67	47	40	80
Evaluator 3	87	60	67	73	70	69	48
Evaluator 4	66	55	74	60	58	65	50
Average Evaluation Score	**68.25**	**67**	**66.25**	**65**	**63.75**	**58.5**	**58**

The total possible score is 100 points.

Request for Proposal – Proposal Evaluation Scores

Evaluation Team	Vendor 15	Vendor 16	Vendor 17	Vendor 18	Vendor 19
Evaluator 1	58	58	44	32	20
Evaluator 2	60	47	80	40	40
Evaluator 3	50	44	30	56	41
Evaluator 4	63	65	50	60	65
Average Evaluation Score	**57.75**	**53.5**	**51**	**47**	**41.5**

The total possible score is 100 points.

Award Recommendation

The HARRIS CENTER for Mental Health and IDD

Award Recommendation
Foreign and Sign Language Translation / Interpretation Services RFP
Project# FY23-0304

The Request for Proposal opened for Foreign and Sign Language Translation / Interpretation Services RFP on Wednesday, June 14, 2023, at 11:00 A.M.

The Project Team consisted of the following members: James Blunt, Buyer II, Sharon Brauner, Purchasing Manager, Demetria Luckett, Interim Compliance Director, Eggla McKinney, Executive Secretary, Joseph Gorczyca, VP Human Resources, and Juan Rios, Interpreter Services Manager.

Forty-eight (48) vendors were contacted. The specifications were posted in three (3) local newspapers, The Harris Center's web site, the State of Texas Electronic State Business Daily website, Women's Business Enterprise Alliance (WBEA), Houston Minority Supplier Development Council (HMSDC) and Houston Business Journal.

Received nineteen (19) responses and all were deemed responsive and evaluated by the project team.

After review of the Proposals, a Best and Final Offer (BAFO) was requested of the nineteen (19) responsive vendors. Thirteen (13) vendors submitted a BAFO.

Recommended Vendors:

1. Flix Translations Group	2. Fox Medical Case Management
3. Globo Language Solutions	4. Ideal Language Services
5. INGO International	6. Interpreters Unlimited
7. Language Line Services	8. Lionbridge Technologies
9. MasterWord Services	10. Nightingale Interpreting Services
11. Translation &Interpretation Network	12. Universe Technical Translations
13. Visual Language Professionals	14. Volatia Language Network
15. Worldwide Interpreters	16. Worldwide Language & Communications

The team members rated each response using a qualitative approach. Based on the project team's evaluation of responses received, it is recommended that all the above listed vendors be selected based on cost effectiveness, availability of languages, presentation, and connectivity.

The initial contract period is anticipated to begin upon award of contract for one (1) base year with four (4) optional annual renewals at the sole discretion of The HARRIS CENTER based upon satisfactory performance, which will be reviewed on an annual basis. The contract shall commence with a tentative commencement date, and shall remain in effect unless terminated, canceled, or extended.

The total NTE (Not to Exceed) for five (5) years is $1,635,340.00 to be funded annually subject to availability of the budget each year.
Forecast for each year is:
FY24 - $327,068.00
FY25 - $327,068.00
FY26 - $327,068.00
FY27 - $327,068.00
FY28 - $327,068.00

The Funding Source is for general revenue to be allocated to various unit numbers.

Submitted By:
James Blunt
James Blunt, C.P.M.
Buyer II

Recommended By:
Sharon Brauner
Sharon Brauner, C.P.M., A.P.P.
Purchasing Manager

Vanessa McKeown
Vanessa McKeown
Chief Financial Officer

EXHIBIT F-6

Status **Pending** PolicyStat ID **12999087**

Origination	N/A	Owner	Luc Josaphat: Director of Quality Assurance
Last Approved	N/A	Area	Environmental Management
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	N/A		
Next Review	1 year after approval		

EM.A.8 Root Cause Analysis Policy

1. PURPOSE:

The Harris Center for Mental Health and IDD (The Harris Center) is committed to improve the quality and safety of patient care through the following:

- Identification and evaluation of errors, hazardous/unsafe conditions that are a threat to patient and staff safety or have the potential to result in patient/staff harm.
- To improve systems and processes.
- To foster a culture of safety and continuous learning across the organization by openly discussing patient safety at all levels.

2. POLICY:

~~It is the policy of the Harris Center to initiate, communicate, conduct and document a Root Cause Analysis related to any errors, medication errors, near misses, hazardous/unsafe conditions, process failures, injuries involving patients, visitors and staff.~~

It is the policy of the Harris Center to initiate, communicate, conduct and document a Root Cause Analysis for sentinel events. For events not categorized as sentinel events, the Chief Medical Officer (or designee) is responsible for determining the need and initiation for a Root Cause Analysis.

3. APPLICABILITY/SCOPE:

~~Within a culture of safety, there is continuous reporting of patient safety events, and hazardous conditions so these occurrences can be analyzed, and processes can be changed, or systems improved.~~

~~4. PROCEDURES:~~

~~- The Chief Medical Officer or designee is responsible to determine the need for a Root Cause Investigation using the Safety Assessment Code Matrix (Attachment: Root Cause Analysis Investigation Procedure).~~

~~- The RCA will include completion of a systematic analysis for identifying factors that contributed to or caused the event to occur, corrective actions to be taken and a timeline for completion of corrective actions.~~

~~- Departmental leaders are required to participate in adverse events occurring in their departments. Leaders are expected to arrange schedules so frontline staff, residents, and attending physicians can attend the RCA process.~~

~~- Interviews and/or group meetings with the staff and physician(s) involved in the event are conducted to determine chronological order of the event findings and each participant's role perspective in the event.~~

~~- All investigations measures, interviews, and meetings are documented and maintained as patient safety work product.~~

~~- Necessary staff will be educated immediately on the actions to be implemented, to mitigate the risk of patient harm. For staff currently not on duty, the education will occur prior to staff members performing direct patient care.~~

~~- It is the responsibility of the Clinical Transformation and Quality Department to notify Risk management/Legal department regarding the event and pending investigation.~~

~~- Upon completion of the RCA, the Chief Medical Officer or designee reports all serious events, investigational analysis, and corrective action plans to the Patient Safety Committee for approval.~~

This policy is applicable to all The Harris Center employees, staff, contractors, volunteers, and interns.

5. RELATED POLICIES/FORMS ~~(for reference only)~~::

EM10P Risk Management Plan

MED19P Infection Control Plan

EM11B Critical Incidents

6. PROCEDURE:

7. REFERENCES: RULES/REGULATIONS/ STANDARDS:

~~The Joint Commission Standards Accreditation Manual (Jul. 2022) CARF 2022 Behavioral Health~~

~~Standards Manual~~

~~Centers for Medicare & Medicaid Services (CMS) 482.21(a)(2)~~

Condition of Participation: Quality Assessment and Performance Improvement Program, 42 CFR §482.21(a)(2)

CARF 1.G. Risk Management

CARF 1.H. Health and Safety

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	10/2023
Final Legal Review	Kendra Thomas: Counsel	10/2023
Department Review	Luming Li: Chief Medical Ofcr (1101 1817)	08/2023
Initial Assignment	Luc Josaphat: Director of Quality Assurance	08/2023

EXHIBIT F-7

Status **Pending** PolicyStat ID **13958979**

Origination	10/2005	Owner	Vanessa McKeown
Last Approved	N/A	Area	Fiscal Management
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	10/2023		
Next Review	1 year after approval		

FM.A.1 Adding and Receiving Equipment

1. PURPOSE:

To uphold appropriate processes and accurately account for all capital items and controlled assets in conformity with sound accounting and financial controls.

2. POLICY:

All The Harris Center for Mental Health and IDD supervisors are accountable for the use and reasonable care of all Capital Items and Controlled Assets assigned to them, assigned to the staff under their authority, and/or located on the premises in which their operations reside. Therefore, it is necessary to properly record and account for all Capital Items and Controlled Assets, including any new Capital Items and Controlled Assets added to their organizational area.

~~3. PROCEDURES:~~

~~Adding and Receiving Equipment~~

4. APPLICABILITY/SCOPE:

The Harris Center for Mental Health and IDD

5. DEFINITIONS:

Capital Item: Equipment, furniture, vehicles & computer related equipment with a historical cost of $5,000 or greater.

Controlled asset: a capital asset that has a value less than the capitalization threshold established for that asset type with a high-risk nature, that is, equipment with a historical cost between $500 and $4,999.99 and classified as one of the following:

- Computer, Desktop
- Laptop Computers
- Smartphones, Tablets & Other Handheld Devices
- Data Projectors
- TV's, Video Players/Recorders
- Sound Systems and Other Audio Equipment
- Camera - Portable - Digital, SLR

6. PROCEDURES:

FM.B.1 Adding and Receiving Equipment

7. REFERENCES: RULES/REGULATIONS/ STANDARDS:

- CARF: Section 1. Subsection F.6.a., Financial Planning and Management **References: Rules/ Regulations/Standards**
- Property Accounting, Texas Government Code §§403.272-403.277
- Generally Accepted Accounting Procedures (GAAP)
- Texas Grant Management Standards (TxGMS)

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	10/2023
Legal Review	Kendra Thomas: Counsel	10/2023
Department Review	Vanessa McKeown	10/2023
Initial Assignment	Vanessa McKeown	10/2023

EXHIBIT F-8

Status **Pending** PolicyStat ID **14251124**

Origination	01/1998	Owner	Rita Alford: Dir
Last Approved	N/A	Area	Information Management
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	10/2023		
Next Review	1 year after approval		

HIM.EHR.A.1 Agency Abbreviations

1. PURPOSE:

To maintain the standardized approved list of abbreviations.

2. POLICY:

It is the policy of the Harris Center that in order to reduce error and foster clarity of written communication, only approved abbreviations and symbols shall be used when making entries in the Patient/Individual's record. An abbreviation list has been developed to establish the continuity of medical terminology and abbreviations for use in the medical records maintained by The Harris Center for Mental Health and IDD.

3. APPLICABILITY/SCOPE:

Applies to all staff, contractors, volunteers, and interns at The HARRIS CENTER for Mental Health and IDD.

4. PROCEDURES:

HIM.B.1 Agency Abbreviations

5. RELATED POLICIES/FORMS (for reference only):

6. REFERENCES: RULES/REGULATIONS/ STANDARDS:

- The Charles Press Handbook of Current Medical Abbreviations, 5th Edition
- Institute for Safe Medication Practices (ISMP) List of Error-Prone Abbreviations, Symbols and Dose Designations

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	09/2023
Legal Review	Kendra Thomas: Counsel	09/2023
Department Review	Mustafa Cochinwala: Dir	08/2023
Initial Assignment	Rita Alford: Dir	08/2023

EXHIBIT F-9

Status **Pending** PolicyStat ID **13958976**

Origination	10/2015	Owner	Vanessa McKeown
Last Approved	N/A	Area	Fiscal Management
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	10/2023		
Next Review	1 year after approval		

FM.A.3 Asset Tracking and Depreciation

1. PURPOSE:

To uphold appropriate processes and accurately account for all capital items and controlled assets in conformity with sound accounting and financial controls.

2. POLICY:

It is the policy of The Harris Center for Mental Health and IDD to conform with the Government Accounting Standards Board and report Center Property Plant and Equipment through the Comprehensive Annual Financial Report.

~~3. PROCEDURES:~~

~~Asset Tracking and Depreciation~~

4. APPLICABILITY/SCOPE:

The Harris Center for Mental Health and IDD

5. RELATED POLICIES/FORMS:

Policies	Reference
Reporting Burglaries or Thefts	~~INC:1~~
Adding and Receiving Equipment	~~BUS-R/I-.6~~
Disposal of Fixed Assets	~~BUS-R/I:7~~

Forms	Reference
Request to Add Property	~~BUS-R/E6.001~~
Request to Transfer Property	~~BUS-R/I:8.001~~
Request to Surplus Property	~~BUS-R/I:7.002~~
Request for Property Disposal	~~BUS-R/I:7.001~~

6. PROCEDURES:

FM.B.3 Asset Tracking and Depreciation

7. REFERENCES: RULES/REGULATIONS/ STANDARDS:

- Property Accounting, Texas Government Code §§403.272-403.277
- Generally Accepted Accounting Principles (GAAP)
- Texas Grant Management Standards (TxGMS)
- CARF: Section 1. Subsection F.6.a., Financial Planning and Management

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	10/2023
Legal Review	Kendra Thomas: Counsel	10/2023
Department Review	Vanessa McKeown	10/2023
Initial Assignment	Vanessa McKeown	10/2023

EXHIBIT F-10

Status **Pending** PolicyStat ID **14121256**

Origination	02/2017	Owner	Rita Alford: Dir
Last Approved	N/A	Area	Information Management
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	10/2023		
Next Review	1 year after approval		

HIM.EHR.A.2 Breach Notification

1. PURPOSE

The Harris Center for Mental Health and IDD (The Harris Center) will enforce a compliance program for data breach reporting and notification. The Harris Center will investigate, communicate, document, notify and report all discovered breaches of protected health information (PHI) in accordance with federal and state law and regulation.

2. POLICY

It is the policy of The Harris Center to investigate, communicate, document, notify and report all discovered breaches of protected health information (PHI) in accordance with federal and state law and regulation.

3. APPLICABILITY/SCOPE

This policy applies to all departments, divisions, facilities and/or programs within the Harris Center.

4. PROCEDURES

HIM.EHR.B.2 Breach Notification

5. RELATED POLICIES/FORMS:

Business Associate

Forms

Online Incident Report

Attachments
Breach Information Log
Risk Assessment Tool

6. REFERENCES: RULES/REGULATIONS/ STANDARDS

Notification in the Case of Breach, American Recovery & Reinvestment Act Title XIII Section 13402
Medical Records Privacy Act, Tex. Health & Safety Code Ch. 181

Identity Theft Enforcement and Protection Act, Tex. Business and Commerce Code Ch. 521
Mental Health Records, Tex. Health & Safety Code Ch. 611
Federal Trade Commission Breach Notification Rules -16 CFR Part 318
Confidentiality of Substance Use Disorder Patient Record, 42 CFR Part 2
HIPAA Privacy and Security Rules, 45 CFR Parts 160 and 164

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	09/2023
Legal Review	Kendra Thomas: Counsel	09/2023
Department Review	Mustafa Cochinwala: Dir	08/2023
Initial Assignment	Rita Alford: Dir	08/2023

EXHIBIT F-11

Status **Pending** PolicyStat ID **14433310**

Origination	10/2020	Owner	Kendra Thomas: Counsel
Last Approved	N/A	Area	Leadership
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	11/2022		
Next Review	1 year after approval		

LD.A.2 Business Associate and Subcontractor Policy

1. PURPOSE:

The purpose of this policy is to ensure The Harris Center executes Business Associate agreements in compliance with the relevant provisions of Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, to establish the permitted and required uses and disclosures of Protected Health Information).

2. POLICY:

It is the policy of The Harris Center to enter into business associate agreements in compliance with the relevant provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. The Business Associate agreements shall comply with the federal requirements.

The contracts shall establish the permitted and required uses and disclosures of Protected Health Information by the business associate. The contract may not authorize the business associate to use or further disclose the information in a manner that would violate the requirements of HIPAA, if done by the Harris Center, except that:

- The contract may permit the business associate to use and disclose protected health information for the proper management and administration of the business associate as provided by HIPAA
- To carry out the legal responsibilities of the business associate; and
- The contract may permit the business associate to provide data aggregation services related to the Harris Center's operations.

A covered entity may disclose Protected Health Information to a business associate and may allow a

business associate to create, receive, maintain, or transmit Protected Health Information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information. A covered entity is not required to obtain such satisfactory assurances from a business associate that is a subcontractor. A business associate may disclose Protected Health Information to a business associate that is a subcontractor and may allow the subcontractor to create, receive, maintain, or transmit Protected Health Information on its behalf, if the business associate obtains satisfactory assurances, that the subcontractor will appropriately safeguard the information.

The Business Associate must sign a Business Associate Agreement prior to the disclosure of protected health information on behalf of The Harris Center and must document the satisfactory assurances.

A covered entity is not in compliance, if the covered entity knew of a pattern of activity or practice of the Business Associate that constituted a material breach or violation of the business associate's obligation under the contract or other arrangement, unless the covered entity took reasonable steps to cure the breach or end the violation, as applicable, and, if such steps were unsuccessful, terminated the contract or arrangement, if feasible. A covered entity is not in compliance, if the covered entity knew of a pattern of activity or practice of a subcontractor that constituted a material breach or violation of the subcontractor's obligation under the contract or other arrangement, unless the covered entity took reasonable steps to cure the breach or end the violation, as applicable, and, if such steps were unsuccessful, terminated the contract or arrangement, if feasible.

If a Business Associate discovers a breach, the breaching party will have the opportunity to cure the breach or end the violation. If the breaching party does not cure the breach or end the violation within a reasonable time frame, or if a material term of the agreement has been breached and a cure is not possible, the non-breaching party may terminate the agreement, upon written notice to the breaching party. A business associate is not in compliance with the federal standards, if the business associate knew of a pattern of activity or practice of a subcontractor that constituted a material breach or violation of the subcontractor's obligation under the contract or other arrangement, unless the business associate took reasonable steps to cure the breach or end the violation, as applicable, and if such steps were unsuccessful, terminated the contract or arrangement, if feasible.

3. PROCEDURES:

Business Associate

4. APPLICABILITY/SCOPE:

All Harris Center programs, employees, volunteers, interns, contractors, subcontractors and business associates.

5. RELATED POLICIES/FORMS (for reference only):

Business Associate Agreement

6. REFERENCES: RULES/REGULATIONS/ STANDARDS:

Health Insurance Portability and Accountability Act of 1996,45 C.F.R. Parts 160 and 164

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	10/2023
Legal Review	Kendra Thomas: Counsel	10/2023
Initial Assignment	Kendra Thomas: Counsel	10/2023

EXHIBIT F-12

Status **Pending** PolicyStat ID **14433298**

Origination	07/1992	Owner	Kendra Thomas: Counsel
Last Approved	N/A	Area	Leadership
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	11/2022		
Next Review	1 year after approval		

LD.A.3 Communication with the Media and Other Entities

1. PURPOSE:

To ensure all staff within The Harris Center for Mental Health and IDD communicates accurately, effectively, and consistently to all media sources to support the organization's mission and strategic plan.

2. POLICY:

The Communications Department is the primary and official liaison to the media and shall be responsible for approving and coordinating the communication of The Harris Center information to the media and other entities. All staff should contact the Communications department for matters related to media contacts, crisis incidents, and general procedures regarding relations with the media.

Any information regarding an individual's identity and treatment is confidential and shall only be released in accordance with The Harris Center policies and procedures, along with state and federal laws and regulations. It is the policy of The Harris Center to comply with the Texas Public Information Act.

3. APPLICABILITY/SCOPE:

All Harris Center staff must adhere to this policy when acting on behalf of The Harris Center. No employee is authorized to speak "off the record" on behalf of The Harris Center.

4. PROCEDURES:

5. RELATED POLICIES/FORMS (for reference

only):

- Media consent form
- Consent for release of confidential information

6. REFERENCES: RULES/REGULATIONS/ STANDARDS:

- CARF Standard: Risk Management 1.G.3. Written procedures regarding communications, including media relations and social media.

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	10/2023
Legal Review	Kendra Thomas: Counsel	10/2023
Initial Assignment	Kendra Thomas: Counsel	10/2023

EXHIBIT F-13

Status **Pending** PolicyStat ID **14121262**

Origination	05/1993	Owner	Rita Alford: Dir
Last Approved	N/A	Area	Information Management
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	10/2023		
Next Review	1 year after approval		

HIM.EHR.A.4 Consents and Authorizations

1. PURPOSE:

To obtain and document consent from the patient or legally authorized representative for treatment. To obtain and document authorizations to allow the exchange of patient information. This ensures information is provide to the patient allowing an informed consent to be made.

2. POLICY:

It is the policy of The Harris Center to utilize and maintain written consents from patients or the legally authorized representative for patient treatment/program services, as well as, other specific purposes, such as medication, transportation, media purposes, etc. Consents shall be reviewed and explained in a manner and language a patient can understand. All consents shall be signed and dated by the patient or legally authorized representative. Consents shall be maintained in a timely fashion and copies shall be scanned in the patient record.

The Harris Center shall obtain written authorizations from patients and legally authorized representatives prior to the use and/or disclosure of protected health information. Under no circumstance will The Harris Center staff use or disclose patient protected health information without permission or authorization as specified by state and federal law.

3. APPLICABILITY/SCOPE:

This policy is applicable to all Harris Center staff, contractors, interns, volunteers and Business Associates.

4. PROCEDURES:

HIM.EHR.B.4 Consents and Authorizations

5. RELATED POLICIES/FORMS (for reference only):

• ~~Research Procedures and the Committee for the Protection of Human Subjects~~Research Procedures and the Committee for the Protection of Human Subjects	MED18A
• ~~Confidentiality and Disclosure of Patient/Individual Health Information~~Confidentiality and Disclosure of Patient/Individual Health Information	HIM6A
• ~~Medical Services~~	
• Consent to Treatment with Medication	MED1A
• Transportation Consent for Minors/Patient/Individuals with Guardians Form	
• Media Consent Form	

~~6. PROCEDURES:~~

~~Consents and Authorizations~~

7. REFERENCES: RULES/REGULATIONS/ STANDARDS:

- Confidentiality of Substance Use Disorder Patient Records, 42 ~~C.F.R.~~CFR Part 2
- Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164
- Consent to Treatment of Child by Nonparent of Child, Texas Family Code Chapter 32
- Rights & Duties in Parent-Child Relationship, Texas Family Code Chapter 151
- Medical Records Privacy, Tex. Health & Safety Code Chapter 181
- Rights of ~~patients~~Patients, Texas Health & Safety Code Chapter 576
- Mental Health Records, Texas Health & Safety Code Chapter 611
- Telemedicine, Title 22 Tex. Admin. Code Chapter 174
- Protection of Clients & Staff-Mental Health Services, Title 25 Texas Administrative Code

Chapter 404, Subchapter E

- Rights & Protection of Persons Receiving Mental Health Services, Title 25 Texas Administrative Code Chapter 414, Subchapter I
- patient Rights' Handbook (MH/MR, 9/2006), Title 40 Texas Administrative Code Chapter 2, Subchapter H

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	09/2023
Legal Review	Kendra Thomas: Counsel	09/2023
Department Review	Mustafa Cochinwala: Dir	08/2023
Initial Assignment	Rita Alford: Dir	08/2023

EXHIBIT F-14

Status **Pending** PolicyStat ID **14121250**

Origination	01/1998	Owner	Rita Alford: Dir
Last Approved	N/A	Area	Information Management
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	10/2023		
Next Review	1 year after approval		

HIM.EHR.A.5 Content of Patient/Individual Records

1. PURPOSE:

To ensure a complete and accurate record (electronic or paper-based) shall be ~~maintained~~maintain for each registered and admitted patient/individual receiving services through The Harris Center.

2. POLICY:

It is the policy of The Harris Center that the content and required documentation in the patient/individual record shall be developed to comply with applicable regulatory, legal~~,~~ and/or accrediting standards.

3. APPLICABILITY/SCOPE:

This policy applies to all employees, volunteers, interns, and contractors of The Harris Center~~.~~

4. ~~RELATED POLICIES/FORMS (for reference only):~~RELATED POLICIES/FORMS:

Policies & Procedures	References
Agency Abbreviations	HIM1A
Patient Records Administration	HIM13A
Request for New, Revised, and Deleted Individual Record Paper Forms	HIM10B
Consents and Authorizations	HIM7A
Assurance of Patient Rights	RR3A

Medication Administration	MED5A

5. PROCEDURES:

~~Content of Patient/Individual Records~~HIM.EHR.B.5 Content of Patient/Individual Records

~~6. PROCEDURES:~~

~~**Policies & Procedures**~~
~~Agency Abbreviations~~
~~Patient Records Administration~~
~~Request for New, Revised, and Deleted Individual Record Paper Forms~~
~~Consents and Authorizations~~
~~Assurance of Patient Rights~~
~~Medication Administration~~

7. REFERENCES: RULES/REGULATIONS/ STANDARDS:

- Medical Records, 22 Tex. Admin. Code Ch. 165
- Prescribing of Psychoactive Medication - Mental Health Services, 25 Tex. Admin. Code Ch. 415, Subchapter A
- Medical Records System, 26 Tex. Admin. Code §301.329
- Psychological Records, Test Data, & Test Materials, 22 Tex. Admin. Code §465.22
- Mental Health Community Service Standards, 26 Tex. Admin. Code Ch. 301, Subchapter G
- Mental Health Case Management, 26 Tex. Admin. Code §306.275
- Service Coordination for Individual with Intellectual Disability, 40 Texas Admin. Code Chapter 2, Subchapter L

Approval Signatures

Step Description	Approver	Date
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Department Review	Mustafa Cochinwala: Dir	08/2023
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EXHIBIT F-15

Status **Pending** PolicyStat ID **14433311**

Origination	06/2006	Owner	Keena Pace: Exec
Last Approved	N/A	Area	Assessment, Care & Continuity
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	10/2023		
Next Review	1 year after approval		

ACC.A.14 Declaration of Mental Health Treatment

1. PURPOSE:

The purpose of this policy is to ensure that The Harris Center staff are informed, trained, and demonstrate competence accordingly with regards to Declarations of Mental Health Treatment. All Harris Center patients have the right to execute a Declaration of Mental Health Treatment.

2. POLICY:

It is the policy of The Harris Center for Mental Health and IDD {The Harris Center) to offer persons served an opportunity to make a Declaration for Mental Health Treatment. This opportunity is offered to each person upon entry into THE HARRIS CENTER services and when services are sought through the Psychiatric Emergency Services programs, including the Crisis Stabilization Unit of The Harris Center. All Harris Center staff have a duty to act in accordance with Declarations for Mental Health Treatment to the fullest extent possible.

3. APPLICABILITY/SCOPE:

This policy applies to all Harris Center staff, employees, contractors, volunteers and the clients and family/legally authorized representatives accessing services with The Harris Center as applicable.

4. PROCEDURES:

ACC.B.14 Declaration of Mental Health Treatment

5. RELATED POLICIES/FORMS:

Assurance of Individual Rights	RR3A

6. REFERENCES: RULES/REGULATIONS/ STANDARDS:

Texas Civil Practices and Remedies Code, Chapter 137-Declaration for Mental Health Treatment
Interventions in Mental Health Services; Staff Member Training, Title 25 Texas Administrative Code §415.257
CCBHC 2.C.3 Availability and Accessibility of Services

Attachments

A: Declaration for Mental Health Treatment

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	10/2023
Legal Review	Kendra Thomas: Counsel	10/2023
Departmental Review	Keena Pace: Exec	09/2023
Initial Assignment	Keena Pace: Exec	09/2023

EXHIBIT F-16

Status **Pending** PolicyStat ID **14433312**

Origination	10/2020	Owner	Kendra Thomas: Counsel
Last Approved	N/A	Area	Environmental Management
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	11/2022		
Next Review	1 year after approval		

EM.A.2 Emergency Codes, Alerts, and Response

1. PURPOSE:

To provide plain language emergency alerts and procedures to be used in response to emergency situations.

2. POLICY:

The Harris Center Emergency Management Services is responsible for using plain language emergency notification to alert staff and prompt appropriate, predetermined actions and responses, in the event of an emergency situation.

3. APPLICABILITY/SCOPE:

This policy is applicable to all employees, staff, interns, volunteers, and contractors of The Harris Center.

4. RELATED POLICIES/FORMS (for reference only):

EM22A: Safety and Risk Management in Center Facilities

5. PROCEDURES:

EM12B Security Alert - Armed Intruder

EM13B Facility Alert - Hazardous Spill

EM14B Facility Alert - Utility Systems Failures

EM15B Medical Alert - Code Blue

EM16B Medical Alert - Crisis Intervention

EM18B Security Alert - Bomb Threat/Suspicious Package

EM19B Security Alert - Hostage Situation

EM20B Security Alert - Missing Child/Abduction of Child

EM21B Facility Alert - Fire Evacuation Plan

EM25B Weather Alert

6. REFERENCES: RULES/REGULATIONS/ STANDARDS:

CARF: Risk Management 1.G.1; Health and Safety1.H.2

ALERT CATEGORIES: MEDICAL, FACILITY, SECURITY, AND WEATHER

A. **Medical Alert:**

i. **Code Blue:** Indicates a suspected or imminent cardiopulmonary arrest

- "Medical Alert + Code Blue + Location"

ii. **Medical Emergency:** Indicates an acute injury or illness which poses an immediate risk to an individual's life or health.

- "Medical Emergency + Location"

iii. **Crisis Intervention:** Indicates patient is harmful to self or others in a Harris Center facility.

- "Medical Alert + Crisis Intervention + Location"

B. **Security Alert:**

i. **Active Shooter/ Armed Intruder:** Indicates there is an active shooter or an armed intruder (knife, bat, etc.) incident in a Harris Center Facility.

- "Security Alert + Active Shooter/ Armed Intruder + Location"

ii. **Hostage Situation:** Indicates there is a hostage situation at a Harris Center facility.

- "Security Alert + Hostage Situation"

iii. **Missing Child:** Indicates a missing or abducted child who is a visitor or child/ adolescent patient in a Harris Center facility.

- "Security Alert + Missing Child & Adult + Location"

iv. **Suspicious Package:** Indicates a bomb threat or the discovery of a suspicious device in a Harris Center facility.

- "Security Alert + Suspicious Package + Location"

C. **Facility Alert:**

i. **System Failure:** Indicates a utility or system failure in a Harris Center facility.

- "Facility Alert + Utility Failure + Location"

ii. **Hazardous Spill:** Indicates an unintentional release of one or more hazardous substances which could harm human health or the environment in and around a Harris Center facility.

- "Facility Alert + Hazardous Spill + Location"

iii. **Code Red:** Indicates an actual or suspected fire in a Harris Center facility.

- "Facility Alert + Code Red + Location"

D. **Weather Alert:**

i. Indicates a severe weather condition (e.g., tornado, flooding, ice storm, etc.) at or near a Harris Center facility.

- "Weather Alert + Description + Location"

PLAIN LANGUAGE ALERT CODES DESK TOOL

Emergency Alerts &Communication	Notification Mode
Code Blue/Medical Emergency Medical Alert+ Code Blue+ Location	Overhead page
Crisis Intervention Medical Alert + Crisis Intervention + Location	Overhead page
Active Shooter/ Armed Intruder Security Alert + Active Shooter/Armed Intruder + Location	Alert System Overhead page
Hostage Situation Security Alert + Hostage Situation + Location	Alert System
Missing Child Security Alert + Missing Child + Location	Alert System & Overhead page
Bomb Threat/ Suspicious Package Security Alert + Suspicious Package + Location	Alert System If bomb threat, use bomb threat checklist
Utility or System Failure Facility Alert + Utility Failure + Location	Alert System

Hazardous Spill Facility Alert + Hazardous Spill + Location	Alert System
Code Red/Fire Facility Alert + Code Red + Location	Overhead page
Tornado, flooding, hurricane Weather Alert + Description + Location	Alert System & Overhead page

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EXHIBIT F-17

Status **Pending** PolicyStat ID **14121249**

Origination	10/2000	Owner	Rita Alford: Dir
Last Approved	N/A	Area	Information Management
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	10/2023		
Next Review	1 year after approval		

HIM.EHR.A.10 Faxing & Emailing Patient Identifying Information

1. PURPOSE:

The Harris Center will protect the confidentiality and privacy of patient/individual identifying information and safeguard such information against impermissible disclosure when faxing and emailing patient/ individual identifying information.

2. POLICY:

It is the policy of The Harris Center to ensure that staff protect all patient health information during all electronic communication.

3. APPLICABILITY/SCOPE:

This policy applies to all departments, divisions, facilities and/or programs within The Harris Center.

4. PROCEDURES:

~~Faxing & Emailing Patient Identifying Information~~HIM.EHR.B.10 Faxing & Emailing Patient Identifying Information

5. RELATED POLICIES/FORMS (for reference only):

Policy and Procedures	References

~~Confidentiality and Disclosure of Patient Identifying Information~~Confidentiality and Disclosure of Patient Identifying Information	HIM~~6A~~: 003
~~Incident Reporting~~On-line Incident Reporting	EM4A
Patient Information Facsimile Cover Sheet	HIM: 009.1

6. REFERENCES: RULES/REGULATIONS/ STANDARDS:

- Health Insurance Portability and Accountability Act, 45 CFR Part 164
- Confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2, Subpart B
- Physician-Patient Communication, Tex. Occupation Code Ch. 159
- Medical Records Privacy, Tex. Health and Safety Code Ch. 181
- Mental Health Records, Tex. Health and Safety Code Ch. 611

Approval Signatures

Step Description	Approver	Date
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CEO Approval	Wayne Young: Exec	09/2023
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Department Review	Mustafa Cochinwala: Dir	08/2023
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EXHIBIT F-18

Status **Pending** PolicyStat ID **14496193**

Origination	11/2022	Owner	Keena Pace: Exec
Last Approved	N/A	Area	Leadership
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	10/2023		
Next Review	1 year after approval		

LD.A.17 Harris Center Advisory Committee

1. PURPOSE:

The purpose of the Advisory Committee shall be to advise The Harris Center of Mental Health and IDD Board of Trustees and/or Executive staff on matters, including planning, policy development, coordination, including coordination with criminal justice entities, resource allocation, and resource development, relative to the provision of services and supports to residents of Harris County.

2. POLICY:

The BH & IDD Advisory Committee gathers information related to existing and/or needed services, identify problem areas regarding consumer services and supports and/or systematic issues, receives input from the community, and ensures the viewpoint(s) of the primary (consumer) and secondary (family member) stakeholders are communicated to the Board of Trustees and the Executive Director.

3. APPLICABILITY/SCOPE:

This policy applies to the Board of Trustees and executive staff of The Harris Center.

4. PROCEDURES:

Harris Center Advisory Committee

5. RELATED POLICIES/FORMS:

N/A

6. REFERENCES: RULES/REGULATIONS/ STANDARDS:

CARF 1. A. Leadership

Certified Community Behavioral Health Clinics (CCBHC). Criteria 6.B: Governance. Standard 6.b.1.

Advisory Committees, Tex. Health and Safety Code §534.012

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Initial Assignment	Keena Pace: Exec	10/2023

EXHIBIT F-19

Status **Pending** PolicyStat ID **14125789**

Origination	N/A	Owner	Evanthe Collins: Dir
Last Approved	N/A	Area	ByLaws
Effective	Upon Approval	Document Type	Bylaws
Last Revised	N/A		
Next Review	1 year after approval		

IDD-PAC Bylaws

SECTION V: POLICIES PERTAINING TO THE HARRIS CENTER ADVISORY COUNCILS

1.00 Bylaws of The Harris Center Advisory Council

(Approved MHMRA Board of Trustees: March 18, 1976)

(Revised MHMRA Board of Trustees: February 15, 1979)

(Revised MHMRA Board of Trustees: January 13, 1982)

(Revised MHMRA Board of Trustees: February 14, 1985)

(Revised MHMRA Board of Trustees: January 21, 1987)

(Revised MHMRA Board of Trustees: March 14, 1989)

(Revised MHMRA Board of Trustees: November 28, 1990)

(Revised MHMRA Board of Trustees: March 27,1991)

(Revised MHMRA Board of Trustees: April 28, 1992)

(Revised MHMRA Board of Trustees: March 22, 1994

(Revised MHMRA Board of Trustees: December 20, 1994)

(Revised MHMRA Board of Trustees: May 23, 1995)

(Revised MHMRA Board of Trustees: January 21, 1997)

(Revised MHMRA Board of Trustees: March 25,1997)

(Revised MHMRA Board of Trustees: December 23, 1997

(Revised MHMRA Board of Trustees: July 21, 1998)

(Revised MHMRA Board of Trustees: August 25, 1998)

(Revised MHMRA Board of Trustees: December 19,2006)

(Revised MHMRA Board of Trustees: May 27, 2008)

1.01 Purposes

A. The primary purpose of the Advisory Councils of The Harris Center shall be to advise The Harris Center Board of Trustees on all matters (including planning) relative to the provision of mental health and intellectual and developmental disabilities services and supports to the residents of Harris County.

B. Other purposes of the Advisory Councils are as follows:

    1. Gather information related to existing and/or needed services, identify problem areas with regard to consumer services and supports and/or systemic issues, receive input from the community, and reflect this information to the Board of Trustees and to the Chief Executive Officer.

    2. Ensure that the viewpoint(s) of the primary (consumer) and secondary (family member) stakeholders is/are communicated to the Board of Trustees and the Chief Executive Officer.

1.02 Responsibilities

Advisory Councils are charged with the following responsibilities:

A. Make recommendations on specific service needs, planning, and implementation of priorities. Participation in the annual and strategic planning processes of the Agency will be a major responsibility of the Advisory Councils. Any recommendations duly adopted by an Advisory Council will be carried by the Board liaison or his/her designee to the appropriate Board Committee at the next regularly scheduled meeting of the appropriate committee following approval of the minutes of the Council meeting in which the recommendations are set forth. The Board Committee will review the recommendations for subsequent presentation to the Board. The Advisory Councils should receive, review, and comment on, reports from staff regarding plan implementation.

B. Serving as a vital communications link between The Harris Center and the community. To accomplish this, following the approval by the council of the minutes in which recommendations are recorded, the approved minutes of each Advisory Council will be placed in each Board member's information packet prior to the next Board meeting. The approved minutes of each The Harris Center Board meeting without attachments will be distributed to all Advisory Council members at the next regularly scheduled council meeting.

C. Establish a variety of action task forces to advise on specific issues and problems.

D. Respond to special charges as assigned or requested by the Board of Trustees or Chief Executive Officer from time to time.

E. Establish lines of formal and informal communication among public and private agencies and

organizations dealing with issues relating to adults and children with mental illness and intellectual and developmental disabilities.

F. The Medical Advisory Council shall be responsible for informing The Harris Center Board of Trustees of the Agency's compliance with all standards which relate to psychiatric and/or medical care as outlined in the Rules of the Commissioner of the Texas Health & Human Services Commission. (Approved MHMRA Board of Trustees: July 21,1977)

1.03 Composition

A. A Medical Advisory Council, Adult Mental Health Council, Child and Adolescent Mental Health Council, and Intellectual and Developmental Disabilities Planning Advisory Council shall be established. Other councils may also be created at the discretion of The Harris Center Board of Trustees.

B. Appointments of members should include a broad representation from the community including consumer and family members, representatives from organizations and agencies, and interested individuals. New appointments to Advisory Councils shall be considered by The Harris Center Board of Trustees Program Committee prior to consideration by the Board. Persons serving as representatives of Board-approved organizations are subject to Board approval. Persons filling Consumer, Family, or Interested Citizen slots will be selected by the Board from nominees recommended by the Program Committee. Candidates for consumer, family, or interested citizen "slots" may be nominated by themselves, organizations or agencies, providers, or Board members. The nomination shall be on a Board approved form which provides sufficient information to make appropriate selections to assure balanced representation. Organizations may be proposed for the Board approved list by submitting a request to the Board Program Committee.

    1. Prior to consideration of an appointment to any of the Advisory Councils, the Program Committee will forward the nominee's application to the appropriate Advisory Council for review and comment.
    2. Each Advisory Council shall establish its process for review of prospective nominees and input to the Program Committee for consideration of the application.
    3. The Advisory Council review process of prospective nominees will have thirty (30) days to provide input to the Program Committee prior to its formal consideration of a nominee.

C. The terms of individuals representing Board approved organizations shall be at the pleasure of Board approved organization, subject to Board of Trustees review and approval. Organizational representatives shall remain on the Councils until such time as the organization replaces them or they resign. The terms of consumer, family member, or interested citizen members shall be for three year period or until successors are appointed. Appointments made to fill unexpired terms shall be for the period of the unexpired term, or until a successor is appointed. Members shall serve no more than two (2) consecutive terms and may be eligible for reappointment one (1) year after the expiration of their two (2) consecutive terms. Honorary members remain on the Councils as nonvoting members. All council positions will be filled within 90 days of the vacancy.

D. Proposed Advisory Council members shall, upon nomination and before appointment, certify in writing that they have read and will be guided by the Code of Ethics of The Harris Center. In

addition, the proposed council member shall agree to reveal any potential conflict of interest in any issue before the Advisory Council prior to participating in the discussion of that issue. Membership on The Harris Center Advisory Council shall not include Agency Employees or their immediate families, members of the Agency's Public Responsibility Committee, or members of other committees or organizations whose membership eligibility precludes existing affiliation with the Agency.

E. Specific composition of the:
    1. Adult MH Advisory Council:
        a. Fifteen (15) slots for Board-approved organizations and interested citizens.
        b. Fifteen (15) slots for Board-appointed consumers, family members, composed of:
            I. Six (6) slots dedicated to consumer representatives of the Consumer Advisory Council of the AMH Division who are actively receiving services and/or supports from the Agency;
            II. Four (4) slots dedicated to persons (priority population) who are past or present consumers of mental health services; and,
            III. Five (5) slots dedicated to family members of persons that are past or present consumers of mental health services (priority population).
    2. Children's Mental Health Advisory Council
        a. The Children's Management Team Agencies of the Children's Mental Health Plan shall be Board approved organizations on the Children's MH Advisory Council.
        b. Four (4) slots dedicated to family members of persons receiving services and/or supports from the Child and Adolescent Services Division
    3. Intellectual and Developmental Disabilities Planning Advisory Council
        a. The council shall be comprised of at least nine (9) members with a maximum of thirty (30) members.
        b. Membership shall either be Organizational or Advocate Memberships.
        c. At least 50% of the members on the Council shall be a person with intellectual and/or developmental disabilities or a family member of a person with intellectual and/or developmental disabilities.
        d. Not less than one (1) member will be dedicated to a person with intellectual and/or developmental disabilities.
        e. Members shall reside in Harris County.

1.04 Officers

A. Each Council shall elect its own Chairperson, Vice Chairperson, and Secretary at the annual meeting and assume office at the next Council meeting.

B. The Chairperson shall preside at all meetings, be an ex-officio member of all committees except the Nominating Committee, call special meetings as needed, and appoint special committees and/or task force groups and their chairpersons.

C. The Vice Chairperson shall be an assistant to the Chairperson and assume the duties of the Chairperson in his/her absence. In the event of the resignation of the Chairperson, the Vice Chairperson shall assume the duties of the Chair until a replacement is elected by the Council.

D. The Secretary shall keep the minutes of the meetings and maintain a file of essential records. The Secretary of each Council shall record member attendance and bring attendance compliance issues to the attention of the Board Program Committee.

E. Officers shall serve for a three-year period.

1.05 Meetings

A. Councils shall meet on a designated date at least quarterly unless otherwise determined by individual Councils or requested by the Board of Trustees. Special meetings may be called at the discretion of the Chairperson with a minimum of seventy-two (72) hours' notice to all members.

B. The last regular meeting before the end of the fiscal year shall be known as the Annual Meeting and shall be for the purpose of electing new officers, receiving reports of officers and committees, and for other business that may arise.

C. Meetings of all Advisory Councils are open sessions. Attendance and participation by the public is encouraged; however, only duly appointed members may vote. Each Advisory Council meeting shall provide an opportunity for public comment.

D. Committee meetings may be called at the discretion of the chairpersons of those committees.

E. Each council shall determine the requirements for constituting a quorum; however, in no case shall a quorum be established at less than twenty-five percent (25%) of current members.

F. Unexcused absences by an individual or organization representative of a council for three (3) consecutive general meetings shall be considered a resignation unless a request for review is brought to the attention of the chairperson before the next meeting. Each Advisory Council shall establish a process to engage members who have attendance problems and provide an opportunity for reinstatement after an automatic resignation prior to the next meeting of the Board Program Committee. Each Advisory Council shall notify the member of his/her automatic resignation in writing prior to the next regular meeting of the Advisory Council.

G. An organization that does not appoint a representative to a Council within six (6) months of initial The Harris Center Board approval or at the end of six (6) months following the vacancy by its representative shall be considered to have resigned its organizational membership on the designated council unless a request to review is brought to the Board Program Committee.

H. Absentee or proxy voting shall not be allowed for any member.

I. General meetings shall follow the standard agenda as prescribed by the Board. The detailed agenda for each meeting shall be prepared jointly by a Board member, the assigned staff member, and the Chairperson of the Council.

    1. Standard Agenda shall consist of:

        a. Call to Order

b. Minutes of Previous Meeting
c. Public Comments (three-minute time limit)
d. Educational presentation
e. Old Business
f. New Business
g. Consideration of communications, advice and recommendations from public and private agencies and organizations.
h. Report from the Board Liaison and consideration of Board requests for advice concerning service needs and/or implementation of priorities.
i. Set date for next meeting and adjourn.

1.06 Committees

Standing and special committees shall be created by the council as needed. Members shall be appointed by the council chairperson. Chairpersons of standing committees shall be appointed by the council chairperson subject to approval by a vote of the council at a general meeting.

1.07 Amendment of Bylaws

These bylaws apply to all Advisory Councils of The Harris Center for Mental Health and Intellectual and Developmental Disabilities, unless otherwise stated. Advisory Councils desiring to make a change in the bylaws should submit the requested change, in writing, to The Harris Center Board of Trustees through the Board Program Committee.

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	08/2023
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Departmental Review	Keena Pace: Exec	08/2023
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EXHIBIT F-20

Status **Pending** PolicyStat ID **14301784**

Origination	09/2015	Owner	Kia Walker: Chief Nursing Officer
Last Approved	N/A	Area	Medical Services
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	10/2023		
Next Review	1 year after approval		

MED.NUR.A.2 Medication Administration

1. PURPOSE:

The purpose of the policy is to describe the medication administration practices provided by The Harris Center for Mental Health and IDD.

2. POLICY:

All nurses employed with or contracted by ~~The~~the Harris Center who administer medications must do so according to their licensing boards. Non-licensed staff who administer or supervise the self-administration of medications **(SSAM)** must meet the education/training requirements and standards. Medications will be administered only upon the specific order of authorized prescribers in Mental Health and IDD Programs. Psychoactive Medications will only be administered when the patient or Legally Authorized Representative (LAR) has provided written consent except during a psychiatric or medical emergency. Programs not providing nursing services will be excluded from any type of medication administration.

3. APPLICABILITY/SCOPE:

This policy applies to all units, programs, and services of ~~The~~the Harris Center where medications are prescribed and administered by licensed practitioners and staff who have been trained and found ~~to~~the be competent and to all units and programs that provide supervision of medication self-administration or medication administration by non-licensed staff.

4. RELATED POLICIES/FORMS (for reference

only):

Pharmacy and Unit Medication/ Drug Inventory

5. PROCEDURES:

- Medication Administration and Documentation Procedure
- CPEP Medication Administration Procedure
- CPEP Medication Education Procedure
- Supervision of Self-Administration of Medications (SSAM)
- Medication Administration in Outpatient Clinics
- IDD Medication Administration
- MED 11A Pharmacy and Unit Medication/ Drug Inventory

6. REFERENCES: RULES/REGULATIONS/ STANDARDS:

- Administration of Medication for Clients with Intellectual and Developmental Disabilities, Tex. Human Resources Code Chapter 161, Subchapter D-I
- Administration of Medication to Patient under Court Order for Mental Health Services, Tex. Health & Safety Code Ch. 574, Subchapter G
- Rights of Persons with an Intellectual Disability, Tex. Health & Safety Code Ch. 592, Subchapter F
- RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Clients with Stable & Predictable Conditions, 22 Tex. Admin. Code Chapter 225
- Consent to Treatment with Psychoactive Medication-Mental Health Services, 25 Texas Administrative Code Ch. ~~Title 25. Texas Administrative Code. Chapter~~ 414, Subchapter I.
- Mental Health Community Services Standards~~.~~ Standards of Care~~. Title~~ Medication Services, 26~~.~~ Texas Administrative Code~~. Chapter~~ §301.355~~. Medication Services.~~
- ~~Title~~Role and Responsibilities of a Local Authority-Health Safety and Rights, 40 Tex. ~~Texas Administrative~~Admin. Code~~. Role and Responsibilities of a Local Authority. Section~~ §2.313~~. Health, Safety and Rights.~~

Approval Signatures

Step Description	Approver	Date

Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	10/2023
Final Legal Review	Kendra Thomas: Counsel	09/2023
Initial Legal Review	Shannon Fleming: Counsel	09/2023
Department Review	Luming Li: Chief Medical Ofcr (1101 1817)	09/2023
Initial Assignment	Kia Walker: Chief Nursing Officer	09/2023

EXHIBIT F-21

Status **Pending** PolicyStat ID **13229546**

Origination	N/A	Owner	Toby Hicks
Last Approved	N/A	Area	Human Resources
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	N/A		
Next Review	1 year after approval		

HR.A.34 Nepotism HR SOP

1. PURPOSE:

The purpose of this policy is to provide guidance for all employees of The Harris Center for Mental Health and IDD and outlines acceptable and unacceptable reporting relationships of relatives to ensure fairness in our hiring practices and work-related matters.

2. POLICY:

The Harris Center prohibits nepotism in hiring, as well as, in any decisions affecting the terms and conditions of employment. ~~No~~To promote a productive work environment, free from conflicts of interests, unfair advantages, whether perceived or real, no nepotism or favoritism of any kind may be shown to one's relatives in work-related matters. Relatives may not be in a direct reporting relationship with one another. They may not work in the same work group or report to the same supervisor. ***As a general guideline, two levels of management should exist between relatives; however, each situation must be evaluated on an individual basis to determine if a conflict of interest exists.***

3. APPLICABILITY/SCOPE:

All employees (direct and indirect) regardless of rank or title.

4. DEFINITIONS

Nepotism is showing favoritism to one's relatives in hiring or in any terms and conditions of employment. Relatives include the following

- Spouse or domestic partner

- Parent or Stepparent
- Child or Stepchild
- Grandparents
- Grandchildren
- Aunt or Uncle
- Niece or Nephew
- Cousins
- Guardian or Ward
- Siblings or Step-siblings (brother. sisters)
- In-laws (brother, sister, mother, father, son or daughter)
- A person living in one's household
- Any other person with such a close bond as to suggest conflict in the employment relationship (for example, a fiance').

~~5. APPLICABILITY/SCOPE:~~

~~All employees (direct and indirect)~~

If two employees marry, cohabit, or become otherwise related, so as to qualify as relatives under this policy's definition, they must report the change in status to the Human Resources Department which will work with the employees to devise a working solution to avoid nepotism problems under this policy.

6. PROCEDURES:

Relatives seeking employment at the Harris Center must use the standard application process at the Harris Center. To avoid creating any barrier to equal employment opportunity, hiring of relatives based exclusively on referrals is not permitted.

An employee that holds one of the following positions may not have relatives working in the same business unit, even if two levels of separation exists.

- Vice President
- Director, includes Program Director. Assistant Program Director, Clinical Directors and Associate Director
- Manager, includes Program Manager, Asst Program Manager, etc
- Supervisor, includes Lead positions
- Back Office

7. RELATED POLICIES/FORMS ~~(for reference only)~~::

- Corporate Compliance Policies - Conflict of Interest

- Employee Handbook

LD.A.13 Code of Ethics Policy

8. REFERENCES: RULES/REGULATIONS/ STANDARDS:

~~LD12A- Code of Ethics Policy~~

Questions regarding this policy should be directed to the HR Business Partner or location manager

These requirements must be followed. Managers/Supervisors who deviate from the requirements are subject to disciplinary action up to and including termination. Exceptions to this SOP must be approved by the VP, Human Resources ~~and~~, Chief Administrative Officer, and General Counsel.

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	08/2023
Legal Review	Kendra Thomas: Counsel	08/2023
Department Review	Joseph Gorczyca	07/2023
Initial Assignment	Toby Hicks	07/2023

EXHIBIT F-22

Status **Pending** PolicyStat ID **13252354**

Origination	11/2020	Owner	Toby Hicks
Last Approved	N/A	Area	Human Resources
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	10/2023		
Next Review	1 year after approval		

HR.A.17 Overtime Compensation

1. PURPOSE:

The purpose of this policy is to comply with applicable local, state and federal laws, and to provide equitable consideration for hours worked over 40 in the standard work week.

2. POLICY:

The Harris Center for Mental Health and Intellectual and Developmental Disability (The Harris Center) in compliance with the Fair Labor Standards Act ~~(FISA~~(FLSA) and the ~~Texas~~Equal Pay ~~Day law~~Act has established a maximum work week of forty (40) hours, except as noted herein. ~~Accordingly~~Unless exempt, ~~The~~the Harris Center will compensate employees for overtime worked in excess of the established workweek in accordance with FLSA and the provisions of this policy. Overtime for certain employees classified as "Exempt" by the FLSA is not required. Overtime for employees classified as "Nonexempt" will be compensated at a rate not less than one and one-half hours for each hour of overtime.

3. APPLICABILITY/SCOPE:

This policy applies to all staff employed by The Harris Center including, both direct and contracted employees.

4. PROCEDURES:

- Employees Exempt from Overtime
- Overtime Approval

- Neuro-Psychiatric Center Overtime Computation
- Overtime Compensation
- Employee Volunteers

5. RELATED POLICIES/FORMS ~~(for reference only)~~:

- Signature for Authorization
- Recording Employee Time Worked and Maintaining Leave Earned and Taken Records
- ~~Shift Differential~~
- Shift Differential
- Employment

6. REFERENCES: RULES/REGULATIONS/ STANDARDS:

- Fair Labor Standards Act 29 U.S.C. § 203
- ~~Texas Pay Day Law~~Equal Pay Law, Texas Government Code §659.001
- The Harris Center's Employee Handbook

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	08/2023
Legal Review	Kendra Thomas: Counsel	08/2023
Department Review	Joseph Gorczyca	07/2023
Initial Assignment	Toby Hicks	07/2023

EXHIBIT F-23

Status **Pending** PolicyStat ID **14121258**

Origination	05/1993	Owner	Rita Alford: Dir
Last Approved	N/A	Area	Information Management
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	10/2023		
Next Review	1 year after approval		

HIM.EHR.A.12 Patient/ Individual Access to Medical Records

1. PURPOSE

To establish guidelines for the contents, maintenance, and confidentiality of patient's/ individual's medical records that meet the requirements set forth in Federal and State laws and regulations, and to define the portion of a patient's/ individual's healthcare information, whether in paper or electronic format, that comprises the medical record.

2. POLICY

It is the policy of The Harris Center that subject to specific contraindications by a qualified professional and to any legal constraints, the content of a patient's/individual's medical record shall be made available to the individual/ patient upon written request.

3. APPLICABILITY/SCOPE

This policy applies to all employees of The Harris Center.

4. PROCEDURES

~~HIM12B~~

HIM.EHR.B.12 Patient/ Individual Access to Medical Records

5. RELATED POLICIES/FORMS

• Confidentiality and Disclosure of Patient/ Individual Identifying Information	HIM6
• Patient/Individual Records Administration	HIM005
• Notice of Privacy Practices	HIM003
• ROI Processing Fee	HIM6B
• Consumer Request to for Review (Appeal) of a Center Decision form	
• Request to Correct/Amend Consumer Health Information form	1
• Request to Restrict the Use/Disclosure of Consumer Health Information form	
• Consumer Request for Confidential Communications form	
• Notice of Privacy Practices Acknowledgement form	
• Request for an Accounting of Disclosures of Health Information	

6. REFERENCES: RULES/REGULATIONS/ STANDARDS

- Physician-Patient Communication, Texas Occupations Code, Chapter 159
- Medical Records Privacy, Texas Health and Safety Code chapter 181
- Mental Health Records, Texas Health and Safety Code Chapter 611
- HIPAA Privacy and Security Rules, 45 CFR Parts 160 and 164
- The 21st Century Cures Act, Pub. L. No. 114-255 (2016); 29 U.S.C. § 1185a; 26 U.S.C. § 9812

Approval Signatures

Step Description	Approver	Date

Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	09/2023
Legal Review	Kendra Thomas: Counsel	09/2023
Department Review	Mustafa Cochinwala: Dir	08/2023
Initial Assignment	Rita Alford: Dir	08/2023

EXHIBIT F-24

Status **Pending** PolicyStat ID **13656070**

Origination	N/A
Last Approved	N/A
Effective	Upon Approval
Last Revised	N/A
Next Review	1 year after approval
Owner	Luc Josaphat: Director of Quality Assurance
Area	Assessment, Care & Continuity
Document Type	Agency Plan

ACC.P.1 Performance Improvement Plan

The Harris Center Performance Improvement Plan

(System Quality, Safety and Experience)

FY 2023

Introduction

The 2023 Quality, Safety, and Experience Plan (previously named The Harris Center's Annual PI Plan) is established in accordance with The Harris Center's mission to transform the lives of people with behavioral health and IDD needs. The center's vision is to empower people with behavioral health and IDD needs to improve their lives through an accessible, integrated, and comprehensive recovery-oriented system of care. Our values as a center include collaboration, compassion, excellence, integrity, leadership, quality, responsiveness, and safety. The Quality, Safety and Experience Plan has been established to embrace the principles of transparency of measures and outcomes, accurate measurement and data reporting, and personal and collective accountability for excellent outcomes.

Vision

Our vision is to create a learning health system focused on a culture of continuous quality improvement and safety at The Harris Center to help people live their healthiest lives possible, and to become a national leader in quality and safety in the behavioral healthcare space as it influences dissemination of evidence-based practices.

Mission

We aim to improve quality, efficiency, and access to care and associated behavioral health and IDD services by delivering education, providing technical support, generating, and disseminating evidence, and conducting evaluation of outcomes in support of operational and service excellence and process management across The Harris Center and with external partners.

FY 2023 Goals

1. Build a learning health system that focuses on continuous quality improvement, patient safety, improving processes and outcomes.
    - Partner with Organizational Development to enhance educational offerings focused on quality and safety education with all new employee orientation (High Reliability, Just Culture, Advanced Quality Improvement methodology, etc.)
    - Hardwire a process for continuous readiness activities that complies with all legislative regulations and accrediting agencies standards (e.g., CARF, CCBHC).
2. Use transparent, simplified meaningful measures to champion the delivery of high-quality evidence-based care and service to our patients and their families and assure that it is safe, effective, timely, efficient, equitable, and patient centered care
    - Define and implement a data management governance strategy to support a transparent environment to provide accessible, accurate, and credible data about the quality and equity of care delivered.
    - Create a transparent and accurate process for public reporting (e.g., MIPS)
3. Develop, integrate, and align quality initiatives and cross-functional approaches throughout The Harris Center organization, including all entities.
    - Enhance current committee structure to cover broad quality and safety work through the System Quality, Safety and Experience Committee (formerly the Patient Safety Committee)
    - Develop a decentralized Quality Forum that reaches frontline performance improvement (PI) and Health Analytics/Data staff to provide education and tools to lead PI initiatives at their local sites.
    - Develop and strengthen two internal learning collaboratives in alignment with the Harris Center strategic plan for care pathways.

- Zero Suicide Implementation Team
- Substance Use Disorders Utilize internal learning collaboratives to synthesize evidence-based practices as applicable to The Harris Center practice setting and to build clinical care pathways to hardwire these practices, targeting implementation and dissemination two care pathways by end of fiscal year 2023

3-Year Long Term Goals (FY 2025)

- Zero preventable serious safety events

- Top quartiles for staff and provider engagement
- Top quartiles for patient satisfaction
- Increased access (numbers served)
- Improved outcomes
- Equitable care delivery
- Exemplar in Quality and Safety for Behavioral Health with national recognition

Governance Structure

Governing Body

The Harris Center for Mental Health and IDD Board of Trustees is responsible for ensuring a planned, system-wide approach to designing quality goals and measures; collecting, aggregating, analyzing data; and improving quality and safety. The Board of Trustees shall have the final authority and responsibility to allocate adequate resources for assessing and improving the organization's clinical performance. The Board shall receive, consider, and act upon recommendations emanating from the quality improvement activities described in this Plan. The Board has established a standing committee, Quality Committee of the Board of Trustees, to assess and promote patient safety and quality healthcare. The Committee provides oversight of all areas of clinical risk and clinical improvement to patients, employees, and medical staff.

Leadership

The Harris Center leadership is delegated the authority, via the Board of Trustees, and accountability for executing and managing the organization's quality improvement initiatives. Quality leadership provides the framework for planning, directing, coordinating, and delivering the improvement of healthcare services that are responsive to both community and patient needs that improve healthcare outcomes. The Harris Center leaders encourage involvement and participation from staff at all levels within all entities in quality initiatives and provide the stimulus, vision, and resources necessary to execute quality initiatives.

Executive Session

The Executive Session of the Quality Committee of the Board is the forum for presenting closed record case reviews, pharmacy dashboard report including medication errors, and the Professional Review Committee report.

~~Professional Review Committee (PRC)~~

~~The Chief Medical Officer (CMO) is delegated the oversight, via the Board of Trustees, to evaluate the quality of medical care and is accountable to the Board of Trustees for the ongoing evaluation and improvement of the quality of patient care at The Harris Center and of the professional practice of licensed providers. The PRC will act as the authorizing committee for professional peer review and system quality committees (Exhibit A). The committee will also ensure that licensing boards of~~

~~professional health care staff are properly notified of any reportable conduct or finding when indicated. The Professional Review Committee has oversight of the following peer protected processes and committees:~~

~~Oversight:~~

- ~~Medical Peer Review~~
- ~~Pharmacy Peer Review~~
- ~~Nursing Peer Review~~
- ~~Licensed Professional Review~~
- ~~Closed Record Review~~

~~Membership:~~

- ~~Chief Executive Officer (Ex-Officio)~~
- ~~Chief Medical Officer (Chair)~~
- ~~Chief Operating Officer~~
- ~~Chief Nursing Officer~~
- ~~Chief Administrative Officer~~
- ~~Legal Counsel~~
- ~~Divisional VPs and (CPEP, MH)~~
- ~~VP, Clinical Transformation and Quality~~
- ~~VP, Enterprise Risk Management~~
- ~~Director of Pharmacy Programs~~

~~**System Quality, Safety and Experience Committee**~~

System Quality, Safety and Experience Committee

The Quality Committee of the Board of Trustees has established a standing committee, The System Quality, Safety and Experience Committee (previously the Patient Safety Committee) to evaluate, prioritize, provide general oversight and alignment, and remove any significant barriers for implementation for quality, safety, and experience initiatives across Harris Center programs. The Committee is composed of Harris Center leadership, including operational and medical staff. The Committee will approve annual system-wide quality and safety goals and review progress. The patient safety dashboard and all serious patient safety events are reviewed. Root Cause Analysis, Apparent Cause Analysis, Failure Modes and Effects Analysis, quality education projects, are formal processes used by the Committee to evaluate the quality and safety of mental health and IDD services, and thus are privileged and confidential. All performance improvement projects through The Harris Center's quality training program or other performance improvement training programs are privileged and confidential as

part of the Quality, Safety & Experience Committee efforts. The Committee also seeks to ensure that all The Harris Center entities achieve standards set forth by the Commission on Accreditation and Rehabilitation Facilities (CARF) and Certified Community Behavioral Health Clinic (CCBHC).

The System Quality, Safety and Experience Committee has oversight of the following committees and/or processes: (Appendix A)

Oversight:

- ~~Pharmacy and Therapeutics Committee~~
- ~~Infection Prevention~~
- System Accreditation
- All PI Councils and internal learning collaboratives (e.g., Zero Suicide, Substance Use Disorders)
- ~~Approval~~Development of Care Pathways
- Patient Experience / Satisfaction

Membership:

- Chief Executive Officer (Ex-Officio)
- VP, Clinical Transformation and Quality (Co-Chair)
- Chief Nursing Officer (Co-Chair)
- Chief Medical Officer
- Chief Operating Officer
- Legal Counsel
- Division Medical VPs and Medical Directors
- Chief Administrative Officer
- Director Risk Management / Audit
- Director of Compliance
- Chief Financial Officer
- Director Health Analytics
- Director, Clinical Transformation, and Innovation
- Director of Quality Assurance
- Director of Pharmacy Programs
- Director of Integrated Care
- Nursing Directors
- Infection Control Director

Organization of Quality Improvement: Priority Setting

The criteria listed below provide a framework for the identification of improvements that affect health outcomes, patient safety, and quality of care, which move the organization to our mission of providing the finest possible patient care. The criteria drive strategic planning and the establishment of short and long-term goals for quality initiatives and are utilized to prioritize quality improvement and safety initiatives.

- High-risk, high-volume, or problem-prone practices, processes, or procedures
- Identified risk to patient safety and medical/healthcare errors
- Identified in The Harris Center Strategic Plan
- Identified as Evidenced Based or "Best Practice"
- Required by regulatory agency or contract requirements

Methodologies

- The Model for Improvement (Appendix B) and other quality frameworks (e.g., Lean, Six Sigma) are used to guide quality improvement efforts and projects
- A Root Cause Analysis (RCA) is conducted in response to serious or sentinel events
- Failure Mode and Effects Analysis (FMEA) is a proactive tool performed for analysis of a high-risk process/procedure performed on an as needed basis (at least annually)

  Data Management Approach and Analysis

  Data is used to guide quality improvement initiatives throughout the organization to improve, safety, treatment, and services for our patients. The initial phase of a project focuses on obtaining baseline data to develop the aim and scope of the project. Evidence-based measures are developed as a part of the quality improvement initiative when the evidence exists. Data is collected as frequently as necessary for various reasons, such as monitoring the process, tracking balancing measures, observing interventions, and evaluating the project. Data sources vary according to the aim of the quality improvement project, examples include the medical record, patient satisfaction surveys, patient safety data, financial data. Benchmarking data supports the internal review and analysis to identify variation and improve performance. Reports are generated and reviewed with the quality improvement team. Ongoing review of organization wide performance measures are reported to committees described in the Quality, Safety and Experience governance structure.

  Reporting

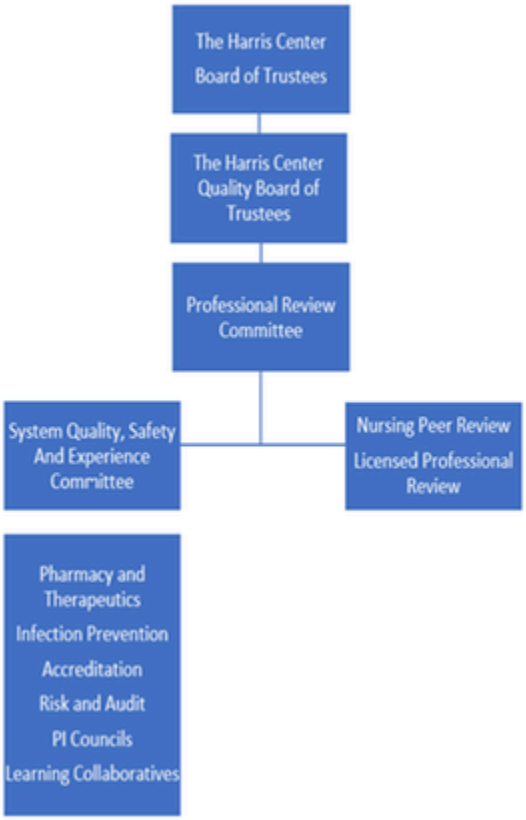
  Quality, Safety and Experience metrics are routinely reported to the Quality, Safety and Experience Committee. Quality, Safety and Experience Committee is notified if an issue is identified. Roll up reporting to the Quality Board of Trustees on a quarterly basis and more frequently as indicated.

  Evaluation and Review

  At least annually, the Quality, Safety and Experience leadership shall evaluate the overall

effectiveness of the Quality, Safety and Experience Plan and program. Components of the plan that need to be expanded, revised, or deleted shall be identified to ensure that the objectives are met, and this document is maintained to reflect an accurate description of the Quality, Safety and Experience program.

(Appendix A)
Committee Oversight



New: System Quality, Safety and Experience (prior Safety Committee) has oversight and reporting of the following committees or functions:

- Pharmacy and Therapeutics
- ~~Infection Prevention~~
- Accreditation
- ~~Risk and Audit~~
- Learning Collaboratives

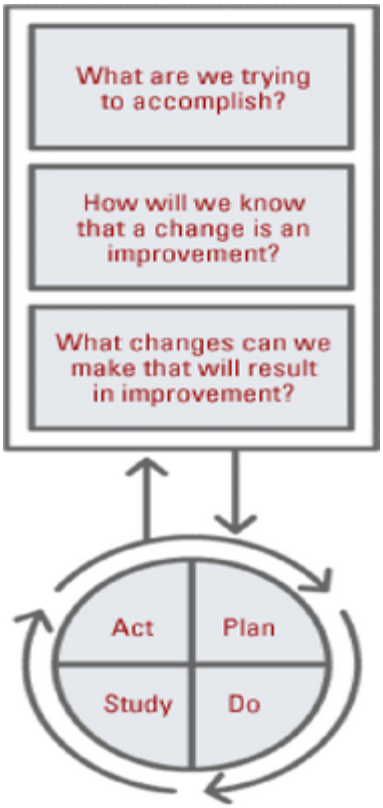
(Appendix B)

The Model for Improvement

Forming the Team

Including the right people on a process improvement team is critical to a successful improvement effort. Teams vary in size and composition. Each organization builds teams to suit its own needs.

Setting Aims Improvement requires setting aims. The aim should be time-specific and measurable; it should also define the specific population of patients that will be affected.
Establishing Measures Teams use quantitative measures to determine if a specific change actually leads to an improvement.
Selecting Changes Al improvement requires making changes, but not all changes result in improvement. Organizations therefore must identify the changes that are most likely to result in improvement.
Testing Changes The Plan-do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting – by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method used for action-oriented learning.
Implementing Changes After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the team can implement the change on a broader scale — for example, for an entire pilot population or on an entire unit.
Spreading Changes After successful implementation of a change or package of changes for a pilot population or an entire unit, the team can spread the changes to other parts of the organization or in other organizations.



Sources:

Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach toEnhancing Organizational Performance.

The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-Do-Check-Act (PDCA) cycle. W. Edwards Deming modified Shewhart's cycle to PDSA, replacing "Check" with "Study." [See Deming WE. *The New Economics for Industry, Government, and Education*. Cambridge, MA: The MIT Press; 2000.]

(Appendix C)

Root Cause Analysis (RCA):

The key to solving a problem is to first truly understand it. Often, our focus shifts too quickly from the problem to the solution, and we try to solve a problem before comprehending its root cause. What we think is the cause, however, is sometimes just another symptom.

One way to identify the root cause of a problem is to ask "Why?" five times. When a problem presents itself, ask "Why did this happen?" Then, don't stop at the answer to this first question. Ask "Why?" again and again until you reach the root cause.

Failure Modes and Effects Analysis (FMEA):

FMEA is a tool for conducting a systematic, proactive analysis of a process in which harm may occur. In an FMEA, a team representing all areas of the process under review convenes to predict and record

where, how, and to what extent the system might fail. Then, team members with appropriate expertise work together to devise improvements to prevent those failures — especially failures that are likely to occur or would cause severe harm to patients or staff. The FMEA tool prompts teams to review, evaluate, and record the following:

- Steps in the process
- Failure modes (What could go wrong?)
- Failure causes (Why would the failure happen?)
- Failure effects (What would be the consequences of each failure?)

Teams use FMEA to evaluate processes for possible failures and to prevent them by correcting the processes proactively rather than reacting to adverse events after failures have occurred. This emphasis on prevention may reduce risk of harm to both patients and staff. FMEA is particularly useful in evaluating a new process prior to implementation and in assessing the impact of a proposed change to an existing process.

Attachments

image1.png

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	06/2023
Legal Review	Kendra Thomas: Counsel	06/2023
Departmental Review	Keena Pace: Exec	06/2023
Initial Assignment	Luc Josaphat: Director of Quality Assurance	06/2023

EXHIBIT F-25

Status **Pending** PolicyStat ID **13959046**

Origination	01/1998	Owner	Rita Alford: Dir
Last Approved	N/A	Area	Information Management
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	10/2023		
Next Review	1 year after approval		

HIM.EHR.A.14 Retention of Patient/Individual Records

1. PURPOSE:

A patient/individual record will be maintained for every individual registered and/or opened for services with the Harris Center.

2. POLICY:

It is the policy of The Harris Center that all patient/individual records shall be retained for specified periods based on legal, accrediting, and regulatory requirements, as well as, its uses for patient/individual care, legal, research and educational purposes. Patient/individual records may be retained in paper-based, images, and EHR.

3. APPLICABILITY/SCOPE:

This policy applies to all departments, divisions, facilities and/or programs within The Harris Center.

4. PROCEDURES:

HIM.EHR.B.14 Retention of Patient/Individual Records

5. RELATED POLICIES/FORMS (for reference only):

Reference	Policy and Procedures
Patient/Individual Records Administration	HIM: ~~013~~13

Security of Patient/~~individual~~Individual Identifying Information	HIM~~: 016~~16

6. REFERENCES: RULES/REGULATIONS/ STANDARDS:

American Health Information Management Association Practice Brief: Retention of Health Information
Confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2, Subpart B
Health Insurance Portability and Accountability Act, 45 CFR §§164.509,164.515
Texas Medical Records Privacy Act, Tex. Health & Safety Code Chapter 181
Medical Records, 22 Tex. Admin. Code, Chapter 165
Psychological Records, Test Data & Test Materials, 22 Tex. Admin. Code §465.22
Rights of All Persons Receiving Mental Health Services, 25 Tex. Admin. Code §404.154

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	09/2023
Legal Review	Kendra Thomas: Counsel	09/2023
Department Review	Mustafa Cochinwala: Dir	08/2023
Initial Assignment	Rita Alford: Dir	08/2023

EXHIBIT F-26

Status **Pending** PolicyStat ID **13923056**

Origination	02/1992	Owner	Keena Pace: Exec
Last Approved	N/A	Area	Assessment, Care & Continuity
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	10/2023		
Next Review	1 year after approval		

ACC.A.9 Return to In-Patient Care of Furloughed Patient

1. PURPOSE:

The purpose of this policy is ensure The Harris Center complies with current state laws regarding furlough of patient receiving inpatient treatment pursuant to a temporary or extended commitment.

2. POLICY:

It is the policy of a The Harris Center to comply with all requirements and special conditions associated with patients released on furlough.

3. APPLICABILITY/SCOPE

This policy applies to all Harris Center staff.

4. PROCEDURES

~~ACC11B - Return to In-Patient Care of Furloughed Patient~~ACC.B.9 - Return to In-Patient Care of Furloughed Patient

5. RELATED POLICIES/FORMS (for reference only):

6. REFERENCES: RULES/REGULATIONS/ STANDARDS:

CARF: Section 3. Subsection J., Inpatient Treatment
Texas Mental Health Code, Texas Health & Safety Code Chapter 574

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	07/2023
Legal Review	Kendra Thomas: Counsel	07/2023
Departmental Review	Keena Pace: Exec	07/2023
Initial Assignment	Keena Pace: Exec	07/2023

EXHIBIT F-27

Status **Pending** PolicyStat ID **13958973**

Origination	06/2000	Owner	Rita Alford: Dir
Last Approved	N/A	Area	Information Management
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	10/2023		
Next Review	1 year after approval		

HIM.EHR.A.16Security of Patient/ Individual Identifying Information

1. PURPOSE:

All patient/individual identifying information, regardless of the medium or format, is considered confidential and shall be available only to authorized users.

2. POLICY:

It is the policy of The Harris Center to maintain the security of all patient/individual identifying information and safeguard this information against loss, destruction, tampering and unauthorized access and use.

3. APPLICABILITY/SCOPE:

This policy applies to all departments, divisions, facilities and/or programs within The Harris Center.

4. PROCEDURES:

~~Security of Patient/ Individual Identifying Information~~HIM.EHR.B.16 Security of Patient/ Individual Identifying Information

5. RELATED POLICIES/FORMS:

• Confidentiality and Disclosure of Patient/~~individual~~Individual Identifying Information	HIM6

• Retention of Patient/~~individual~~Individual Record	HIM14
• Patient/~~individual~~Individual Records Administration	HIM13
• Incident Reporting	EM4

6. REFERENCES: RULES/REGULATIONS/ STANDARDS:

- American Health Information Management Association - Practice Brief on Information Security
- Medicare Conditions of Participation for Hospitals
- Health Insurance Portability and Accountability Act

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	09/2023
Legal Review	Kendra Thomas: Counsel	09/2023
Department Review	Mustafa Cochinwala: Dir	08/2023
Initial Assignment	Rita Alford: Dir	08/2023

EXHIBIT F-28

Status **Pending** PolicyStat ID **13959025**

Origination	03/1995
Last Approved	N/A
Effective	Upon Approval
Last Revised	10/2023
Next Review	1 year after approval
Owner	Rita Alford: Dir
Area	Information Management
Document Type	Agency Policy

HIM.EHR.A.17 Standardized Patient Record Form

1. PURPOSE:

To ensure compliance with standards and Center Policies and Procedures and to avoid duplication of information.

2. POLICY:

It is the policy of The Harris Center that all patient/individual record forms shall be standardized throughout the Center to every extent possible. All patient/individual record forms must be approved by the Center's ~~Records~~EHR Request Committee. Only agency approved forms are to be used for documenting in a patient/individual's record.

3. APPLICABILITY/SCOPE:

This policy applies to all employees, contractors and interns of The Harris Center.

4. PROCEDURES:

~~HIM:017B S~~tandardized Patient Record Forms~~HIM.EHR.B.17 Standardized Patient Record Forms

5. RELATED POLICIES/FORMS (for reference only):

Content of Patient/individual Records Policy and Procedures - HIM: ~~006~~8
The Development and Maintenance of Center Policies and Procedures - ~~ADM~~LD:~~ 1~~18

Attachments

- Sample Instruction Sheet - #1
- Questions to Ask Before Creating a New Form - #2

6. REFERENCES: RULES/REGULATIONS/ STANDARDS:

Attachments

Instruction Template #1.doc

Questions to ask before Creating a New Form #2.doc

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	09/2023
Legal Review	Kendra Thomas: Counsel	09/2023
Department Review	Mustafa Cochinwala: Dir	08/2023
Initial Assignment	Rita Alford: Dir	08/2023

EXHIBIT F-29

Status **Pending** PolicyStat ID **14496187**

Origination	08/2019
Last Approved	N/A
Effective	Upon Approval
Last Revised	11/2022
Next Review	1 year after approval
Owner	Kendra Thomas: Counsel
Area	Leadership
Document Type	Agency Policy

LD.A.8 Subpoenas

1. PURPOSE:

To ensure all staff of The Harris Center for Mental Health and Intellectual and Developmental Disability (The Harris Center) properly respond and meet deadlines to comply with legal obligations with respect to subpoenas.

2. POLICY:

It is the policy of The Harris Center to comply and timely respond to subpoenas to avoid any delay in the legal proceedings while protecting the legal rights of The Harris Center, its staff and persons served.

The Harris Center's Legal Services Department/General Counsel Office is administratively responsible for all legal matters related to The Harris Center, including management of litigation. A person who is served with a subpoena related to behavioral healthcare services provided to persons served or any business conducted by The Harris Center must immediately notify the Legal Services Department. The subpoena and any accompanying documents shall be immediately forwarded to The Legal Services Department to review and ensure the subpoena is proper and meets legal requirements, to avoid delay and to protect the interests of The Harris Center, staff/volunteers/interns/contractors and persons served.

3. APPLICABILITY/SCOPE:

All Harris Center Staff, contractors, volunteers and interns.

4. PROCEDURES:

5. RELATED POLICIES/FORMS (for reference only):

N/A

6. REFERENCES: RULES/REGULATIONS/ STANDARDS:

- Subpoenas, TEX. R. av. P. 176
- Subpoena & Attachment, Tex. Code Crim. Proc. Ann. Art 24
- Subpoena, FED. R. CRIM. P. 17.
- Subpoena, FED. R. av. P. 45.
- Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. §§ 2.13; 2.61 — 2.67
- Health Insurance Portability and Accountability Act of 1996,45 C.F.R. §§ 160.314; 160.520; 164.512 CARF: Section 1. Subsection E.2., Legal Requirements

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	10/2023
Legal Review	Kendra Thomas: Counsel	10/2023
Initial Assignment	Kendra Thomas: Counsel	10/2023

EXHIBIT F-30

HR Update: Benefits Review

Presented by:

Joe Gorczyca, VP-HR
October 2023

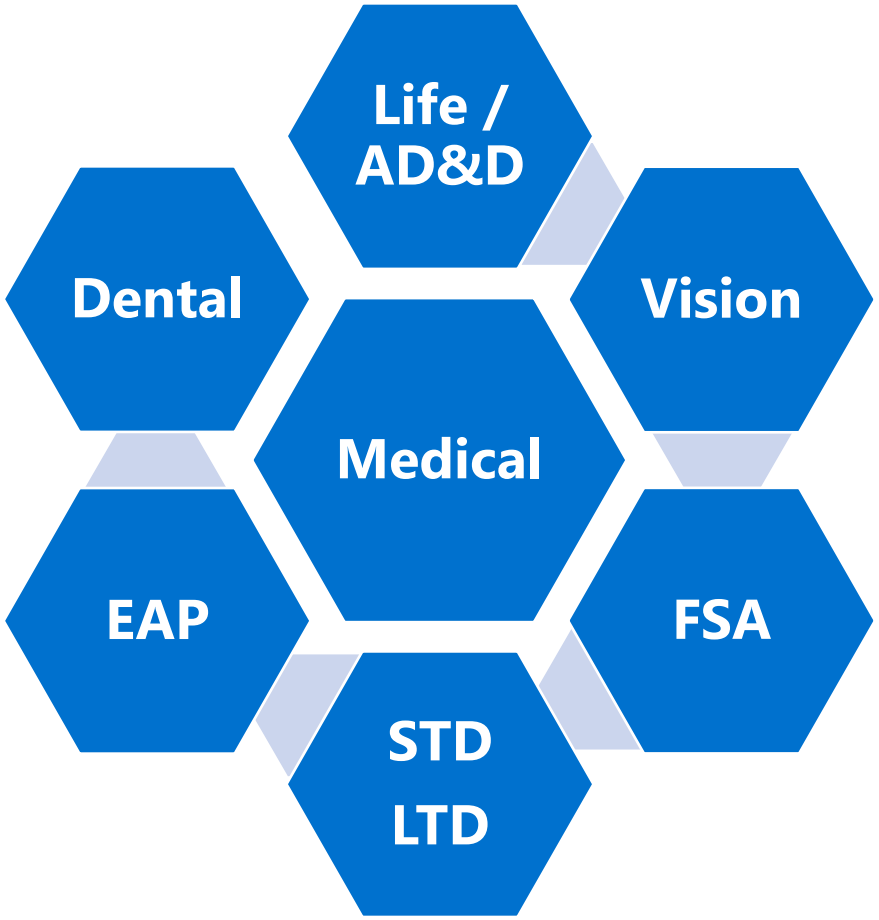
Total Rewards

Kip Baughman
Director, Total Rewards

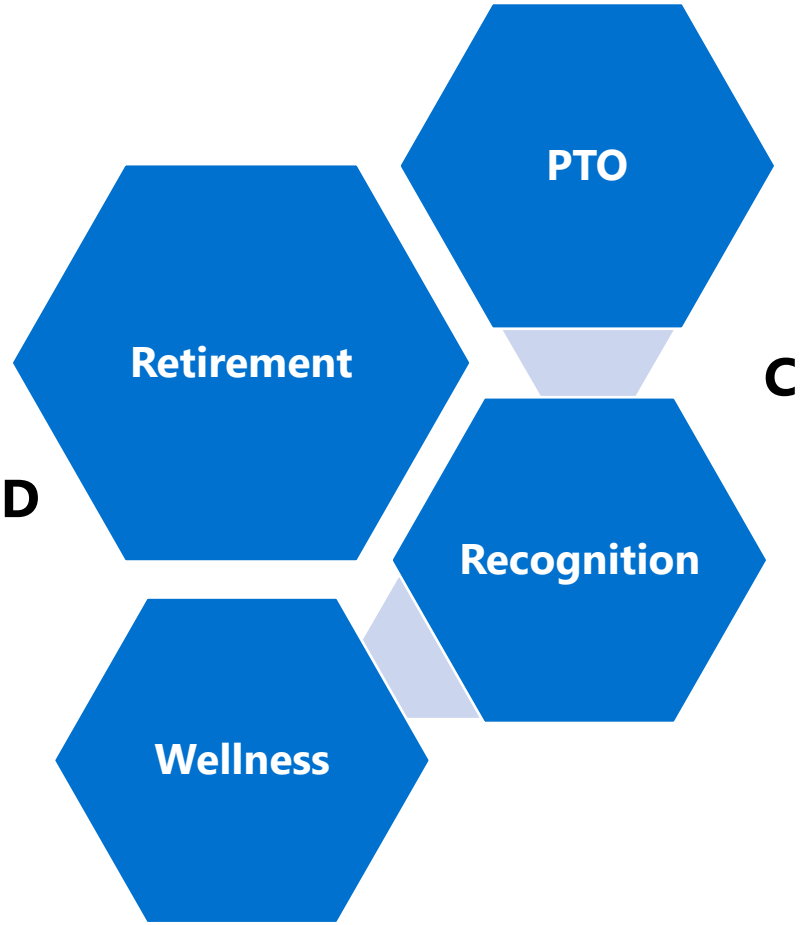
Sally Dwyer
Benefits Manager

Shannon Demny
Benefits Clerk Sr.

Total Rewards – Benefits Review



- Medical
- Dental
- Vision
- Life / AD&D
- STD / LTD
- EAP
- FSA



Custom per THC

- Retirement
- PTO
- Wellness
- Recognition

Overview of Plans

Medical

- Carrier: Blue Cross Blue Shield
- Agency Cost: 80%
- Employee Cost: 20%
- Market Comparison: At Market

- Features four (4) plans to provide for different needs of our diverse employees

1) Essentials HMO: 29% of enrollees

Category	In-Network Only
Annual Deductible (Ind / Family)	$0 / $0
Out of Pocket Maximum (Ind / Family)	$6,600 / $13,200

2) PPO with Deductible: 61% of enrollees

Category	In-Network	Out-of-Network
Annual Deductible (Individual / Family)	$1500 / $3000	$5000 / $10,000
Out of Pocket Maximum (Ind / Family)	$5000 / $10,000	$10,000 / $20,000

3) PPO without Deductible: 7% of enrollees

4) High Deductible Health Plan: 3% of enrollees

Medical: CY2024 Rates

Core Plan Review (FT, with HRA) - Cost Per Pay Period

Model= Blw50=Same;Abv50=Keep 50/50 $Split

		Salary Cutoff Point <$50,000							
		Below				Above			
Plan	Tier	% EEs	Curr EE $	New EE $	EE $ Chg	% EEs	Curr EE $	New EE $	EE $ Chg
Essentials	EE	10%	$ 30.56	**$ 31.66**	$ 1.10	10%	$ 32.40	**$ 42.40**	$ 10.00
	EE+C	2%	$ 79.41	**$ 82.09**	$ 2.68	4%	$ 84.22	**$ 94.26**	$ 10.04
	EE+S	0%	$ 210.51	**$ 215.88**	$ 5.37	1%	$ 210.51	**$ 220.50**	$ 9.99
	EE+F	0%	$ 278.93	**$ 286.63**	$ 7.70	2%	$ 278.93	**$ 288.91**	$ 9.98
PPO wDed	EE	16%	$ 52.58	**$ 54.02**	$ 1.44	25%	$ 59.44	**$ 69.44**	$ 10.00
	EE+C	4%	$ 113.89	**$ 117.55**	$ 3.66	9%	$ 124.47	**$ 134.47**	$ 10.00
	EE+S	1%	$ 278.70	**$ 286.14**	$ 7.44	2%	$ 285.56	**$ 295.54**	$ 9.98
	EE+F	0%	$ 369.28	**$ 379.72**	$ 10.44	4%	$ 376.13	**$ 386.12**	$ 9.99
PPO woDed	EE	1%	$ 160.57	**$ 164.92**	$ 4.35	3%	$ 167.95	**$ 177.93**	$ 9.98
	EE+C	0%	$ 250.47	**$ 257.11**	$ 6.64	1%	$ 257.86	**$ 267.88**	$ 10.02
	EE+S	0%	$ 428.15	**$ 439.77**	$ 11.62	1%	$ 438.17	**$ 450.21**	$ 12.04
	EE+F	0%	$ 567.30	**$ 581.71**	$ 14.41	1%	$ 577.32	**$ 592.15**	$ 14.83
HDHP	EE	0%	$ 53.63	**$ 55.21**	$ 1.58	0%	$ 53.63	**$ 63.65**	$ 10.02
	EE+C	0%	$ 177.57	**$ 182.50**	$ 4.93	0%	$ 177.57	**$ 187.59**	$ 10.02
	EE+S	0%	$ 273.19	**$ 280.40**	$ 7.21	0%	$ 273.19	**$ 283.21**	$ 10.02
	EE+F	0%	$ 361.96	**$ 371.66**	$ 9.70	0%	$ 361.96	**$ 372.00**	$ 10.04

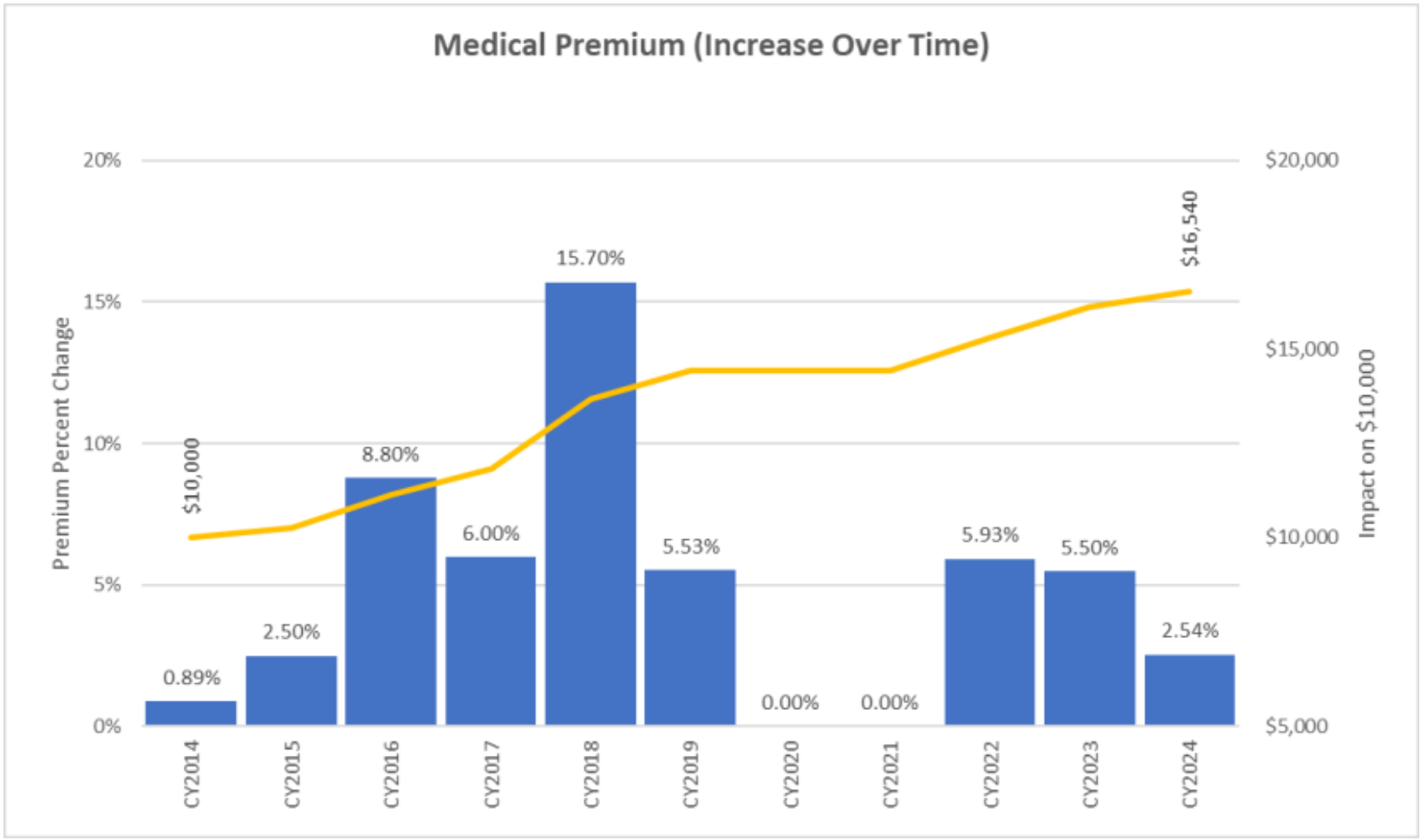
Above plans cover 97% of all medical enrollees

Above plans for EE and EE+C Tiers cover 85% of all medical enrollees

Lower premium increases for employees <$50K

Medical Premium Increases Over Time

Compound Annual Growth Rate = 4.7%



Premium Cost Comparison (same coverage)

2014: $10,000
2024: $16,540

Overview of Plans

Dental

- Carrier: Blue Cross Blue Shield
- Agency Cost: NA
- Employee Cost: 100%
- Market Comparison: At Market

Features

- Two (2) dental plans to provide for our employee needs
- Includes 'in-network' and 'out of network' options

Type of care	Industry Standard	THC DPPO	THC DPPO: Limited
Preventive Care	100%	100%	100%
Basic Procedures	80%	80%	50%
Major Procedures	50%	50%	30%
Calendar Year Max	$1000-$2000	$1250	$750

Refer to p. 21 in Benefits Booklet

Overview of Plans

Vision

- Carrier: Blue Cross Blue Shield
- Agency Cost: NA
- Employee Cost: 100%
- Market Comparison: At Market

Refer to p. 22 in Benefits Booklet

Features

- Two (2) Vision plans to provide for our employee needs
- Includes ‘in-network’ and ‘out-of-network’ options

Overview of Plans

Life / AD&D

- Carrier: UNUM
- Agency Cost: Core Life / Core AD&D: 100%
- Employee Cost: Supplemental Life / Additional AD&D: 100%
- Market Comparison: At Market

Refer to p. 23-26 of Benefits Booklet

Features

- Core Life Insurance: Two times (2x) annual salary to a maximum of $350K
  Supplemental Life Insurance: Employee ($500K); Spouse ($50K); Child ($10K)

- Core AD&D: Three times (3x) annual salary to a max of $350K
  Additional AD&D: Election coverage from $25K - $250K

Overview of Plans

Disability Plans

- Carrier: UNUM
- Agency Cost: Long-term disability: 100%
- Employee Cost: Short term disability: 100%
- Market Comparison: At Market

Features

Terms	Industry Standard Short-term	THC Short-term Disability	Industry Standard Long-term	THC Long-term Disability
Beginning date	7 – 30 days 14 days is average	8th day of an accident 15th day of illness	Qualified disabilities that extend >90 days	Qualified disabilities that extend >90 days
Coverage amount	40%-70% of basic earnings	60% of basic earnings	60% of basic earnings	60% of basic earnings
Duration	12 weeks – 24 weeks	12 weeks for accident 11 weeks for illness	Maximum up to SSNRA (66-67 yrs old)	Maximum up to SSNRA (66-67 yrs old)

Refer to p. 27-29 of Benefits Booklet

Special Care: Critical illness, Cancer coverage

- Carrier: Colonial / MetLife
- Agency Cost: NA
- Employee Cost: 100%
- Market Comparison: At Market

Special Care

Features

- Coverage available for spouse and eligible dependent children
- Benefits paid directly to employee
- Can continue coverage when you retire or change jobs
- May receive benefits regardless of any other insurance

Refer to p. 33 of Benefits Booklet

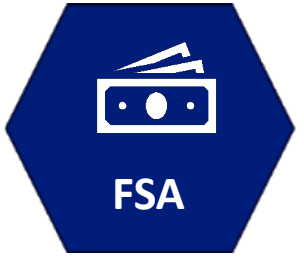
Employee Assistance Program (EAP)

- Carrier: Cigna
- Agency Cost: 100%
- Employee Cost: NA
- Market Comparison: At Market

Features

- Therapists, Psychologists, and Counselors are available for in-person appointments and 24-hour telephonic assistance
- Employees not required to be enrolled in THC Medical Plan to access EAP
- Services available to employees and family members
- Services cover (partial list):
  stress management, depression / anxiety, family planning, parenting, emotional issues, workplace issues, alcohol / drug issues, domestic violence

Flexible Spending Accounts (FSA)



- Carrier: WEX
- Agency Cost: NA
- Employee Cost: Per elected contribution
- Market Comparison: At Market

Features

- Health Care FSA: Maximum contribution of $2800 per plan year (pre-tax)
- Pays uncovered portions of medical, dental, and vision
- Dependent Care FSA: Maximum contribution of $5000 per plan year (pre-tax)
  Pays for daycare for eligible dependents (child, disabled spouse, elderly parent)

Refer to p. 31 of Benefits Booklet

Retirement: 401(a), 403(b), 457(b): 5-5-5 Plan

- Carrier: Lincoln Financial Group
- Agency Cost: 401(a): 100% Contribution / 100% Match
- Employee Cost: 403(b): 100% Deduction / 457(b): 100% Deduction
- Market Comparison: Above Market

Retirement: 401(a), 403(b), 457(b): 5-5-5 Plan

Features

- 401(a) - Employer Base Contribution: 1st 5%
  Employee does not have to participate in 403(b) to receive contribution
- 403(b) – Employee Elective Contribution: 2nd 5%
  This plan is like a 401(k) plan; employee contributes own money (pre-tax)
- 401(a) – Employer Matching Contribution: 3rd 5%
  If employee makes elective contributions under 403(b) plan, the Center will match savings, dollar for dollar, between 1% and 5% of eligible compensation
- 457(b) – Deferred Compensation Plan
  Allows employees to defer income taxation on retirement savings into future years
- High satisfaction level with service provided by Lincoln Financial Group (employee surveys)

401(a) Retirement Plan	403(b) Retirement Plan	401()a) Retirement Plan
Funded by the Center	Funded by Employee	Funded by the Center
Employer Based Contribution: 1st 5%	Elective Contribution: 2nd 5%	Employer Matching Contribution: 3rd 5%

PTO / Holidays

- Carrier: NA
- Agency Cost: 100%
- Employee Cost: NA
- Market Comparison: Above Market

Features

- PTO Accrual – based on years of service; to be used for vacation and sick time

Service Years	Industry Standard	THC Annual Accrual (Days)	THC Max Balance (Wks)
0 – 4	10 days PTO; 7-8 sick days	23 days / 4.6 weeks	12 weeks
5 – 9	15 days PTO; 7-8 sick days	28 days / 5.6 weeks	14 weeks
10 – 14	20 days PTO; 7-8 sick days	33 days / 6.6 weeks	16 weeks
15+	25 days PTO; 7-8 sick days	38 days / 7.6 weeks	18 weeks

PTO Sell: Up to 3 days (24 hours) per year Holidays: Eleven (11) per year + Anniversary holiday (after 5 years)

Wellness

- Carrier: BCBS
- Agency Cost: NA
- Employee Cost: NA
- Market Comparison: Above Market

Features

- Health Risk Assessments: Lower premium cost
- Opportunity to receive credits for Wellness initiatives that will enhance the health and well-being of our employees
- Examples of Wellness initiatives:
  - Biometric screenings - stroke or cardiovascular risk; carotid artery; home blood draw kit
  - Mobile Mammograms and Mobile Prostate exams

Employee Appreciation & Recognition

- Carrier: NA
- Agency Cost: 100%
- Employee Cost: NA
- Market Comparison: At Market

Features

- Annual event for celebrating milestone anniversaries
- Special recognition for: Nurse's Week, Doctor's Day, PA Day, Social Worker's Month, Counseling Awareness Month, Administrative Professionals Day, Mental Health Month
- Send out Birthday cards to employees (home)
- 'Snappy' Awards for special accomplishments
- Holiday events: Pictures with Santa; Presents / visits to client cottages
- Provide cookies to employees on 'Employee Appreciation Day'

Thank You!

EXHIBIT F-31

Transforming Lives

The HARRIS CENTER for Mental Health and IDD

Strategic Plan

FY2022 – FY2024

Presented By: Wayne Young, MBA, LPC, FACHE

Chief Executive Officer

Summary: Domains and Goals

Domain	Goal	FY2022	FY2023	FY2024
1 Quality	1.1 Develop and implement 3 clinical care pathways (1 per year) and measure their adherence	Yr 1: 30%	Yr 2: 50%	Yr 3: 70%
	1.2 Minutes in seclusion	61.73	61.11	60.49
	1.3 Increase percentage of security officers and medical staff trained in zero suicide	25%	50%	75%
	1.4 Increase 7-day face-to-face follow-up rates for HCPC and SMHF discharges	75%	77%	79%
	1.5 Decrease 30-day readmission rates to HCPC/SMHFs	10.25%	9.75%	9.25%
	1.6 Number of individuals with a history of mental illness housed	(10%) 306	(20%) 334	(30%) 361
	1.7 Develop and Implement Robust Quality Improvement Infrastructure Consistent with Industry Standards	Implement		
2 People	2.1 Increase percentage of employee participating in Harris Center sponsored professional development education 20% annually	20%	40%	60%
	2.2 Decrease the "days open" for vacant positions from FY2021 baseline	56	50	45
	2.3 Achieve progressively improving overall employee engagement scores compared to industry	50th %	60th %	70th %
	2.4 Increase overall patient satisfaction	89%	90%	91%
	2.5 Board approved Capital Facilities Plan complete each year	Y/N	Y/N	Y/N
3 Integration	3.1 Increase the number of patients receiving Primary Care at The Harris Center	1,100	1,200	1,300
	3.2 Reduce the cost of care as measured by the OPTUM project	10%	12%	15%
	3.3 Average monthly 3rd party prescriptions filled	2,300	2,415	2,536
4 Access	4.1 Add 10 access points across the agency targeting underserved communities (specifically including IDD site expansions)	6 (1 IDD)	8 (2 IDD)	10 (2 IDD)
	4.2 Add service strategies that either extend clinic hours and availability or enhance service array offered to persons served	6	8	10
	4.3 Develop 5 additional programs to enhance ability to deliver substance use treatment	3	4	5
5 Community	5.1 Increase total number served from top 20 focus zip codes 2.5% per year	3,865	3,962	4,061
	5.2 Increase participation in educating community and natural supports regarding MH/IDD issues and where to find support	1,200	1,500	1,875
6 Innovation	6.1 Enroll persons served in MyChart	10%	20%	30%
	6.2 Implement a telehealth hub	Implementation	1,000	5,000
	6.3 Build a Harris Center application	Implementation	1,000	5,000
	6.4 Increase the number of MCOT Rapid Response calls from HPD 911/CCD that did not require law enforcement assistance on scene requested by the MCOT Rapid Response Team	50%	60%	75%

Progress Dashboard

✔ Achieved On Track Haven't Given Up 🔴 Won't Achieve

Domain	Goal	FY2022	FY2023
1 Quality	1.1 Develop and implement 3 clinical care pathways (1 per year) and measure their adherence	🔴	✔
	1.2 Minutes in seclusion	✔	✔
	1.3 Increase percentage of security officers and medical staff trained in zero suicide	✔	🔴
	1.4 Increase 7-day face-to-face follow-up rates for HCPC and SMHF discharges	🔴	🔴
	1.5 Decrease 30-day readmission rates to HCPC/SMHFs	✔	✔
	1.6 Number of individuals with a history of mental illness housed	✔	✔
	1.7 Develop and Implement Robust Quality Improvement Infrastructure Consistent with Industry Standards	✔	✔
2 People	2.1 Increase percentage of employee participating in Harris Center sponsored professional development education 20% annually	✔	✔
	2.2 Decrease the "days open" for vacant positions from FY2021 baseline	🔴	🔴
	2.3 Achieve progressively improving overall employee engagement scores compared to industry	✔	✔
	2.4 Increase overall patient satisfaction	✔	✔
	2.5 Board approved Capital Facilities Plan complete each year	🔴	✔
3 Integration	3.1 Increase the number of patients receiving Primary Care at The Harris Center	✔	✔
	3.2 Reduce the cost of care as measured by the OPTUM project	✔	✔
	3.3 Average monthly 3rd party prescriptions filled	🔴	🔴
4 Access	4.1 Add 10 access points across the agency targeting underserved communities (specifically including IDD site expansions)	✔	✔
	4.2 Add service strategies that either extend clinic hours and availability or enhance service array offered to persons served	✔	✔
	4.3 Develop 5 additional programs to enhance ability to deliver substance use treatment	✔	✔
5 Community	5.1 Increase total number served from top 20 focus zip codes 2.5% per year	✔	✔
	5.2 Increase participation in educating community and natural supports regarding MH/IDD issues and where to find support	✔	✔
6 Innovation	6.1 Enroll persons served in MyChart	✔	✔
	6.2 Implement a telehealth hub	✔	🔴
	6.3 Build a Harris Center application	🔴	✔
	6.4 Increase the number of MCOT Rapid Response calls from HPD 911/CCD that did not require law enforcement assistance on scene requested by the MCOT Rapid Response Team	✔	✔

Quality:
Clinical Care Pathways

Domain: Quality	2022	2023	2024
✔ Goal 1.1: Develop and implement 3 Clinical Care Pathways (1 per year) and measure their adherence	Yr 1: 30%	Yr 2: 50%	Yr 3: 70%

- Enhanced training: suicide screening, assessment, and care management (AIM Model)
- Create suicide BPA in Epic build including suicide toolkit
- Monitor results of use risk and protective factors in clinical note when PHQ-9 is 15 or above,
  positive Columbia or positive suicidal ideation in mental status note
- Monitor results of the use of safety plan related to moderate risk category level
- Monitor results and give feedback back to clinical staff on completion of BPA

Status: Achieved the Goal of 50% for Year 2.

- Suicide care pathway implemented
  - Complete Suicide care pathway for new intakes in MH CLINIC and actively measuring initial metrics
  - Over 400 cilnical team members now trained in risk assessment
  - Current adherence since launch:
    - New Intake Screening AMH/CAS (December 2022-Present): 89.63%
    - Same Day Assessment AMH/CAS (March 2023-Present): 78.43%
    - Same day safety planning AMH/CAS (March 2023-Present): 41.42%
    - Total Average Adherence: 69.8% to all metrics
  - Existing client pathway in progress for implementation

- Opioid use disorder detox pathway implemented
  - Continued Epic optimizations for tracking
  - New best practices implemented
  - Current Adherence:
    - Overdose Safety Plan at Discharge: 64.48%
    - Completed Motivational Interviewing (BNI): 66.11%
    - Retention Into Program Post Medical Clearance Send Out: 37.50%
    - Detox Program Successful Completion: 48.95%
    - Narcan distribution (new metric): 59.33%
    - Total Average Adherence: 55.3%

Next Steps
- Creation of 3rd pathway in progress
- Finalize existing client suicide care pathway
- Add Risk Assessment Training to all new applicable clinician orientations
- Refine SUD reporting and data availability
- Continuous PDSA cycles

Quality:
Minutes in Seclusion | Zero Suicide Training

Domain: Quality	2022	2023	2024
✔ Goal 1.2: Minutes in seclusion	61.73	61.11	60.49
• Seclusion minutes - establish target average for next three fiscal years • Evaluate reduction in the number of seclusions and impacts to other emergency intervention measures • Educational trainings and update for physician, nursing, psych tech, and admin staff on de-escalation techniques • Incorporate trauma informed care strategies to reduce seclusion minutes	**Status: Achieved the goal of less than 61.11 minutes in seclusion at 48.97 minutes.** **Next Steps** • Continue monitoring data and address outlier events when indicated • Continue real time education and reviewing cameras after any seclusion or restraint. • Ensuring direct care staff are trained in NPC Handle With Care III		
🔴 Goal 1.3: Increase percentage of security officers and medical staff trained in zero suicide	25%	50%	75%
Train all new incoming officers at the mid-point of their new employee training cycle on the principles of zero suicide • Collaborate with HCSO Training Department regarding the appropriate place to roll out the Zero Suicide training to current staff • Train HCSO Medical Providers on the principles of zero suicide and roll the training out via key medical leadership • Train HCSO Mental Health Deputies • Train HCSO Deputies at sensitive/clinical units (Admin Separation, Mental Health Infirmary, Medical Infirmary, Mental Health Step down units) • Train regular deputies in housing units • Train deputies assigned to courts	**Status: Did not achieve the goal of 50% trained.** • 23 trainings completed since 4/13/2023 • Currently 26.4% detention division trained (619/2345 employees) • Currently 49% Harris Center jail-based staff trained (68/139.5 employees) • Training embedded into new hire detention orientation as of 9/6/2023 (which should capture 100% of new detention staff) • Harris Health System is going live with training by Oct 1, 2023 **Next Steps** • Training for HCSO detention staff is ongoing with trainings scheduled through the summer • Zero Suicide table events upcoming for prevention month • Collaborating for officer wellness in Zero Suicide • Subgroups forming to work on goals: incarcerated resident training, documentation, communication		

Quality:
Follow-up Rates for HCPC & SMHF Discharges

Domain: Quality	2022	2023	2024
Goal 1.4: Increase 7-day face-to-face follow-up rates for HCPC and SMHF discharges	75%	77%	79%

- Develop a plan to ensure all patients at Harris County Psychiatric Center are seen by The Harris Center at admission
- Develop a flow in coordination with Harris County Psychiatric Center to have patients seen at discharge
- Develop protocols to do outreach for patients to assist them in connecting with outpatient providers
- Develop the coordination to do referrals via warm handoffs between all providers
- Continue to increase collaboration between MH and IDD for youth services

Status: Did not achieve the goal of increasing the face to face follow up rates to 77%.

Currently 74.3%*

Next Steps

- HCPC LPHAs using tele for after discharge outreach to assist in connecting to outpatient providers.
- Enhance warm handoffs between CPEP and Behavioral outpatient providers. CRU pilot program has been fully implemented.
- Utilize clinic SAIs to connect with established patients via notification of discharge by COC.

*Reported in MBOW did not capture data accurately for FY23. Percentage is based on hand count at HCPC.

Quality:
Readmission Rates | Housing

Domain: Quality	2022	2023	2024
✔ Goal 1.5: Decrease 30-day readmission rates to HCPC/SMHFs	10.25%	9.75%	9.25%
Develop a plan to ensure all patients at Harris County Psychiatric Center are seen by Harris Center at admission • Develop a flow in coordination with Harris County Psychiatric Center to have patients seen at discharge • Develop protocols to do outreach for patients to assist them in connecting with outpatient providers • Develop the coordination to do referrals via warm handoffs between all providers • Start up an Assertive Community Treatment (ACT) program at a third Clinic (Southeast and Northwest Clinics have established programs) • Continue to increase collaboration between MH and IDD for youth services • Expand the HCPC high utilizer program to identify additional active patients who are readmitting	**Status: Achieved the goal of decreasing admission rates to under 9.75%.** Currently: 5.44% average for FY23 **Next Steps** • Increase Continuity of Care face to face contact at HCPC prior to discharge. • Clinics being notified by COC of discharges to make contact with patients within 30 days. • Enhance warm handoffs between CPEP and Behavioral outpatient providers.		
✔ Goal 1.6: Number of individuals with a history of mental illness housed	306 (10%)	334 (20%)	361 (30%)
• Partner with the Coalition for the Homeless to house homeless individuals with mental illness • Continue to develop housing options for homeless individuals with mental illness • Partner with City and County Housing Authorities to obtain vouchers for housing *the reported rates may vary as we continue to refine the reporting logic and master EPIC data flows **HCHA Housing Vouchers have been on a freeze since FY21	**Status: Achieved the goal of increasing the number of housed with mental health history to greater than 334 (20%)** • CPEP – 919; Represents all clients housed within CPEP programs. • MOU with the Coalition for the Homeless; have program staff trained on how to complete housing assessments for Coordinated Access housing program – complete • BH- housing assistance to 138 clients **Next Steps** • Continue to seek housing for homeless individuals		

Dennis Residential Housing

50% of Dennis residents obtained employment while in programs.

Quality:
Quality Improvement Infrastructure

Domain: Quality	2022	2023	2024
✔ Goal 1.7: Develop and Implement Robust Quality Improvement Infrastructure Consistent with Industry Standards	Implementation		

Redesign performance improvement (PI) team to be resourced consistent with behavioral health industry benchmarks to proactively address organizational performance improvement needs

- Review all current quality metric reporting and evaluate as related to compliance function (state regulatory requirements, contractual obligations) vs. internal operations and meaningful quality measurement
- Update Divisional and Board-reported quality metrics to be clinically relevant, customer service focused toward improving outcomes and patient experience
- Update center-wide Performance Improvement Plan to highlight specific areas for improvement with specific aims and metric targets (access to care, clinical outcomes, and seclusion/restraint measures)
- Review committee structures and enhance incident reporting toward facilitating communication, driving performance improvement, and upholding organizational quality standards
- Update policies and procedure documents that define organizational quality standards
- Incorporate industry standard peer review practices into clinical incident review
- Obtain CARF re-certification and maintain CCBHC standards

Status: No goal for FY 23 year.

Next Steps

- Continue building internal and external visibility to quality and develop learning collaboratives to transform care
- Continue work on quality improvement projects to drive meaningful improvement in access and safety
- Developed patient satisfaction steering team and now focused review of satisfaction outcomes
- Strengthening accreditation and certification preparedness through yearly preparations and needs assessment

People:
Professional Development Education | Days Open for Vacant Positions

Domain: People	2022	2023	2024
✔ Goal 2.1: Increase percentage of employees participating in Harris Center sponsored professional development education 20% annually	20%	40%	60%
• Identify continuing education hour requirements by function/license • Identify approved and accredited continuing education content – professional development and required CE • Communicate education opportunities • Track participation by Function/License, and survey participants for satisfaction • Host professional development and/or CE events	**Status: Achieved the goal of increasing the percent of employees participating in sponsored development to 40%.** • Currently at 45.41%; Total 722 CEU Hours Awarded **Next Steps** • Continue to offer monthly Harris Center sponsored events; increase advertisement of added Professional Development e-learning opportunities in our Learning Management System (The D.E.S.K.) • Leadership development track has been developed and will increase opportunities for new and existing leaders		
🔴 Goal 2.2: Decrease the "days open" for vacant positions from FY2021 baseline	56	50	45
• Build a talent pipeline through proactive sourcing of candidates • Automate the hiring process utilizing technology to increase communication with applicants and leaders, transparency with operational leaders, and efficiency over life cycle of applicants • Develop structured interview process to obtain consistent and reliable outcomes	**Status: Did not achieve the goal of reducing "days open" to under 50 days.** • Currently: Average of 63.76 days to fill positions, down from 73.5. **Next Steps** • Validate if positions opened greater than 90 days are still necessary • Continue to execute against recruiting strategic plan		

Organizational Development

Continuing Education Opportunities

Monthly CEU Opportunities

Harrisphere dedicated page to highlight mostly free virtual CEU opportunities

On Demand CEU Opportunities

We highlight various opportunities from Optum that are available at any time!

CME Clinical Transformational

Twice a month, Dr. Li and her team work to put on a continuing education event! See Harrisphere for future topics!

Harris Center Sponsored Events

We work collaboratively with various entities at the Harris Center to offer free and exciting CEU opportunities!

Texas Council Risk Management Fund

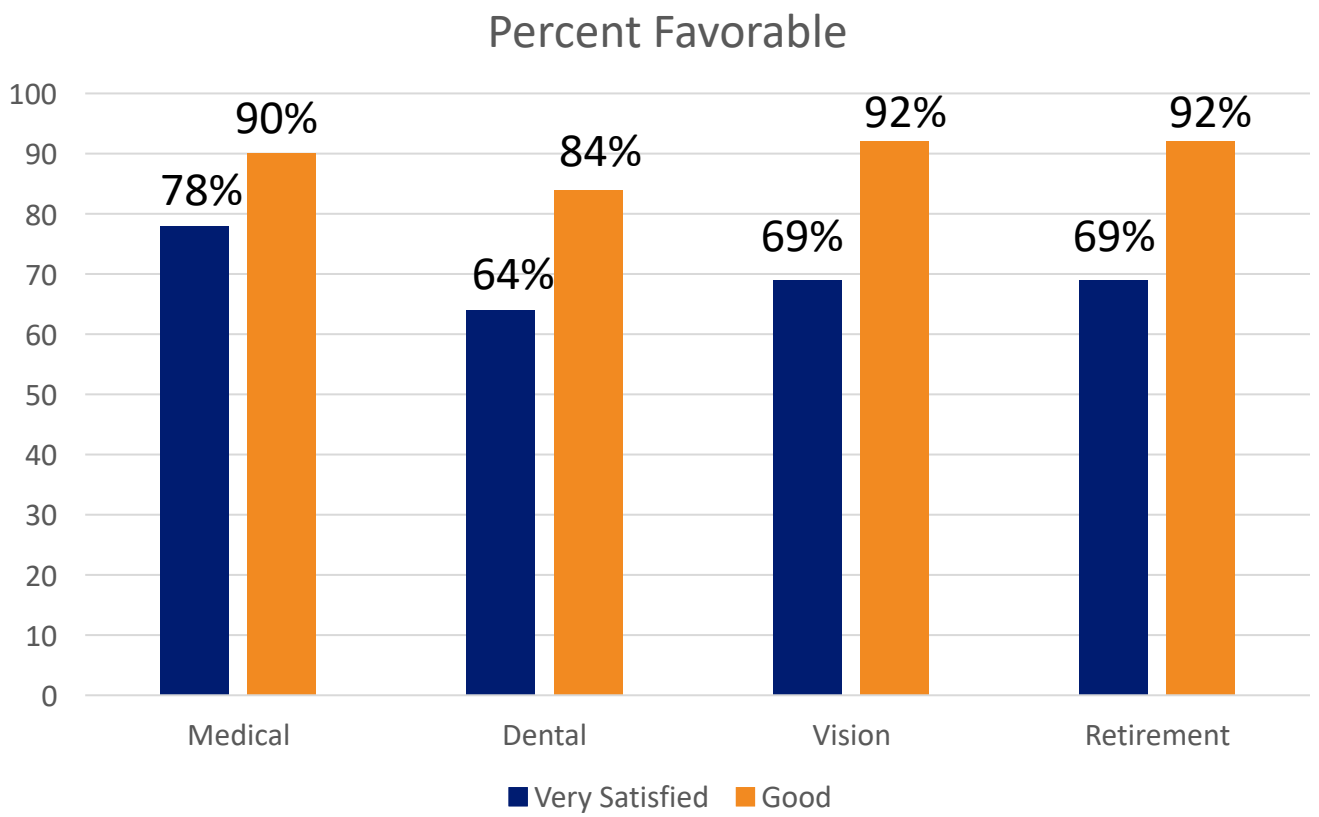
Providing various leadership courses that also provide CEU's; they will provide in person training in the spring, and host virtual events every month

High Priority: in response to employee survey feedback

People:
Employee Engagement | Patient Satisfaction

Domain: People	2022	2023	2024
✔ Goal 2.3: Achieve progressively improving overall employee engagement scores compared to industry	50th %	60th %	70th %
• Develop and implement career ladders for at-risk jobs • Increase learning and development opportunities • Implement leadership competencies for each career level • Continue to constructively improve working conditions (Cut-The-Tape)	**Status: Achieved goal of improving overall employee engagement scores to 60%.** • For FY2023, employee engagement score was 76th %. Goal of 60th % was Achieved. • HR Business Partners will provide division specific data to Sr. Leadership for action planning with each Operational Leader **Next Steps** • Upon approval of action plan recommendations, leaders will initiate action plans within their respective business units in an effort to improve scores YoY.		
✔ Goal 2.4: Increase overall patient satisfaction	89%	90%	91%
• Revamp training methods to incorporate Trauma Informed Care elements • Develop broader training for staff on patient partnerships and engagement techniques with patients • Create an agency-wide customer service protocol, trainings, and refresher trainings • Monitor program-specific results and develop action plans as needed	**Status: Achieved improving patient satisfaction to 90%.** Currently at 92.21% **Next Steps** • Aggregate satisfaction narrative from individual served for areas of improvement • Collaborate with division and site leaders to address areas identified for improvement from individuals served feedback • Set site specific patient satisfaction goals for improvement that align with strategic goals • Develop new survey process for improved response rate • Continue to review, revised training for staff on trauma informed care and engagement		

Employee Benefits: Survey Results 2023



Employee Satisfaction Scores

Medical Benefits
Excellent

Vision Benefits
Very Good

Retirement Benefits
Very Good

Dental Benefits
Good

COMMUNITY RECOGNITION / AWARDS

HBJ Diversity in Business Award Honoree

Award Honoree for Community Leader of the Year

CENIKOR

Award Honoree for Exceptional Support and Service

FIRST 3 YEARS

Award Honoree: Wayne Young

People:
Board Approved Capital Facilities Plan

Domain: People	2022	2023	2024
✔ Goal 2.5: Board approved capital facilities plan complete each year	No	Y/N	Y/N
• Develop overall completion plan with operational leaders • Coordinate and communicate completion plan with procurement and contracts • Report progress or issues to operational leaders and Board on a consistent basis	**Status: Achieved goal of 100% completion of Board approved Capital Facilities Plan.** **FY23** **Status** • Non-multi-year: 10 of 10 Complete • Multi-year Projects 5 of 8 Complete **Next Steps** • On-going		

9 Capital Multiyear/Multi-phased Projects: 10 of 19 phases completed.

- NPC Renovation Project
- NE & Coffee House Design Projects
- 6168 Apartments CSP
- 5959 Long DR Building Demo
- Loading Dock & Garage Assessments Projects
- Dennis Elevator Modernization Project

10 FY23 Capital Projects

- Completing 10 of 10 projects
- Whole home generators, IDD home windows, 6160 perimeter fence, NW restroom renovation, and several smaller projects

24 FY23 Non-Capital Projects

- Necessary for operations and comfort of staff and consumers.
- Approximately $290K in costs.

Integration:
Primary Care Services | Cost of Care (Optum)

Domain: Integration	2022	2023	2024
✔Goal 3.1: Increase the number of patients receiving Primary Care at The Harris Center	1,100	1,200	1,300
• Fully implement the Certified Community Behavioral Health Center grant, hiring the additional primary care providers • Develop and implement billing for services to increase funds available for growth • Continue developing The Harris Center's relationship with the University of Houston • Improve on referral and staffing protocols to encourage full integration of services • Develop strategies for training staff to deliver weight management guidance to patients • Hire a full-time dietician to develop classes and training materials for staff to use with patients • Continue to expand number of medical providers at each of the four main outpatient clinics • Develop the ability to deliver integrated services remotely and target underserved areas	**Status: Achieved goal of increasing the number of patients receiving primary care past 1200.** Currently at 1,865 open clients in 8/2023 in primary care clinics. **•Next Steps** Pursue FQHC Look Alike Status •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 mental health screenings & engagements , emotional & wellness education to underserved areas & existing clients with poor access to our clinics (Mobile Wellness Vehicle). •Build community partnerships-wellness activities (Mobile Wellness Vehicle). •Create Events Calendar & Engagements/tracking existing clients for the Mobile Wellness Clinic Services. •Hire full-time NP.		
✔Goal 3.2: Reduce the cost of care as measured by the Optum project	10%	12%	15%

• Increase patient adherence to medications
• Decrease patient all cause readmissions
• Increase follow up to patients post discharge
 	
• Proposed Update:
  • Decrease Ambulatory Care – Emergency Department Visits
  • Build community relations with outpatient behavioral facilities to improve the 7-Day Follow-up
  • Deliver Monthly lunch and learns to introduce Optum Project to hospital discharge planners
  • Implement dashboard and tracking tool to improve the delivery of care coordination services
  • Remove - Improve percentage of patients receiving diabetes screening based on new contract
	Status: Achieved goal of reducing the cost of care as measured by Optum by 12%.
	
	Currently 13.67% reduction for cost of care.
	
	Next Steps
	Launch NCQA Goals/Patient Outcomes Measures to track patient-centered outcomes.
	Continue working to connect with FQHCs and ERs to help coordinate patient care		

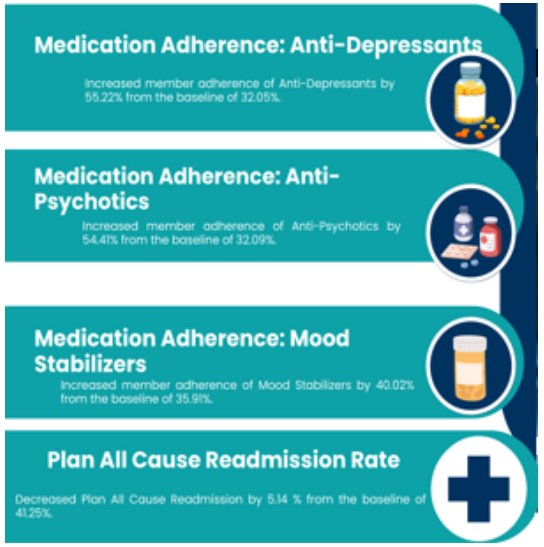
Optum Performance Measures Report 2023 Q2

Medication Adherence: Anti-Depressants	353	690	32.96%	51.16%	55.22%	2.0
Medication Adherence: Anti-Psychotics	338	683	32.05%	49.49%	54.41%	2.0
Medication Adherence: Mood Stabilizers	365	726	35.91%	50.28%	40.02%	2.0
Plan All-Cause Readmission Rate	558	1,426	41.25%	39.13%	-5.14%	1.0
Utilization Measures						
Measure	**Numerator**	**Denominator**	**Baseline**	**Your Performance**	**Percentage Change from Baseline**	**Points Earned**
Ambulatory Care – Emergency Department Visits	3,406	11,214	613.46	303.73	-50.49%	2.0
Inpatient Utilization - General Hospital/Acute Care	877	11,214	174.79	78.21	-55.25%	2.0
Rate of Inpatient Behavioral Health Admissions	1,023	11,214	179.13	91.23	-49.07%	2.0
					Total Quality/Utilization Points Earned:	**13.0**
					Percentage of Quality/Utilization Points Earned:	**59.09%**

United Behavioral Health and United Behavioral Health of New York, I.P.A., Inc. operating under the brand Optum U.S. Behavioral Health Plan, California doing business as OptumHealth Behavioral Solutions of California

Utilization

Quality



Integration:
3rd Party Prescriptions Filled

Domain: Integration	2022	2023	2024
🔴Goal 3.3: Average monthly 3rd party prescriptions filled	2,300	2,415	2,536

- Monitor Patient Satisfaction Survey suggestions and continuously improve our services to maintain quality
- Implement delivery service to provide convenience to the patients, especially those with transportation issues
- Educate all Harris Center Staff and prescribers on the value of getting patient RX's filled at The Harris Center Pharmacies, encourage "one-stop shopping"
- Implement Prescriber and Nursing Pharmacy Satisfaction Surveys to validate and continuously improve our clinic pharmacies
- Implement IVR (interactive voice response) system to notify patients (text/email) of refills and allow for auto refill for approved medications

*Medicaid and contractual challenges held up implementation and continue to bottleneck the process

Status: Did not achieve average monthly 3rd party prescriptions filled to 2415.

Currently FY 23 monthly average 1823

- Total RX's since inception 23,461 – went live 1/31/2022*
- Total RX's FY23 – 21,881
- FY23 monthly average RX's – 1,823
- Aug 2023 monthly billing Total RX's – 3,969
- Q4 FY23 monthly average RX's – 3,151

Next Steps

- Continue physician, nursing, treatment team and patient education initiatives
- Maintain physician, nursing and patient satisfaction scores and create Prescription Cost Saving Portal assisting under-insured to drive patient choice

Access:
Access Points to Underserved | Service Strategies

Domain: Access	2022	2023	2024
✔Goal 4.1: Add 10 access points across the agency targeting underserved communities (include IDD)	6 (incl 1 IDD)	8 (incl 2 IDD)	10 (incl 2 IDD)

- Collaborate with MH Division and open satellite service sites for IDD staff at MH locations
- One additional IDD coffeehouse or day habilitation program in the northeast area
- Detox
- State hospital step down
- Additional H2H beds
- The Villas at Eastwood (co-locate with HCHA)
- City Navigation Center
- Precinct 2 hubs
- 2 children's co-locations
- Telehealth intake hub

Status: Achieved goal of adding 8 access points targeted at underserved communities.

Currently at 20 (incl 2 IDD)

- Jail Reentry Program
- State Hospital Step Down Program
- Detox Program
- Enrichment Center at the Villas at Eastwood
- Navigation Center
- Coffee House @ NW **(IDD)**
- THC Independent Living
- Ibn Sina access community co-location
- 3 – Memorial Hermann access community co-locations
- NE Smart Pod Precinct 2
- 4 – Precinct 1 Community Groups
- 2- HMHC Covid grief groups
- HHH enhanced collaboration
- The Center employment expansion and vocational apprenticeship program **(IDD)**

✔Goal 4.2: Add service strategies that either extend clinic hours and availability or enhance service array	6	8	10

- Re-establish weekend hours at outpatient clinic sites
- Add evening and extended hours of service at outpatient clinics
- Add "Clubhouse" type operations in the outpatient clinics
- Review adding/expanding evidence-based practices
- Expanded offerings of Mental Health First Aid
- Increase the number of peers who are certified

Status: Achieved goal of adding 8 service strategies to either extend hours or enhance service array.

Currently at 11

- CIRT (6 new teams)
- Additional MST Team
- Nutrition and Wellness Groups
- Dietician services to ECI
- Expanded SW PCP Clinic to 5 days
- SE PCP Clinic to 5 days a week.
- Behavioral Health Response Team (BHRT)
- New Start at NE Clinic
- NE Youth and Wellness services started
- Weekend resident therapy groups at SW Clinic
- Food Bank partnership for main clinics

Next Steps

- Access hub
- Add additional clubhouse type operations
- Increase # of peers certified, multiple peers hired
- Continue to expand MH First Aid
- Expanding in-person customer service training

*At 6160 South Loop East

Youth Diversion Center

Access:
Substance Use Treatment

Domain: Access	2022	2023	2024
✔ Goal 4.3: Develop 5 additional programs to enhance ability to deliver substance use treatment	3	4	5

• Enhance training to our employees regarding substance use treatments
• Establish Medication Assisted Treatment process and protocols for outpatient
• Create a detox program
• Provide Suboxone training to increase number of providers who can administer buprenorphine for the treatment of opioid use disorders
• Develop and implement a full smoking cessation program
	Status: Achieved the goal of developing 4 additional programs to enhance substance abuse treatment.
	• 5
	  • Substance Use Disorder Outreach Program (SUDOP)
	  • Detox Program
	  • Outpatient Substance Abuse Treatment Program
	  • UT Health MAT (medication assisted treatment) Program – 2022
	  • New Be Well Texas at UT Health San Antonio Grant funding to contract for opiate abuse treatment for Harris Center clients
	
	Next Steps
	• Begin offering Substance Use trainings programs through Council on Recovery
	• Implement SIM recommendations		

Community:
Focus Zip Codes | Educating Community & Natural Supports

Domain: Community	2022	2023	2024
✔ Goal 5.1: Increase total number served from top 20 focus zip codes 2.5% per year	3,865	3,962	4,061
• Identify opportunities to co-locate or expand physical footprint • Identify opportunities for education, training, and awareness with community • Leverage Harris Center community outreach and support infrastructure to improve awareness and relationships with natural supports • Develop and implement targeted communications plan	**Status: Achieved the goal of increasing the total number served from the top 20 focus zip codes above 3962.** Currently at 10,660 **Next Steps** • 4+ community outreach meetings (Pediatric groups and healthcare centers) to increase ECI referrals • MOU signed with Origins Learning Community (ECI)		
✔ Goal 5.2: Increase participation in educating community and natural supports (including faith-based and service entities) regarding MH/IDD issues and where to find support (MH First Aid)	1,200	1,500	1,875
• IDD will add additional trainings in the community • Training groups with NAMI • Implement Survivors of Suicide Loss Support Groups • Increase Mental Health First Aid and other community outreach trainings	**Status: Achieved the goal of increasing participation in educating the community by 1500 individuals.** Currently at 3,396 **Next Steps** • Continue community engagement activities		

Innovation:
MyChart | Telehealth Hub

Domain: Innovation	2022	2023	2024
✔ Goal 6.1: Enroll persons served in MyChart	10%	20%	30%
• Educate users on the benefits and features • Staff will encourage and assist with MyChart setup • Targeted marketing and education campaign on MyChart • Host educational sessions on MyChart	**Status: Achieved the goal of enrolling 20% of individuals in MyChart.** Currently at 21% (12,975 of 60,407) **Next Steps** • Continue to work with clinical and Administrative leadership to promote enrollment		
🔴 Goal 6.2: Implement a telehealth hub	Implementation	1,000	5,000
• Initial structure of the hub design and approval by management team • Video platform selection • Build telehealth module in Epic • Onboard clinicians and physicians to support the hub • Digital marketing of the hub • Improve ability to schedule an appointment • Provide functionality for same-day appointments • Provide ability for cross-coverage at all locations • Partner with community agencies for physician coverage needs	**Status: Did not achieve the goal of providing 1000 visits through the telehealth hub.** Currently 415 visits completed **Next Steps** • Expand pilot to add all other providers • Roll-out On-Demand service • Agencywide roll-out		

Innovation:
Harris Center App | MCOT Rapid Response

Domain: Innovation	2022	2023	2024
✔ Goal 6.3: Build a Harris Center application	Implementation	1,000	5,000
• Select a new platform for the new Harris Center external website (Content Management System) • Build a new Harris Center website • Develop new content with communications and division leaders • Design initial interface and features for the mobile app/site and approval from management team • Develop mobile app/site • Digital marketing of the Harris Center app	**Status: Achieved the goal of having more than 1,000 users download The Harris Center app.** Currently at 1037 external downloads **Next Steps** • Ongoing enhancements • Marketing plan for Website & Mobile App		
✔ Goal 6.4: The number of MCOT Rapid Response calls from HPD 911/CCD that did not require law enforcement assistance on scene requested by the MCOT Rapid Response Team	50%	60%	75%
• Increase appropriate MCOT Rapid response referrals • Partner with law enforcement to provide extensive training to clinicians and law enforcement • Advocate for the expansion of dispatch call codes eligible for CCD	**Status: Achieved the goal of increasing the percentage of MCOT Rapid Response calls not requiring law enforcement to 60%.** Currently at 80% (3317 out of 4126) **Next Steps** • Continue to work to resolve calls for service without law enforcement involvement. • Continue to collaborate with HPD, HFD, and dispatch to increase call codes that CCD can attempt to divert.		

The HARRIS CENTER for Mental Health and IDD

Transforming Lives

Thank You

EXHIBIT F-32

The HARRIS CENTER for Mental Health and IDD
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Facilities Capital Projects FY 2023 Summary

Todd McCorquodale, Director of Facilities Services

Facilities Capital Projects – Multi-Year

Location	Project	Project Number	FY2023 Budget	Project Completion	Status
NPC	Renovations	FM21.1126.02	$ 6,200,000	Q1 FY2024	65%
South Loop East RRR (6168)	Apartment Design	FM21.1126.23	$ 12,117,509	Q2 FY2024	100%
	Apartment Construction	FM21.1126.23	$ 12,117,509	Q2 FY2024	5%
NE Clinic	Clinic Design	FM21.1126.18	$ 1,461,782	Q4 FY2025	15%
	mStrategic, Owners Rep	FM21.1126.18	$ 379,000	Q4 FY2025	47%
	Clinic Construction	FM21.1126.18	$ 14,723,268	Q4 FY2025	
	TPWD Grant - Design		$ 75,000	Q4 FY2025	100%
	TPWD Grant - Construction		$ 4,648,268	Q4 FY2025	
	Land Purchase	FM21.1126.18		Q4 FY2025	100%

Facilities Capital Projects – Multi-Year

Location	Project	Project Number	FY2023 Budget	Project Completion	Status
NW Clinic	Clinic Land	FM21.1126.03		Q2 FY2026	100%
	Clinic Design	FM21.1126.03		Q2 FY2027	0%
SE Clinic	Building Demo	FM23.1126.01	$330,000	Q4FY2028	100%
	Clinic Land Purchase	FM23.1126.01		Q4FY2028	100%
SW Clinic (Loading Dock Assessment)	Arborist Assessment	FM23.1126.08	$ -	Q2FY2024	100%
	Sewer / Storm Sewer Scope	FM23.1126.08	$ 7,939	Q2FY2024	100%
	Soil Assessment	FM23.1126.08	$ 50,000	Q2FY2024	100%
Dennis St	Elevator Modernization	FM23.1126.09	$ 75,000	Q3FY2024	10%
SW Garage	Garage Assessment	FM23.1126.10	$ 12,000	Q4 FY2023	100%
Center for Pursuit	Coffee House 2 The Center for Pursuit	FM23.1126.02	$ 110,000	Q3FY2024	25%

Strategic Goal FY23

Location	Project	Project Number	FY2023 Budget	Project Completion	Status	$ Total Project Budget	$ Spend-to-Date
SE Clinic	Pharmacy and Business Office Relocation	FM22.1126.10	$ 761,200	Q4 FY2023	100%	$ 274,116.00	$26,690
Residential Homes	Whole-Home Generator Installation (7 Locations)	FM22.1126.16	$ 168,615	Q3 FY2023	100%	$ 168,615.00	$118,509
Residential Homes	Window Replacement (6 Locations)	FM22.1126.17	$ 132,000	Q2 FY2023	100%	$ 132,000.00	$115,099
6160	Perimeter Fence	FM22.1126.19	$ 253,300	Q1 FY2023	100%	$ 253,300.00	$253,300
SE Clinic	SE Clinic Land Design Demo	FM23.1126.01	$ 330,000	Q3 FY2023	100%	205,000 (125,000)	$86,416
SW Clinic	SW Clinic Sensory Room Buildout Assessment	FM23.1126.03	$ 22,000	Q3 FY2023	100%	$ 22,000.00	$8,100
Humble	Humble Awning/Flooring/RR	FM23.1126.04	$ 46,200	Q2 FY2023	100%	$ 46,200.00	$10,436
SW Clinic	SW Clinic Buildout (SUD)	FM23.1126.05	$ 165,000	Q3 FY2023	100%	$ 165,000.00	$133,704
Agencywide	Agencywide Update Patient Space	FM23.1126.06	$ 137,500	Q4 FY2023	100%	$ 137,500.00	$17,402
NW Clinic	NW Clinic Restroom Reno	FM23.1126.07	$ 60,500	Q2 FY2023	100%	$ 60,500.00	$54,014

Other Projects

Airline	Fence around Play area	1876		FY2023	100%	$ 2,800.00
Youth Diversion Center	Youth Diversion Center	6500		FY2023	100%	$ 68,220.00
Southwest Clinic	2nd Floor Feeding Clinic	1817		FY2023	100%	$ 5,750.00
South East Clinic	Unit 3 Replacement	1858		FY2023	100%	$ 18,458.00
Southwest Clinic	NAMI Office Split / Minor Renovation	1817		FY2023	100%	$ 2,837.00
RRR	Fire Panel Replacement	1869		FY2023	100%	$ 53,500.00
Jackson St - PEERS	Fire Panel Replacement	1850		FY2023	100%	$ 10,600.00
Southwest Clinic	Remodel CFP Dental Area for Feeding clinic	1817		FY2023	100%	$ 449.00
Southwest Clinic	VAV Replacement	1817		FY2023	100%	$ 11,092.00
Southwest Clinic	Lobby broken tile replacement	1817		FY2023	100%	$ 4,410.00
Southwest Clinic	Awning replacement	1817		FY2023	100%	$ 2,100.00
South East Clinic	RTU 8 Replacement	1858		FY2023	100%	$ 12,403.00
South East Clinic	Dumpster pad concrete	1858		FY2023	100%	$ 10,480.00
RRR	Kitchen prep for contractor	1869		FY2023	100%	$ 4,275.00
Airline	Floor repair / replacement	1849		FY2023	100%	$ 2,748.00
Southmore	Rm 5 Bariatric Mods	1829		FY2023	100%	$ 1,291.00
RRR	6160 Wellness yard Gazebo	1869		FY2023	100%	$ 3,354.00
RRR	Boiler Replacement	1869		FY2023	100%	$ 33,646.00
Northwest Clinic	RTU 14 Replacement	1809		FY2023	100%	$ 12,984.00
Bristow	Replace Water Heater	1814		FY2023	100%	$ 1,200.00
Bristow	Paint PATH Area	1814		FY2023	100%	$ 11,800.00
Pasadena A & B	Add Safety Rails to porch	1874/1875		FY2023	100%	
Pasadena B	Fire Panel Replacement	1875		FY23	100%	$ 4,594.00
Southmore	replace access control to entry gate	1829		FY2023	100%	$ 12,044.00

NPC Remodel Project

Before

After

The HARRIS CENTER for Mental Health and IDD
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Southeast Clinic
5959 Building Demolition

Before

After

Southeast Clinic Pharmacy Renovation and Relocation

Before

After

IDD Residential Home Generators

"Power went out in Applewhite (Katy) area for over two hours last night. Generator kicked in immediately and stayed on till power came back before 10 pm. You make a difference. Thank you"

Lily Pan
Program Director, Residential & TxHml Services.
August, 2023

Pasadena Cottage

Applewhite House

Stonechase House

Jackson Peers House

Westbury House

IDD Residential Home Window Replacements

Windows Replaced at:

- Stonechase
- Applewhite
- Donsky
- Westbury
- Jackson Street
- Pasadena A & B

The HARRIS CENTER for Mental Health and IDD
Transforming Lives

Southwest 3rd Floor
Substance Abuse Clinic Renovation

North West Clinic Restrooms Renovation

Before

After

Youth Diversion Center Renovation

Southmore Location
Sidewalk Awning Installation

Humble Location
Awning Installation

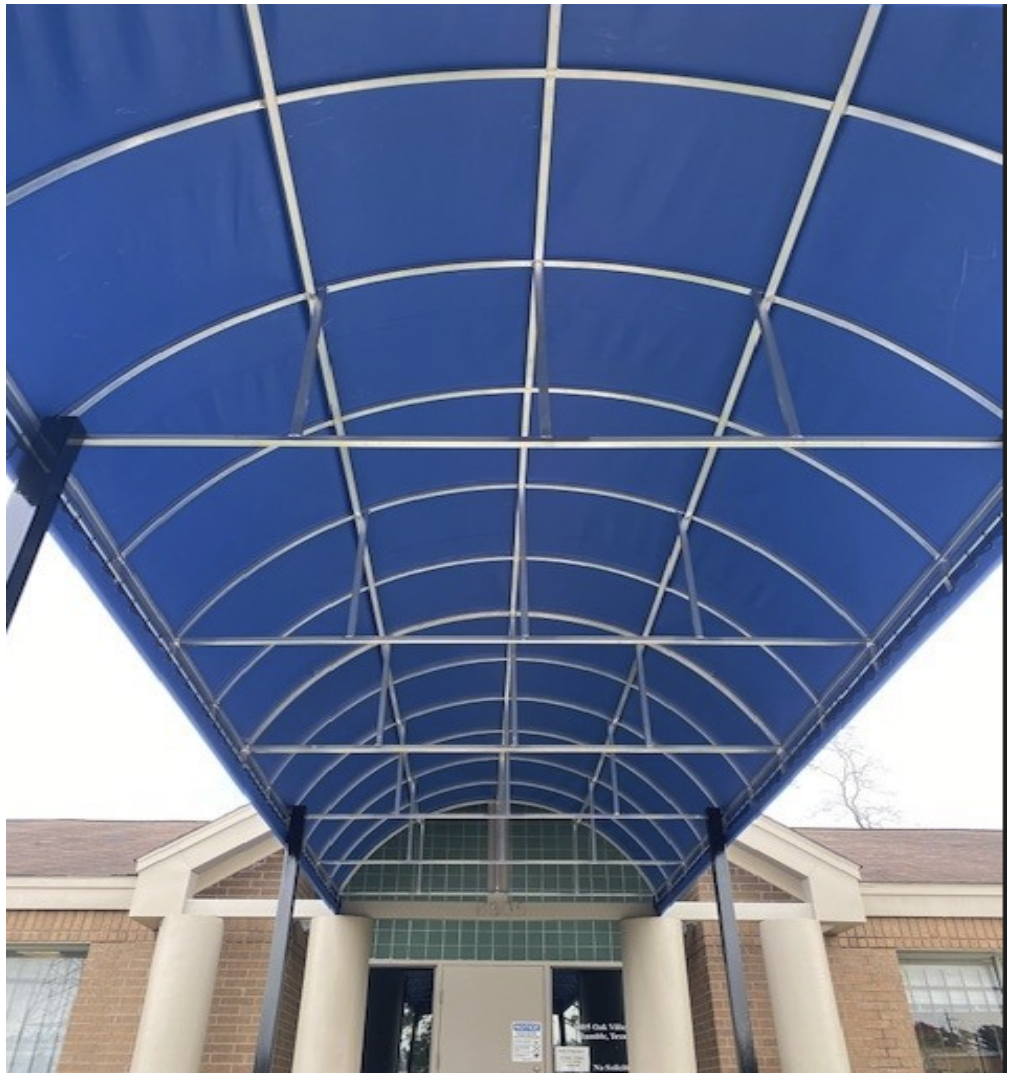

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EXHIBIT F-33

$2.5 Billion Bond Overview

HARRISHEALTH

Harris County Hospital District d/b/a Harris Health System is the public healthcare provider serving the residents of Harris County through an integrated network of two hospitals (Ben Taub and Lyndon B. Johnson) and nearly 40 clinics, health centers and specialty facilities. Its mission is to improve the health and well-being of all residents, through comprehensive medical services and programs delivered in collaboration with academic and medical school partners: Baylor College of Medicine, UTHealth Houston and MD Anderson Cancer Center.

Background: Harris County's population has nearly doubled in the time since Harris Health's two hospitals opened more than 30 years ago, and this rapid growth is projected to continue. This places significant pressure on Harris Health's infrastructure with its facilities often exceeding capacity.

Proposal: The bond will support Harris Health's proposed $2.9 billion strategic facilities plan, which calls for new construction and renovations to meet the growing needs of Harris County.

Tax Impact: If approved, financial support of the bond translates to about a two cent tax increase for property owners—meaning an owner of a $300,000 property would pay about $6 a month for the bond.

Timeframe: Pending approval of the bond, construction of a new LBJ Hospital and planning and design for the new community clinics and upgrades to Ben Taub Hospital begin in 2024.

What's in the plan?

New LBJ Hospital

$1.6 billion for the construction of a new hospital on the Lyndon B. Johnson Hospital campus, to include Level I trauma capability. The new hospital also will nearly double inpatient bed capacity, add new services to treat conditions like heart attacks and strokes, and address other service gaps.

Community Clinics

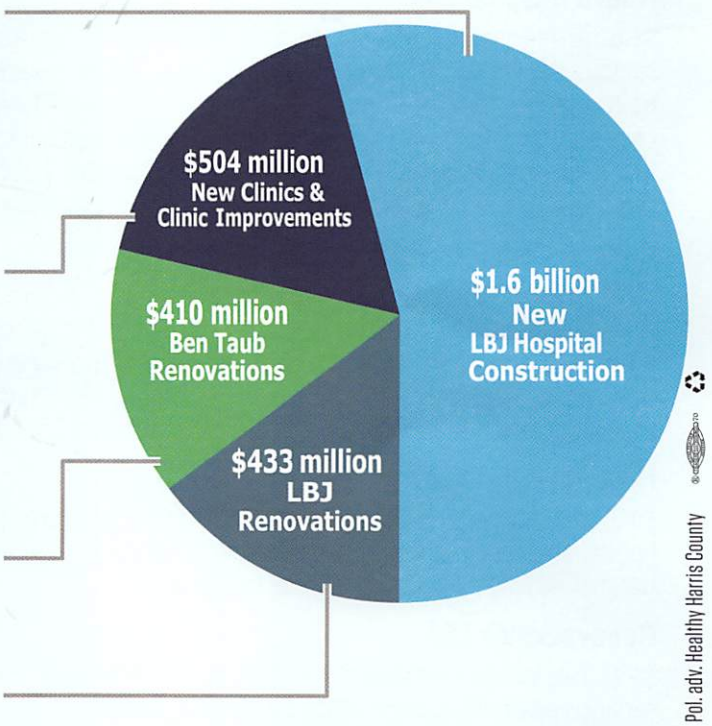
$504 million for new community clinics and improvements to existing community clinics to promote overall health and disease prevention. Harris Health plans to establish new sites in Northwest, Southwest and East Harris County to serve the evolving population densities and reach more of the community.

Ben Taub Hospital

$410 million to renovate Ben Taub Hospital to add more inpatient rooms, enhance trauma care and extend the hospital's life span.

LBJ Renovations

$433 million to renovate the existing LBJ Hospital to provide additional services, such as mental healthcare.



Pol. adv. Healthy Harris County

Scan this QR code to learn more about Harris Health's first-ever bond proposal or visit nextlevelharrishealth.org

Descripción del Bono de $ 2.500 millones

HARRISHEALTH

El Distrito Hospitalario del Condado de Harris conocido como el Harris Health System es el proveedor de atención médica pública que presta servicios a los residentes del condado de Harris a través de una red integrada de dos hospitales (Ben Taub y Lyndon B. Johnson) y casi 40 clínicas, centros de salud e instalaciones especializadas. Su misión es mejorar la salud y el bienestar de todos los residentes, a través de programas y servicios médicos integrales brindados en colaboración con socios académicos y de escuelas de medicina: Baylor College of Medicine, UTHealth Houston y MD Anderson Cancer Center.

Contexto: La población del condado de Harris casi se ha duplicado desde que abrieron los dos hospitales de Harris Health hace más de 30 años, y se prevé que este rápido crecimiento continúe. Esto pone una presión significativa sobre la infraestructura de Harris Health, ya que sus instalaciones a menudo superan su capacidad.

Propuesta: El bono respaldará el plan de instalaciones estratégicas de $2.9 mil millones propuesto por Harris Health, que exige nueva construccion y renovaciones para satisfacer las crecientes necesidades del condado de Harris.

Impacto Fiscal: Si se aprueba, el apoyo financiero del bono se traduce en aproximadamente un aumento de impuestos de dos centavos para los propietarios, lo que significa que un propietario de una propiedad de $300,000 pagaría alrededor de $6 al mes por el bono.

Plazo: A la espera de la aprobación del bono, la construcción de un nuevo Hospital LBJ y la planificación y diseño de las nuevas clínicas comunitarias y las mejoras al Hospital Ben Taub comienzan en 2024.

¿Qué hay en el plan?

Nuevo Hospital LBJ

$1.6 mil millones para la construcción de un nuevo hospital en el campus del Lyndon B. Johnson Hospital, para incluir capacidad de traumatología de Nivel I. El nuevo hospital también casi duplicará la capacidad de camas para pacientes hospitalizados, agregará nuevos servicios para tratar afecciones como ataques cardíacos y accidentes cerebrovasculares y abordará otras deficiencias en los servicios.

Clínicas Comunitarias

$504 millones para nuevas clínicas comunitarias y mejoras a las clínicas comunitarias existentes para promover la salud general y la prevención de enfermedades. Harris Health planea establecer nuevos sitios en el noroeste, suroeste y este del condado de Harris para atender el aumento de la población y llegar a más comunidad.

Hospital Ben Taub

$410 millones para renovar el Hospital Ben Taub para agregar más habitaciones para pacientes hospitalizados, mejorar la atención de traumatología y extender la vida útil del hospital.

Renovaciones LBJ

$433 millones para renovar el Hospital LBJ existente para brindar servicios adicionales, como atención de salud mental.

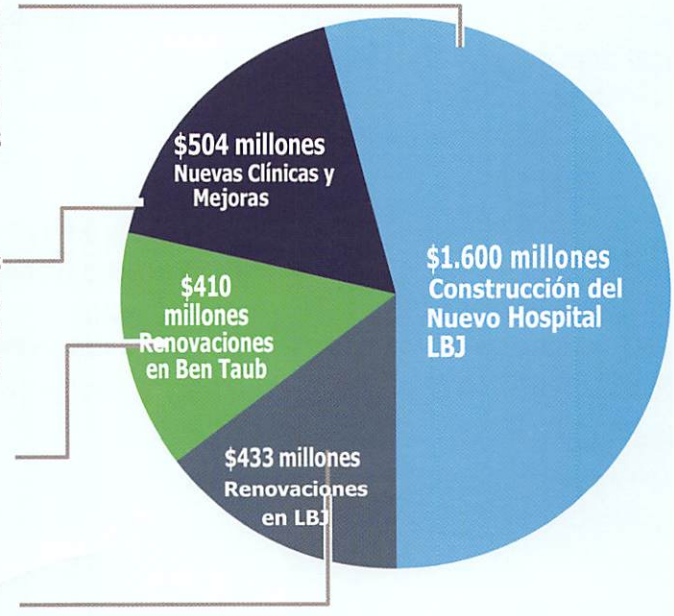


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EXHIBIT F-34

Editorial

Evolution of the Assisted Outpatient Treatment (AOT) Program Through the Application of a Social Work Lens

Research on Social Work Practice
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Abstract

Assisted Outpatient Treatment (AOT) is a court-mandated program intended to engage adults with serious mental illness who have challenges with voluntary treatment adherence. AOT programs are designed to promote outpatient treatment participation, reduce emergency care, and decrease justice involvement. Research has found AOT programs to be effective in reducing hospitalizations and justice involvement. Yet, concerns have been raised, including limiting individual autonomy and self-determination and overrepresentation of individuals from BIPOC backgrounds. This article describes the evolution the AOT Houston Model. Through applying the social work lens, this innovative model builds on AOT strengths and addresses limitations. The Houston AOT Model has five goals guided by the core tenets of client empowerment and self-determination. This Model prioritizes six elements including housing, employment, access to public benefits, transportation, service continuity, and care coordination/communication. Implications for practice and policy are presented with strategies for successful implementation of comprehensive AOT programs in other jurisdictions.

Keywords

Assisted Outpatient Treatment, AOT, serious mental illness, SMI, civil commitment

Assisted Outpatient Treatment (AOT) Programs were originally developed in the 1980s to address the issue of treatment non-adherence in individuals experiencing serious mental illness (SMI) and concurrent justice system involvement. SMI is defined as any mental, behavioral, or emotional disorder that seriously impairs functioning across multiple domains and impacts one or more major life activities (Lamb & Weinberger, 2017). These intensive programs, which combine therapeutic interventions coupled with supervision from the court, were originally instituted to minimize the likelihood of those with unaddressed SMI engaging in violent behavior. As the years have passed, AOT programs have become more refined and have shifted their focus from societal protection to participant care. This article describes an innovative Houston AOT model that is designed to ensure treatment engagement, adherence, and social support and to facilitate improvements in participants' overall quality of life. Implications for social work practice and policy are presented along with strategies for successful implementation of comprehensive AOT programs in other jurisdictions.

Background and Initial Development of AOT Programs

Assisted Outpatient Treatment (AOT), also referred to as outpatient civil commitment, is a court-mandated program designed to motivate adults with SMI who have challenges with voluntary treatment engagement. AOT programs are designed to focus the attention of treatment providers and those they serve on the importance of keeping participants engaged in ongoing and effective treatment (Treatment Advocacy Center, n.d.).

AOT programs are designed to reduce repeated emergency psychiatric care usage and decrease justice system involvement resulting from untreated mental illness while promoting treatment engagement and long-term recovery for those with SMI and/or substance use disorders (SUDs). Seabury and colleagues (2019) estimate the lifetime burden of SMI as $1.85 million per patient, representing a significant financial cost to the larger community, especially if emergency healthcare or justice system-based services are used instead of routine outpatient care.

AOT programs were first developed in the U.S. in the 1980s after the closing of many state and county-funded residential mental health treatment facilities (Hiday, 2003). The goals of these programs were to 1) increase outpatient treatment adherence for those with SMI, 2) reduce emergency mental health service utilization (hospitalizations), and 3) reduce interaction with the criminal justice system. Individuals with untreated SMI who have become engaged with the legal system may be mandated to participate in AOT programs where they typically receive intensive outpatient mental health and substance use treatment services,

including counseling and medication management. These programs are typically administered by a state or county-based public mental health system in coordination with a local civil court system.

The inception of Kendra's Law in 1999 changed how AOT programs were conceptualized and implemented. The State of New York enacted Kendra's Law (1999/2006) following the murder of Kendra Webdale by a man with untreated SMI. As a result of this incident, civil commitment shifted from being a mental health program designed to increase ongoing treatment engagement for those experiencing SMI to a robust public safety program. Unlike prior civil commitment programs, Kendra's Law required expansion of AOT services to include intensive case management to better meet the psychosocial needs of participants, such as housing, transportation, employment, and education, that may serve as barriers to ongoing treatment adherence (Cornwell & Deeney, 2003; Swartz et al., 2009; Torrey & Zdanowicz, 2001). Similar laws, such as California's AB 1421 also known as "Laura's Law" in (2002), were subsequently passed in response to violent deaths by individuals with untreated SMI (Swartz et al., 2009; Worthington, 2009).

Over the years, there have been a handful of AOT programs nationally, mostly located in major urban areas. However, funding for access to AOT programs was further expanded under the Protecting Access to Medicare Act (PAMA) (2014), and in 2016, the Substance Abuse and Mental Health Services Administration (SAMHSA) announced a four-year, $13 million pilot program to implement and evaluate AOT programs nationwide (SAMHSA, 2020). During the same year, the 21st Century Cures Act (2016) provided increased grant funding to strengthen state and county AOT programs.

Currently, 47 states have implemented some form of an AOT program (Swartz et al., 2009), with 45 states and the District of Columbia having civil commitment laws regarding how AOT programs should operate. Research on AOT programs has consistently found AOT programs to be effective in reducing repeated hospitalizations and decreasing criminal justice involvement (Schneeberger et al., 2017; Starks et al., 2022; Wagner et al., 2003). Studies have also shown that the availability of multiple services within an AOT program (such as housing assistance, employment, and educational assistance in addition to traditional behavioral health treatment) is significantly more influential on positive outcomes than any singular intervention on its own (Schneeberger et al., 2017). Thus, more and more jurisdictions have implemented AOT programs during the past ten years.

Defining What Constitutes an AOT Program

The majority of AOT programs may receive support from multiple funding sources, including state, county, and local funds, which are built in as a "line item" in recurring budgets. Others are funded through grant programs administered by federal entities such as SAMHSA. Current AOT programs funded through SAMSHA are required to implement nine essential elements designed to provide ongoing support and service linkage to participants (SAMHSA, 2020). These nine essential elements are:

1. Identification of non-adherent individuals in need of treatment for SMI who also meet AOT criteria for that state;
2. Instead of the community acting, the mental health system gathers all evidence to petition the court for AOT programming;
3. Due process of rights is safeguarded throughout all AOT proceedings;
4. Clear communication between court and mental health teams to ensure the court has all clinical information needed to guide decision making;
5. Evidence-based treatment provided with emphasis on therapeutic engagement and ongoing stability to safely re-enter the community;
6. Routine treatment evaluation to ensure adequacy of care and to guide needed adaptations in the participant's treatment plan;
7. Specific protocols employed for non-engaged consumers;
8. Routine evaluation at end of commitment period to determine next steps (e.g., continuation of AOT commitment or transition to voluntary care); and
9. Continued care coordination after transitioning out of the AOT program to maintain stability and safety.

Concerns and Controversies Related to AOT

AOT programs have frequently been criticized for having a racialized component, as historically, the majority of AOT participants have been Black, Indigenous, and other People of Color (BIPOC). Accordingly, some critics assert that AOT programs are a form of social control on the lives and choices of BIPOC individuals (Swanson et al., 2009). For example, a New York study examining racial disparities among AOT participants found that African Americans experiencing SMI were disproportionately referred to AOT services relative to White individuals with SMI. These results indicate racial disparities in SMI diagnosis as well as an increased likelihood of being referred for civil commitment.

In addition to issues of racial bias, concerns about limiting individual autonomy and self-determination within the healthcare and judicial systems are present among opponents of AOT programs. Vocal critics of civil commitment in general, and AOT programs specifically, characterize these programs as efforts to socially control individuals with SMI and further stigmatize them as violent or dangerous

(Munetz et al., 2019; Swanson et al., 2009; Worthington, 2009). These critics frame AOT programs as coercive, limiting individual self-determination and promoting societal control through social policy. In a study evaluating perceptions of coercion of individuals participating in a civil commitment program in North Carolina, researchers found that individuals with more severe symptom acuity, African Americans, and individuals with co-occurring mental health and SUDs were more likely to feel coerced (Swartz et al., 2002). In addition, certain aspects of the program itself, such a case managers' reminders of consequences for not adhering to the program were interpreted as coercive (Swartz et al., 2002), as AOT program participation is often framed as an alternative to incarceration. However, literature on the effectiveness of AOT programs considers the necessity of such programs for reducing recidivism and hospitalizations to outweigh the concerns of diminished civil liberties (Munetz et al., 2014).

Although the majority of prior research has found AOT programs to be effective (Schneeberger et al., 2017; Starks et al., 2022; Wagner et al., 2003), other research has highlighted concerns with AOT programs regarding issues of limited standardization across state and county-run programs, low fidelity in intervention delivery, inadequate resources to support full implementation, lack of enforcement for non-adherent participants, difficulty with inter-agency and cross-system collaboration, and providers' reluctance to participate in such programs (Cripps & Swartz, 2018; Meldrum et al., 2016).

Evolution of a New AOT Model Addressing Prior Concerns: The Houston AOT Model

Given the limitations and concerns about the impact of AOT programs related to participants' self-determination and choice, the Houston AOT Model's primary objective was to shift the focus of AOT programs from the application of a criminal justice lens focusing on public safety, to a social work lens focused on addressing the unique needs of an individual participant within his/her own social and environmental context. This requires a shift from considering AOT participants as justice-involved individuals who present a risk to society due to their treatment non-adherence to viewing them as individuals who simply have a number of unmet psychosocial needs, one of them being unaddressed mental health and/or substance use concerns. This social work focus draws from a person-in-environment perspective (Hutchison, 2018), which is then applied to meet the needs of an individual within their various complex systems.

Viewing AOT participants through a person-centered social work lens also supports key tenets of the mental health recovery model, empowering participants to be active co-creators of their treatment plans so they may become productive members of their communities. By applying this framework, the vision for the Houston AOT Model was contingent upon building a coalition of key stakeholders involved in the civil commitment process. These stakeholders included those experiencing SMI, first responders, behavioral healthcare providers, and the court system, thereby expanding existing collaborations to develop an AOT program that emphasizes an iterative partnership between the consumers and the systems rather than a unidirectional mandate. This partnership empowers the consumers to address their mental health and substance use needs more consistently by encouraging participants to be actively involved in all aspects of their treatment-related decision-making while participating in the program and beyond. Individualized treatment planning is guided by participants to best meet both their current needs and their long-term recovery goals. Participant input regarding all aspects of care is considered essential to program success and thus is elicited during all phases of the engagement and treatment process. To provide an individualized treatment experience that incorporates the participant's needs and preferences, every participant can decline one or more services. However, if a service is declined, education is provided on how these services may be useful to improve participants' overall quality of life and meet their future recovery goals.

Through applying the social work lens, the goals of the Houston AOT Model were to 1) increase existing collaborations between public behavioral health entities and the probate/civil court system to support the development and implementation of a sustainable, evidence-based AOT program, 2) identify appropriate consumers experiencing untreated SMI to refer to the AOT program, 3) meet the individual psychiatric, social, and medical needs of each participant in the AOT program, 4) address existing concerns about prior AOT programs, and 5) evaluate the Houston AOT Model to ensure its congruence with program consumers' needs and state law through both formative and summative evaluation components, along with continual program improvement and quality assurance efforts. Guided by the core tenets of consumer empowerment and self-determination, the Houston AOT Model prioritizes the following six elements:

1. Housing

   Incorporating housing into AOT programming is seen as an essential component for stabilization, engagement, and maintenance in treatment, as well as for future goal acquisition. The vast majority of currently implemented AOT programs do not include services to address the needs of those who are unstably housed. Through the incorporation of funding, the Houston AOT Model implemented elements of a 'housing first' approach to mental health treatment to ensure all program participants had access to safe and affordable housing as a part of program participation (Robbins et al., 2006; Starks et al., 2022). The

housing first model asserts that it is not necessary for participants to have adequately addressed their mental health and/or substance use needs prior to providing them with housing assistance. In the Houston AOT Model, participants are often housed in personal care homes, which serve individuals with mental and/or physical healthcare concerns, and housing is available for participants for up to 12 months.

2. Employment

   Participants in the Houston AOT Model with employment goals are referred to an employment specialist to provide support with employment-related activities such as resume creation and interviewing skills. These employment services are tailored to the individual, and participants are encouraged to explore multiple employment options based on their unique skill sets and challenges related to their mental health. For example, a participant who functions well in environments with lower levels of stimulation may be referred for employment at a library as opposed to a more stimulating environment such as a restaurant.

3. Access to Public Benefits

   In the Houston AOT Model, all participants meet with their case managers to review which types of public benefits they may be entitled. These benefits may include food assistance in the form of Supplemental Nutrition Assistance Program (SNAP) benefits, a review and application for supplemental security income (SSI) for permanent disability related to their SMI, long-term housing vouchers, (Section 8), clothing vouchers, transportation assistance such as passes for public transportation, and other material resources.

4. Transportation

   As transportation can often become a barrier to treatment, especially in cities such as Houston where public transportation options are limited and often do not extend to suburban areas of the metroplex where most of the mental health services are located, the Houston AOT Model provides enhanced transportation services. These include transportation vans that provide transportation from the participant's home to any healthcare or social services appointment. Additional means of addressing transportation issues implemented through the Houston AOT Model are the provision of 'in-home' services, expanded use of telehealth for medical and behavioral healthcare appointments, and holding 'virtual' court status hearings instead of requiring participants to attend hearings in person.

5. Service Continuity

   In the Houston AOT Model, participants can choose to remain engaged with a higher level of services longer than court-mandated to ensure successful transition to routine outpatient care. To facilitate this transition, the Houston AOT Model offers a step-down option for participants to engage in Assertive Community Treatment (ACT) when they are ready to transition out of AOT, but they are not ready to engage in less intensive traditional outpatient services.

6. Care Coordination and Communication

   The Houston AOT Model has an interdisciplinary and collaborative team of providers who actively promote connections between the core stakeholders. There is consistent and routine communication among team members where successes are shared and barriers are addressed in order to support problem-solving and reduce service provision siloing. A variety of service provider partners are essential to a successful AOT program. The role of each of these partners and how they work together to support favorable participant outcomes is provided in the following section.

Care Coordination Team

Each participant in the Houston AOT Model is assigned a care coordinator who forms a partnership with the participant and is involved in all aspects of their care. The care coordinator ensures that the participant has all necessities (such as toiletries, food, and clothing) and provides transportation and support during the participant's psychiatric and medical appointments. If requested by the participant, the care coordinator sits in on the participant's appointments to provide support, advocate for them, and support post appointment follow up. The care coordinator delivers psychiatric medications to the participants as directed by the psychiatrist and monitors medication adherence. The care coordinator meets with the participant at least weekly (usually more frequently) at their residence to address other aspects of the participant's treatment plan goals, such as obtaining identification, applying for food or other governmental assistance, and addressing all other individualized needs expressed by the participant. Whenever possible, a participant will have the same care coordinator for the duration of their participation in the AOT program.

Psychiatrists

In the Houston AOT Model, the majority of prospective participants are identified and referred by psychiatrists while under their care during an acute psychiatric hospitalization. Inpatient psychiatrists in conjunction with the AOT program's hospital liaison determine if AOT services may be appropriate and beneficial for a client and if AOT participation is the best approach to support them in their recovery. Inpatient psychiatrists are responsible for diagnosing the individual and beginning the process of reducing their psychiatric symptoms through medication management and other services provided in the hospital. These psychiatrists frequently communicate with the AOT program's psychiatry team about

the client's progress while hospitalized to facilitate a smooth transition to outpatient care.

For ongoing support and treatment, the Houston AOT Model assigns an outpatient psychiatrist to each participant that transitions back into the community. Outpatient psychiatrists work to form a partnership with the participant, keeping them involved in all aspects of their care, and work to support self-determination and client choice regarding their treatment and ongoing medication management. Outpatient psychiatrists will also be clarifying diagnoses to better tailor a treatment plan. By confirming or identifying the most accurate diagnoses psychiatrists and the AOT team are able to deliver more appropriate therapies as well as reducing medication and/or side effect burden on participants. This has the added benefit of strengthening participant trust and alliance with psychiatrists and the AOT as a whole. In addition, the outpatient psychiatrist supports the care coordination team through frequent, often multiple times per week, team meetings to discuss participant goals, progress, and barriers to treatment. This ensures a collaborative, shared focus and approach from all members of the treatment team. The relationship between the participant and outpatient psychiatrist is designed to be long-term and will often continue long after an individual's involvement with the AOT program has ended.

Hospital Liaison

The hospital liaison is another crucial role that has increased communication and continuity of care in the Houston AOT Model. This position is housed at the inpatient psychiatric hospital, and it serves as a liaison between the inpatient and the outpatient AOT treatment teams. The hospital liaison is responsible for screening and evaluating all referrals for the program and communicating with the inpatient treatment team regarding the history and current presentation at the time of the referral. The hospital liaison supports the inpatient treatment team in completing and filing documentation required by the court for the initial commitment to the program. This individual is also responsible for encouraging awareness of the program and educating hospital staff and potential referral sources about the program, as well as providing an overview of the program to potential participants. Finally, the hospital liaison ensures a smooth transition from residential to outpatient care for new and current participants by working with the AOT treatment team to make all arrangements for housing, transportation, and aftercare following discharge from inpatient services. This process helps create a more seamless experience for participants as they transition from one level of care to another.

Court Liaison

To ensure cross-system care coordination in the Houston AOT Model, a liaison works with the court, local county psychiatric hospital, and outpatient care team. This court liaison accepts and processes all court documents required for program participation and coordinates all the necessary paperwork and other communications from the AOT treatment team and attorneys regarding the needs of participants. In addition, the court liaison provides education to and supports potential referring doctors on the AOT program, procedures, timelines, and required paperwork.

Another aspect of the Houston AOT Model considered essential to its success is the development of effective court status hearing procedures for participants with support from the AOT treatment team. These status hearings allow participants and the civil court judge to discuss the participant's current needs, progress toward their goals, and any barriers to treatment as well as work in conjunction with the participant and treatment team to address these barriers. The supportive nature of these hearings encourages participants' participation, but it also allows for guidance from the court when a participant's behaviors do not support their safety or wellbeing. In addition to the reduced transportation burden, holding status hearings virtually has increased participation of participants in these hearings. Remote participation has also been beneficial in allowing the judge to get a better idea of the living conditions and other factors impacting treatment that would not be as readily observable if the participant was required to physically appear in court.

Peer Support Specialist/Peer Educator

The role of peer support specialist/peer educator in the Houston AOT Model provides participants with support from those who have lived experience with SMI, who are able to provide an insider perspective and other resources to support participants' individualized recovery process. These individuals work to educate participants about their diagnosis(es) by providing materials to promote health literacy and/or sharing their own experiences of recovery. Peer support services decrease isolation, reduce stigma about mental health and substance use disorders and help to problem-solve other barriers often experienced by those in need of ongoing mental health treatment. Peer support specialists also facilitate 12-step based peer support meetings and lead skill-building groups related to emotional regulation and positive interaction with one's social environment.

Advisory Committee

In the Houston AOT Model, a meeting of an advisory committee of key internal stakeholders is held quarterly to assist with continual quality improvement efforts. This committee is comprised of clinicians and representatives from the public psychiatric hospital, court system, outpatient mental health services organization, and evaluation team, as well as former AOT program participants, and other community representatives. During these meetings, the advisory committee

receives information concerning program performance, service gaps, and other program needs and provides feedback to address the issues discussed. Recommendations and feedback on the program provided by current and former AOT participants (e.g., collected through satisfaction surveys, participant reports to the court, and participant focus groups), in additional to feedback and suggestions from the AOT treatment team, are discussed during advisory committee meetings in order to guide and inform ongoing program improvement.

Evaluation Team

The Houston AOT Model has further support from an external independent university-based evaluation team to review and improve procedures and outcomes. The evaluation team provides ongoing feedback to stakeholders on program-related processes, including identification, recruitment, enrollment, and barrier identification. This team also conducts ongoing data collection on and evaluation of provider and participant burden, satisfaction, and program attrition, and examines potential racial and/or diagnostic disproportionality among AOT participants. In addition, the evaluation team has developed a fidelity guide to ensure consistent implementation across all service providers. Fidelity is essential for the appropriate delivery of evidence-based treatment (Gearing et al., 2011), and ensures that all clients receive quality care. The results of the evaluation process, which includes both an evaluation of standardized outcome measures in the electronic health record and data collected from satisfaction surveys and focus groups, is presented to The Harris Center for Mental Health and IDD leadership and the funder (SAMHSA) annually as a comprehensive evaluation report.

Success of the Houston AOT Model

In the three years since its inception in August 2020 thought July 2023, the Houston AOT Model has served 92 past and 41 current participants. The program has graduated 37 participants, and other participants have successfully transitioned into alternative programs for ongoing mental health treatment, such as ACT, Recovery Oriented Treatment Program (ROTP), IDD focused services, assisted living facilities, and residential substance treatment programs. Participants have also been observed to achieve their individual treatment goals, such as obtaining employment, sustaining abstinence from substance use, obtaining social security benefits or long-term housing, and other similar achievements. For example, 22 program participants have obtained employment. Another 14 participants have been approved for long-term benefits through social security (SSI or SSDI), and the AOT treatment team has supported an additional four participants in reinstating previously terminated benefits. A total of 78 participants engaged in at least one session of individual therapy (most attending multiple sessions), and 34 engaged in ongoing work with a Licensed Chemical Dependency Counselor to address substance use needs. One hundred past and current participants engaged in peer support services, nine participated in peer-based support groups, with another five participants receiving assistance in attending regular 12 step support meetings. Moreover, 88 program participants have received housing assistance to increase treatment stabilization and prevent experiences of homelessness. Additionally, 32 participants had zero re-hospitalizations since participating in the program, with 13 participants having only one re-hospitalization during their time in the program, potentially saving millions in healthcare costs.

Adapting and Implementing AOT in Your Community: Recommendations

When considering the adoption of an AOT program in one's community, one must first identify areas of communication, siloing, and disintegration of services that may prevent the development and implementation of such a program with a social work focus. One way to identify these challenges is to look at prior successes and areas of ongoing opportunity in relation to continuity in service provision and integrated multidisciplinary care. For example, identifying service provision siloing would be a first step to improving communication and reducing barriers within the AOT program that decrease fidelity and inter-agency collaboration. Shifting the focus to a participant-centered approach allows for the intersectionality of multiple issues related to the individual's care to surface. For example, the peer educator and the care coordinator are first-line sources to identify barriers and gaps in service needs.

Addressing Concerns Levied About Past AOT Programs

For many individuals with SMI, mental health services are not adequate, available, or suitable. Furthermore, individuals with SMI may not find traditional services to be sufficiently engaging or fully support their needs. Using a social work lens, the Houston AOT Model sought to build upon the established programmatic strengths and address known limitations specifically related to low fidelity, lack of enforcement for non-compliant participants, racial disproportionality, difficulty with inter-agency and cross-system collaboration, and limiting individual autonomy and self-determination.

To strengthen low-fidelity service delivery and standardize program processes, the Houston AOT Model integrated care coordinators, a hospital liaison, a court liaison, and an advisory committee to ensure a solid partnership and engagement for the participant across the entire program. The inclusion of an active court liaison and incorporating virtual court status hearings has enabled the Houston AOT Model to reduce barriers of location and travel thereby addressing issues related to the lack of enforcement for non-compliance. The Houston

AOT Model has focused on inter-agency and cross system collaboration through the use of the advisory committee and the evaluation team. Thus, collaboration is assessed to enhance the program and limit barriers, as well as providing accountability with team members and stakeholders. Across each step in the Houston AOT Model the participant is a partner and their needs and approach to addressing their needs is incorporated through personalized treatment. Care providers and partners actively seek out and prioritize participant autonomy and self-determination in the development and any ongoing adjustment of their treatment plans.

In addition, during Year 1, the evaluation team explored the potential overrepresentation of African American participants in the AOT program. AOT participation rates were compared to rates of outpatient and emergency psychiatric services usage, and no differences were found between the AOT participation rates and rates of other types of service usage for any cultural group. This analysis was conducted to raise awareness of this important issue across stakeholders not only at the program's inception but also during subsequent years of the program in the hopes of decreasing existing race based mental health disparities.

Lessons Learned from the Implementation of the Houston AOT Model

The following lessons were learned from the work done during the first 3 years of the Houston AOT Model, which may be helpful for other jurisdictions considering implementing this type of programming.

1. Importance of self-determination, advocacy, and a participant-centered approach.
2. Importance of leadership buy-in at all levels and across all systems.
3. Importance of identifying program members focused on collaboration, trust, supportive supervision, and teamwork.
4. Using a person-in-environment perspective to assess a participant's needs to provide a more holistic intervention.
5. Importance of ongoing communication and collaboration between the healthcare system and the court system.
6. Engaging all key stakeholders in the initial conceptualization and installation of the project, as well as in its ongoing implementation.
7. Ability to pivot when necessary to improve cross system collaboration and participant outcomes.
8. Importance of incorporating well developed, evidence-based substance use treatment services.
9. Securing adequate funding and resources to support positive long-term outcomes for the program and for its participants to ensure long-term program success and sustainability.
10. Need for multilingual service providers to address the needs of the local community.
11. Autonomy for participants' engagement and ongoing participation.
12. Importance of requesting and incorporating the feedback of current and former participants in the ongoing process of program improvement.

Future Research

There are a number of opportunities for further research regarding the development, installation, implementation of AOT programs, in addition to research regarding program outcomes. Future research may benefit from focusing on standardizing methods to measure various aspects of AOT programs including ongoing progress and future sustainability. Development of a structured protocol for assessing and evaluating AOT programs, which includes a fidelity management tool is recommended. Additionally, there may be a need for quantifying the work of each liaison, psychiatrist, and care coordinator so that case load can be appropriately measured and scaled depending on the jurisdiction implementing the AOT program. Future researchers may also wish to conduct a comprehensive evaluation of potential overrepresentation of participants with certain diagnoses (such as schizophrenia spectrum disorders) or those from various racial/ethnic backgrounds. Also, future researchers/evaluators may wish to consider conducting a cost benefit analysis to supplement other evaluation activities to provide funders with the potential savings to the healthcare and justice systems resulting from effective implementation of an AOT program. The evolution of AOT programs offers the opportunity to address existing concerns while maximizing treatment benefits for individuals who have not responded to traditional mental healthcare.

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RESEARCH ARTICLE

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Treatment outcomes for children with chronic food refusal in a community behavioral health center

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Abstract

Abnormal patterns of feeding behavior are seen in children with and without developmental disabilities; if not treated early, these patterns may lead to a diagnosis of avoidant/restrictive food intake disorder (ARFID). A multitude of treatments for ARFID varying in theoretical orientation, intensity, and modality exist in the literature. Given the potential for complexity in the clinical presentation of ARFID, intensive interdisciplinary treatment programs are often the preferred intervention choice. However, due to the limited availability of these highly controlled settings, underserved populations are often limited to any outpatient feeding therapy that is available locally. This study focused on examining the outcomes of a behavioral outpatient feeding program in a community behavioral health center. Results show that there were statistically significant treatment outcomes when comparing observable feeding behaviors and caregiver satisfaction measures from admission to discharge. Moreover, these gains were maintained at follow-up supporting the treatment efficacy of such programs.

KEYWORDS

ARFID, feeding disorder, food refusal, outcomes, pediatric feeding

1 | INTRODUCTION

Avoidant/restrictive food intake disorder (ARFID), also commonly referred to as a pediatric feeding disorder, is characterized by a lack of interest in or avoidance of food or eating manifested by significant weight loss, malnutrition, enteral feeding or supplement dependence, or psychosocial difficulties (American Psychiatric Association [APA], 2013) without the presence of cognitive distortions related to weight or body shape (Kurz et al., 2015). Avoidance based on sensory properties of foods, fear of consequences related to food intake, and general lack of interest in food or eating make up the three core presentations of ARFID (APA, 2013). Though ARFID commonly develops in infancy and early childhood, prevalence estimates are unclear for this age group; however, Kurz et al. (2015) found an estimated 3.2% prevalence of ARFID in a large middle childhood (3rd-6th grade) sample. Others suggest pediatric feeding disorders occur in a third of typically developing children and 80% of children with disabilities (Field et al., 2003; Gouge & Ekvall, 1975; Shreck et al., 2004). It should also be noted that a new code for pediatric feeding disorders was recently included in the ICD-10-CM. This new code appears to be more inclusive than the code reserved for ARFID as it absorbs those with comorbid medical diagnoses or dysphagia. Although not relevant for the present study, as data were collected before this new code was released, a closer look at how the change in this code will impact clinical practice moving forward is warranted.

2 | FEEDING INTERVENTIONS

The research base for treatment of children with feeding disorders ranges from treatments that focus on antecedent manipulations (e.g., Ahearn, 2003; Johnson & Babbitt, 1993; Kerwin et al., 1995; Luiselli, 2000) to consequence manipulations. However, most of the research in the treatment of food refusal has largely shown that (a) procedures designed to address negative reinforcement (e.g., non-removal of the food presented) are often vital for treatment success (Cooper et al., 1995; Reed et al., 2004), and (b) with few exceptions (e.g., Casey et al., 2006; Wilder et al., 2005), positive reinforcement strategies alone often are insufficient to adequately reduce food refusal and increase bite acceptance (Casey et al., 2009).

Although there is a large literature base supporting the use of behavioral techniques to increase the variety and volume of foods that children will eat, most studies are limited by way of small sample sizes and scarcity of follow-up data. Laud and colleagues addressed this in 2009 by measuring the treatment outcome of 46 children with autism spectrum disorder (ASD) admitted to an intensive interdisciplinary feeding program. The study included directly observable measures of treatment efficacy and follow-up data. Sharp et al. (2009) also added to the literature by examining the outcomes of a group of 13 children with ASD that received intensive interdisciplinary treatment for food refusal. While both studies were conducted in highly controlled settings with the resources necessary to treat patients with complex presentations, the number of institutions in the country with these capabilities and expertise are not common. The fact remains that intensive interdisciplinary treatment options are not easily accessible for children with chronic food refusal in many counties in the United States. For that reason, most families rely on single-disciplinary outpatient programs that are locally available to treat their children's food refusal.

2.1 | Feeding treatment in Texas community behavioral health centers

Traditionally, community behavioral health centers deliver services to underserved populations, including individuals from ethnic minority groups and lower socioeconomic backgrounds. Given the mental health service disparities experienced by diverse groups, it has been suggested that more clinical studies take place outside of highly controlled research settings to better represent the routine and unique treatment experiences of these populations (Lyon & Budd, 2010). While community behavioral health centers operate from a social justice and health equity

lens, there are marked differences in access to resources, equipment, as well as integrated and interdisciplinary care. In pediatric feeding programs, for example, some families have access to licensed psychologists, speech language pathologists, occupational therapists, nutritionists, social workers, physicians, and nurses in university or academic medical settings (e.g., Clark et al., 2019; Laud et al., 2009). At present, there exists a gap in the feeding literature of caregiver-focused behavioral interventions in community behavioral health centers, as well as in patient populations with diverse backgrounds.

This study takes place in the state of Texas, where in the past decade, the Hispanic/Latinx population in the state has exploded. As of 2023, the Hispanic/Latinx population makes up 40% of the demographic landscape in the state. However, economic and political gains have not kept up with population growth. Hispanic/Latinx families living in Texas are disproportionately burdened. Up against longstanding education disparities, they are less likely to have reached the higher levels of education that offer social mobility (Ura, 2023). For them and other marginalized racial/ethnic groups, community behavioral health centers are often the primary providers of healthcare. Specifically in the feeding literature, there is limited research that focuses on how culture influences food choices and behaviors with children who exhibit food selectivity. Rancaño and colleagues in 2021 suggest greater food selectivity may be present in children with an intellectual disability who have a Hispanic/Latinx parent compared to children with an intellectual disability with a parent from another racial/ethnic group. Differences in food selectivity across parental racial/ethnic background may in part be explained by cultural differences in food preparation (e.g., use of various spices). For example, adolescents and young adults with ASD are less likely to report enjoying foods with a strong flavor such as 'spices' and 'strong mints/candies' (Kuschner et al., 2015). The present study is unique in that the majority of participants are Hispanic/Latinx and have Medicaid as their primary funding source. This may serve as a springboard toward further examination of how culture and socioeconomic status impact food selectivity in children.

It is also important to note that Texas was one of the last states in the country to allow individuals who rely on Medicaid to have access to applied behavior analysis (ABA) therapy, and during data collection, this legislation had not passed (Benestante, 2022). Consequently, while historically underserved populations may have access to ABA services in other states, such as the behavioral feeding intervention program focused here, access is a significant struggle for the same population in Texas. This discrepancy makes the findings of this paper all the more important. If there is further evidence that significant gains can be made with a more socioeconomically disadvantaged population, then the hope remains that ABA therapy would continue to be funded for those that rely on Medicaid thereby providing an avenue for early access to intervention for the most vulnerable among us.

2.2 | Study aims

The current study aimed to expand on existing literature by measuring the treatment outcomes of children with ARFID in a single-disciplinary outpatient feeding program within a community behavioral health center. The present study methodology was guided by previous literature the first author contributed to (Laud et al., 2009). In their study, treatment outcomes for 46 children with ASD who completed an intensive interdisciplinary feeding program were reported and showed successful overall and follow-up data (Laud et al., 2009). Patients in the study received treatment for 5–7 days per week for a period of 6–8 weeks. Additionally, patients received input from a behavioral team, a gastrointestinal (GI) doctor, a pediatrician, a speech/occupational therapist, a nutritionist, and a social worker. The present study aimed to replicate the previous successful outcomes with that of a far less intensive outpatient behavioral feeding program in which treatment was provided by a single discipline for 1 hour once per week. The intention was also to contribute novel information to existing literature on outpatient feeding intervention with the inclusion of follow-up data. We first hypothesized that there would be an improvement in observable treatment outcomes from admission to discharge as indicated by (1) an increase in child weight, (2) an increase in acceptance of foods, (3) a decrease in inappropriate mealtime behavior, (4) an increase in the complexity of food texture, and (5) an increase in the number of foods consumed. Second, we hypothesized that there would be an improvement

in caregiver assessment measures as indicated by (1) an increase in caregiver satisfaction with their child's mealtime experiences from admission to discharge, and (2) maintenance of gains made following discharge from the program based on caregiver report.

3 | METHODS

3.1 | Setting

The Harris Center's Pediatric Feeding Disorders Program is an outpatient program housed at the Harris Center for Mental Health and IDD, a quasi-governmental entity that was created by the Texas Legislature in 1964. The Harris Center is a Certified Community Behavioral Health Center (CCBHC). Most individuals served at the Harris Center are Medicaid eligible or do not have medical insurance. The Harris Center's Pediatric Feeding Disorders Program was started in December 2016 by the first author who received her doctorate in clinical psychology. She completed her pre- and post-doctoral training at the Johns Hopkins School of Medicine/Kennedy Krieger Institute's Pediatric Feeding Disorders Program and remained there for an additional 2 years following her training. Over the span of 4 years, she treated children admitted to the day treatment and inpatient programs by working alongside an interdisciplinary team of GI doctors, pediatricians, speech and occupational therapists, nutritionists, and social workers. She attended conferences and published research to make further advancements in the field. Following her move to Texas, she opened the Harris Center's Pediatric Feeding Disorders Program to use her training to treat children who struggled with food and/or liquid refusal, texture or type selectivity, general mealtime problem behavior and refusal to self-feed. Williams and Seiverling (2023) stressed the need for adequate knowledge and training for clinicians, particularly in outpatient settings where access to interdisciplinary teams may not be available. Given the potential complexity of feeding disorders, behavioral clinicians should know when to alert medical providers to the possible presence of medical issues which may require evaluation and treatment.

In order to qualify for the Harris Center's Pediatric Feeding Disorders Program, a child must be between the ages of 9 months and 18 years and must exhibit mealtime behavior that warrants clinical intervention. If a child has significant physiological and/or oral motor challenges, they will not be admitted into the program, and instead referred for the appropriate services (i.e., speech therapy, occupational therapy, etc.). Further, all children must submit a signed physician's clearance form stating that the child does not exhibit any physical/medical contraindications for eating.

For the purposes of the current study, all data for children admitted to the Harris Center's Pediatric Feeding Disorders Program between December 2016 and December 2020 were analyzed. The Harris Center's Institutional Review Board (IRB) granted approval to conduct the chart review prior to the study. It should be noted that for the last 9 months of this period, all incoming admissions to the program were halted due to the COVID-19 pandemic and active patients were offered the option of telehealth appointments only. This disruption decreased the number of children that would have otherwise participated in the study.

From the initial pool of 56 children who had been discharged during this time period, 8 children were excluded from the present study for not starting treatment and/or treatment ending prematurely due to personal reasons (e.g., unable to fit in sessions due to work schedules, transportation difficulties, or financial issues) and/or lack of follow-through. Further, 16 children were dropped due to missing data during their admission. Four were missing data due to lack of cooperation (e.g., accurate weights were not obtained due to child refusing to stand on the scale), 5 did not have data collected in the way it was defined for the rest of the sample (e.g., treatments such as meal planning and self-monitoring food journals were used based on the needs of the patients), and 7 had completed treatment but did not return to complete their discharge paperwork. Overall, 32 children met criteria for participation in this study. Data were collected by trained therapists in accordance with accepted procedures to secure patient confidentiality throughout each participant's admission. Informed consent was obtained from the caregivers as a routine part of their admission into the clinic.

A Chi Square analysis was done to compare the 32 participants included in the study to the 24 whose data were not included based on gender, age, and race to see if there were descriptive differences in those samples. Results showed that there were no statistical differences between the two groups on gender (χ^2 (1) > = 0.389, p = 0.533). However, there was a statistical difference between the two groups on age (t (54) = −2.95, p = 0.005) and ethnicity (χ^2 (5) > = 15.138, p = 0.010). Specifically, the group of children whose data were not included were more likely to be older with three highschoolers in the group compared to none in the other. It is possible that caregivers of older children were less likely to continue bringing their children in for treatment given the difficulty in pulling older children out of school weekly, which may also highlight the advantage of early intervention. In addition, behavioral feeding treatment with older children is done much differently (i.e., behavioral contracts, food journals, and self-monitoring), and those data were dropped due to the inability to quantify and compare with behavioral data collected during live meals. There were also more African Americans in the group whose data were not included. Future studies should look closely at this finding and examine what other variables, potentially linked to systemic barriers, may have played a role in the attrition rate.

4 | PARTICIPANTS

The sample of participants included 32 children between the ages of 2 and 7 years (mean age at initial intake appointment = 4.14 years). There were 23 males and 9 females included. There were a variety of ethnicities represented in our sample including 15 Hispanic/Latinx, 7 White/European American, 2 African American/Black, 2 Asian American/Pacific Islander, and 6 others/unknowns. Fourteen of the 32 participants had received some form(s) of feeding therapy/intervention prior to admission. This included speech and/or occupational therapy (10), gastrostomy tube feed dependence (4), completion of an interdisciplinary feeding program (3), ABA therapy (3), Early Childhood Intervention (2), and recommendations from a nutritionist (1). Although behavioral therapy is offered at the Harris Center, none of these participants received any of their prior therapies there. The 3 participants who had completed an interdisciplinary feeding program prior to admission stated that they had all attended the same 1–2 month intensive feeding program in another part of the state but did not meet their goals while there. This interdisciplinary program did accept those with Medicaid but was not primarily behavioral in nature. The treatment had a greater emphasis on a speech and occupational therapy approach along with the guidance of medical staff. Of the sample included in our study, 2 participants were prescribed psychotropics at the time of the intake assessment. Funding sources varied including Medicaid (n = 24), Private Insurance (n = 6), General Revenue (unallocated funds acquired through business and property taxation; n = 3), and self-pay (n = 1). If participants had two different funding sources, both were included (see Table 1). Finally, of the 32 participants in our sample, 22 had a diagnosis of ASD and a minority of them had a presence of medical diagnosis/issues.

4.1 | Dependent variables

Data on weight and feeding behaviors at admission and discharge were collected for each participant (see Table 2). The primary caregiver of each participant was also interviewed to determine the number and texture of foods the participant was eating without refusal, as well as their satisfaction with the participants' feeding and mealtime behavior at admission and discharge.

4.1.1 | Weight

Each participant's weight (in pounds) was obtained at admission and discharge using the same scale in the clinic. Notations were made regarding whether shoes were being worn at the time of initial measurement and this was kept

TABLE 1 Participant demographics.

Child Race/Ethnicity (*n*)	
White/European American	7
African American/Black	2
Hispanic/Latinx	15
Asian American/Pacific Islander	2
Other	5
Unknown	1
Gender (*n*)	
Male	23
Female	9
Funding source (*n*)	
Medicaid	24
Private insurance	6
General revenue	3
Self-pay	1

TABLE 2 Dependent variables.

	[M (SD)] **Range**
Weight (lbs)	
Admission	37.34 (8.77)
	23.2–60
Discharge	44.64 (11.66)
	24.6–81
Bite acceptance (%)	
Admission	63.89 (29.43)
	0–100
Discharge	86.96 (20.11)
	2.33–100
Inappropriate mealtime behavior (frequency per bite)	
Admission	13.47 (37.10)
	0–199.33
Discharge	0.97 (2.92)
	0–16.37
Caregiver satisfaction (total score)	
Admission	17.31 (6.14)
	5–31
Discharge	35.59 (7.57)
	20–45

consistent for each subsequent weight check. At each weight check, the weight would be taken twice and both trials had to match for the weight to be recorded.

4.1.2 | Bite acceptance

Bite acceptance was defined as when the participant opened their mouth and the entire bolus was deposited within 5 s of the initial verbal prompt (e.g., "Billy, take your bite") for non-self-feeders and within 10 s of the initial verbal prompt for self-feeders. Bites were presented on a large maroon Mothercare spoon.

4.1.3 | Inappropriate mealtime behavior

Inappropriate mealtime behavior was defined as each time the participant turned their head (and/or body) more than 45° past the midline during the presentation of the bite for non-self-feeders. During self-feeding sessions, behaviors were scored when a participant moved the spoon to a position more than 45° from midline. Inappropriate mealtime behaviors also included each time any part of the participant's body came into contact with the therapist's hand/arm or legs while the bite was presented.

4.1.4 | Texture advancement

The texture of foods consumed were divided into groups including pureed (blended food with only a smooth texture), junior (blended food with minimal texture such as applesauce), mashed/soft, and regular (table food, either cut into 2-inch pieces or whole). Liquid dependent participants only consumed liquids by mouth, and tube dependent participants required some form and amount of tube feeds to sustain their growth. Increasing liquid variety was not a main focus of treatment as most participants had adequate intake and were drinking from an open cup. Texture advancement was measured by comparing the texture consumed at admission to the texture consumed at discharge. When needed, texture advancement was completed by moving through the texture stages (i.e., puree, junior, mashed, etc.).

4.1.5 | Number of foods consumed

The number of foods consumed was collected by a caregiver interview in which all foods consumed without refusal by the participant were listed. The number of foods listed as consumed at admission were compared to those at discharge to measure improvement in quantity of foods consumed.

4.1.6 | Caregiver satisfaction

Caregiver satisfaction scores were obtained for each participant via a structured 9-item questionnaire that was completed by the participant's primary caregiver at intake assessment, discharge, and follow-up. Questions on the 1-5 Likert-type scale were related to the caregiver's satisfaction with their child's mealtime behavior in various settings, as well their satisfaction with the variety, volume, and texture of the foods they were eating at the time the questionnaire was administered. The questions also reflected how often individuals participated in meals in various settings. The overall satisfaction score was derived by adding the scores on each question that was answered. Although this questionnaire was not normed or validated, the purpose was to have a consistent measure of caregiver satisfaction

related to feeding at multiple points during the admission, as well as to replicate the use of the same questionnaire that was utilized by Laud and colleagues in 2009.

4.2 | Procedure

Children were admitted to the feeding program after completing an intake assessment and returning a signed physician's clearance form stating that there were no medical/physical contraindications for eating. Once admitted into the program, assessment included a mealtime observation. During the mealtime observation, caregivers presented a variety of preferred and nonpreferred foods to their children. Methods to achieve food acceptance, as well as behaviors maintaining inappropriate mealtime behavior were evaluated. Due to the unique time constraints of the setting, instead of formal functional analysis, functional assessment results were derived primarily from caregiver reports, semi-structured interviews, and mealtime observations at intake. Previous literature supports the use of formal functional analyses to develop specific, efficacious, and effective treatments (Bachmeyer, 2009). However, almost all functional assessments show that feeding problems are maintained by escape, attention, or both (Bachmeyer, 2009; Saini et al., 2019). The near consensus is that the time and energy expended to conduct a functional analysis is better utilized advancing treatment.

Children in the feeding program received behavioral feeding therapy 1 h a day, 1 day per week. The number of treatment sessions from admission to discharge ranged from 6 to 58, with an average of 23.38 (overall treatment period of about 6 months). Caregivers gave the feeding team a list of foods that they considered preferred, semi-preferred, or non-preferred based on their perception of their child's response to different foods. The feeding team would then start with the most preferred food on the list that was the lowest texture (e.g., yogurt, mashed potatoes, refried beans, and cream of wheat) in order to decrease demand thereby increasing the likelihood of consumption. Once the participant learned the rules of the meal and was eating their preferred food, lower textured semi and non-preferred foods would gradually be introduced. Each participant started out with a bite fading procedure where the ultimate goal was to serve 30 bites of food at each session (with bolus size being gradually increased to a rounded spoonful for each bite). Participants typically started out eating 2 foods per session with one being a "mastered" food and the other "non-mastered". Once the overall bite acceptance was above 80% and the average frequency of inappropriate mealtime behavior was less than 1 per bite for two consecutive 30-bite sessions, then the "non-mastered" food was considered "mastered" and would be included into the rotation of "mastered" foods. Once the child had mastered at least 3 new foods, caregiver training would begin. This was the standard protocol for all cases, but individualized changes in the treatment plan were carried out contingent on the needs of each participant. By discharge, the team aimed to master at least 2 non-preferred foods in each of the four food groups (fruits, vegetables, starches, and proteins) and have these foods be consumed regularly by the participants at home. Notably, the order in which new foods were introduced was caregiver-led based on cultural preferences.

4.2.1 | Interventions used

Behavioral interventions are one of the most common and effective interventions for feeding disorders and have the most empirical support (Bachmeyer, 2009; Fischer & Silverman, 2007; Linscheid, 2006; Lukens & Silverman, 2014; Sharp et al., 2010). Treatment goals often include decreasing food refusal and increasing food acceptance and can involve multiple components (Fischer & Silverman, 2007; Linscheid, 2006). Antecedent-based procedures such as stimulus fading (i.e., gradually changing the ratio or concentration of preferred and non-preferred foods or liquids), simultaneous (i.e., presenting a less preferred food and a more preferred food at the same time), and sequential presentation (i.e., presenting a preferred food/drink immediately after acceptance of a non-preferred food) have also been found to be effective for improving feeding outcomes (Bachmeyer, 2009; Piazza et al., 2002).

TABLE 3 Behavioral techniques utilized (*n*).

Escape Extinction	32
DRA with praise	32
Bite board	32
DRA/RC/NCR with preferred tangible	26
Simultaneous presentation	4
Finger prompt	6
Side deposit	2
"Beat the buzzer"	4

Note: The "Beat the Buzzer" technique was used with self-motivated participants who were capable of self-feeding. Participants were presented with food portions and were instructed to finish all their bites in a predetermined amount of time (e.g., 30 bites in 30 min). If the participant beat the buzzer, they were given access to a preferred tangible (e.g., toy prize).

For the purposes of the present study, all meals were conducted by a licensed psychologist and trained staff members utilizing behavioral techniques. Therapy consisted of systematic meal sessions with individualized behavioral protocols involving antecedent and consequence manipulation in meals. Treatment included positive reinforcement with the use of verbal praise, prize boxes, and access to preferred tangibles based on acceptance of food. The removal of preferred tangibles or a response cost (RC), was also used contingent on inappropriate behavior.

When reinforcement contingencies did not result in an increase in consumption, after receiving parental consent, treatment also included escape extinction (EE). Escape extinction is a procedure where the spoon or cup remains at the child's mouth until the bolus is consumed or the session timed out. EE is implemented when escape is presumed to be negatively reinforcing a child's mealtime behavior (Bachmeyer, 2009; Piazza et al., 2003). Escape from bites or drinks has been found to be the most common reinforcer for inappropriate mealtime behavior (Piazza et al., 2003, 2020; Saini et al., 2019). Common EE procedures include non-removal, in which the spoon or cup is kept at the child's mouth until the bolus is accepted, and physical guidance, which could involve placing gentle pressure on the child's mandibular joint or chin to guide the mouth open (i.e., jaw prompt), or placing one's finger along the child's upper gum line until meeting resistance (i.e., finger prompt) (Ahearn et al., 1996; Borrero, et al., 2013; Hoch et al., 1994; Rubio et al., 2021). It should be noted that EE techniques can sometimes produce side effects such as an increase or burst in inappropriate mealtime behavior (Bachmeyer, 2009; Piazza et al., 2020; Woods & Borrero, 2019). For this reason, implementation of EE requires sufficient therapist training and requires high treatment integrity (Piazza et al., 2020). Furthermore, caregiver perceptions and beliefs regarding EE should also be considered because when evidence-based interventions are seen as unacceptable to parents, they can be rendered ultimately ineffective (Kazdin, 2000; Rosenbrock et al., 2021). Therefore, it is strongly advised that clinicians are thoroughly trained in this procedure and practice within their scope of competence before implementing EE procedures (Piazza et al., 2020).

All participants in this study came into contact with EE at some point during their admission, particularly when the use of specialized techniques such as the finger prompt/side deposit were warranted. A side deposit procedure in which the therapist uses a NUK© brush to roll the bolus of food on the inside of the child's cheek has also been found to be effective for cases of passive refusal (Rubio et al., 2015). Other techniques used included visual aids (e.g., bite boards or token systems), simultaneous presentations of high and low preference foods, and "Beat the Buzzer" games to encourage increasing the pace of the meal (see Table 3).

4.2.2 | Caregiver training

Caregivers observed each session through a one-way window and all treatment procedures were discussed and agreed to by caregivers prior to implementation. Once the child began eating at least 3 new foods without significant

behavioral issues, they were brought into the room to be trained. Once caregivers were trained to feed their child using the protocol, the feeding team would leave the room and observe sessions from behind the one-way window. Treatment integrity was evaluated informally (e.g., feeding team observation), and caregivers were given instructional support through a one-way intercom speaker in the feeding room. If the caregiver could successfully feed a meal without intervention from the behavior team, they were provided instructions to begin feeding under the trained protocol at home. The behavior team would then continue introducing new foods in the clinic and once those foods met the criteria for being "mastered", caregivers would start rotating the new food into their structured meal times at home. It should be noted that telehealth services were also incorporated into the treatment package toward the end of the study due to constraints associated with the COVID-19 pandemic.

4.2.3 | Follow-up

Attempts were made to contact the primary caregivers of all 32 participants over a 3-week period as part of this study's procedures. To be clear, follow-up did not occur at a set time after the conclusion of treatment (e.g., 3 months after discharge). The follow-up interview consisted of asking questions related to the participant's weight, gastrostomy tube dependence (if any), texture of foods consumed, improvement of inappropriate mealtime behavior since discharge, whether the participant was self-feeding their meals, whether the caregivers sought out further feeding treatment, whether caregivers were continuing to follow a structured feeding protocol, and whether the program would be recommended to others. Mealtime observations were not included at follow-up for this study. A total of 21 (65.62%) caregivers of participants completed the follow-up interview. The average time between the date of discharge and collection of the follow-up data was 2.45 years.

5 | RESULTS

5.1 | MANOVA

Criteria for program evaluation were analyzed and the results are described below. All analyses were computed using the Statistical Package for the Social Sciences Version 27 (SPSS; Kulas et al., 2021). A one-way repeated measures Multivariate Analysis of Variance (MANOVA) was conducted to test the hypothesis that there would be significant improvements across weight, bite acceptance, inappropriate mealtime behavior, and caregiver satisfaction from admission to discharge. Time (admission vs. discharge) was the within subjects factor. A statistically significant MANOVA effect was obtained, $F(4, 28) = 54.87$, $p < 0.001$, Pillai's Trace = 0.89. The Pillai's Trace test statistic gives more robust results than the other test statistics when moved away from the normal distribution and the homogeneity of the covariance matrices is not achieved (Olson, 1974). The multivariate effect size was estimated at 0.89, which implies that 89% of the multivariate variance of the dependent variables is associated with the time factor.

5.2 | ANOVAs

A series of one-way ANOVAs were performed to examine individual mean difference comparisons of each of the dependent variables from admission to discharge (see Figures 1–4). To protect against Type I error, a traditional Bonferroni procedure was used decreasing the p value to 0.01. The results revealed that all but one of the mean comparisons (inappropriate mealtime behavior) were statistically significant at $p < 0.001$. Specifically, weight (W; $F[1, 31] = 56.89$, $p < 0.001$), bite acceptance (BA; $F[1, 31] = 30.84$, $p < 0.001$), and caregiver satisfaction (CS; $F[1, 31] = 151.35$, $p < 0.001$) increased significantly from admission to discharge. To account for expected weight gain over

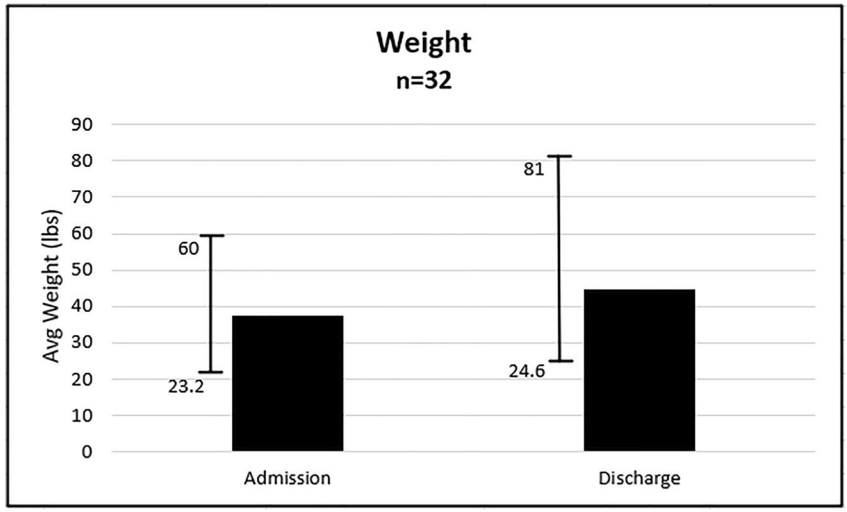

FIGURE 1 Weight comparison from admission to discharge. Minimum and maximum values displayed by range bars.

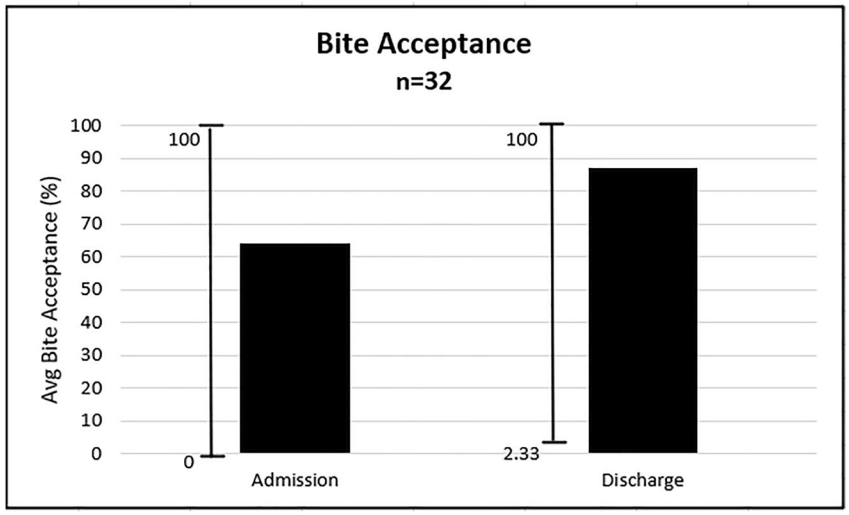

FIGURE 2 Bite acceptance comparison from admission to discharge. Minimum and maximum values displayed by range bars.

time, a percentile of weight for age was calculated for each participant at admission and discharge. Results showed that the average weight percentile went from 45.95% at admission to 52.76% at discharge. Utilizing non-parametric Wilcoxon analysis to compare pre- and post-treatment average weight percentiles, the results indicated a statistically significant relationship between the variables. This finding implies that changes in these average weight percentiles from admission to discharge are not random and are likely influenced by the treatment provided.

Though not statistically significant, frequency of inappropriate mealtime behavior did approach significance with a substantial decrease from admission to discharge (MR; $F[1, 31] = 3.61$, $p < 0.067$). Although inappropriate mealtime behavior only focused on the turning of the head and contact with the feeder, it should be noted that other problematic mealtime behaviors were observed and treated. This included packing food (i.e., keeping food stored in the cheek during bite presentations), expelling food (i.e., spitting the bolus of food out of the mouth), and emesis (i.e.,

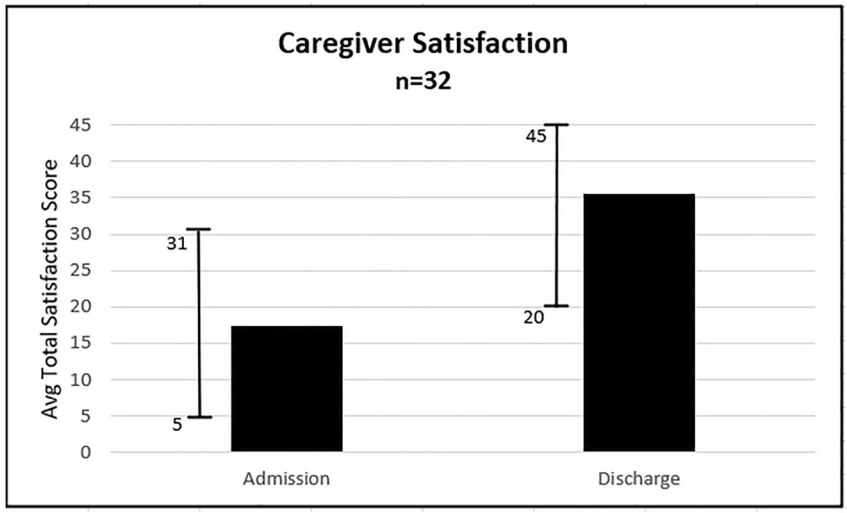

FIGURE 3 Caregiver satisfaction score comparison from admission to discharge. Minimum and maximum values displayed by range bars.

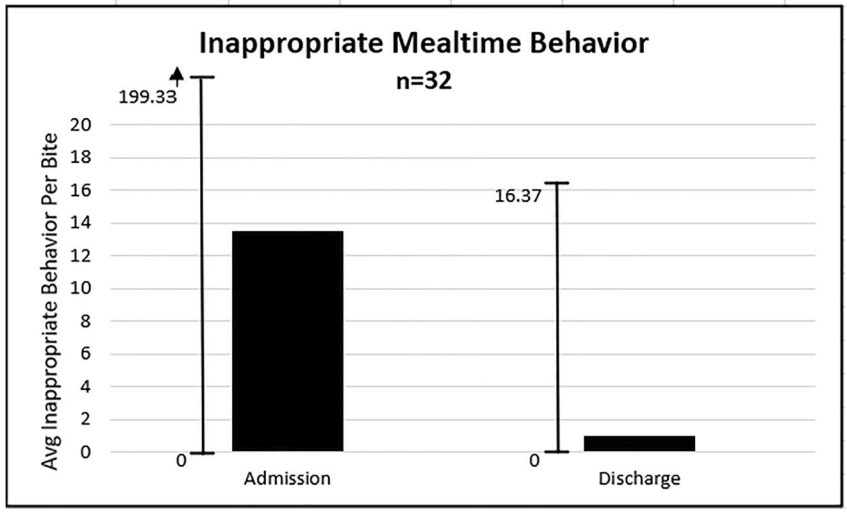

FIGURE 4 Frequency of inappropriate mealtime behavior comparison from admission to discharge. Minimum and maximum values displayed by range bars.

vomiting). Treatment for these behaviors included the manipulation of preferred tangible items, redistributing packed food with a NUK© brush, representing bites of expelled food, and the simultaneous presentations of high and low preferred foods.

5.3 | Texture advancement and number of foods consumed

All foods consumed were categorized into hierarchical texture categories [none, liquid, pureed, junior (applesauce texture), mashed/soft, regular (table food)]. Improvement from admission to discharge was indicated when a participant advanced from a lower category (e.g., pureed) to a higher category (e.g., regular). It was noted that out of the 32

participants, 7 had the opportunity to advance texture from admission (i.e., they consumed foods less advanced than regular textured foods), and 5 out of the 7 (71.43%) successfully were able to do that following treatment.

The number of foods consumed were categorized into numerical groups (i.e., 1–5, 6–10, 11–15, 16–20, 21–25, 26–30, >30). Improvement from admission to discharge was indicated when a participant advanced from a lower category (e.g., 1–5 foods) to a higher category (e.g., 6–10 foods). Following this criterion, 27 of 32 participants (90.00%) showed improvement. It should be noted that the number of foods consumed is difficult to capture by a caregiver report and is vulnerable to error.

5.4 | Caregiver satisfaction and follow-up

Caregiver satisfaction was measured based on a 9-item questionnaire administered at admission and discharge for each child. Each question was answered based on a 5-point Likert scale ranging from either 'very unhappy to very happy' or from 'almost never' to 'almost always'. Statistically significant improvement was seen across total scores and the pre and post scores are listed below (see Table 4).

Twenty-one of the 32 participants completed a follow-up questionnaire and the average time between the date of discharge and collection of the follow-up data was 2.45 years. Follow-up interviews were conducted with the same caregiver who was interviewed at discharge; further, the caregivers selected to answer questions were the ones who attended the majority of the treatment sessions. These included mothers (n = 17), fathers (n = 1), mothers/fathers (n = 1), and extended family members (e.g., aunts and grandparents) (n = 2) of participants. Three of the twenty-one follow-up respondents reported receiving some form of feeding therapy following discharge from the program (i.e.,

TABLE 4 Caregiver satisfaction survey.

	Admission [M (SD)] Range	Discharge [M (SD)] Range
How happy are you with the variety of foods the individual is currently eating?	1.94 (1.22) 1–5	4.38 (0.83) 3–5
How happy are you with the texture of foods the individual is currently eating?	2.25 (1.11) 1–5	4.03 (1.0) 2–5
How happy are you with the volume of foods the individual is currently eating?	2.25 (1.02) 1–4	4.38 (0.71) 3–5
How happy are you with the individual's participation in meals at home?	1.97 (1.06) 1–4	4.22 (0.91) 2–5
How often does the individual participate in family meals at home?	2.13 (1.13) 1–5	4.03 (1.28) 1–5
How happy are you with the individual's participation in meals at daycare/school/playgroup?	2.13 (1.33) 1–5	3.70 (1.09) 2–5
How often does the individual participate in meals at daycare/school/playgroup?	2.25 (1.33) 1–5	3.97 (1.30) 1–5
How happy are you with the individual's participation in meals in the community (restaurants, birthday parties, etc)?	1.78 (1.07) 1–5	3.72 (1.02) 1–5
How often does the individual participate in meals in the community (restaurants, birthday parties, etc)?	1.91 (1.12) 1–5	3.66 (1.23) 1–5

TABLE 5 Follow-up survey data % (n = 21).

Protocol usage (n)	
Using protocol	23.81 (5)
Not using protocol	52.31 (11)
Using modified protocol	23.81 (5)
Inappropriate mealtime behavior (n)	
Has improved since discharge	85.71 (18)
Gotten worse since discharge	0.00 (0)
Stayed the same since discharge	14.29 (3)
Continued receiving feeding treatment (n)	
Yes (Speech/OT)	14.29 (3)
No	85.71 (18)
Would you recommend the program? (n)	
Yes	100.00 (21)
No	0.00 (0)
Maybe	0.00 (0)

speech therapy to work on texture advancement). Further, none of the participants were dependent on tube feeds at the time of follow-up, including 3 of the 4 participants who were 100% gastrostomy tube dependent at the time of admission. It should be noted that adjustment to tube feeds was always determined by the child's pediatrician, nurse practitioner, or nutritionist. A total of 18 (85.71%) participants ate regular textured food, and the rest ate junior textured (e.g., applesauce texture) food. All participants were able to self-feed with utensils, with only five (23.80%) needing feeding assistance part of the time. All the participant's caregivers recommended the outpatient program to others (see Table 5).

6 | DISCUSSION

The effectiveness of behavioral interventions in the treatment of ARFID has been well documented in the literature. Single case and group designs have been used to demonstrate the efficacy of these interventions in the neurotypical and atypical pediatric populations. Most group studies looking at treatment outcomes of children diagnosed with ARFID have been done in intensive interdisciplinary feeding programs, many of which have the capabilities to provide state-of-the-art equipment and around-the-clock care. The question remained as to whether children from more sociodemographically diverse populations that have a markedly different access to integrated healthcare, equipment, and resources would be able to make long term gains in an outpatient single-disciplinary feeding program. To better address this question, the study done by Laud and colleagues in 2009 was replicated to the best of the present researcher's abilities given the staffing and resource issues that often accompany safety net service providers (i.e., providers that deliver services to the uninsured, Medicaid eligible, or other vulnerable patients). One aspect of the sociodemographic differences between both studies was evidenced by racially/ethnically marginalized persons only encompassing about 48% of the participants in the former study as opposed to minorities making up about 78% of the participants in the present one. The vast majority of participants in both studies were male and the average age of participants across both studies was not drastically different with both being evaluated at around the age of 5. Both studies reported that a minority of their participants exhibited medical diagnoses and issues, although the former study had more variability when it came to this. In the present study 75% of the participants were Medicaid funded. While funding sources for the prior study was unreported, it is unlikely that Medicaid would be the primary funding

source given the expense of running an intensive interdisciplinary system. Finally, one of the limitations clearly stated by Laud and colleagues was that the efficacy of various treatment modalities in a less intensive outpatient setting for children with ASD should be evaluated. While the present study was not limited to only those with ASD, the results did suggest that significant treatment outcomes can be obtained in a less intensive environment and gains following discharge can be maintained.

6.1 | Improvements in observable treatment outcomes

The first hypothesis in the present study was that there would be an improvement in observable treatment outcomes from admission to discharge as indicated by child weight, acceptance of foods, inappropriate mealtime behavior, complexity of food texture, and the number of foods consumed. This hypothesis was substantiated for all feeding behaviors observed with the exception of a statistically significant decrease in inappropriate mealtime behavior.

Statistically significant improvements in weight gain and acceptance of foods were a worthwhile finding given that these two outcomes tend to be the benchmark of success for many caregivers, pediatricians, and gastroenterologists. The average acceptance of food at admission was relatively high at 63.89% which may appear confusing given that the reason the participants were admitted to the feeding program was that they did not eat well. However, as noted in the methods section, fading procedures were used to gradually introduce new foods. It was not uncommon to start the first few sessions of each admission with familiar and often preferred foods in order to teach the rules of the meal and to promote success. After the participant came in contact with the reinforcing elements of the mealtime protocol, newer less preferred foods were gradually introduced. Despite this confounding variable, acceptance at discharge was statistically increased which corroborates the idea that children from various sociodemographic backgrounds can demonstrate significant improvements if given appropriate access to evidence-based outpatient behavioral treatment for ARFID. A further analysis of what factors predicted the best outcomes for these patients should be considered and a particular focus should be on the severity of the feeding disorder as there is certainly a need for more intensive interdisciplinary programs when treating complex cases.

While the means of inappropriate mealtime behavior drastically decreased from admission (13.47) to discharge (0.97), there was a wide variance in outcomes which would not be visible in a simple examination of means. This variance prevented the comparison from reaching statistical significance, although it was certainly approaching it. Further, limited statistical observations of power (0.452) because of error variance may have played a role in limiting the significance in this case. It should be noted that such a drastic decrease in the frequency of behavior indicative of a child being in distress, while statistically insignificant, may be clinically relevant to a concerned caregiver. Additionally, there was a significant increase in acceptance of foods indicating children were taking in the foods as needed at discharge, despite engaging in low levels of inappropriate mealtime behavior.

Improvements in increasing complexity of food texture was also found. Given that advancement in levels of textures was not possible for 25 of the 32 participants who were already eating regular textured food (i.e., table food), a ceiling effect was demonstrated. Nevertheless, of the 7 children that had room to improve in texture advancement, 5 of them did so. It should be noted that if a child did not have the oral motor skills or ability to progress with texture, texture advancement was not a goal of the program and referrals were made to the appropriate oral motor therapists once mealtime behavior issues improved.

Progress in the number of foods consumed was descriptively analyzed as well given that caregiver report proved to be prone to error. In most cases, caregivers would list recent foods the child had eaten; however, many had difficulty giving a comprehensive list of all foods the child would eat without refusal. For example, many caregivers would state, “My child will eat that with no problems, but we haven't given it to him in months, so I didn't think to list it here.” It should also be noted that at both admission and discharge, the list of foods that the caregivers considered “consumed” was defined as not tasting, but regularly consuming an age-appropriate amount. Future studies may consider a better way of operationally defining how a food is considered “consumed”. Despite this, 27 of the 32

participants showed an increase in the number of foods consumed from admission to discharge, with most reporting an increase of 10–15 foods.

6.2 | Improvements in caregiver assessment measures

It was hypothesized that there would be an improvement in caregiver assessment measures from admission to discharge as indicated by caregiver satisfaction with their child's mealtime experiences and maintenance of gains at follow-up from the program. Both caregiver assessment measures demonstrated positive results.

Studies have found that a severe feeding disorder not only affects the child's overall health and development, but also greatly impacts the caregiver-child relationship, which can lead to significant emotional distress in the caregivers (Budd et al., 1992). Greer et al. (2007) found that an intensive interdisciplinary feeding program could significantly improve caregiver stress in addition to child outcomes. In the present study, while caregiver stress was not specifically targeted, significant improvements from admission to discharge in caregiver satisfaction were found. Satisfaction scores were totaled across different facets of feeding behavior (e.g., variety, texture, volume, feeding behavior in different settings) and caregivers appeared to find an improvement in almost all areas. This is an important finding as a caregiver's perception of improvement is in many ways just as important as the clinical measure of improvement. If a caregiver continues to be dissatisfied with their child's progress in feeding, this can have a negative impact on the caregiver-child relationship ultimately leading to a regression in mealtime behavior. From a clinical standpoint, caregivers who have clinically elevated stress levels at admission may require more attention and social support as they progress through the program. This is an area that should be further explored, particularly in families who come from lower socioeconomic backgrounds.

The final finding from this study was that of the follow-up results. All caregivers, with the exception of three, reported their children's feeding behavior continued to improve after discharge. Further, no caregivers reported feeding behavior had gotten worse since discharge, and all stated they would recommend the program. Another useful finding was that only 23.81% of caregivers reported continuing to use the structured protocol they were taught in treatment. If almost all participants in the study reportedly improved their feeding behavior at follow-up but most were no longer needing a structured protocol, this suggests that generalization of positive mealtime behavior had occurred. This is a particularly promising finding for families who have limited means and do not often have the ability to provide a structured mealtime routine on a consistent basis. Ultimately, the goal for most caregivers is that they can place a well-balanced meal in front of their child and expect it to be eaten with little intervention and the follow-up findings suggested that this can occur in children of various sociodemographic backgrounds.

6.3 | Limitations

Though the contribution of this study is to provide affirming evidence that sociodemographically diverse children and families can benefit from an outpatient behavioral feeding program, several limitations should be considered and if applicable, addressed in future studies. First, the setting disallowed the inclusion of more medically complicated participants with feeding disorders. This limitation includes the inability to formally assess for and treat oral motor challenges (i.e., children who do not know how to chew). From a health equity lens, this perpetuates limited availability of resources for lower resourced populations who need more intensive care. Second, though all staff members were trained on taking behavioral data in treatment sessions by a licensed psychologist, inter-rater reliability was not measured due to limited staff resources. This may have an implication on the measurement of bite acceptance and inappropriate mealtime behavior at admission and discharge across all participants which can impact procedural integrity. Further research is critical to determine how these barriers common to community-based settings can be reduced for the benefit of children and families. Third, behavioral data was collected on acceptance and frequency

of inappropriate mealtime behavior, but an emphasis was not placed on the amount consumed for each participant. Although each participant in the study was consistently eating 30 rounded bites of food at each session by discharge, the amount of food consumed was not obtained in a measurable way (e.g., weight in grams). This would have provided a more exact measurement of how much food was consumed at each session and will be considered for future studies. Fourth, although caregiver satisfaction was included in analyses, caregivers were not asked to rate their satisfaction by treatment component (e.g., intake assessment, EE strategies, reinforcement-based strategies, etc.). Collecting this data for future research would provide an opportunity for researchers to better understand the social validity of the different components of behavioral feeding interventions, for the ultimate purpose of improving the treatment experience for families. Fifth, follow-up procedures were only based on indirect assessment. Specifically, follow-up did not include a mealtime observation, therefore, caregiver reports of protocol usage were not confirmed by the feeding team. Laud et al. (2009) also stated this as a limitation in their study given that most caregivers did not return for direct mealtime observations. Finally, caregivers who followed a "modified protocol" were not asked which components of the protocol they were taught had been modified. Future studies should explore this at follow-up as a potential indication of treatment acceptance, integrity, and adherence.

7 | CONCLUSION

The present study was an attempt to replicate the work done by Laud and colleagues in 2009 within the confines of a less intensive single-disciplinary feeding program. The contribution to existing literature on the outpatient behavioral treatment of pediatric feeding disorders remains significant, particularly with a unique addition of long-term follow-up results which are not commonly cited in other studies. For children and families from historically underserved and under-resourced backgrounds, evidence-based behavioral procedures in an outpatient setting can produce lasting change in children's feeding and mealtime behavior.

A unique point to highlight is that the majority of participants in this study were of Hispanic/Latinx origin. Given the limitation of research on the impact that culture plays in food selectivity, exploration in this area is warranted. Anecdotally, we noticed that the Hispanic/Latinx mothers in particular, were specifically concerned about their children being underweight, despite many of them being near the 50% percentile compared to their peers. Many of the Hispanic/Latinx mothers were also more likely to cater to their children as evidenced by making separate meals for them and taking highly preferred foods to their schools on a daily basis during lunch time. Similarly, we saw what appeared to be a greater level of guilt with the Hispanic/Latinx mothers in particular, with one of them even insinuating that she was a bad mother because a "mother's job is to feed her child nutritious foods". In one case, a mother was concerned when she saw that the treatment room did not have a sink in it. She stated that the only way her son would eat is if he was playing with running water so she would feed him sitting next to the kitchen sink at each meal at home. We placed great importance on rapport building with all of the families we worked with, but with our Hispanic/Latinx families in particular, we found they appreciated the extent we went to make them comfortable. For example, in-person interpreters were present upon request to ensure that caregivers felt understood. Families brought in their own food, and we often encouraged them to choose foods that they would feed the rest of their families at home. All prompts/verbal comments including "take your bite", "chew", "open", "close", "swallow", and "good job" were done in Spanish at the family's request. A recent addition to our feeding program was a feeding generalization room that was built to resemble a kitchen complete with a camera. This was done based on feedback by many of our Hispanic/Latinx families who wished for a more natural setting in which their family could eat together at a table. While these anecdotal observations represent a piece of the puzzle, programs may be improved by providing tailored recommendations based on feeding practices commonly used within specific cultures to reduce the severity of food selectivity. More research, however, is needed to fully understand the antecedents of food selectivity and how they differ by racial/ethnic group.

While the results of this study are promising, it should be noted that children exhibiting medical fragility, severe oral motor difficulties, and/or intense behavioral issues due to an extensive problematic feeding history are better

served in settings with the proper interdisciplinary team members to meet their specific needs. Readers should be cautioned that the complexity of each case should be closely assessed as outpatient treatment may not always be a suitable option. Unfortunately, all too often community behavioral health centers are taxed in resources and are unable to find the funding to provide intensive interdisciplinary treatment. To ensure adherence to ethical standards, Williams and Seiverling (2023) recommended that an experienced clinician with interdisciplinary knowledge specific to feeding problems should be involved in not only the assessment process, but also ongoing treatment. Further, it is clear that severity of feeding disorders often has a linear relationship with age, so an emphasis on early intervention cannot be overstated. Nevertheless, researchers and practitioners should consider evidence-based behavioral feeding treatment in outpatient settings as a way of reaching many children whose feeding issues are not severe enough to warrant an intensive interdisciplinary approach. Research extending this work can better inform providers of the unique treatment experiences of diverse populations, better equip them to dismantle widespread treatment disparities, and emphasize the need for early intervention.

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CONFLICT OF INTEREST STATEMENT

There are no financial interests associated with this research, nor do the authors have any conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICS STATEMENT

Finally, the contents of the manuscript are consistent with the Committee on Publication Ethics guidelines relative to research and publication ethics.

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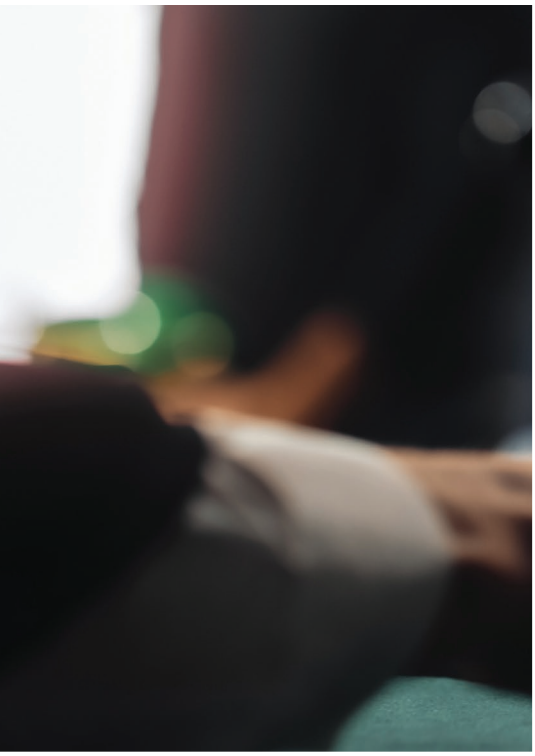
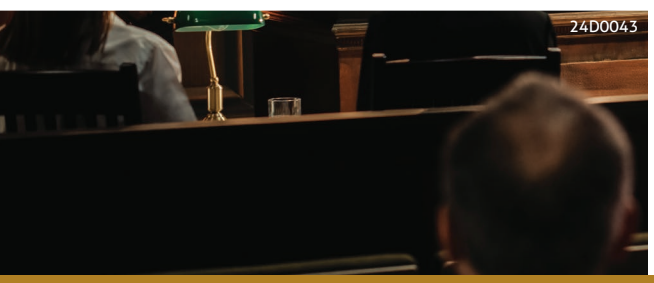
EXHIBIT F-36



Texas Competency Restoration Guide

September 2023



TEXAS BEHAVIORAL HEALTH AND JUSTICE TECHNICAL ASSISTANCE CENTER

TEXAS Health and Human Services

Table of Contents

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Introduction

The competency to stand trial process is designed to protect the rights of people who do not understand the charges pending against them and are unable to assist in their own defense. In Texas, the prosecution, defense, or trial court can suggest that the person accused of a crime may be incompetent to stand trial (IST). The court can dismiss the charges against the person or pause court proceedings and order a competency evaluation if, after conducting an informal inquiry, the court determines that evidence exists to support a finding of incompetency. If the court does not dismiss the charges and the person is found IST, the court can order the person to receive competency restoration (CR) services in an inpatient facility, outpatient or community-based program, or jail-based setting.

The purpose of this guide is to provide general guidance and education to judges, lawyers, mental health and intellectual and developmental disability providers, law enforcement, family, and other members of the community on the CR process. The provided guidance is meant to be suggestive rather than prescriptive and used in the context of the services and support available in a community. Although the CR system in Texas serves justice-involved people with mental illness or intellectual or development disabilities, this guide focuses exclusively on the services and support provided to people with mental illness.

Foundations of Competence to Stand Trial

The competency to stand trial process is designed to protect the rights of people with mental illness or an intellectual or developmental disability. A person may be found incompetent to stand trial (IST) if they do not have (1) sufficient ability to consult with their lawyer with a reasonable degree of rational understanding or (2) a rational and factual understanding of the proceedings against them (Code of Criminal Procedure (CCP) Art. 46B.003).

In Texas, the competency to stand trial process begins when the prosecution, defense, or trial court raises the issue of competency. The court may dismiss the charges against the person or pause court proceedings and order a competency evaluation if, after conducting an informal inquiry, the court determines that evidence exists to support a finding of incompetency. Local courts are liable for the costs associated with the provision of a competency evaluation.

If the court orders a competency evaluation and the person is found IST, the court can order the person to competency restoration (CR) services. These services are designed to stabilize symptoms of mental illness and provide legal education so that the criminal trial can resume. The appropriate use of the competency to stand trial process and consideration of alternatives to inpatient CR services can reduce the strain placed on state, county, and municipal resources when demand for CR services exceeds capacity.

Interventions used to restore competency may include psychotropic medications, legal education, and specialized or individualized treatments. Psychotropic medications are the most common form of treatment for people found IST and research strongly supports their use in CR. Legal education provided during CR may vary by program, but generally includes multiple elements of legal education to ensure the participant understands the criminal justice system. The education component of CR may also include skills training on how to manage stress or other adverse experiences that can occur before, during, or after court. Specialized treatments may include deficit-focused remediation, individual or group therapy, and life skills training. Depending on the person receiving services, deficit-focused remediation may focus on deficits in rational understanding as it pertains to the charges against them and their ability to consult with their attorney.

It is important to note that CR is not designed to be an avenue to ongoing treatment for people with MI or IDD. A person may be connected to ongoing treatment over the course of their engagement in CR, but connection to ongoing treatment is not a requirement for successful program completion. CR is intended only to ensure that criminal proceedings may resume.

CR services can be provided in multiple settings, including state hospitals, jails, and in community-based outpatient programs. Although the interventions used by a CR program may vary between providers and settings to a small degree, all can provide psychiatric medication and legal education as primary foundations. The primary differences between CR settings may be program structure and the level of supervision.

Inpatient CR takes place in a secure hospital setting and includes medication stabilization, treatment planning, and legal education. Inpatient care is the most expensive form of CR.[1] The expense associated with inpatient CR increases when considering the costs of incarceration incurred by counties for the period between arrest and receipt of CR and the period between hospital discharge and the resumption of criminal proceedings. A national study found that the average length of stay for inpatient CR in a state hospital setting was 73 days with a rate of restoration of 80 to 90 percent.

For a person committed to a non-maximum security (Non-MSU) inpatient CR unit in Texas in 2023, the average total cost of incarceration prior to hospital admission and inpatient CR is approximately $361,000.[2] For a person committed to a maximum-security unit (MSU), the average total cost of incarceration prior to hospital admission and inpatient CR is $248,000. The cost of incarceration and hospitalization can increase or decrease depending upon the period between arrest and the issuance of a commitment order, the period between the issuance of the commitment order and hospital admission, and the hospital length of stay required to restore the person to competence.

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[1] Danzer, G.S., Wheeler, E.M.A., Alexander, A.A., & Wasser, T.D. (2019). Competency Restoration for Adult Defendants in Different Treatment Settings. *Journal of the American Academy of Psychiatry and the Law Online, 47(*1), 68-81. DOI: https://doi.org/10.29158/JAAPL.003819-19

[2] Calculation is based on the average number of days a person is incarcerated prior to receipt of competency restoration services, the average length of stay for a person receiving inpatient CR services in a state hospital, and county jail and state hospital bed day costs.

Jail-based competency restoration (JBCR) is provided in jail to people found IST. In Texas, the Local Mental Health Authority (LMHA) or Local Behavioral Health Authority (LBHA) must contract with the county jail to provide CR services (CCP Art. 46B.091(c)). The JBCR program must:

- Operate in a designated space in the jail to conduct JBCR services;
- ensure coordination of general health care; supply clinically appropriate psychoactive medications to administer court-order medications to program participants; and

provide weekly competency restoration hours commensurate to the hours provided as part of a competency restoration program at an inpatient mental health facility (CCP Art. 46B.091(d)). When the length of time for admission to an inpatient facility is great, JBCR services can be provided more expediently. For a person placed in JBCR in Texas, the average total cost of incarceration and the provision of CR services prior to adjudication is approximately $55,000.[3]

Outpatient competency restoration (OCR) may be provided by the LMHA or LBHA to people found IST and released on bail after consideration of public safety and effectiveness of treatment. OCR is the least restrictive setting in which to provide CR services, and service recipients may also have access to additional behavioral health services and support offered by the CR provider, including housing, case management, and peer support.

For a person placed in OCR in Texas, the average total cost is approximately $17,000.[4] OCR programs can be structured in various ways and may include housing or housing assistance. OCR programs that include housing are generally more costly on a per participant basis than those without a housing component.

Table 1 provides summary information concerning each setting in which CR can be provided.

[3] Calculation is based on the number of days a person is incarcerated, including time in a JBCR program and a county jail bed day cost of $100.

[4] Calculation is based on HHSC contract costs. The estimated cost of OCR does not include the average cost of incarceration for people ordered to OCR for the period between the person's arrest and their admission to the OCR program.

Table 1: Summary Information on CR by Setting

Type of Competency Restoration	Inpatient Competency Restoration	Outpatient Competency Restoration	Jail-Based Competency Restoration
Physical Location	State Hospital or Contracted Facility	Community or residential	In jail in designated space separate from general population
Bond Status	Bond NOT required	Bond required	Bond NOT required
Eligibility	No eligibility criteria	Specific eligibility criteria set by OCR provider	Specific eligibility criteria set by JBCR provider
Treatment Length **(Initial commitment)**	- Misdemeanor- up to 60 days (CCP Art. 46B.073) - Felony- up to 120 days (CCP Art. 46B.073) - Possibility of requesting a 60-day extension (CCP Art. 46B.080)	- Class B Misdemeanor – up to 60 days (CCP Art. 46B.0711) - Class A Misdemeanor or Felony – up to 120 days (CCP Art. 46B.072) - Possibility of requesting a 60-day extension (CCP Art. 46B.080)	- Misdemeanor – up to 60 days (CCP Art. 46B.073) - Felony – 60 days + may continue to provide services for authorized period unless inpatient or OCR slot available (CCP Art. 46B.091) - Possibility of requesting a 60-day extension (CCP Art. 46B.080)

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Principles of Competency Restoration

The following principles are intended to provide general guidance to judges, lawyers, mental health clinicians, law enforcement, family, and other community members to support an effective and efficient CR system. These principles are meant to be suggestive rather than prescriptive and used in the context of the services and support available in a community.

The principles were developed through a collaborative process:

- The Substance Abuse and Mental Health Services Administration (SAMHSA) GAINS Center hosted an expert panel of CR experts in August 2022;
- attendees from the Texas delegation formed the Steering Committee to support development of this guide;
- the TA Center hosted two focus groups with subject matter experts from across the state; and
- additional review was solicited through a peer-review process.

Principles of Competency Restoration

1. Access to robust, appropriate, and timely community-based services and support is essential to divert people with mental illness from the criminal justice system and to promote reentry after a period of incarceration. This is the foundation for reducing the number of people determined incompetent to stand trial (IST) who need CR.

The National Association of Counties describes a behavioral health continuum of care as programs and practices that help people before, during, and after an emergency. The central components are:

Before an emergency by connecting them to treatment and services in the community that target unmet behavioral and physical health needs before they escalate to a crisis;

During an emergency through a coordinated crisis response system that provides community members with someone to call, someone to respond and somewhere to go; and

After an emergency via continuing system collaboration and linkages to social services, peer support, and recovery care.

SAMHSA developed the Certified Community Behavioral Health Clinic (CCBHC) model to ensure access to coordinated comprehensive behavioral health care for people with mental health and substance use conditions. CCBHCs are required to provide a comprehensive array of behavioral health services and care coordination to help people navigate behavioral health care, physical health care, social services, and the other systems. In Texas, all LMHAs and LBHAs are certified as CCBHCs. For more information, see, Texas Certified Community Behavioral Health Clinics.

In the context of this guide, the term "diversion" or "divert" describes any action or intervention that reduces justice involvement for people with behavioral health conditions. Communities have many options for diverting people with behavioral health conditions from the criminal justice system. Examples include specially trained law enforcement officers, behavioral health and law enforcement co-responder programs, diversion or drop-off centers, and specialty court programs. The Sequential Intercept Model (SIM) offers communities and partners a framework for identifying potential diversion opportunities at each stage of the criminal justice process.

Preventing justice involvement may be the most effective and efficient way to create an effective CR system. SAMHSA's Principles of Community-Based Behavioral Health Services for Justice-Involved Individuals can help behavioral health providers and their partners identify the core components of services to reduce and prevent justice-involvement for people with mental illnesses.

In addition to developing robust, appropriate, and timely community-based services, communities may need to undertake a public outreach and education initiative to raise awareness of the services and support available to the community, including targeted outreach to criminal justice partners such as law enforcement, the District Attorney's Office, the Public Defender's Office, the private defense bar, Managed Assigned Counsel Programs, and District and County Judges and court staff.

2. People for whom the compelling interest to prosecute is low are not considered for CR. People for whom the compelling interest to prosecute is high receive CR services in the least restrictive setting as appropriate.

How a community understands compelling interest may depend on its priorities, preferences, needs, and resources. In instances when a person with mental illness is charged with a crime due to the nature of their mental illness, variables to consider when determining compelling interest may include:

- Nature of the charged offense and aggravating factors;
- circumstances under which the offense was committed;
- concerns and safety of the alleged victims and community;
- Availability of inpatient CR; and
- wait time to receive CR in the context of the maximum sentencing term provided by law for the alleged offense.

There may also be differences in the understanding of compelling interest between partners within a community. To establish a uniform understanding and application of compelling interest, a community may need to improve communication, coordination, and collaboration between partners that serve people at risk of justice-involvement, especially those who may interact with the CR system. Effective communication, collaboration, and coordination within a community may support greater understanding of compelling interest within such community as it pertains to the utilization of CR and CR placement decisions.

Common charges for which the compelling interest to prosecute may be low include non-violent misdemeanor offenses such as criminal trespass, criminal mischief, disorderly conduct, and those that relate to a person's substance use disorder. Community partners may benefit from training and education on the impact that mental illness can have on the commission of these or similar offenses.

Partners may also consider the purpose of CR as described in the introduction to this guide relative to the identified objective and preferred outcome of the court proceedings. For example, if the objective of the proceedings is to connect the person to ongoing community-based care, CR is not the most efficient and effective means to accomplish this objective. When the purpose of CR does not match the

objective or preferred outcome of the court proceedings, partners may consider alternative dispositions.

People for whom the compelling interest to prosecute is low and therefore not considered for CR may still require mental health services. Partners who interact with the CR system may benefit from education on the services and support available and accessible in their community, to ensure that people who are not considered for CR are considered for alternative mental health services and dispositions.

3. CR is used only to stabilize symptoms of mental illness and provide legal education to allow for the resumption of the adjudicative process.

The purpose of CR is to stabilize symptoms of mental illness and provide legal education so that a person may continue in the legal process. Psychotropic medications are the mainstay treatment to stabilize symptoms of mental illness for people who are IST. The limited scope of services provided to restore competency may mean that an alternative disposition that allows for substance use treatment, assertive community treatment (ACT), forensic assertive community treatment (FACT), or post-arrest diversion may better meet the needs of the person, court, and community.

CR services may include counseling, case management, and life skills training to help the person successfully transition back to the community upon case dismissal or discharge. People found IST who do not receive supplemental mental health services may experience challenges with community reintegration and stability.

4. The CR system provides clear accountability for systematic efficiency, equity, quality evaluators and evaluations, and is committed to confidentiality.

Article 46B.022 of the Texas Code of Criminal Procedure outlines the qualification criteria to be appointed as an expert to conduct a competency evaluation (See: Appendix D). However, adherence to the evaluator qualification criteria does not guarantee that the evaluator observes best- or promising practices when conducting an evaluation.

The Journal of the American Academy of Psychiatry and the Law provides principles and practices for competency evaluators to conduct quality evaluations, including that the evaluator should:

- Learn about the state's allegations and the actions that led to the prosecution, defense, or court to question the person's competence, and review court orders, discovery materials, court filings, indictments, transcripts, depositions, and other relevant collateral records or documents;
- obtain pertinent background information, including the personal and family history, housing status, and academic or occupational history; and
- consider the potential impact of cultural and social differences between the evaluator and the person being evaluated as they relate to the evaluator's assessment of the variables to be included in the written report.

The utilization of a peer review tool can improve the adoption of best and promising practices by competency evaluators in conducting competency evaluations. Peer guidance on ways in which evaluators can improve their performance and recognition of elements of the evaluation process that exceed established standards can contribute to greater efficiency and efficacy in the CR system. Elements or items of interest in peer evaluations may include an assessment of the evaluator's disclosure of the purpose of the evaluation and the process description provided prior to evaluation; necessity, sufficiency, and relevance of background information collected; completeness of the clinical review and mental status examination; full consideration of the patient's motivation; and adequacy of information provided in the evaluation.

The peer review process also provides forensic evaluators with the opportunity to engage in collegial peer-to-peer feedback. Peer-to-peer learning provides space for an open dialogue on ways to better incorporate psychological testing and the ways in which evaluators describe cognitive impairments, intellectual disabilities, and instances of feigning or exaggeration of symptoms. Evaluators may also identify opportunities for additional training opportunities to support ongoing improvement in report writing.

Similar to the qualification criteria for competency evaluators, the Code of Criminal Procedure stipulates the information that must be included in a competency evaluation but does not include best or promising practices to enhance the quality, accuracy, and utility of these evaluations.

The Council of State Governments' (CSG) publication Just and Well: Rethinking How States Approach Competency to Stand Trial provides guidance on providing quality and equitable competency evaluations, including that jurisdictions should consider

conducting evaluations, to the degree possible, in the community to ensure that people are able to stay close to home and in the least restrictive setting possible. Videoconferencing applications can be used to expedite the evaluation process in rural and remote communities in which a competency evaluator may not be readily available.

Partners in the CR process must also emphasize the importance of confidentiality when handling or sharing Protected Health Information (PHI) and observe the protections provided by state and federal law. Information on state and federal privacy and information sharing provisions can be found below.

- Section 533.009 of the Health & Safety Code: Exchange of Patient Records
- Section 611.004 of the Health & Safety Code: Authorized Disclosure of Confidential Information Other Than in Judicial or Administrative Proceedings
- Section 614.017 of the Health & Safety Code: Exchange of Information
- Title 42, Part 2 of the Code of Federal Regulations: Confidentiality of Substance Use Disorder Patient Records

Please see **Appendix D: Qualifications of Competency Evaluators and Competency Evaluation Requirements** *for references to Texas statute on competency evaluator qualifications and requirements for competency evaluations.*

5. The CR system emphasizes early identification and intervention, matching the services provided to the person's needs, and ensures continuity of services and support for people moving between treatment settings.

Preventing justice involvement may be the most effective way to create an efficient CR system. Diversion before arrest, when appropriate, and connection to treatment can reduce the demand for CR.

Once a person has been arrested, opportunities for early identification include mental health screening at jail booking and CCP Article 16.22 interviews. Timely assignment of defense counsel can support early identification of people who may have a mental illness, including those who may be IST. In Texas, jails must run the Texas Law Enforcement Telecommunications System (TLETS) Continuity of Care Query (CCQ) at every booking to identify people who have received mental health

services at an LMHA, LBHA, Local Intellectual and Developmental Disability Authority (LIDDA), or state hospital in the previous three years.

CR providers may consider utilizing a competency screen when they believe a patient has restored to trial competency to assist in determining if a full reevaluation may be necessary. Competency screens save time and resources and improve the efficient and effective utilization of the CR system. Competency screens may be used as possible credible evidence of immediate restoration in a motion to re-evaluate trial competency for people awaiting CR.

There is no one-size-fits-all solution or treatment for people with mental illness. The most effective treatment for one person can be different for another person, even in instances when they share a diagnosis, treatment histories, and socioeconomic or demographic characteristics. Ensuring that the services provided meet the unique needs of each person with a mental illness, including those who may be IST, can help to improve treatment outcomes and reduce the strain placed on local and state mental health treatment providers.

Continuity of services and support for people moving between treatment settings relates to people who have been restored to competency who return to jail to await adjudication as well as people who have been adjudicated, had their case dismissed or discharged, and have returned or will return to their community. Continuity of services and support also captures people who "step up" or "step down" to a higher or lower level of care, based on service engagement or treatment outcomes.

Clear and consistent communication between local mental health providers and criminal justice partners is essential to early identification, service matching, and service continuity.

6. The CR system is defined by strong collaboration among mental health providers, law enforcement, jail administration, prosecutors, defense attorneys, the judiciary, and all three branches of state and local government.

The primary partners involved in the CR system include judges, prosecutors, defense attorneys, jail administrators and medical staff, and mental health clinicians. Each partner plays an important and complimentary role in each step of the CR system. The Eliminate the Wait Toolkit for rightsizing CR services in Texas provides partner-specific checklists with ways in which to improve coordination and collaborate across the CR system.

To successfully collaborate, partners should create a coordinated process for communication and action.

7. Partners involved in the CR process observe and promote appropriate and statutorily required timelines for tasks that fall within their respective domains.

The Texas Code of Criminal Procedure (CCP) provides timeframes within which the steps in the CR process must be complete. This guide includes steps that are part of the early identification process as well.

- The Sheriff or municipal jailer must notify the magistrate within 12 hours of the receipt of credible information that may establish reasonable cause to believe that a person in their custody has a mental illness (Art. 16.22(a)(1)).

- If ordered to conduct an Article 16.22 interview, the service provider that contracts with the jail, LMHA or LBHA, LIDDA, or other qualified MI or IDD expert must submit a written report of the interview to the magistrate within 96 hours of the issuance of the order or, if the person is no longer in custody, within 30 days of the issuance of the order except as permitted by the magistrate for good cause shown (Art. 16.22(b)(1) and 16.22(b)(2))

- If competency proceedings are initiated, the disinterested expert or experts who complete a competency examination must submit their report on the person's competency or incompetency within 30 days of the order for the exam except as otherwise permitted by the court for good cause shown (Art. 46B.026).

- If a person is committed to outpatient competency restoration (OCR), the program must report to the court the person's progress toward achieving competency within 14 days of the onset of CR services and at least once every 30 days until the defendant is released from the OCR program (Art. 46B.077).

- If a person is committed to inpatient CR or jail-based CR, the facility or program must report to the court the person's progress toward achieving competency at least once during the commitment period (Art. 46B.077).

- The CR provider must notify the court not later than 15 days before the expiration of the initial restoration period that the restoration period is about to expire (Art. 46B.079(a)).

- If the person has not been transported to court within 15 days of the date on which the court received notification that the CR period is about to expire or the person has attained or is unlikely to attain competency in the foreseeable future, the CR program administrator must cause the person to be promptly transported to the court and placed in the custody of the sheriff of the county in which the court is located (Art. 46B.082).

- The court shall notify the prosecution and defense of the person's return to the court within 1 business day of their return (Art. 46B.084(a)(1)).[5]

- Within 3 business days of the date that notice is received, or, on a showing of good cause, a later date specified by the court, the attorney for the person shall meet and confer with them to evaluate whether there is any suggestion that the defendant has not yet regained competency.[6]

- The court must make a determination on the person's competency to stand trial within 20 days of the date the court received notice from the program administrator or within 5 days of the person's transport to the court, whichever occurs first (Art. 46B.084(a-1)(1)).[7] In most circumstances, the court must give preference over other matters before the court to the trial of a person found IST who has been restored to competency (Art. 32A.01)

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[5] Notwithstanding Subdivision (1), in a county with a population of less than 1.2 million or in a county with a population of four million or more, as soon as practicable following the date of the defendant's return to the court, the court shall provide the notice required by that subdivision to the attorney representing the state and the attorney for the defendant, and the attorney for the defendant shall meet and confer with the defendant as soon as practicable after the date of receipt of that notice (Art. 46B.084(a)(2)).

[6] *Ibid.*

[7] Notwithstanding Subdivision (1), in a county with a population of less than 1.2 million or in a county with a population of four million or more, the court shall make the determination described by that subdivision not later than the 20th day after the date on which the court received notification under Article 46B.079, regardless of whether a party objects to the report as described by that subdivision and the issue is set for a hearing under Subsection (b) (Art. 46B.084(a-1)(2)).

- The court must resume criminal proceedings within 14 days of the court's determination that the person's competency has been restored (Art. 46B.084(d)(1)).[8]

Adhering to post-restoration timelines are critical to ensuring a person does not decompensate prior to the resumption of criminal proceedings.

Please see **Appendix E: Competency Restoration Flowcharts** *for CR process flowcharts that include information on statutorily allotted timelines for the completion of certain steps in the CR process.*

8. Partners implement data-driven decision-making processes, to include a data collection, analysis, and dissemination strategy.

There may be as many data systems with unique data elements and definitions as there are partners engaged in the CR system. However, enhanced coordination between partners may present the greatest opportunities to improve local and state CR systems.

Data points to consider when utilizing data to drive decision-making in the CR process include:

- Exact and probable TLETS matches to identify the percentage of people who have received services from an LMHA, LBHA and state hospital in the last three years that are being booked into jail.
- Percentage of people referred to CR with misdemeanor charges and types of offenses to assess if diversion opportunities are being utilized by law enforcement.
- Number or percentage of people for whom the issue of competency is raised and were previously found incompetent to stand trial and not restorable.

[8] Notwithstanding Subdivision (1), in a county with a population of less than 1.2 million or in a county with a population of four million or more, on the court's own motion criminal proceedings in the case against the defendant shall be resumed as soon as practicable after the date of the court's determination under this article that the defendant's competency has been restored (Art. 46B.084(d)(2)).

- Average and median number of days a person is involved with the criminal justice system (incarcerated or on bond) from the time a person is arrested to a court order for CR to assess court efficiencies.

- SAMHSA's *Data Collection Across the Sequential Intercept Model (SIM): Essential Measures* provides guidance on how to collect, use, and share data, as well as data points to consider for collection relative to each intercept on the SIM, from community-based services and crisis response to community corrections and reintegration.

9. Partners are knowledgeable about the CR process, including the sequence of events, terminology, and processes.

Professionals and practitioners engaged in the CR system require expertise in their scope of responsibility. However, all partners can benefit from a full understanding of the CR system and the roles and responsibilities of each professional. A shared understanding of the CR system by all partners can support ongoing improvement and innovation in supporting people who may be IST and in the delivery of CR services.

Please See **Appendix E: Competency Restoration Flow Charts** *for a comprehensive flow chart of the CR system published in the Texas Mental Health and Intellectual and Developmental Disabilities Law Bench Book as published by the Texas Judicial Commission on Mental Health.*

10. CR placement decisions are guided by research, data, statute, administrative rule, and the best available tools to support decision-making that consider legal severity, clinical acuity, and risk of recidivism.

Inpatient settings are often the default when considering where a person will receive CR services. However, when outpatient and or jail-based CR services are available, the least restrictive setting should be utilized when appropriate. Using a structured decision-making tool that balances research, statute, and public safety, such as the one in this guide, can help judges, attorneys, and providers determine the most appropriate setting.

Please see **Appendix A: Principles of Competency Restoration** *for a printable graphic of the Principles of CR with select definitions and practical pointers.*

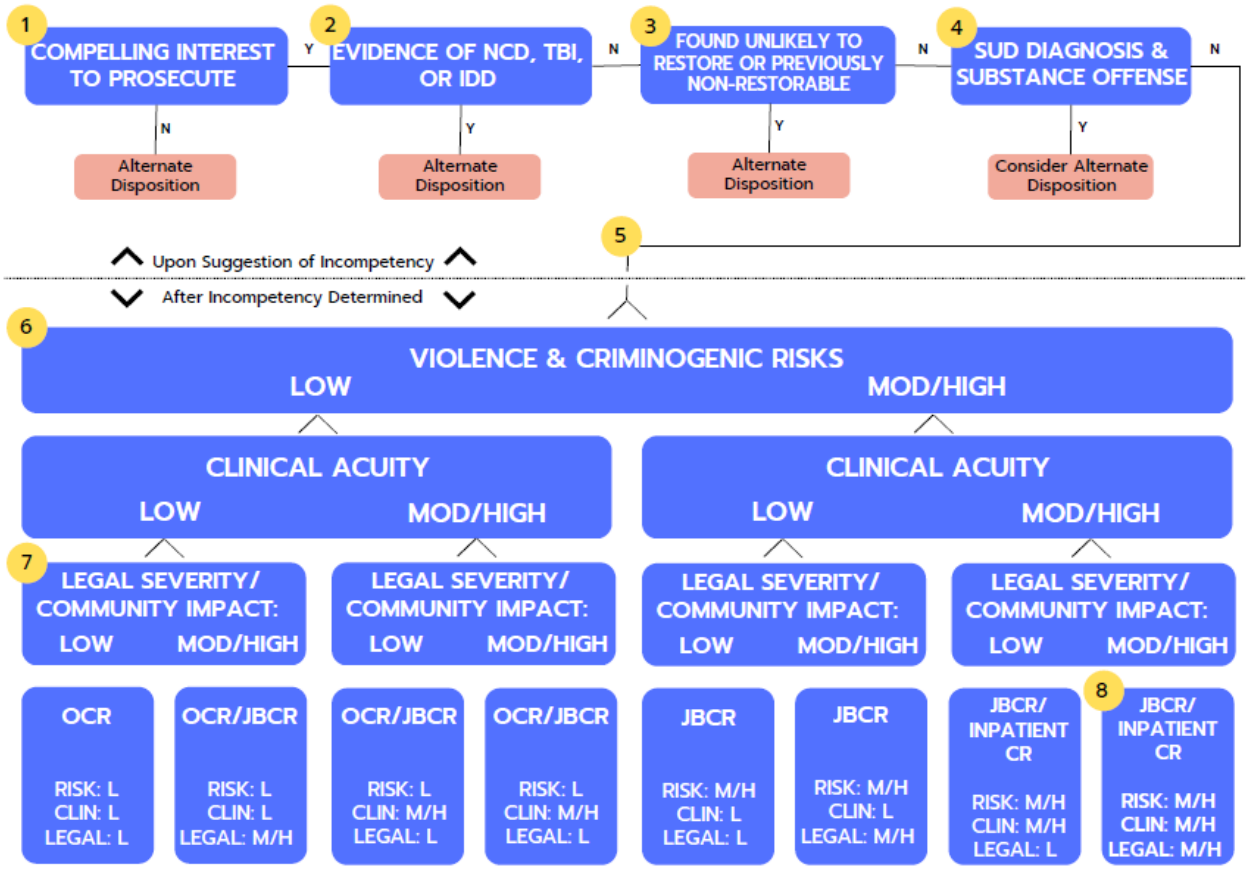
Competency Restoration Placement

The CR placement decision-tree was developed to help judges, lawyers, and mental health clinicians identify and prioritize the various factors that can be used to determine the best available CR placement for people who are IST. This decision tree is meant to be suggestive rather than prescriptive and used in the context of the services and support available in a community.

The decision-tree was developed through a collaborative process:

- The SAMHSA GAINS Center hosted expert panel of CR experts in August 2022;
- attendees from the Texas delegation formed the Steering Committee to support development of this guide;
- the TA Center hosted two focus groups with subject matter experts from across the state; and
- additional review was solicited through a peer review process.

Competency Restoration Placement Decision-Tree



Supplemental Guidance

The below guidance provides additional explanation or clarification for certain steps in determining the most appropriate CR placement, as indicated by the number inside the yellow circle provided in the graphic.

1. CCP Articles 46B.0711, 46B.072, and 46B.073 may require certain placements if the person is charged with a Class B misdemeanor.

2. Neurocognitive Disorders (NCDs) include a group of conditions previously classified as dementia, which manifest as declines in attention, executive function, learning, memory, language, and social cognition. NCDs are degenerative in nature and the likelihood of restorability declines over time. Traumatic Brain Injuries (TBIs) may impact brain functioning and cognition. Both NCDs and TBIs may be independent of or co-occurring with mental

illness. Alternate placements can include nursing homes or assisted living facilities. Restoration may or may not be likely for people with NCD or TBI.

3. People who have received CR services in the past and been determined unlikely to restore may be less likely to restore to competency on subsequent commitments. Partners may consider the fiscal implications to local and state systems as well as the health and legal impacts to an individual when pursuing CR for people previously found unlikely to restore or assessed unlikely to restore in the foreseeable future during a competency evaluation. Alternate dispositions can include a dismissal of charges or dismissal of charges and transfer to civil commitment.

4. People with a primary diagnosis of a substance use disorder (SUD) who are charged with a substance-related offense may be better served in a setting that can provide robust substance use treatment. SUD treatment can be provided in inpatient and outpatient settings. Partners may consider the person's willingness and ability to participate in SUD services prior to a referral to SUD treatment. Courts may order SUD treatment under Health and Safety Code Chapter 462. Alternate dispositions may include services provided by the LMHA, Salvation Army, or other non-profit entities, as well as services accessible through private or public health insurance.

5. If a person who is IST is in the community on bond, OCR, where available, may be the most appropriate and least restrictive setting to receive CR services.

6. Clinicians should use validated and reliable assessment tools to measure violence and criminogenic risks. Violence risk assessments, such as the *Historical-Clinical-Risk Management-20 (HCR-20)*, must be completed by a clinician. Criminogenic risk assessments, such as the *Texas Risk Assessment System (TRAS)*, can be completed by anyone trained to use the TRAS. Validated and reliable assessment tools can be utilized pre-trial to help divert people with behavioral health conditions from further involvement in the criminal justice system. See the Bureau of Justice Assistance's Public Safety Risk Assessment Clearinghouse for more information on criminogenic risk assessment instruments.

7. Considerations of legal severity and community impact may include violence and risk of recidivism, the nature of the offense, the severity of the offense,

and the potential impact to public safety if the person was to return to the community.

8. A person committed to inpatient CR may be able to transition to an alternative setting if they are clinically ready and can be safely transferred to OCR or JBCR.

Please see **Appendix B: Competency Restoration Placement Decision-Tree One-Pager** *for a printable graphic of the Principles of Competency Restoration with select definitions and practical pointers.*

Appendix A. Principles of Competency Restoration

1. Access to robust, appropriate, and timely community-based services and support is essential to divert people with mental illness from the criminal justice system and to promote reentry after a period of incarceration. This is the foundation for reducing the number of people found incompetent to stand trial (IST) who need CR.

2. People for whom the compelling interest to prosecute is low are not considered for CR. People for whom the compelling interest to prosecute is high receive CR services in the least restrictive setting as appropriate.

3. CR is used only to stabilize symptoms of mental illness and provide legal education to allow for the resumption of the adjudicative process.

4. The CR system provides accountability for systematic efficiency, equity, quality evaluators and evaluations, and is committed to confidentiality.

5. The CR system emphasizes early identification and intervention, matching the service provided to the person's needs, and ensures continuity of services and support for people moving between treatment settings.

6. The CR system is defined by strong collaboration among mental health providers, law enforcement, jail administration, prosecutors, defense attorneys, the judiciary, and all three branches of state and local government.

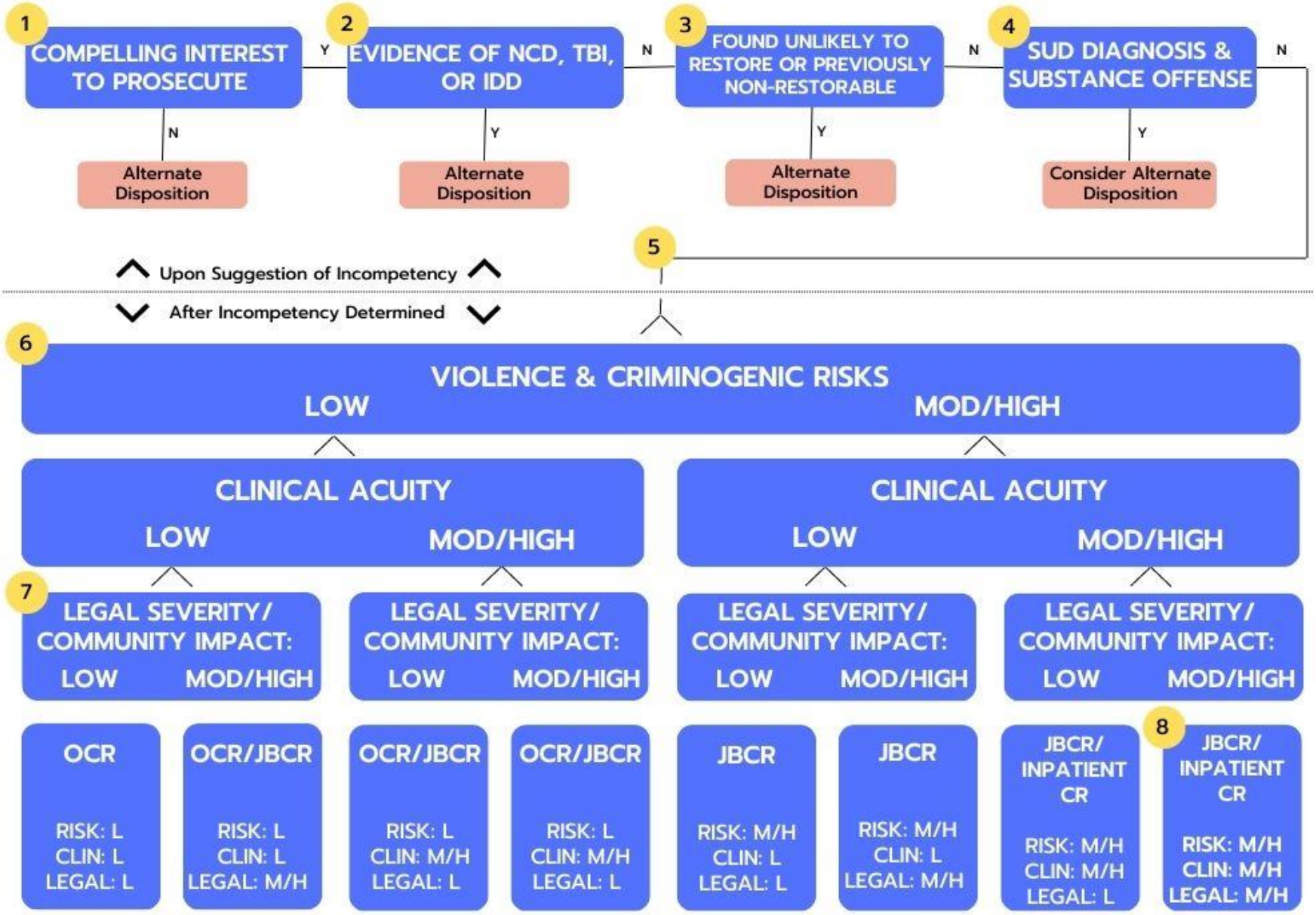
7. Partners involved in the CR process observe and promote appropriate and statutorily required timelines for tasks that fall within their respective domains.

8. Partners implement data-driven decision-making processes, to include a data collection, analysis, and dissemination strategy.

9. Partners are knowledgeable about the CR process, including the sequence of events, terminology, and processes.

10. CR placement decisions are guided by research, data, statute, administrative rule, and the best available tools to support decision-making that considers legal severity, clinical acuity, and risk of recidivism.

Appendix B. Competency Restoration Decision-Tree



1. The Code of Criminal Procedure (CCP) Articles 46B.0711, 46B.072, and 46B.073 may require certain placements if the person found IST is charged with a Class B misdemeanor.

2. Neurocognitive Disorders (NCDs) include a group of conditions previously classified as dementia, which manifests as declines in attention, executive function, learning, memory, language, and social cognition. NCDs are degenerative in nature and the likelihood of restorability declines over time. Traumatic Brain Injuries (TBIs) may impact brain functioning and cognition. Both NCDs and TBIs may be independent of or co-occurring with mental illness. Alternate placements can include nursing homes or assisted living facilities. Restoration may or may not be likely for people with NCD or TBI.

3. People who have received CR services in the past and been determined unrestorable may be less likely to restore to competency on subsequent commitments. Alternate dispositions can include a dismissal of charges, consideration of civil commitment, or alternative mental health services.

4. People with a primary diagnosis of a substance use disorder (SUD) who are charged with a substance-related offense may be better served in a setting that can provide robust substance use treatment interventions.

5. If a person has bonded out of jail, outpatient competency restoration (OCR) may be the most appropriate and least restrictive setting to receive CR.

6. Clinicians should use validated and reliable assessment tools to measure violence and criminogenic risks.

7. Considerations of legal severity and community impact may include violence and criminogenic risks, the nature of the offense, the severity of the offense, and the impact if the person was to return to the community.

8. A person committed to inpatient CR may be able to transition to a less restrictive setting if the person is clinically ready and can be safely transferred to outpatient or jail-based CR.

Appendix C. Competency Restoration Research and Resources

The following research on CR may support the efficient and effective utilization of the CR system for people with unique needs and experiences who may be IST.

American Bar Association. (2016, August 8). *Criminal justice standards on mental health.* https://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/mental_health_standards_2016.authcheckdam.pdf

Ash, P., Roberts, V. C., Egan, G. J., Coffman, K. L., Schwenke, T. J., & Bailey, K. (2020). A jail-based competency restoration unit as a component of a continuum of restoration services. *Journal of the American Academy of Psychiatry and the Law*, *48*(1), 43. 10.29158/JAAPL.003893-20

Callahan, L., & Pinals, D. (2020). Challenges to Reforming the Competence to Stand Trial and Competence Restoration System. *Psychiatric Services, 71(7)*. https://doi.org/10.1176/appi.ps.201900483

Colwell, L. H., & Gianesini, J. (2011). Demographic, criminogenic, and psychiatric factors that predict competency restoration. *The Journal of the American Academy of Psychiatry and the Law, 39*(3), 297–306.

Danzer, G., Wheeler, E., Alexander, A., & Wasser, T. (2019). Competency Restoration for Adult Defendants in Different Treatment Environments. *The Journal of the American Academy of and the Psychiatry Law, 47(1),* Online. https://doi.org/10.29158/JAAPL.003819-19

Gowensmith, W.N., Frost, L.E., Speelman, D.W., & Therson, D.E. (2016). Lookin' for beds in all the wrong places: Outpatient competency restoration as a promising approach to modern challenges. *Psychology, Public Policy, and Law, Vol 22*(3), Aug 2016, 293-305

Heilbrun, K., DeMatteo, D., Locklair, B., Giallella, C., Wright, H.J., Griffin, P.A., & Desai, A. (2019). Treatment for Restoration of Competence to Stand Trial: Critical Analysis and Policy Recommendations. *Psychology, Public Policy, and Law, 25(4),* 266-283. https://doi.org/10.1037/law0000210

Lewis, D. E., Ash, P., Roberts, V. C., Schwenke, T. J., Pagán-González, M., & Egan, G. J. (2023). Jail-Based Competency Restoration Services in the United States: The Need, the Controversy, the Impact of COVID-19, and Implications for Future Treatment Delivery. *Criminal Justice and Behavior, 50*(2), 216–234. https://doi.org/10.1177/00938548221120280

Mikolajewski, A. J., Manguno-Mire, G. M., Coffman, K. L., Deland, S. M., and Thompson, J. W. (2017) Patient Characteristics and Outcomes Related to Successful Outpatient Competency Restoration. *Behavioral Sciences & the Law*, 35: 225– 238. https://doi.org/10.1002/bsl.2287

Murrie, D. C., Gardner, B. O., & Torres, A. N. (2022). The impact of misdemeanor arrests on forensic mental health services: A state-wide review of Virginia competence to stand trial evaluations. *Psychology, Public Policy, and Law, 28*(1), 53. https://doi.org/10.1037/lhb0000417

National Center for State Courts. (2021, August 2). *Leading Reform: Competence to Stand Trial System: A Resource for State Courts*. https://www.ncsc.org/newsroom/behavioral-health-alerts/2021/august-2-2021

Pinals, D. A., & Callahan, L. (2020). Evaluation and restoration of competence to stand trial: Intercepting the forensic system using the sequential intercept model. *Psychiatric Services, 71*(7), 698-705. https://doi.org/10.1176/appi.ps.201900484

Pirelli, G., & Zapf, P.A. (2020). An Attempted Meta-Analysis of the Competency Restoration Research: Important Findings for Future Directions. Journal of Forensic Psychology Research and Practice, *20*(2), 134-162. https://doi.org/10.1080/24732850.2020.1714398

Warburton, K., McDermott, B., Gale, A., & Stahl, S. (2020). A survey of national trends in psychiatric patients found incompetent to stand trial: Reasons for the reinstitutionalization of people with serious mental illness in the United States. CNS Spectrums, 25(2), 245-251. doi:10.1017/S1092852919001585

Appendix D. Qualifications of Competency Evaluators and Competency Evaluation Requirements

Qualifications of Competency Evaluators

Article 46B.022 of the Code of Criminal Procedure stipulates that, to qualify for appointment to conduct competency evaluations in Texas, a psychiatrist or psychologist with a doctoral degree in psychology must:

1. As appropriate, be licensed to practice in Texas;
2. have the following certification or training:
    a. The American Board of Psychiatry and Neurology with qualifications in forensic psychiatry;
    b. the American Board of Professional Psychology in forensic psychology; or
    c. completed at least 24 hours of specialized forensic training related to incompetency or insanity evaluations and at least 8 hours of continuing education related to forensic evaluations completed within the 12 months preceding the appointment; and
3. complete six hours of required continuing education in courses in forensic psychiatry or psychology within the 24 months preceding the appointment.

Quality Competency Evaluations

Regarding competency evaluations, Article 46B.024 of the Code of Criminal Procedure requires a competency evaluator to consider the capacity of the person to:

(1) Rationally understand the charges against them and the potential consequences of the pending criminal proceedings;

(2) disclose to counsel pertinent facts, events, and states of mind;

(3) engage in a reasoned choice of legal strategies and options;

(4) understand the adversarial nature of criminal proceedings;

(5) exhibit appropriate courtroom behavior; and

(6) testify.

The evaluator must also consider, as supported by current indications and the person's history:

(7) whether the person is a person with a mental illness or IDD;

(8) whether the identified condition has lasted or is expected to last continuously for at least one year;

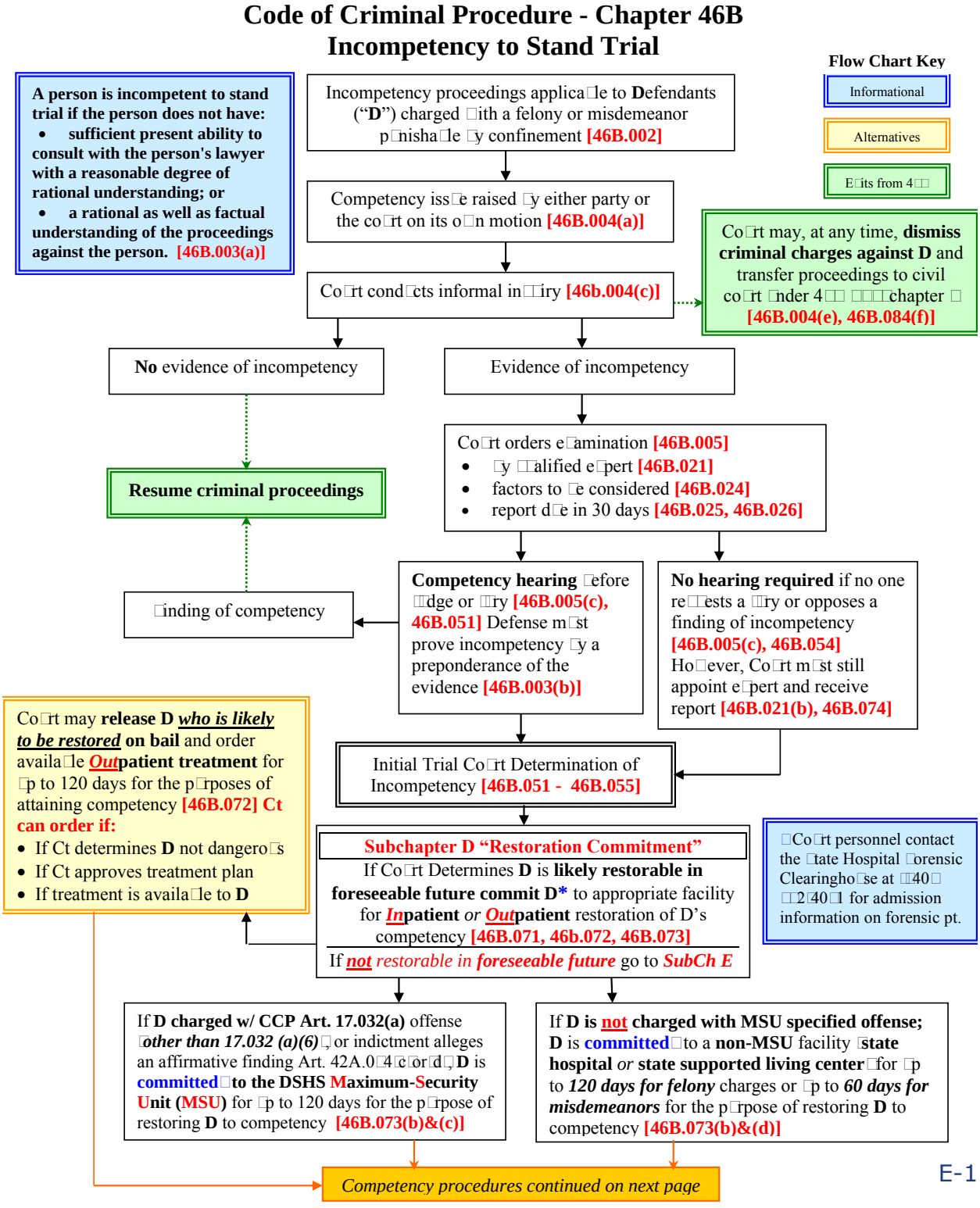
(9) the degree of impairment resulting from mental illness or IDD and the specific impact on the person's capability to engage with counsel in a reasonable and rational manner; and

(10) if the person is taking psychoactive medications, whether the medication is necessary to maintain the person's competence and the effect, if any, the medication may have on the person's appearance, demeanor, or ability to participate in the proceedings.

The information that must be included in the competency report submitted to the court by the evaluator can be found in Article 46B.025 of the Code of Criminal Procedure.

Appendix E. Competency Restoration Flow Charts

The following flowcharts can be found in the *Texas Mental Health and Intellectual and Developmental Disabilities Law Bench Book* published by the Texas Judicial Commission on Mental Health.



Competency procedures continued from first page

Treatment Facility Responsibilities during **Subchapter D "Restoration Commitment"** apply to ***In*patient** and ***Out*patient MH treatment facilities** and **ID-State Supported Living Centers [46B.077(a)]**

- Develop individual treatment program for **D**
- Assess whether **D** will attain competency in the foreseeable future
- Report to the court and local MH/ID Authority on **D's** progress toward competency

Head of *Inpatient* or ***Jail-Based Competency Restoration*** **JBCR** programs sends **Notice to Court** when:

- **D** has attained competency **[46B.079(b)(2)]**
- **D**, while not competent, **is clinically ready for OCR** program **[46B.079(b)(1)]**
- **D** won't attain competency in foreseeable future **[46B.079(b)(3)]**
- Term of commitment is set to expire [illegible]1 days **[46B.079(a)]**

Head of *Outpatient* program sends **Notice to Court** when**:**

- **D** has attained competency **[46B.079(b-1)(1)]**
- **D** won't attain competency in foreseeable future **[46B.079(b-1)(2)]**

When giving **Notice to Court** the facility supplies the committing court a **Final Report** stating reasons for **D's** discharge/transfer and a list of types and dosages of medications **D** was on during treatment **[46B.079(c)]**

If the facility believes that a **non-restored D** meets **civil commitment criteria** the facility supplies court with either two Certificate of Medical Examination ("CME") for mental illness *or* affidavit supporting **D's** intellectual disability should also include IDT recommendation on least restrictive appropriate setting **[46B.083(a)/(b)]**

Head of facility may request one **60-day extension** of restoration order **[46B.079(d); and 46B.080]**

D is to be **returned to court** within **15 days*** of notice under **46B.079** and court must make determination on **D's** current competency within **20 days** of receiving final Report **[46B.084(a-1)]**

If **D** not returned to ct. in 15 days, facility shall return **D** and charge the county for costs **[46B.082(b)]**

Even if a party **objects** to the findings of the **Final Report**, the issue of **D's** current competency **must still be heard within 20 days of receiving report [46B.084(a-1)]**

If the hearing is before the court, the hearing may be by electronic broadcast system **[46B.084(b-1); 46B.013]**

If **no objection** to the **Final Report** the court can determine competency based solely on the report **without a hearing [46B.084(a)]**

D found competent

Resume criminal proceedings

D found ***in*competent**

Are **criminal charges** against **D dismissed?**

D found competent

Resume criminal proceedings

Charges not dismissed [46B.084(e)] after [illegible]chapter D commitment **or** if **D** ***not*** *likely to be restored in foreseeable future* **[46B.071(b)]**

Charges dismissed [46B.084(f)]

Court determines if there is evidence of mental illness or intellectual disability **[46B.102(a); 46B.103(a)]**

Court determines if there is evidence of mental illness or intellectual disability **[46B.084(f); 46B.151]**

***46B - Subchapter E* "Civil Commitment; Charges Pending"**

- **Criminal court** conducts commitment hearing *in*patient or *out*patient for **D** with **mental illness** pursuant to [illegible]title C, Title [illegible], Health and Safety Code **(Mental Health Code) [46B.102(b)]**
- Commitment proceedings for **D** with **intellectual disability** are conducted pursuant to [illegible]title D, Title [illegible], Health and Safety Code **(Persons with Intellectual Disability Act) [46B.103(b)]**

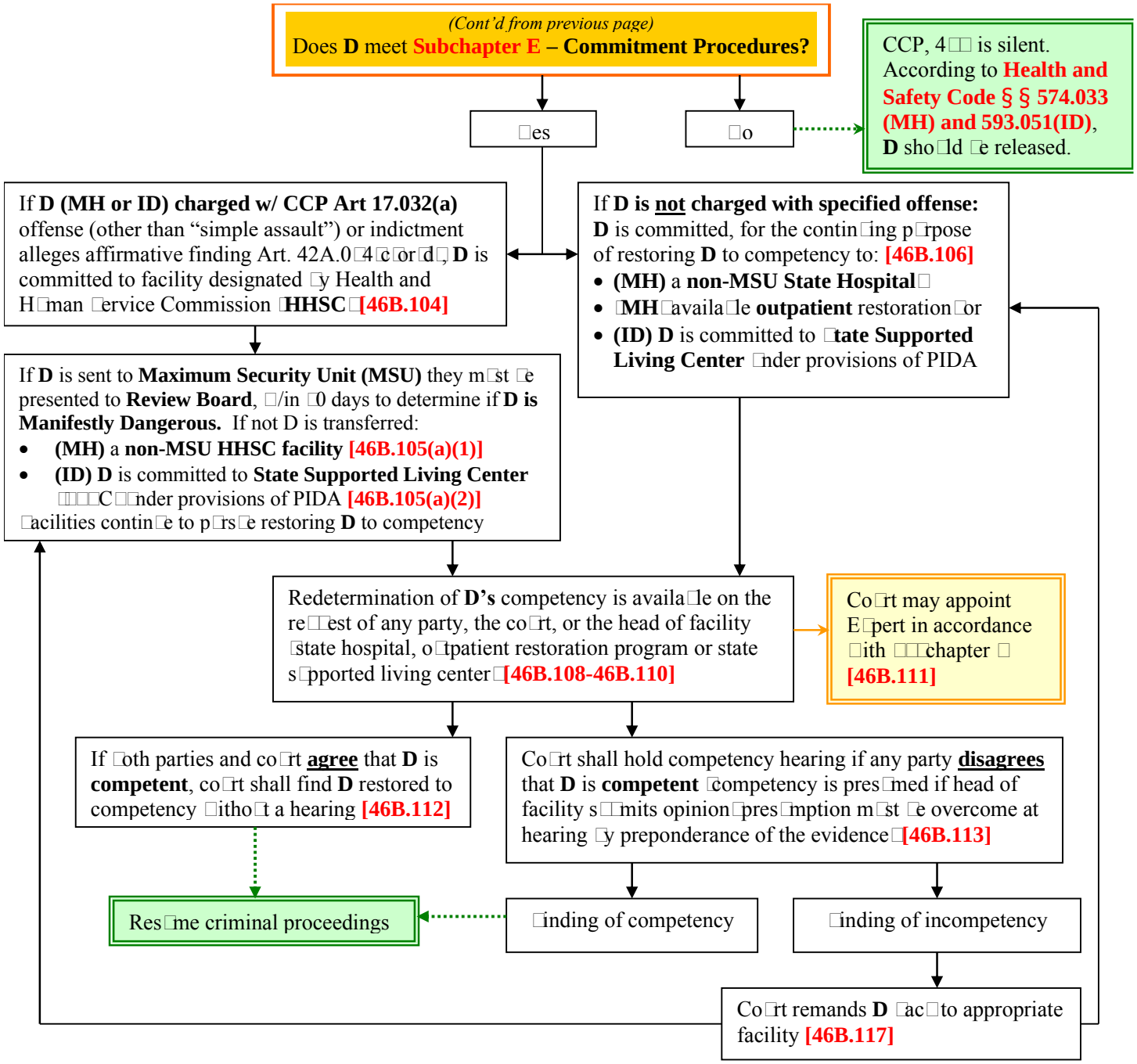
Evidence of mental illness or intellectual disability

No evidence

D released **[46B.151(d)]**

Pursuant to **Subchapter F,** court **transfers D's** case to **civil court** for commitment proceedings **[46B.151(b)]**

***Subchapter E** commitment procedures continued on next page*



The head of facility must notify the committing court if they determine that D on **Subchapter E commitment** should be **released**. This should include a release date to:

- **expiration of D's commitment** under the Mental Health Code
- facility determination that **D no longer meets commitment criteria** under title C or D, Title , Health and Safety Code Mental Health Code/ Persons with Intellectual Disability Act [46B.107(a)-(c)] or
- **D** has "Timed Out" via Maximum Term of Commitment [46B.0095]

The court may hold a hearing on these matters by means of an **electronic broadcast system** [46B.107(d)(2), 46B.013]

If the court determines **release is not appropriate**, the court shall enter an **order** directing **D** not be released [46B.107(e)]

EXHIBIT F-37

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CLINICAL PHARMACY FORUM

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Role of Board-Certified Psychiatric Pharmacists in child and adolescent psychiatry

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Abstract

In the context of ongoing workforce shortages, rising symptom severity, and increased rates of psychotropic prescribing, the 2021 declaration of a national emergency in child and adolescent psychiatry (CAP) has highlighted the need for innovative strategies to address access to quality care. As valued members of the interdisciplinary team, Board-Certified Psychiatric Pharmacists (BCPPs) in CAP are well-positioned to address these needs as they are integrated across various settings (e.g., ambulatory clinics, and psychiatric hospitals) and have expertise in psychiatric and neurodevelopmental disorders. As educators and advocates for evidence-based psychotropic medication management, BCPPs in CAP decrease polypharmacy, increase medication adherence and knowledge, and enhance patient outcomes. Given the need for interdisciplinary collaboration among BCPPs, CAP, and primary care providers, it is crucial for pharmacy administrators to respond and recognize the

Abbreviations: AACAP, American Academy of Child and Adolescent Psychiatry; AAPP, American Association of Psychiatric Pharmacists; ADHD, attention-deficit/hyperactivity disorder; ASD, autism spectrum disorder; ASHP, American Society of Health-System Pharmacists; BCPP, Board-Certified Psychiatric Pharmacist; CAM, complementary and alternative medicine; CAP, child and adolescent psychiatry; CDTM, collaborative drug therapy management; CMM, comprehensive medication management; CPA, collaborative practice agreement; IDD, intellectual and/or developmental disability; LAI-A, long-acting injectable antipsychotic; MOUD, medications for opioid use disorder; NCQA, National Committee for Quality Assurance; OUD, opioid use disorder; PHQ-9, patient health questionnaire-9; PWUD, person who uses drugs; SBIRT, screening brief intervention and referral to treatment; SMI, severe mental illness; SNRIs, serotonin-norepinephrine reuptake inhibitors; SSRIs, selective serotonin reuptake inhibitors; SUD, substance use disorder; TJC, The Joint Commission.

necessity of integrating pharmacy services into CAP and integrating BCPPs into pharmacy departments.

KEYWORDS
child and adolescent psychiatry, mental health, psychiatric pharmacy, substance use, youth

1 | INTRODUCTION

Board-Certified Psychiatric Pharmacists are members of the interdisciplinary team who work collaboratively with patients, their families, and providers to optimize short- and long-term outcomes among individuals with psychiatric disorders, including substance use disorders (SUDs).[1–3] They are educators and advocates for the evidence-based use of psychotropic medications through comprehensive medication management (CMM). In addition to unique settings and roles, BCPPs work with a variety of patient populations, including children and adolescents.[4,5] The American Association of Psychiatric Pharmacists (AAPP) is the community of practice for BCPPs, and it initiated this exploration of the role of BCPPs in child and adolescent psychiatry (CAP). A general literature search was performed to accumulate relevant studies pertinent to this topic.

While mental health challenges facing children and adolescents are not new, rising rates of suicide and emergency department visits related to suicide and other mental health crises prompted a 2021 national state of emergency declaration in children's mental health.[6–8] As a result, national pediatric and CAP organizations have urged government agencies to address longstanding workforce challenges in CAP, expand access to care, and strengthen efforts to integrate mental health services into primary care.[7]

BCPPs are well positioned to collaborate with CAP, pediatricians, and other team members to help address these needs.[4,9–12] This manuscript aims to (1) describe the unique role of BCPPs on an interdisciplinary CAP team; (2) outline opportunities for education and collaboration among BCPPs in CAP and their patients, interdisciplinary team, and community; and (3) identify strategic areas to integrate BCPPs across the mental health and pediatric workforce.

2 | CAP—CURRENT STATE

It is estimated that 8%–12% of children and adolescents are prescribed psychotropic medications, with stimulants, nonstimulants (i.e., alpha-2 agonists), antidepressants, and atypical antipsychotics among those most frequently prescribed.[13] Neurobiologic changes during childhood, pediatric-specific risk for adverse effects, and developmental considerations (e.g., physical development) warrant thorough evaluation of psychotropic medication use in this patient population.[13]

Vulnerable populations are prescribed psychotropic medications at even higher rates. Children and adolescents in foster care, juvenile justice systems, and with developmental or intellectual disabilities are the most likely to be prescribed high-risk psychotropic medication regimens (e.g., >1 agent from the same pharmacologic class, ≥ 3 concomitant psychotropic medications).[13,14] Not only are 13%–31% of youth in foster care prescribed at least one psychotropic medication, but they are four times as likely to be prescribed at least three psychotropic medications and twice as likely to be prescribed at least one concomitant antipsychotic as those, not in foster care.[15,16]

Children and adolescents experienced disproportionate harm to their mental health during the coronavirus disease 2019 (COVID-19) pandemic. Emergency department visits associated with suicide attempts increased 50.6% in females 12- to 17-year-olds in February to March 2021 as compared to 2019.[8] Overdose deaths primarily related to unintended fentanyl exposure among 14- to 18-year-olds increased 94% from 2019 to 2020 and 20% from 2020 to 2021, despite non-prescribed drug use declining overall among surveyed middle and high school students during this time period.[17] Increased reports of disordered eating and rising rates of hospital admissions/readmissions secondary to medical complications of eating disorders were also seen during the COVID-19 pandemic and are ongoing.[18] The need for specialized pharmacotherapy expertise in these and other high-risk patient populations is evident.

2.1 | The role of a BCPP in CAP

Addressing the increasing mental health and complex psychotropic medication needs of children and adolescents is difficult, with a national average of only 14 child and adolescent psychiatrists per 100 000 children.[19] Board-Certified Psychiatric Pharmacists in CAP can help to mitigate this provider shortage through collaborative, innovative, and practical strategies that can improve quality of care. For example, psychotropic stewardship is a model in which BCPPs play a key medication management role on the interdisciplinary CAP team (Figure 1).[1]

Board-Certified Psychiatric Pharmacists work in a variety of unique pediatric settings, including children's hospital psychiatric pavilions, ambulatory clinics, and psychiatric hospitals, and work with diverse CAP patient populations (Table 1).[8,10,12–15,17,18,20–31] Where properly integrated, BCPPs are viewed as valuable members of the CAP team by CAP, pediatricians, and foster care social workers, among others.[4,10,15,32] Through implementation of CMM, BCPPs address pediatric polypharmacy, increase medication adherence and knowledge, and enhance patient outcomes.[4,9,32,33] Board-Certified Psychiatric Pharmacists in CAP can also support medication decisions and monitoring for medical comorbidities.[20]

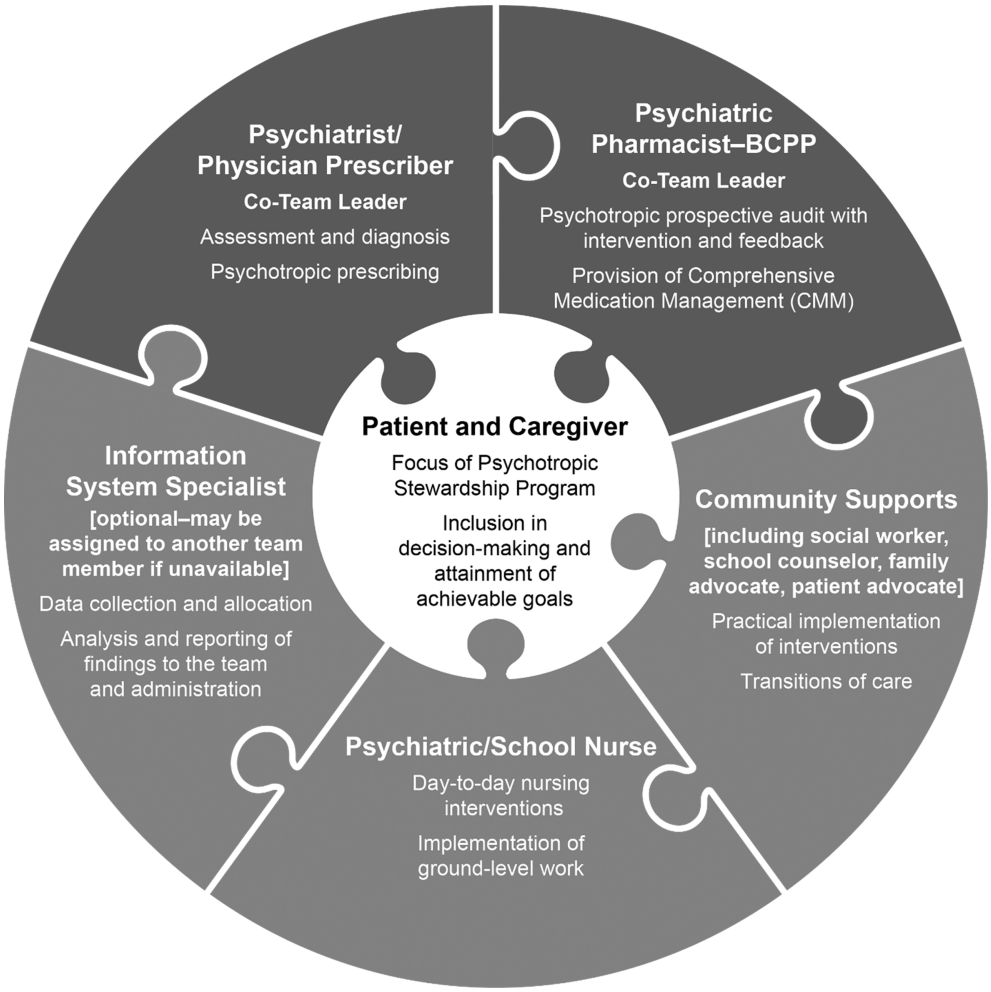

FIGURE 1 Board-Certified Psychiatric Pharmacist's (BCPP's) role in child and adolescent psychiatry interdisciplinary team.

2.2 | Evidence-based practice

Landmark trials, pediatric-specific guidelines, state-driven initiatives, and regulatory standards aim to support the evidence-based use of psychotropic medications in children and adolescents.[13] Collaborative decision-making among the treatment team, patients, and their caregivers is also essential and should include a review of short- and long-term benefits, risks, treatment goals, target symptoms, and expected duration of treatment. Board-Certified Psychiatric Pharmacists in CAP can broadly support the use of psychotropic medications in children and adolescents with a variety of mental health conditions (Table 1), and regulatory standards are of a critical point of focus (Table 2).

2.3 | Regulatory standards

Given prescribing complexity, pediatric-specific risk for adverse effects, and changing trends in psychotropic prescribing, evidence-based CAP standards have been established to promote best practices for psychotropic prescribing, monitoring, and follow-up.[34] Regulatory standards, including the Hospital Based Inpatient Psychiatric Services measure set, a collection of quality measures created by The Joint Commission, aims to standardize the quality of care patients receive in psychiatric care settings.[1,35] Board-Certified Psychiatric Pharmacists in CAP are well positioned to support these quality care initiatives given their roles in medication monitoring, deprescribing practices, medication safety, medication reconciliation, and psychotropic stewardship (Table 2).[1,4]

2.4 | Prescribing antipsychotics

The American Academy of Child and Adolescent Psychiatry (AACAP) recommends avoiding simultaneous use of multiple antipsychotics given the risk for additive adverse effects and lack of evidence to support the routine use of more than one antipsychotic.[36] As part of the quality care initiatives, the Pediatric Quality Measures Program (PQMP), the Agency for Healthcare Research and Quality Centers for Medicare and Medicaid Service, and the National Collaborative for Innovation in Quality Measurement Center of Excellence developed standards assessing the safe and judicious use of antipsychotics in youth. These include evaluating the percentage of children and adolescents (1) prescribed ≥2 concurrent antipsychotics for ≥3 months, (2) prescribed an antipsychotic for an off-label use in conjunction/after appropriate psychosocial intervention(s), and (3) receiving annual metabolic monitoring.[35]

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TABLE 1 Unique patient populations served and childhood conditions treated by BCPPs in CAP.

Patient population	Opportunity	BCPP interventions
Youth in Foster Care[12,13,15]	• Higher rates of antipsychotic prescribing, supratherapeutic dosing, and off-label use • Higher rates of off-label psychotropic prescribing • Higher rates of psychotropic polypharmacy • Increased barriers to medication access, particularly across transitions of care	• Provide medication education for the foster care team • Reduce inappropriate prescribing, medication errors, and drug–drug interactions • Support transitions of care • Develop guidelines for the safe use of psychotropic medications • Support deprescribing, when appropriate
Youth in the Juvenile Justice System[13,14]	• Higher rates of psychotropic prescribing, including off-label use • Increased risk for inappropriate use of antipsychotics for behavioral control • Increased risk for antipsychotic metabolic side effects due to limited physical activity and access to nutritious foods	• Provide medication education, reduce inappropriate prescribing • Support transitions of care • Improve metabolic monitoring • Develop guidelines for the safe use of psychotropic medications • Support deprescribing, when appropriate
Transgender Youth[25]	• Higher rates of anxiety and depression • Higher risk for suicide • Lack of specific guidelines regarding treatment of psychiatric comorbidities	• Provide recommendations regarding pharmacotherapy for anxiety and depression • Prevent and manage medication-related problems (e.g., drug–drug interactions with gender-affirming hormone treatment)
Youth with Risky Substance Use/SUDs[17,24]	• Early onset associated with changes in developing brain • Increasing rates of marijuana and hallucinogen use • Increasing rates of electronic cigarette use • Increasing rates of overdose-related deaths	• Provide SBIRT and recommend evidence-based pharmacotherapy, when needed • Offer harm reduction strategies (e.g., naloxone and fentanyl/xylazine test strips) and education regarding overdose recognition and response • Improve access to pharmacologic treatment and improve treatment outcomes
Youth with ASD[10,13]	• Higher rates of side effects with psychotropic medications • Higher rates of psychiatric comorbidities • High rates of polypharmacy • High rates of CAM use • Limited data on long-term medication use	• Reduce medication-related problems such as improper medication selection, medication non-adherence, and subtherapeutic doses • Support thoughtful deprescribing, when appropriate • Educate families regarding evidence-based use of CAM • Mitigate potential drug–drug and drug-CAM interactions • Support medication adherence through unique dosage formulations (e.g., chewable or liquid)
Youth with IDD[10,13]	• High rates of polypharmacy • High rates of off-label antipsychotic use; concern for overuse of antipsychotics • High rates of long-term psychotropic use • Greater vulnerability to psychotropic adverse effects • Challenges in monitoring for psychotropic adverse effects, with low rates of metabolic monitoring with antipsychotics	• Reduce medication-related problems, such as improper medication selection, medication non-adherence, and subtherapeutic doses • Support thoughtful deprescribing, when appropriate • Engage in quality improvement programs to improve metabolic monitoring
Youth with Early Onset Schizophrenia[23]	• Greater need for early, aggressive, multimodal treatment • Greater need for family education and support • Underutilization of clozapine • Limited data on the use of LAI-A	• Engage in quality improvement programs to improve metabolic monitoring • Recommend clozapine, provide education, and support monitoring • Provide high-quality education to increase the comfort of team members in using LAI-A
Youth Eating Disorders[18,26]	• Higher rates of hospital admissions during the COVID-19 pandemic (2020–2021) compared to previous years • High risk for readmission due to medical complications post-COVID-19 lockdown • High rates of co-occurring SUDs	• Support role of alternative treatment strategies (e.g., calcium/vitamin D, thiamine, and zinc) collaboratively with dieticians • Recommend evidence-based use of psychotropic medications (e.g., avoid SSRIs during weight restoration, bupropion is contraindicated in bulimia nervosa/anorexia nervosa) • Recommend treatment strategies in setting of comorbidities, including SUDs

TABLE 1 (Continued)

Patient population	Opportunity	BCPP interventions
Youth with SMI[27]	• Need for early identification and treatment • Increased likelihood of response, improved functioning, and increased likelihood of recovery with effective pharmacologic treatment	• Ensure early, effective, safe treatment, and thoughtful use/stewardship of psychotropics • Recommend clozapine, provide education, and support monitoring
Youth with Bipolar Disorder[31]	• High rates of suicidal ideation or suicide • More time spent symptomatic compared to adults • Lack of long-term data on medications	• Provide education to patients and caregivers regarding means restriction • Ensure appropriate use of antipsychotics and mood stabilizers • Evaluate therapeutic drug monitoring to optimize mood stabilizer safety/efficacy • Educate families about treatment options and benefits/risks of medications
Youth with Depression/ Suicidal Ideation[8,28]	• Increased rates of depression • Increased rates of emergency department visits for suicidal ideation or attempts during COVID-19 pandemic[8]	• Improve medication adherence through medication therapy management, adherence counseling, and education • Discuss black box warnings for antidepressants and importance of close monitoring • Provide education about behavioral activation/agitation when starting SSRIs/SNRIs. • Review pharmacogenomic test results with patients, caregivers, and interdisciplinary teams
Youth with Anxiety Disorders[30]	• One of the most common pediatric psychiatric disorders • High comorbidity with other psychiatric disorders	• Discuss black box warnings for antidepressants and importance of close monitoring • Provide education about behavioral activation/agitation when starting SSRIs/SNRIs
Youth with ADHD[21,22,29]	• Increasing rates of stimulant prescribing during COVID-19 pandemic • High comorbidity (>50%) with other psychiatric conditions • Need for innovative treatment strategies among youth with complex ADHD	• Improve access to care, time to follow-up, monitoring, side effect management, and patient satisfaction • Collaboratively prescribe ADHD medications and increase follow-up care • Support prescribing decisions during stimulant shortages • Ensure effective use of medications in those with complex ADHD • Review pharmacogenomic test results (CYP2D6) with patients, caregivers, and interdisciplinary teams for patient-prescribed atomoxetine
Youth with Comorbid Psychiatric and Medical Conditions[20]	• Bidirectional effect of physical and mental health conditions • Increased health care utilization • Impact on quality of life of patient and family	• Build therapeutic relationships to aid transition of both medical and psychiatric care from adolescence to adulthood • Educate patients to improve medication adherence

Abbreviations: ADHD, attention-deficit/hyperactivity disorder; ASD, autism spectrum disorder; CAM, complementary and alternative medicine; COVID-19, coronavirus disease 2019; CYP2D6, Cytochrome P450 2D6; IDD, intellectual and/or developmental disability; LAI-A, long-acting injectable antipsychotics; PHQ-9, patient health questionnaire-9; SBIRT, screening, brief intervention, and referral to treatment; SMI, severe mental illness; SNRIs, serotonin norepinephrine reuptake inhibitors; SSRIs, selective serotonin reuptake inhibitors; SUDs, substance use disorders.

TABLE 2 TJC cap regulatory standards.

Regulatory standard[40]	Knowledge and skills needed to provide this care	Pharmacy setting to implement service	Potentially billable service
Follow-up care for children prescribed ADHD medication	Training in ADHD medication prescribing, monitoring, and patient/family education. Expertise in updated ADHD treatment guidelines and understanding of current medication shortages	Outpatient psychiatry, primary care, other specialty outpatient clinics; psychiatry day treatment programs; and telehealth services	Yes, through CMM; CDTM/CPA creation Additional value is added given medication shortages
Use of first-line psychosocial care for youth on antipsychotics	Training in treatment guidelines, understanding of on-label use for antipsychotics in youth	Inpatient psychiatry units, inpatient pediatric service; psychiatry day treatment programs; outpatient psychiatry, and primary care clinics	Yes, through CMM; CDTM/CPA creation
Use of multiple concurrent antipsychotics	Training in guideline recommendations for antipsychotic prescribing and monitoring, with consideration for deprescribing, when appropriate	Inpatient psychiatry units, inpatient pediatric service; psychiatry day treatment programs; outpatient psychiatry, and primary care clinics	Yes, through CMM; CDTM/CPA creation
Metabolic monitoring for children and adolescents on antipsychotics	Training in guideline recommendations for metabolic monitoring in youth including frequency, interpretation, and management. Understanding of relative metabolic risk among atypical antipsychotics	Inpatient psychiatry units, inpatient pediatric service; psychiatry day treatment programs; outpatient psychiatry, and primary care clinics	No, but value is added by optimizing metabolic monitoring rates
Depression remission or response for adolescents	Training in antidepressant medication prescribing, monitoring, and patient/family education. Expertise in updated depression treatment guidelines	Inpatient psychiatry units, inpatient pediatric service; psychiatry day treatment programs; outpatient psychiatry, and primary care clinics	Yes, through CMM; CDTM/CPA creation
Follow-up after psychiatric hospitalization and/or Emergency Department visits	Training in psychotropic medication prescribing, monitoring, and patient/family education. Expertise in updated treatment guidelines, transitions of care, and medication reconciliation	Inpatient psychiatry units, inpatient pediatric service; psychiatry day treatment programs; outpatient psychiatry, and primary care clinics	Yes, through CMM; CDTM/CPA creation
Pharmacotherapy for OUD	Training in OUD medication prescribing, monitoring, and patient/family education. Expertise in updated OUD treatment guidelines	Inpatient psychiatry units, inpatient pediatric service; psychiatry day treatment programs; outpatient psychiatry, and primary care clinics. Telehealth services. Emergency department	Yes, through CMM; CDTM/CPA creation Yes, for SBIRT

Abbreviations: ADHD, attention-deficit/hyperactivity disorder; CAP, child and adolescent psychiatry; CDTM, collaborative drug therapy management; CPA, collaborative practice agreement; CMM, comprehensive medication management; OUD, opioid use disorder; TJC, The Joint Commission.

Through the implementation of psychotropic stewardship, BCPPs have an opportunity to optimize these PQMP standards.[1] When pharmacists are involved in decision-making regarding prescribing antipsychotics, the rates of antipsychotic polypharmacy decrease in both inpatient and outpatient levels of care.[37] According to the National Committee for Quality Assurance (NCQA), in 2018, of youth prescribed an antipsychotic, 2.6% (Commercial Health Maintenance Organization [HMO]), 2.7% (Commercial [Preferred Provider Organization {PPO}]), and 2.4% (Medicaid HMO) were prescribed ≥2 concurrent antipsychotics for ≥3 months.[35]

2.5 | Antipsychotic metabolic monitoring

Routine metabolic monitoring is crucial because children and adolescents are more susceptible to the metabolic effects of atypical antipsychotics than adults, including a threefold risk of developing type 2 diabetes, weight gain, and dyslipidemia.[38,39] Pediatric guidelines provide recommendations for the frequency of metabolic monitoring among youth prescribed atypical antipsychotics.[39] According to the NCQA, only 35.6% (Commercial HMO), 34.6% (Commercial PPO), and 36.6% (Medicaid HMO) of children and adolescents prescribed antipsychotics received the recommended annual metabolic monitoring in 2021, with national averages between 30% and 38% since 2015.[35]

In collaboration with child psychiatrists and pediatricians, BCPPs can play an essential role in optimizing metabolic monitoring through participation in CMM, psychotropic stewardship, and primary care education via collaborative education models (e.g., Extension for Community Health Outcomes [ECHO], The REsource for Advancing Children's Mental Health [REACH] Institute).[1,40,41] Although collaboration among child psychiatrists and pediatricians improves the rates of metabolic monitoring, these rates continue to be low.[42] Pharmacist involvement in metabolic lab monitoring is associated with increased engagement in metabolic monitoring.[43] When a pharmacist is embedded in an outpatient psychiatry clinic, pharmacist-driven lab ordering, patient/provider notification, and primary care provider collaboration are associated with improvement in lab completion rates and follow-up on abnormal lab results.[43] Additionally, pharmacist development of a collaborative practice agreement (CPA) improves metabolic monitoring in inpatient psychiatry units.[44]

2.6 | Attention-deficit/hyperactivity disorder medication follow-up

Expertise in the treatment of attention-deficit/hyperactivity disorder (ADHD) allows BCPPs to play an important role in ADHD medication follow-up. When pharmacists collaborate with psychiatrists in outpatient settings, access to care, time to follow-up, monitoring, side effect management, and patient satisfaction have been shown to improve.[21,22] Additionally, a billing model has been described, with the creation of a BCPP—psychiatrist CPA.[22] In 2021, 38.7% (Commercial HMO), 35.6% (Commercial PPO), and 39.7% (Medicaid HMO) of 6–12-year-olds had follow-up within 1 month after initiation of ADHD medication, and 46.7% (Commercial HMO), 44.1% (Commercial PPO), 50% (Medicaid HMO) had two follow-up visits in 9 months.[35] Board-Certified Psychiatric Pharmacists can support the quality of ADHD prescriptions by participating in ADHD drop-in clinics, educational efforts (e.g., ECHO, The REACH Institute, and psychiatry residency program teaching), supporting transitions of care (e.g., hand-off to primary care provider at discharge from higher level of care), collaboration with prescribers (e.g., psychiatrists, pediatricians, neurologists) and the development of decision-support tools (e.g., stimulant shortage management and dose conversions), in addition to involvement in ADHD medication follow-up visits.[40,45,46]

2.7 | Medication for opioid use disorder

When BCPPs are involved in decisions regarding SUD treatment, improvements are observed in medication adherence, safety, treatment outcomes, and treatment access.[47] With median monthly overdose deaths among 10- to 19-year-olds increasing 109% in the second half of 2021 compared to 2019, it is critical that strategies targeting children and adolescents are implemented. Notably, approximately 90% of these deaths involved opioids, and 84% involved illicitly manufactured fentanyls.[17] This data highlights the need to ensure access to SUD screening, harm reduction strategies, and evidence-based treatment.

Harm reduction strategies reduce morbidity and mortality in people who use drugs (PWUD), recognize social inequities surrounding drug-related harm, and call for nonjudgmental services that promote individual and community well-being. As part of an interdisciplinary team, BCPPs can play a critical role in (1) providing education surrounding harm reduction, (2) increasing access to evidence-based harm reduction tools through clinical practice and advocacy efforts, and (3) reducing stigma toward PWUD. Some practical examples of harm reduction strategies that BCPPs can support include furnishing intranasal naloxone and fentanyl test strips to adolescents, in addition to training adolescents and their caregivers on overdose recognition and response.[48,49]

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an integrated, public health approach for the delivery of early intervention and treatment of individuals with SUD, as well as those who are at risk of developing SUD.[50] Board-Certified Psychiatric Pharmacists, as part of the interdisciplinary team, are well positioned to provide SBIRT given their established role in SUD treatment. Notably, reimbursement is available for SBIRT. When an opioid use disorder (OUD) is identified, BCPPs can support use of medications for opioid use disorder (MOUD). While effective OUD treatment for adolescents includes psychosocial treatments (e.g., cognitive behavioral therapy) and MOUD, pharmacotherapy is underutilized in this population with only 10%–30% of adolescents prescribed MOUD.[17,24,51] Board-Certified Psychiatric Pharmacists can increase access to MOUD through development of a CPA.[47]

3 | EDUCATION AND COLLABORATION

Education provided by BCPPs to patients, caregivers, trainees, and colleagues is a practical way to enhance the quality of care provided to

children and adolescents, support collaborative decision-making among youth and their caregivers, increase visibility and understanding of CAP regulatory standards, and enhance interdisciplinary collaboration among pediatric providers. Education among trainees and colleagues may take the form of in-services, didactics, topic discussions, journal clubs, learning collaboratives, and more. Psychotropic medication training sessions led by BCPPs have demonstrated high rates of participant satisfaction (95% very satisfied), intent to apply information within work (88%), and post-training topic confidence (93%) among interdisciplinary audiences.[23] Through such educational initiatives, BCPPs can extend their reach beyond clinical settings to include academic settings, communities, and state/national organizations.

3.1 | Patients and caregivers

Patient and caregiver education is successfully provided in both group and individual settings by BCPPs. Patient medication education groups (PMEG) are unique opportunities for BCPPs to provide education in group settings and are associated with improved medication-related outcomes, patient satisfaction, and cost savings.[33] On an inpatient CAP unit, PMEGs co-led by a BCPP and pharmacy interns are opportunities to optimize medication-related interventions.[33] In addition to PMEGs, BCPPs provide individual education to patients and/or their caregivers at hospital discharge, lead multifamily groups in outpatient settings, and create tools to support children in various developmental stages (e.g., medication picture schedules).

3.2 | Interprofessional trainees

Board-Certified Psychiatric Pharmacists are often involved in leading didactic lectures, journal clubs, and patient-case discussions to support CAP fellows, residents, and students. A pharmacotherapy rotation model for CAP fellows led by BCPPs has been described.[52] This specialized rotation received positive feedback from CAP fellows and served to increase knowledge of pharmacotherapy considerations, an area of need identified by the Accreditation Council for Graduate Medical Education survey to all United States-accredited CAP fellowship training programs.[52] National residency listings also highlight the opportunity for BCPPs to provide clinical pharmacy rotations for Advanced Pharmacy Practice Experience Students, postgraduate year one (PGY1) Pharmacy Residents, and postgraduate year two (PGY2) Psychiatric Pharmacy Residents.[53,54]

3.3 | Interprofessional colleagues

Board-Certified Psychiatric Pharmacist collaboration with child and adolescent psychiatrists has been reported to improve outcomes (e.g., reduced hospital stays and reduced emergency department visits), quality of care (e.g., improved patient engagement/adherence), and patient safety (e.g., prevented adverse events).[4] Additionally, strengthening efforts to integrate mental health services into primary care is necessary. Pediatricians are often the primary team members providing mental health treatment for youth; at least 33% have prescribed atypical antipsychotics to children and adolescents.[55] Project ECHO is another way in which BCPPs can partner with child and adolescent psychiatrists, and other team members to improve psychotropic knowledge among pediatric primary care providers. Inclusion of a BCPP within the Child Psychiatry Project ECHO has been shown to increase pediatric primary care provider knowledge of psychotropic medication, increase implementation of evidence-based interventions, and decrease psychotropic polypharmacy (2.8% to 2.2% of patients prescribed ≥3 psychotropic medications).[40]

4 | DISCUSSION

It is important to acknowledge limitations to these proposed strategies. First, there are currently not enough BCPPs to partner with all interprofessional teams that care for children and adolescents prescribed psychotropic medications. Second, while many of the proposed opportunities in this manuscript have been established in adult health systems, they have not systematically been established in pediatric health systems. For example, there are not clearly established models by which BCPPs liaison with the foster care and juvenile justice systems. This warrants further exploration and consideration for state-based organizations that support children and adolescents prescribed psychotropic medications, such as the Texas medication Psychotropic Prescribing Guidelines.[34] Third, not all BCPPs have direct and practical access to pediatricians. This is of utmost importance knowing that the majority of psychotropic medications are prescribed in the primary care setting. Board-Certified Psychiatric Pharmacists can continue to partner with programs like ECHO and The REACH Institute, among others, to broaden their interprofessional impact in primary care.

Notwithstanding these limitations, further integration of BCPPs into the CAP workforce is essential. With pediatric health-system expansions (e.g., building psychiatry pavilions) to meet growing CAP needs, pharmacy administrations must be prepared to acquire expertise in these growing patient care areas. The 2023 pharmacy forecast by the American Society of Health-System Pharmacists Foundation revealed that 63% of pharmacy departments feel somewhat or very unprepared to meet the increased demand for pharmacists with advanced training in mental health.[56] Postgraduate year two Psychiatric Pharmacy Residents and BCPPs can be a cost-effective addition to the department to address this evolution in health care and are equipped to implement psychotropic stewardship to meet regulatory standards and optimize the evidence-based use of psychotropic medications.[1,4,57,58] The Core Outcome Set for Psychiatric Pharmacists is used to standardize outcome reporting by BCPPs and serves as an evidence-based tool to track data.[59]

Like child psychiatrists, BCPPs in CAP have opportunities for diverse training experiences in both adult and pediatric patient populations. While there are many skilled clinical pharmacists, the BCPP credential provides verification that the pharmacist has achieved a

significant level of relevant expertise to provide psychotropic stewardship to children and adolescents. The BCPP examination content domain 1.21 requires knowledge of the management of mental health conditions in specialty populations, including pediatrics and those with intellectual disabilities.[3] Many BCPPs have completed a PGY2 psychiatric pharmacy residency, which requires that they achieve competency in all aspects of a variety of mental illnesses and their treatments, including psychiatric disorders in children and adolescents and developmental disorders (e.g., autism spectrum disorder, Down syndrome, Wilson's disease, and Prader-Willi syndrome).[3] Some PGY2 programs also provide other rotations and learning experiences within CAP, including outpatient psychiatry in an ADHD clinic, consult and liaison psychiatry at a children's hospital, and clinics that serve youth with intellectual and/or developmental disabilities.

Even if a department hires a pharmacist who has not yet earned the BCPP credential, the BCPP should be maintained as the gold standard that establishes the expected level of knowledge and expertise. Pharmacy administrators can foster and promote the expansion of psychiatric pharmacy services within CAP by (1) supporting and rewarding board certification of its pharmacists, (2) supporting learning experiences for both PGY1 and PGY2 residents at their institution, (3) providing CAP rotations for student pharmacists to expose future pharmacists to psychiatry, and (4) forming affiliation agreements with other health systems (e.g., partnering with a local children's hospital).

Compelling outcomes are being achieved in CAP through interprofessional collaboration among child and adolescent psychiatrists, primary care providers, and BCPPs, among other team members. Thus, it is crucial for administrators to respond to the ongoing state of emergency by integrating pharmacy services into CAP and BCPPs into pharmacy departments.

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CONFLICT OF INTEREST STATEMENT

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Invited commentary

Community Initiated Care: A blue-print for the practical realization of contextual behavioral science

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ABSTRACT

There is a vast unmet need for mental health care and support in the United States and globally. Although expanding specialty services is needed, this is neither sufficient nor necessary to comprehensively address the current and future demand. Traditional models of care which have focused on mental disorders, while useful for many, remain out of reach, unaffordable, and not timely for helping the vast majority of individuals in need of mental health support. There is a growing movement of community-based networks and organizations which aim to fill this need by harnessing existing community resources to promote mental health and prevent mental and substance use disorders. This paper describes our effort to derive a blue-print for an approach, which we call "Community Initiated Care (CIC)", building on these real-world experiences and the growing science on lay person delivered brief psychosocial interventions in community settings. CIC serves as a back-bone for training lay persons to support the mental health and well-being of others in their communities. CIC is envisioned as an equitable, efficient, safe, and timely form of contextualized support to promote mental health and prevent self-harm, mental health and substance use problems. CIC is not intended to replace clinical interventions; instead, we envisage the supportive encounter to use a person-centered approach to bolster existing positive coping skills, promote positive social engagement, reduce risk of future mental health problems, and encourage other forms of help seeking when appropriate. This article explores how our thinking is aligned with and responsive to the strategies and tactics of the Contextual Behavioral Science Task Force to promote programs that are multi-dimensional, process-based, prosocial, practical, and multi-level. Development, implementation, and evaluation of CIC will not only advance contextual behavioral science but also move society forward to more equitable mental health and well-being.

1. Introduction

It is widely acknowledged that the US is in the midst of a historic mental health crisis. It appears that no matter that the country spends more on mental health care than most other high-income countries, Americans report substantial financial and other barriers to accessing care, and every indicator suggests a worsening of population mental health in the US (Tikkanen et al., 2020). Prior to the pandemic, there were already high rates of suicide deaths, overdose deaths among persons with substance use disorders, and increasing mental illness among children and adolescents, and these indicators have further deteriorated during the pandemic (Friedman & Hansen, 2022; Greenleaf et al., 2022; Jones et al., 2022; McKnight-Eily et al., 2021; Soares et al., 2022; Valdes et al., 2022). Whereas other health fields have shown substantial improvements in recent decades, such as a 30% decrease in the burden of disease due to cardiovascular disorders since 1990, the burden of disease attributable to mental disorders has worsened in that same time period (Herrman et al., 2022).

A new path forward is needed for mental health and well-being. The shortcomings of our assumptions and architecture of mental health services were revealed and exacerbated during the pandemic. Three key shortcomings have been a) the social inequities in the structure and operation of professional mental health services; b) the overreliance on categorical approaches to mental illness, i.e., someone is either mentally

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ill or they are not; and c) the profound human need for social connection in terms of both caring for others and being cared for by others to sustain mental health and well-being. In this commentary, we summarize these three shortcomings. Then we outline a path forward based on recent theoretical advances and supporting evidence, including the role of Contextual Behavioral Science (Hayes et al., 2021). Finally, we propose Community Initiated Care (CIC), as one part of the solution to advancing care and improving mental health.

2. The heart of the mental health crisis

The first shortcoming highlighted by the pandemic was inequities in mental health services along racial, ethnic, and economic fault lines in US society (Friedman & Hansen, 2022). The pandemic only amplified the historic lack of diversity amongst providers, inequitable policies and practices among insurance companies, and financial, geographic, and other cultural barriers to receiving appropriate treatment. Fewer than 50% of people with depression living in high-income countries, such as the US, had engaged a provider in the prior 12 months, and only 1 in 5 received minimally adequate care (Vigo et al., 2020). Across the US, health care providers were half as likely to conduct depression screening with Hispanic/Latinx and Black/African American patients compared to non-Hispanic White Americans; and Asian Americans were only a third as likely to be screened (Kato, Borsky, Zuvekas, Soni, & Ngo-Metzger, 2018). With regard to treatment, standard depression medications are 11% less effective with non-White populations and among persons with lower socioeconomic status (Mills et al., 2022). The metrics for psychological treatments are even worse; for patients who do receive treatment for depression, the vast majority—about 87%—are prescribed antidepressant medications, while only about 23% receive psychotherapy, and Black and Hispanic patients are less likely overall to receive depression treatment compared to Whites (Olfson, Blanco, & Marcus, 2016). This imbalance is despite the fact that the majority of patients express a preference for psychological treatments, in particular those from racial and ethnic minority groups; and patients who receive their preferred treatment report greater satisfaction, higher rates of treatment completion, and superior clinical outcomes (Cuijpers et al., 2020; Lindhiem, Bennett, Trentacosta, & McLear, 2014; McHugh, Whitton, Peckham, Welge, & Otto, 2013). Barriers to engaging with interventions among historically marginalized groups is not surprising given that only 10% of psychiatrists (American Psychological Association, 2015) and 16% of psychologists (Wyse, Hwang, Ahmed, Richards, & Deville, 2020) come from historically minoritized backgrounds. Moreover, few behavioral health providers are in geographic proximity to Black/-African American and Hispanic/Latinx communities (Wielen et al., 2015).

A host of indicators suggest that these inequities worsened during the pandemic when the demand grew and many in-person services were suspended (Goldmann et al., 2021; McKnight-Eily et al., 2021). Although there has been a boom in transitioning to tele-health services, the access is impacted by the digital divide with many middle and low-income families not being able to consistently engage this type of care (Blake, Bihm, Nkwanyuo, & Oshodi-Abikan, 2021). In addition, there has been a gap in mapping out mental health utilization and gaps to best understand who is in need of services and where services are being accessed; this contributes to the risk of widening inequities or putting precious dollars into programs that people are not using (Kohrt, 2021). Resources have been focused on treatment with a noticeable absence of prevention initiatives, particularly lacking in marginalized communities (Carbone, 2020). These mental healthcare inequities have mirrored the physical healthcare inequities during the pandemic, resulting in an increase in both physical health and mental health morbidity and mortality from COVID (Kim & Bostwick, 2020).

The second shortcoming of our current approach to mental health care is how mental health and illness are conceptualized (Fried, Flake, & Robinaugh, 2022). Training, financing, and health system designs rely upon categorical, diagnosis driven, models of mental disorders. This approach is contradicted by the solid evidence from diverse scientific traditions of a continuum of mental health and illness which requires a staged model across the life course in terms of symptoms, trajectories, and impairments (Herrman et al., 2022). Neither the symptoms of mental illness nor the treatments used can easily be siloed into a one-size-fits-all, disorder-specific paradigm. Moreover, the lack of a dimensional approach creates artificial boundaries and barriers to developing and implementing a spectrum of promotion, prevention, and early intervention strategies which can leverage diverse human and digital resources and platforms of delivery (Fried et al., 2022). Especially damaging in this categorical biomedical framework has been the professional and public perceptions that mental health problems must be treated by mental health specialists who are the sole proprietor of the diagnostic and treatment skills to rescue people from their illnesses. This mindset has been adopted by policy makers who consistently push for more specialty providers. An approach to understanding mental health and illness that acknowledges its fundamental dimensional architecture will open the space for care and support that is considerably more diverse and comprehensive than what is currently on offer (Herrman et al., 2022). It also allows for promotion and prevention to be a part of the continuum of care, which demands different payment and policy options.

The third issue highlighted by the pandemic is the importance of social connections. The disruption in social connectedness during the pandemic has led to increased risk for mental health problems and their perpetuation (Okabe-Miyamoto & Lyubomirsky, 2021; Smith & Lim, 2020). Despite the growing evidence that isolation, loneliness, and loss of social connection, all contribute to worsening mental health (Bethell et al., 2021; Kim, Cole, Carver, Antoni, & Penedo, 2021), the majority of interventions and services have focused on internal individual processes (e.g., changing cognitions, coping skills, and other individual behaviors) delivered by professionals who are hierarchically disconnected from beneficiary populations (for example, by psychologists or psychiatrists). For example, apps that one engages without any human connection have been pushed as major part of the solution to increased distress, but there is no definitive evidence of their wider adoption and impact. Moreover, the evidence suggests that lacking social connections during the pandemic is driving this distress across the life course, in particular for young people (Jones et al., 2022; McElroy-Heltzel et al., 2022). Youth is a period of rapidly shifting social relationships and growing reliance on peer social support compared to parental and family social engagement. Lack of connectedness has profound implications for their well-being and drives the high suicide rates in this demographic. For older adults, loneliness, worsens not only mental health, but also physical health (Kim et al., 2021). Moreover, virtual social engagements, which became an even more common form of connection during the pandemic, may contribute to an interplay among feelings of loneliness that drive internet use, and this may displace time spent potentially through in-person interactions (Nowland, Necka, & Cacioppo, 2018). Although in-person social connections reduce inflammation and promote anti-viral activity, this is not the case with online or virtual social interactions in terms of psycho-social-biological benefits (Snodgrass et al., 2022). Ultimately, the experience of many people with moderate to severe levels of distress throughout the pandemic has been the need to forge social connections with others who share their experiences.

3. The path ahead for improved mental health

Course correction in mental health care will require that it be delivered more equitably across the population. The first opportunity is to embrace the strategy of task-sharing, i.e., deploying non-specialist providers for addressing health problems which have historically been captured by specialist services. Task-sharing of psychosocial interventions, traditionally delivered only by mental health specialists, have shown effectiveness in diverse low-resource settings around the

world, including in the US (van Ginneken et al., 2021). For example non-specialist providers ranging from teachers and nurses to community health workers and religious leaders have been able to effectively deliver psychological treatments and social interventions for a range of common and severe mental disorders (Singla et al., 2017). The suite of techniques and therapies which have been adapted, alongside carefully designed training and supervision approaches, include behavioral activation, problem solving, motivational enhancement, social support, befriending, and trauma-focused cognitive behavioral techniques. Engagement in self-help practices using Acceptance and Commitment Therapy (ACT) under the guidance of trained community-members can reduce distress as well as prevent progression along the stages toward potential illness (Purgato et al., 2021). Persons who are not mental health specialists can also be trained to identify who needs mental health services and effectively engage them in care (Jordans, Kohrt, Luitel, Komproe, & Lund, 2015).

Task-sharing is being increasingly advocated to improve access to and reduce historic inequities in mental health care in the US. (Stevens et al., 2020). SAMHSA recommends that non-specialists in Black/Latinx communities play a role in outreach and linking with specialists, e.g., 'navigator' programs (SAMHSA, 2020). The White House's announcement in March of 2022 on a strategy to address the US national mental health crisis highlighted the need for more involvement on community-based programs, including embedding behavioral health in Women Infant Children (WIC) programs, libraries, and other settings, as well as increased involvement of community health workers, peer providers, and other paraprofessionals (White, 2022). Although non-specialists do not have formal mental health professional qualifications, they are more representative of the populations they serve (Kohrt et al., 2018). Delivery of interventions through task-sharing not only fills care gaps but also offers the benefit of greater congruence of life experiences between clients and their service providers, who are drawn from local communities, and enhances social-connectedness (Hoeft, Fortney, Patel, & Unützer, 2018; Kohrt et al., 2018; Mendenhall et al., 2014). This reduces barriers to treatment for minoritized groups, including the stigma and cost associated with seeing a mental health specialist. The benefits of non-specialists who are drawn from one's own community are not surprising when one considers the historical and cross-cultural evidence that humans have biological and cultural evolutionary drives to alleviate the psychological distress of members of their social groups (Kohrt, Ottman, Panter-Brick, Konner, & Patel, 2020). Thus, task-sharing can successfully address the shortcomings described above, from offering low-intensity psychosocial interventions for persons whose mental health problems have not reached the severe end of the dimension, allowing a larger and more diverse pool of providers from the same community to be engaged in mental health care, and reduce inequities in access to psychosocial interventions. This is consistent with CBS's focus on evolutionary frameworks in psychological sciences (Hayes et al., 2021).

The second opportunity is to align mental health care with the dimensional model of mental health and illness by embracing staged models of care (Fried et al., 2022), building on the evidence that, symptoms and impairment appear to progress along stages, with onset of certain symptoms likely to trigger subsequent clusters of symptoms when moving from one stage to the next (Robinaugh, Hoekstra, Toner, & Borsboom, 2020). Dimensional approaches, such as the Research Domain Criteria (RDoC) (Insel et al., 2010) from the US National Institute of Mental Health and the Hierarchical Taxonomy of Psychopathology (HiTOP) (Watson et al., 2022), are increasingly used to conceptualize dimensional models of mental health and illness. Moreover, theories of resilience, flourishing, and thriving have also demonstrated that well-being is not merely subtraction of disorder-specific symptoms, but rather the presence of other behaviors, supports, and resources (VanderWeele, McNeely, & Koh, 2019). The design of psychological treatments, in particular those which are delivered by non-specialist providers, is also increasingly moving away from disorder-specific psychological interventions to a search for "active ingredients" which not only target the putative mechanisms of specific clusters of symptoms or types of impairments, such as behavioral activation for symptoms associated with depression, but are also brief in duration (Hayes & Hofmann, 2021). This approach is well-aligned with the principles of CBS that interventions comprise kernels of therapeutic processes, and these kernels have particular mechanisms of action and influence over outcomes rather than interventions requiring only one fixed constellation of engagement (Hayes et al., 2021).

Third, any approach to mental health care needs to emphasize social connection. This is evolutionarily consistent with our understanding of the factors which enable human well-being (Kohrt et al., 2020), and, is consistent with social support benefiting both the person giving and the person receiving care (Cole et al., 2015; Eisenberger & Cole, 2012). We have previously outlined a model for the evolution of interpersonal healing processes based on evolutionary principles of multi-level selection as outlined by Hayes and colleagues (Kohrt et al., 2020). Social connectedness, such as when older adults mentor the younger generation are associated with reduced inflammation, improved mental health and greater resistance to viral infections (Seeman, Merkin, Goldwater, & Cole, 2020). Psychological healing serves the purpose of maintaining group cohesion and inclusion when there have been ruptures and associated distressful emotions, and is a reinforcing cycle where there are not only benefits to the person in distress, but the person providing support also experiences biopsychosocial benefits that reinforce the helping behavior. The evolutionary principles are that group cohesion and cooperation is vital for the survival and flourishing of individuals. The practical realization of this observation is to deploy persons from within the same community or social group to deliver mental health care. In addition to CBS′ evolutionary framework, the focus on social connection is also consistent CBS's recommendations for prosocial practices and promoting human cooperation (Hayes et al., 2021).

The CBS′ Task Force Recommendations are ideal to guide this process forward for a multi-dimensional, process-based, prosocial, practical, and multi-level strategy to improve mental health and wellbeing. CIC uses evolutionary science framework (Recommendation #1) with regard to structuring the conditions most likely to contribute to flow of empathy among groups members. CIC uses intervention kernels (Recommendation #8) such as promoting hope, problem solving, and behavioral activation. The Task Force's emphasis on quality standards (#14) by can be addressed by evaluating competency of CIC helpers and other implementation outcomes. CIC is designed to be implemented across diverse context (#16) with the curriculum to be contextualized for each communities' needs. CIC fosters prosocial behaviors (#23) be providing the tools for community members to become more engaged helpers. CIC also accommodates diversity through community-based helpers (#24) who will represent the diversity of the communities they serve. Similar to the prosocial objective, CIC promotes human cooperation (#25) also drawing upon the socioemotional processes of group functioning. Echoing the focus on diverse context and diversity, CIC has a cross-cultural focus (#29) in the intention that the target needs and explanatory models of those needs are resonant with the implementing communities. Finally, CIC comes out of the recognition that a new generation of CBS practitioners is needed to reduce the mental health treatment gap (#31).

4. A vision for Community Initiated Care

In the current mental health system, a person is typically reliant upon recognizing the signs of psychological distress in themselves, then knowing where to go to the get the appropriate treatment (assuming there is a skilled provider who is accessible), at which point they receive diagnoses that dictates disorder-specific care, which is typically delivered individually, most commonly through medication, and much less commonly psychological treatment which is evidence-based. The mental health crisis presents a historic opportunity to reimagine our

approach to population mental health by introducing novel ways of understanding mental health and illness and how care can deliver. We propose the concept of CIC as one such approach. At the heart of the CIC approach is meeting people in need where they are most comfortable (typically in their own community), providing support guided by both psychological science and the principles of social-connectedness, and deploying a widely-available resource to do so, i.e., members of the same community.

Imagine, that aspects of care were ubiquitous in the community. That knowledge and programs on mental health care were democratized and shared throughout the community – where people live, work, and play. Co-workers, family members, friends, and other community members would help point out the signs of distress and provide the support needed for the "psychic nicks and cuts of everyday life," (Galea, 2022). The care provided by these individuals would be helpful regardless of whether someone meets the criteria for a particular disorder. This support would help a person get through transient difficulties and help to prevent exacerbation of distress into more debilitating forms that would severely impair individual, social, and occupational functioning. This support would be integrated into everyday interactions rather than requiring a separate clinical encounter, which is figuratively and literally walled off from daily interactions. This care would comprise elements from commonly used, evidence-based, psychosocial interventions, leveraging personal psychological capabilities and social connections. Moreover, this care would not only help those receiving support, but it would also mentally and physically benefit the person giving the support.

In CIC, a trained helper offering the intervention to a colleague, neighbor, family member, or other community member who is experiencing distress. This would be indicated by difficulty in coping and struggling with response to stressful situations. The CIC-helper would recognize this difficulty and would engage with the person by empathic listening and a supportive conversation, which are common factors of all effective psychological treatments. The CIC-helper would then support the person in identifying her strengths and positive coping skills. After exploring the person's strengths, the CIC-helper supports the person to identify one positive actionable and feasible step forward. The step forward is something objective that a CIC-helper can provide reinforcement and praise for when completed. The CIC-helper is also taught to provide warm handoffs if additional support is needed.

The proposed CIC curriculum emphasizes mental health support delivered in single encounters, building on the growing evidence for the benefit of single session psychosocial interventions for persons with mental health difficulties (Dobias, Schleider, Jans, & Fox, 2021; Schleider et al., 2022; Sung, Mumper, & Schleider, 2021). However, one size does not fit all and there is the possibility that a person may need more support in the long-term or from other sources. This could be in the form of arranging to meet again to check-in on how the person is doing or connecting the person to appropriate specialist mental health, legal, financial, educational, job training, child care or other resources. Ultimately, this is not some new radical way of interacting, but rather, it is reconnecting with those evolutionary social processes that help humans to function as successful groups.

CIC can be distinguished from some other interventions by its emphasis on task-sharing through members of one's own community, blending both the active ingredients of evidence-based psychological treatments and leveraging the therapeutic potential of social connectedness from multiple perspectives: (a) it encourages people in the community to reach out to others in need; (b) it fosters social connection because the helper is from the same community with a shared socioeconomic background and life experience, fostering a more authentic empathy; (c) it leverages existing community resources and networks; and (d) ultimately, it is intended to change the culture of communities with greater social connectedness between its members.

An example of a current program that reflects many of the CIC aspirations is the "Healthy Minds, Healthy Communities" program in Harris, Texas, which encompasses the Houston metropolitan area. Through funds from the American Rescue Program Act (ARPA), The Harris Center for Mental Health is implementing a multi-year program that engages diverse members of the community to offer mental health support where people are already seeking other services. The first phase focuses on listening to communities, beginning to change attitudes, and creating interventions based on the identified community needs. The next phase is about linkages among community members, leaders, other service providers, and mental health professionals, and begin evaluating services. The third phase explores pathways to sustainability, including empowering neighborhoods, innovating more for personalization to communities, and seeking ongoing funding.

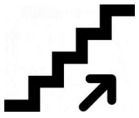
The initiative has identified 10 focus communities to start the initiative, with 60% of the focus communities having a majority of monolingual or bilingual Spanish speakers. In these communities, the Engagement phase comprises community learning circles to connect with existing resources and build ownership for Healthy Minds, Healthy Communities as implemented in their neighborhoods. Each community has conducted a workshop to map out the opportunities, barriers, dreams, and next steps. The process helped to identify community collaborations, such as the county public health office, food banks, housing support program, existing community-based mental health services, wraparound service providers, and local youth and ministerial groups.

5. Proposed curriculum for training in Community Initiated Care

The current blueprint for the CIC curriculum is provided in Table 1. To prepare helpers to deliver support in their communities, we envision each helper completing up to eight training modules. Module 1 introduces helpers to the concept of CIC, presents mental health and mental illness as a continuum model, and frames mental health and wellbeing within the context of community stressors and resources. Module 2 is a training on recognizing persons who would benefit from CIC; this uses a dimensional, non-categorical approach. Module 3 provides the steps to start conversations with persons in need and focuses on building trust as crucial to fostering psychosocial support. Module 4 guides the process of working with people in distress to articulate their current difficulties and to identify strengths, including resources in relationships and in the community, to respond to distress. Module 5 focuses on selecting and planning the one step forward to mitigate the distress. Module 6 is training for helpers on how to identify other community resources to mitigate distress. Module 7 relates to following-up with the person in distress to check-in on their progress. Finally, Module 8 is about self-care for the CIC helper to manage their personal mental health.

CIC is grounded in the commitment to community-centered and person-centered care, which frames the individual and her social group as the experts in guiding what is needed and how it can best be delivered. The CIC curriculum has co-design elements with community members as well as a collaborative approach with persons experiencing distress. CIC scales up the rich evidence on task-sharing through delivery by community members who do not have mental health professional expertise, but who are trained on kernels of evidence-based programs which are in the process of being made widely available through the EMPOWER digital learning platform (Patel, 2022), followed by continuing support to the helpers, such as through monthly listening circles. CIC can be delivered in through brief, single encounter, exchanges rather that defaulting to the traditional models of months-long psychotherapy, but also allowing tailoring to enable a follow-up encounter if needed. CIC is built on the foundation of strong trusting relationships, which we know matters a great deal in achieving improvement in outcomes. CIC is grounded in the science that helping others has mental and physical benefits for those providing care. Greater permeation of CIC therefore means that many people will benefit, not only those who give care, but also those who provide it.

Table 1
Modules for training in Community Initiated Care

Module	Skill	Learning objectives	Description
1 	**Explaining CIC to others**	● Learn what CIC is. ● Understand why CIC is important to communities and to the helper. ● See CIC in the broader context of social and mental wellbeing resources in the community	Background on CIC (what and why – including reference to evidence supporting this model, potential benefit, application in community settings). Boundaries for providing support (open communication on support limitations, ethics in handling sensitive information). General resources and technical assistance for CIC helpers. The module introduces the idea that there is a continuum of wellbeing and distress, and that each person is somewhere on the continuum in response to our life experiences, and the goal is to move towards, and remain at, the well-being end of the continuum by fostering inner strengths and healthy processes of change.
2 	**Recognizing persons in need**	● Recognizing who may need support ● Identifying common signs of distress (that is, struggling with psychological experiences) ● Understanding common reactions to difficult life circumstances and adversity	This module will prepare CIC-helpers to identify persons experiencing difficulty that examines thoughts and feelings such as sadness, anxiety, and stress within a particular context. This module will be based on the evidence-base for detection of psychological distress. Examples of proactive engagement with persons in distress can be used here (e.g., Community Informant Detection Tool, CIDT, which has been used in diverse global settings by non-specialists for detection of persons in distress). The goal will be to talk in terms of psychological distress rather than a disorder-based or diagnostic approach. Thus, no diagnostic labels are used.
3 	**Starting a conversation and building trust**	● Initiating a conversation with a person in need ● Showing empathy and genuineness ● Verbal and non-verbal communication skills ● Addressing stigma and misconceptions	This module is based on how to effectively initiate conversations about wellbeing and distress. The focus on non-stigmatizing and non-biomedical language, as well as responding to possible misconceptions about well-being. Skills common to all forms of supportive counseling, such as verbal and non-verbal communication skills, and demonstrating empathy and genuineness are emphasized. This module will also emphasize a person and process centered approach to mental health support. The module will address the factors that influence.
4 	**Identifying difficulties and strengths**	● Seeing the problem from the person's point of view ● Validating difficulties and needs, and responses to difficulties ● Identifying and promoting healthy coping mechanisms ● Identifying the person's preferred response to stress ● Increasing awareness of and reducing unhealthy forms of coping ● Orienting the person toward personal goals and values	The module will focus on identifying problems and identifying and cultivating strengths and flexibility in the person in distress. This will use validation techniques, as well as components of acceptance, values, and commitment to needed changes in relation to emotional distress associated with life experiences. The assumption of this module is that all individuals have coping skills and resilience, therefore a CIC-Helper's role is to help the person in distress connect with these existing skills, and prepare to put them into action.
5 	**One step forward**	● Being collaborative ● Applying strengths to current challenges ● Creating a learning mindset ● Developing actionable plans for moving forward ● Identifying resources needed to respond to current challenges	The CIC-Helper should be able to collaboratively identify with the person in need, one next step that they could take to move forward. The CIC-Helper should use a person and process centered approach to identify what resources in a person's social world could be mobilized to support the next step. The CIC Helper should help establish a continuous learning mindset that will engage the person in a cycle of self-exploration, learning by doing, and increasing awareness of what works and what doesn't, rather than expecting perfection and instant success.
6 	**Getting support for persons in need**	● Determining who may need additional support ● Common problems needing additional support ● Being aware of local helping agencies	This module is based on the dimensional model of mental health and illness which acknowledges that some persons in need may benefit from greater levels of support, potentially from providers with greater mental health expertise. The CIC-Helper receives basic information in this module about what concerns should be escalated to a coach or supervisor to determine what additional support is needed, and to the appropriate information to provide to the person-in-need.
7 	**Following-up**	● Reconnecting with the person in need when appropriate ● Appropriate follow-up strategies ● Determining limits of care	Whereas the modules above are focused on the idea of the single encounter for support, in some instances, there may be follow-up where the person in need meets with the CIC-Helper again. This module addresses when a follow-up may be needed how to be supportive during follow-up, and how to discuss challenges that may arise in subsequent encounters. In addition, this module discusses establishing healthy boundaries so that CIC-Helpers do not feel obligated to solve all of a person's problems and to avoid other difficult situations when boundaries risk being crossed. Examples of follow-ups could be phone and text check-ins.
8 	**Self-care**	● Managing personal wellbeing and stress ● Helping yourself to help others ● Helping others to promote person well-being ● Become aware of self-help resources	The final module is focused on self-care for the CIC-Helper so that they can manage their own distress and challenges in the course of helping others. The module discusses common ways that helpers can manage distress and promote well-being. In addition, the module reviews how helping oneself is key to helping others, as well as appreciating that helping others is also something that promotes physical and mental wellbeing in the helper. The elements in this module will echo and amplify the skills that are targeted in the earlier modules when dealing with persons in need. In that way this final module will help solidify the skills, knowledge, and role of the CIC-Helper, providing personal experiences that will facilitate their work.

CIC uses a dimensional model of mental health and illness such that its provision is not contingent upon meeting disorder-based diagnostic criteria. In this way, it offers a bridge in the continuum between promotion and prevention on the one hand and early intervention on the other. In contrast to most community-based mental health care models that see the community primarily as a referral system, the CICprogram is designed such that community members can provide support and may therefore reduce the need for referrals to already burdened, expensive and often inaccessible formal care services. We are conscious that one of the most vulnerable groups in the community are those with existing serious mental illness whose mental health condition often intersects with other vulnerabilities. We plan to expand the scope of CIC to include skills to support the recovery process and social inclusion of such persons in the future by contributing to collaborative care models and community-based psychosocial rehabilitation. Moreover, CIC promotes self-care behaviors so that CIC helpers can support and grow their mental health and wellbeing.

Implementation of CIC would need to take into account limitations such as the lack of availability of members of minoritized populations, if the assumption is that only members of minoritized populations can support one another. However, through the community engagement process in designing a CIC program, one would hope that a diversity of roles, interactions, and shared lived experience could be identified to foster empathic interactions. It would be misguided to assume that common race, ethnicity, or language are the only proxies for shared lived experience. Another potential limitation is that by emphasizing community members caring for one another, there is the issue that community helpers have the ongoing exposure to similar stressors as the people they are helping in their communities. High rates of structural violence, substance abuse, and discrimination will also be things that helpers are encountering on a daily basis. Therefore, assuring help for the helpers through supportive supervision, peer supervision, and empowerment to respond to these stressors is vital. Another important limitation is that some roles for a cascade of care, both social roles or interpersonal connections, might preclude contacting s ome CIC support people. For example, working with religious leaders opens to doors to some community members getting more access to mental health support. However, this may alienate other community members and increase their distress. Therefore, it is vital to have a range of CIC-trained helpers and not be limited to only one cadre, such as only teachers, or only religious leaders, or only hair dressers.

We, as the developers of the CIC curriculum, welcome feedback on this blueprint. This blueprint is not written in stone; instead, we see this blueprint as a ‘core curriculum’ which can be enhanced based on the felt needs of the community and the learnings derived from implementation. Thus, we envision scenarios where, working directly with community members, we learn what skills they feel are most important to possess and build them out and to undertake revisions based on their real-world experiences. No matter what skills are requested, CIC will remain grounded in a core evidence-informed curriculum that has, at its core, kernels of interventions that are based on empirical psychological science and practice. Community members help select kernels that are appropriate and feasible, and community members also guide implementation strategies.

In conclusion, brief encounters based on kernels of psychological treatments delivered through supportive conversations by fellow members of one’s own community are crucial components of the continuum of mental health care and for promoting the journey to mental health and well-being. Fostering these encounters reduces the barriers to accessing support while also contributing to the well-being of the community members engaged in delivering CIC. Ultimately, the widespread implementation of CIC can help create a more socially connected and flourishing community.

Declaration of competing interest

The authors declare no conflicts of interest.

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EXHIBIT F-39

Dartmouth Health

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Today's Code Is:

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RSS: Psychiatry Grand Rounds
Session Date: 10/17/2023 **Topic: Integrated Health Home & Value-Based Care**
Session Speaker: Dr. Stanley Williams, PhD

Dartmouth Health is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Dartmouth Health designates this live activity for a maximum of 1 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Learning Outcome Statement:
Participants will be able to describe neurobiological and psychological bases of a broad-range of neuropsychiatric disorders, while working collaboratively with multidisciplinary treatment team to implement evidence-based diagnostic and treatment approaches.
.

Disclosure:
The activity director(s), planning committee member(s), speaker(s), author(s) or anyone in a position to control the content for this activity have reported NO financial relationship(s)* with ineligible companies**.

** A "financial relationship" includes employee, researcher (named as the PI), consultant, advisor, speaker, independent contractor (including contracted research), royalties or patent beneficiary, executive role, and/or an ownership interest (not including stocks owned in a managed portfolio).*
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Transforming Lives

The HARRIS CENTER for Mental Health and IDD

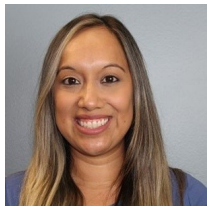
Lesson Objectives

1. Understand the separate systems of Health and Mental Health
2. Understand the role of Integrated primary and behavioral healthcare
3. Describe the Health disparities of not treating the whole person
4. Understand the consequences of unmet – whole care needs
5. Describe SDOH and Health related disparities
6. Understand the metrics, methods and approaches to establish a behavioral health home
7. Describe some of the benefits of the Harris Center Integrated Behavioral Health Home from the outcome data and member experiences.

Integrated Health Homes & Value Based Care

Key Lessons and Outcomes

Dr. Stanley Williams, PhD Director of Integrated Health



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

The Harris Center

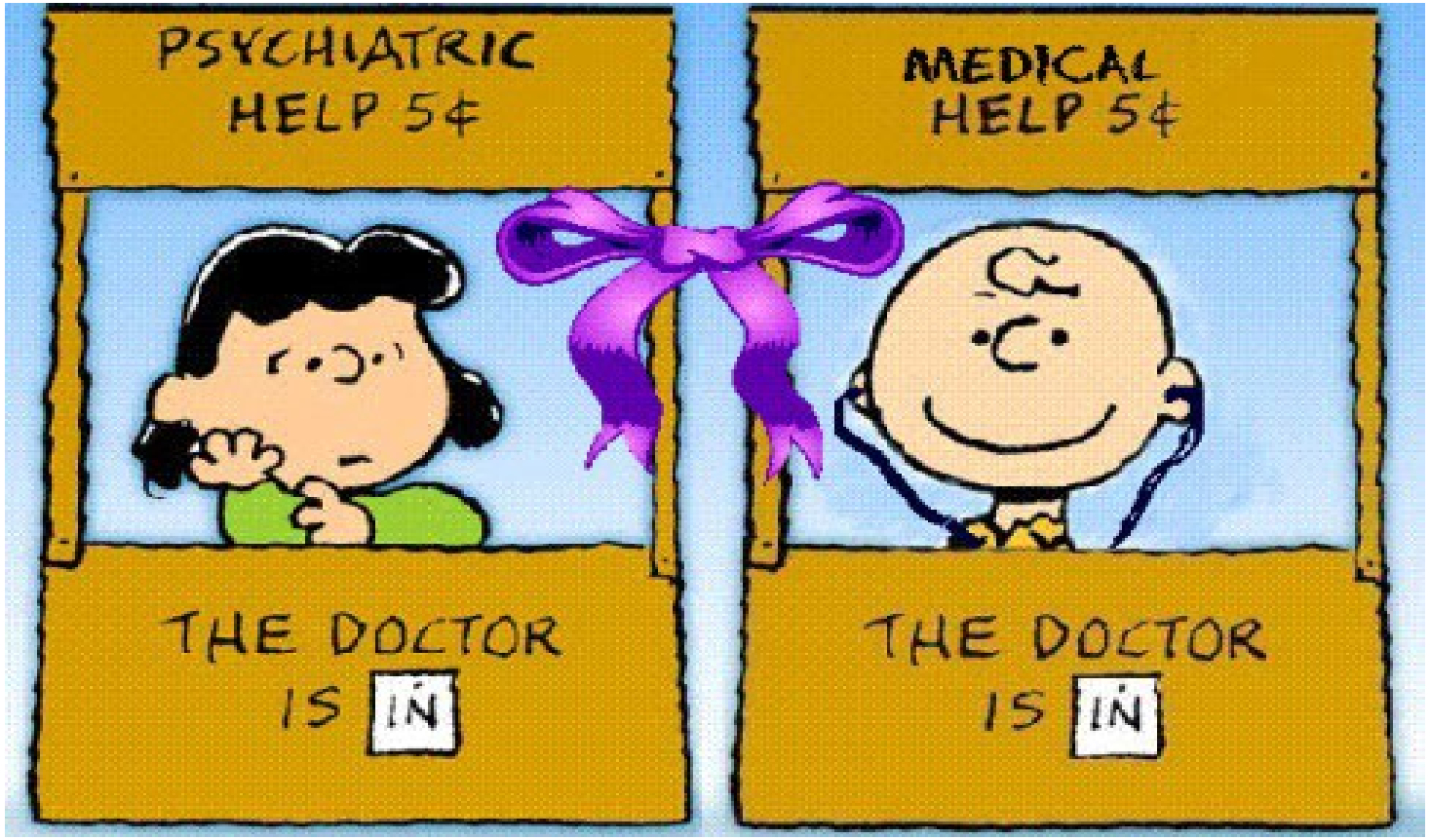
Houston, TX

As the largest behavioral and developmental disability care center in Texas, The Harris Center provides a full continuum of services to 88 sites across Harris County and serves over 80,000 individuals annually.

Services are offered in over 40+ languages to better serve one of the most diverse and multi-cultural communities in the nation.

The Harris Center is the state-designated Local Mental Health Authority and the Local Intellectual and Developmental Disability Authority serving Harris County, Texas.

Integrated Care's Legacy of Separate and Parallel Systems



Separate and Parallel Systems: Challenges

Medical Care

Mental Health Care

A forced choice between:

- 2 kinds of problems
- 2 kinds of clinicians
- 2 kinds of clinics
- 2 kinds of treatments
- 2 kinds of insurance

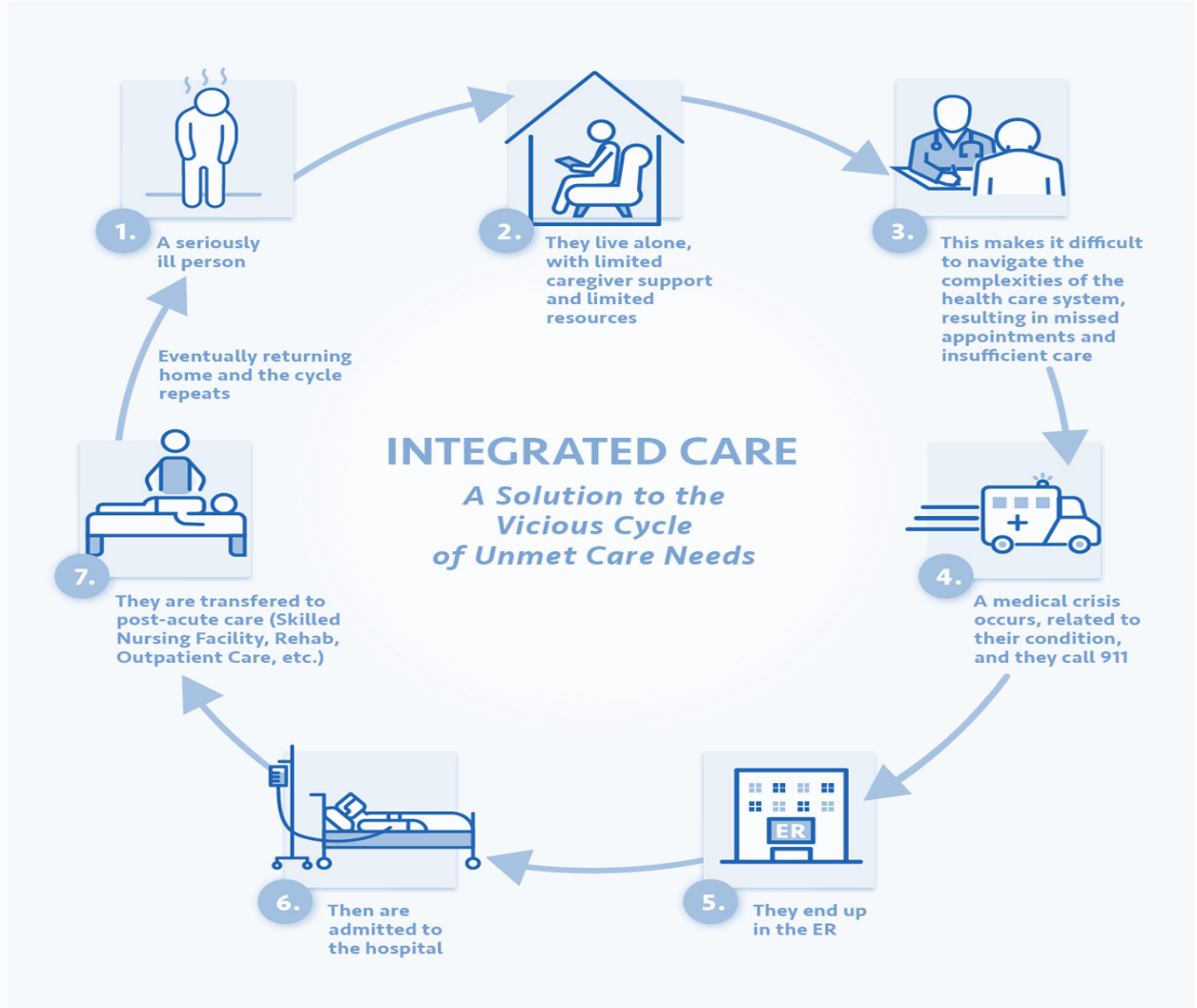
Integrated behavioral health leads to a better match of clinical services to the realities that patients and their clinicians face daily.

Original Source: CJ Peek 1996

People with Serious Mental Health & Co-Occurring Chronic Health Conditions – Vicious Cycle of Unmet Needs -

Some believe that the lack of proper care addressing SDOH and integrated health of people with behavioral health conditions results in Health Disparities

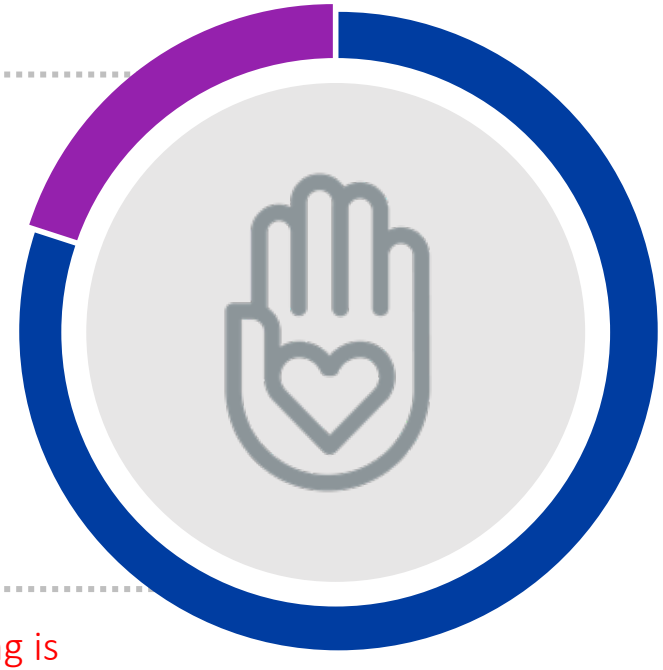
Improper Treatment Leads to Iatrogenic disease:
Any adverse conditions in a patient occurring as a result of treatment that does not incorporate the proper diagnosis, manner of treatment, failure to address conditions and problems.



Social Determinants of Health by the numbers

20%

of health outcomes can be directly attributed to clinical care[1]



80%

of health and wellbeing is tied to social and economic factors, physical environment and health behaviors[1]

91%

of Medicaid plans report activities to address social determinants of health[2]

19

states require Medicaid managed care plans to screen for and/or provide referrals for social needs[2]

85%

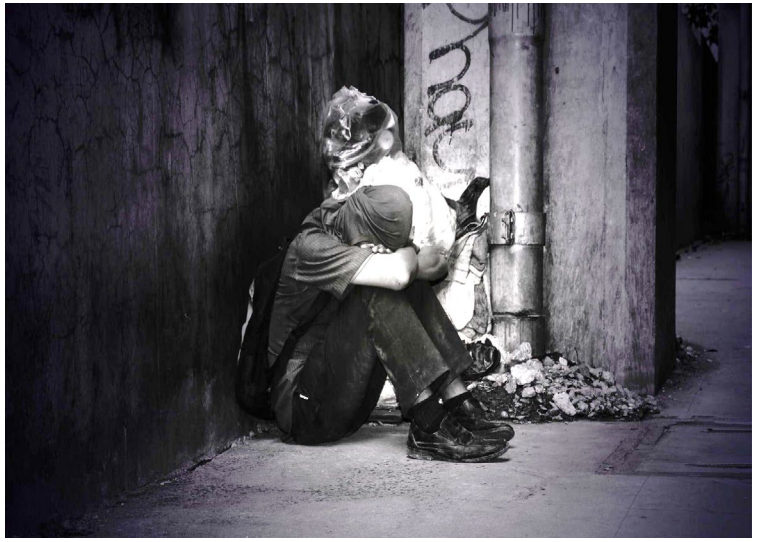
of physicians' report that unmet social needs lead to poorer health outcomes[3]

20%

of physicians are confident in their ability to address unmet social needs[3]

[1] Robert Wood Johnson Foundation, County Health Rankings, "Relationships between Determinant Factors and Health Outcomes"
[2] Kaiser Family Foundation, "Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity"
[3] Robert Wood Johnson Foundation, "Health Care's Blind Side"

Unmet Integrative Health Needs Poor Access – Integrative Care –



- 67% with a behavioral health disorder do not get behavioral health treatment[1]
- 30-50% of referrals from primary care to an outpatient behavioral health clinic don't make first appt[2,3]
- Two-thirds of primary care physicians (N=6,660) reported not being able to access outpatient behavioral health for their patients due to: Shortages of mental health care providers, health plan barriers, and lack of coverage or inadequate coverage, untreated substance abuse mental health services within health settings [1,2,3, 4]

1. Kessler et al., NEJM. 2005;352:515-23.
2. Fisher & Ransom, Arch Intern Med. 1997;6:324-333.
3. Hoge et al., JAMA. 2006;95:1023-1032.
4. Cunningham, Health Affairs. 2009; 3:w490-w501.

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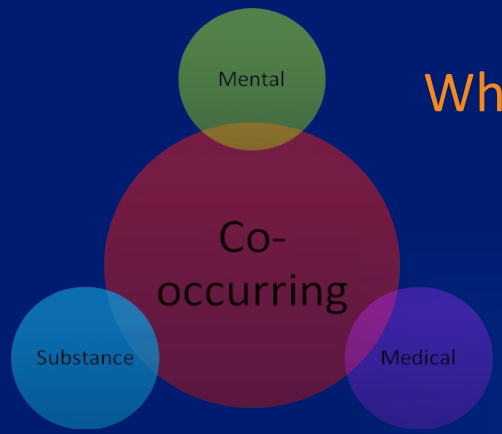
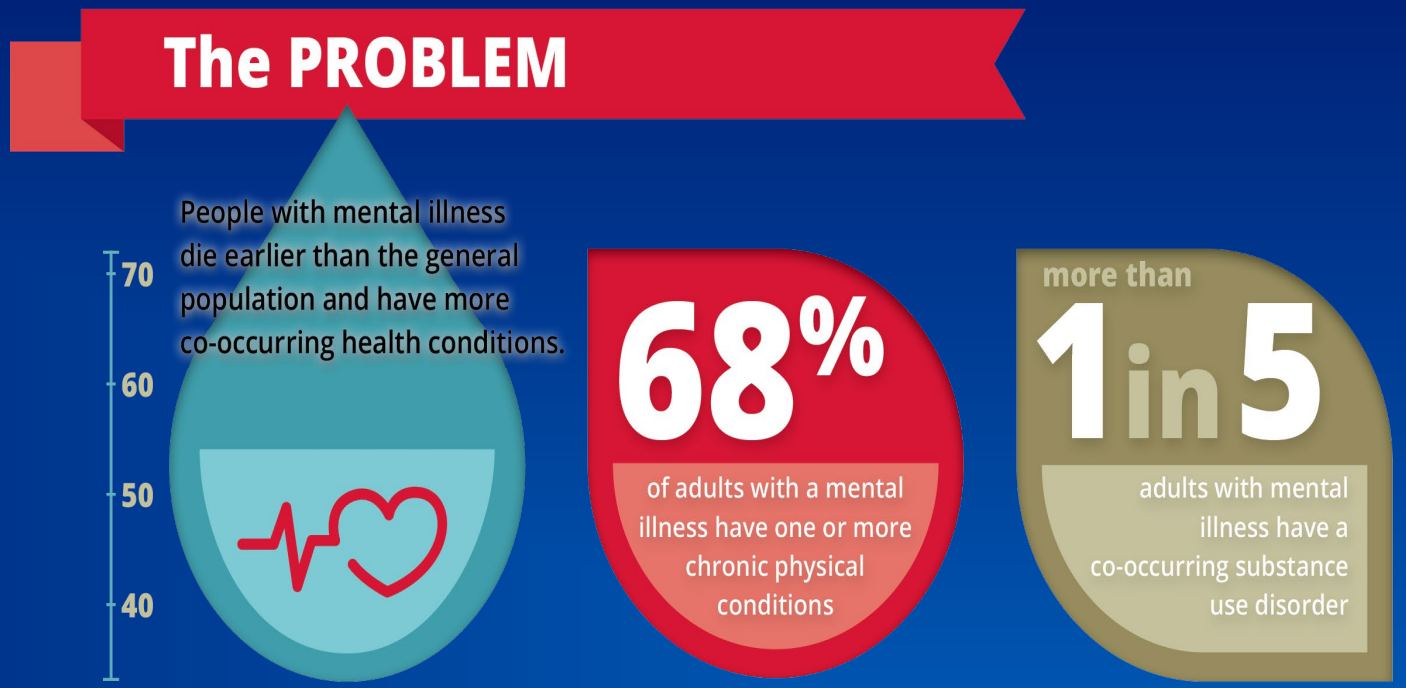
Why Behavioral Health Practitioners Need Competency in Integrated Behavioral Health Care



- Individuals with SMI die on average at the age of 53 years old
- Have elevated (and often undiagnosed) rates of:
  - hypertension,
  - diabetes,
  - obesity
  - cardiovascular disease
- Patient Challenges- SMI hampers self-care, medication compliance, adherence to primary care & medical treatment plans



Chronic conditions and comorbid psychological disorders Milliman Research Report. July 2008

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Health Disparities associated with unmet integrated health

- *Access problems*
- High rates of physical illness with mental illness
- Premature mortality
- People with mental illness receive a lower quality of care in primary care settings
- High cost of physical illness with mental illness

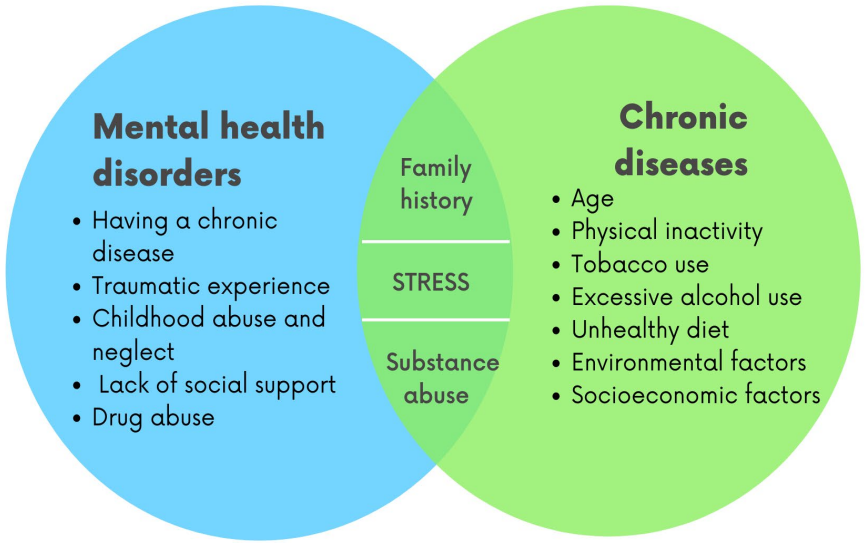
Definition of Health Disparities “Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific (racial and ethnic, cultural, gender) populations in the United States. ”

Populations in which disparities exist experience worse outcomes for chronic conditions, have higher health care cost, experience lower quality of life

25 years

Average span by which American adults with serious mental illness die earlier than others

– National Alliance on Mental Illness



Source: CDC, https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm

Rationale for Integrative Behavioral Health Home Approach

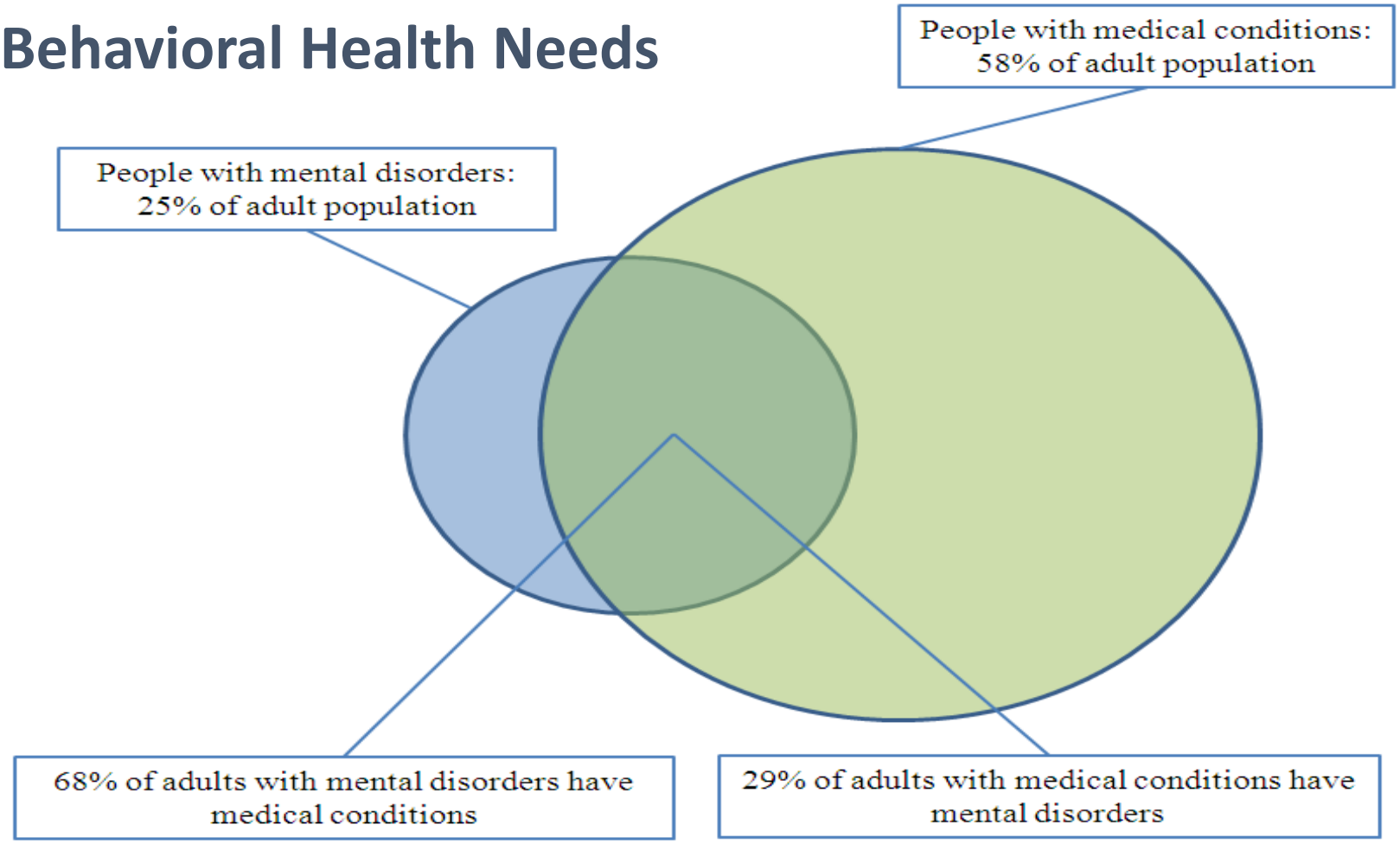
People with serious mental illness (SMI) are dying 25 years earlier than the general population.

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)

Unmet Behavioral Health Needs



Source: AHRQ, The Academy Integration Map. Accessed September 2014. http://integrationacademy.ahrq.gov/ahrq_map

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Trends and Data Associated with Mental Health and Chronic Diseases

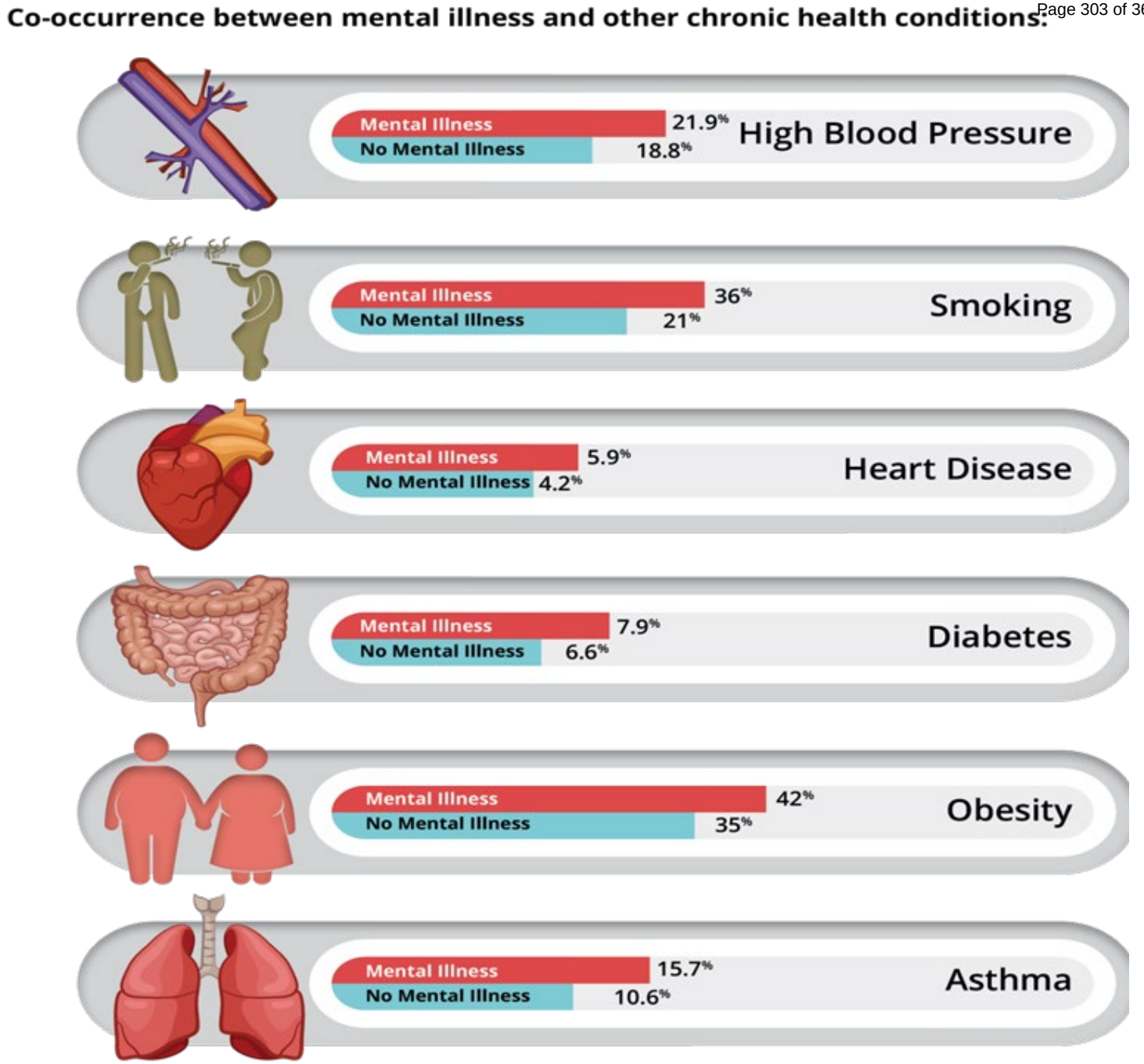
Annual Per Person Cost of Care
Common Chronic Medical Illnesses with Comorbid Mental Condition
"Value Opportunities"

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

Co-Occurrence Between Mental Illness & Chronic Health Conditions

- Source: AHRQ, The Academy Integration Map. Accessed September 2014. http://integrationacademy.ahrq.gov/ahrq_map



Patient Experiences with SMI in Primary Care

Primary care is a first point of contact and continuing point of care for many individuals with mental health and/or substance use issues. Yet, individuals with SMI reported poorer access to and lower quality of the primary care received relative to those without mental health conditions

1. Benjamin-Johnson R, Moore A, Gilmore J, Watkins K. Access to medical care, use of preventive services, and chronic conditions among adults in substance abuse treatment. Psychiatr Serv. 2009;60:1676-9.
2. Kilbourne AM, McCarthy JF, Post EP, Welsh D, Pincus HA, Bauer MS, et al. Access to and satisfaction with care comparing patients with and without serious mental illness. Int J Psychiatry Med. 2006;36:383-99.

Primary Care Doctors Preferred Treating Depression and Anxiety and not SMI

- Primary Care Physicians expressed greater comfort **treating common diagnoses, such as depression and anxiety**, than serious mental illnesses (SMI). They also repeatedly cited patients with co-occurring personality disorders as the most difficult to treat (1)

1.Primary Care Physician Perceptions on Caring for Complex Patients with Medical and Mental Illness Danielle F. Loeb, MD1, Elizabeth A. Bayliss, MD, MSPH2,3, Ingrid A. Binswanger, MD, MPH1,4,5, Carey Candrian, PhD6, and Frank V. deGruy, MD, MSFM3

Poor Health Disparities for People with SMI Triggered Movement to Whole Care within Behavioral Health Treatment

The Surgeon General's Report on Alcohol, Drugs, and Health found Integrated Care for primary care, mental health, and substance use-related problems to produce the best outcomes and provide the most effective approach for supporting whole-person health and wellness

https://ncbi.nlm.nih.gov/books/NBK424848

The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), along with the National Council for Mental Wellbeing have stated that , "the solution lies in integrated care, the systematic coordination of general and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs"

https://integration.samhsa.gov/about-us/what-is-integrated-care

Harris Center Survey – Determinats of Health Findings

"Social determinants of health (SDOH) are known to influence mental health outcomes, which are independent risk factors for poor health status, emotional wellness and physical illness."

Journal of the American Medical Informatics Association, 26(8-9), 2019, 895–899

Eight key DOH related findings from the Harris Center survey revealed the following:

The Harris Center, anticipating the potential of the significant and devastating impact of COVID-19 on direct behavioral health patient care developed and administered a survey entitled *Harris Center COVID-19 & Impact Social Determinants of Health.*[18] This survey was administered to patients by care managers through telephonic, socially distanced in person contact, and telehealth between April 2020 and April 2021. The survey was administered to 7,560 individual clients using a random number recruitment of active outpatient adult (81% adults) and children (19%) with SMI and or SED conditions.

***Food Insecurity**	34.69% Believed that they would run out of food
***Percent Uninsured:**	39.26 % Uninsured
Economic Insecurity	56.86% Found it difficult to pay for basic needs (i.e., food)
Feeling lonely & isolated:	54.16% Frequently felt lonely and isolated
***Fearful about the future:**	52.46%
***Can't keep up with medications:**	44.49%
***Lost access to health appointments:**	24.75%
***Have not seen a healthcare provider**	31.43% in last year

Barriers to Primary Care Doctors Treating Complex Conditions (SMI and Health Conditions)

- **Lifestyle and lived experiences Determinants of Health (DOH) factors** (isolation, access to transportation, employment, food insecurities, social biases) **impacting people SMI are barely considered in primary care.**

- **Primary care settings do not have the care management staff in community** to assist doctors with engaging patients with SMI with medication adherence, follow-up appointments, care plan and modifiable lifestyle factors important to improve health outcomes
- **Lack of integrative care for on-going side effects of psychotropic medications** (weight, high blood pressure, etc.) impacting SMI patients with hypertensive and diabetic condition either worsens conditions or cause patients not to take either primary care or psychiatric medications

Physical illness in patients with severe mental disorders.. Prevalence, impact of medications and disparities in health care p1World Psychiatry 2011;10:52-77 – cited by 2423

Integrated Behavioral Health Home Approach

By building an infrastructure around integrative health, SDOH, data directed clinical decisions that correlate to measures, we can create a bridge to improve health outcomes

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

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

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

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Integrated Health: Primary Health Care Services & Certified Community Behavioral Health Clinic (CCBHC)

UNIVERSITY of HOUSTON

Primary Care Services – Partnership with University of Houston College of Medicine

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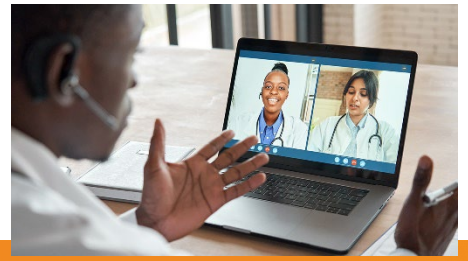
The HARRIS CENTER for Mental Health and IDD

Transforming Lives

Enhancing Integrated Primary Care: Structured and Planned Communication



FRAMEWORK

- Primary Care Behavioral Health Staffing Meeting
- Team Huddles – multi-discipline (psychiatry, primary care, care mgr., care navigators, nursing , counselors)
- Primary Care weekly meeting
- Screen, treat, a range of conditions - low to moderate manageable within our basic clinic and basic formulary (examples- but may vary - smoking cessation, obesity, Elevated & Hypertension Stage 1, pre-diabetes and medication adhered diabetes)
- Curbside consultations – virtual team meetings
- Care Coordination with Community Primary Care Specialist and Primary Care Clinics

FUNCTION

Promote access to complex and chronic disease management

Promote communication within Harris Center BH and Primary care

Align and coordinate care of more complex chronic disease management & care with community primary care providers

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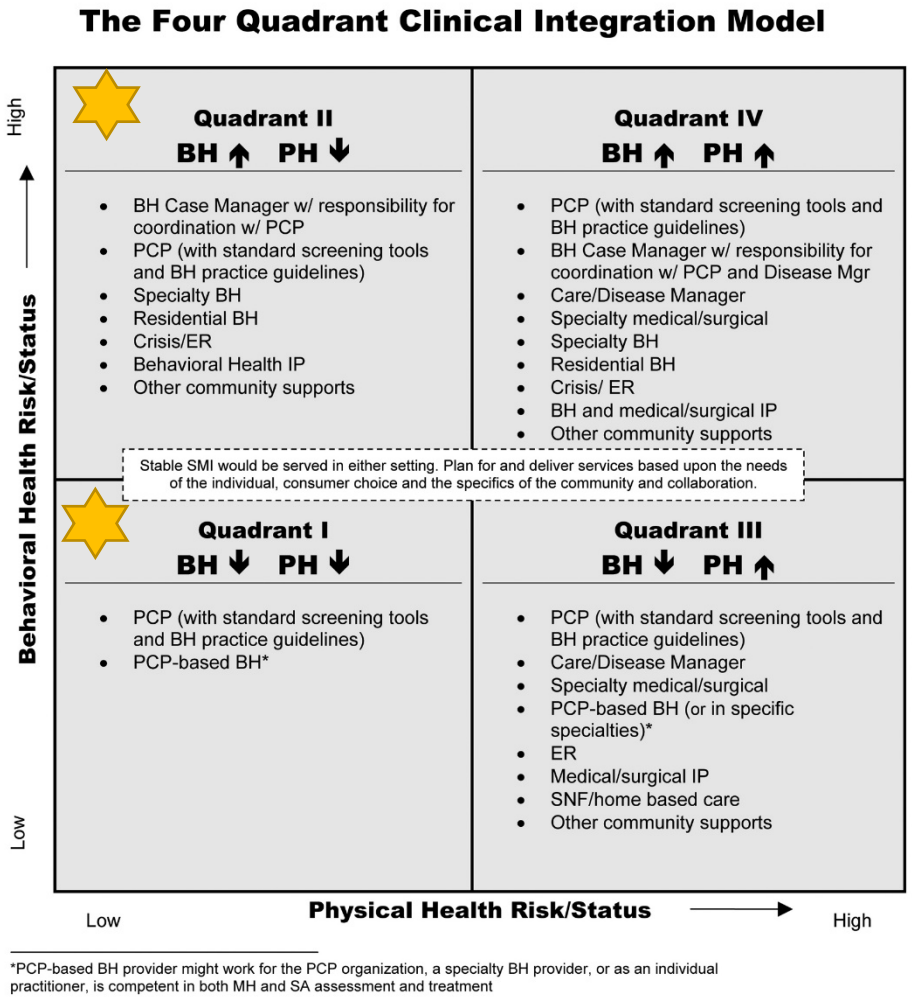
Integrative Collaborative Care Framework



This Four Quadrant Model is a conceptual framework for population-based planning and understanding the diverse integration initiatives that are currently underway. It was developed by Barbra Mauer under the auspices of the National Council for Community Behavioral Healthcare (NCCBH);

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The Harris Center Health Home

Your Health and Wellness Partner

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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 – Value-based care approach

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

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Why is The Harris Center a unique partner for a value-based care pilot?

Care coordination already part of the model

In-built scale due to size of local mental health authority (specialized therapy)

Full continuum of services across crisis, outpatient, and jail

Experienced clinicians who naturally translated to care manager roles

Alignment with other agency-wide efforts (CCBHC, pursuit of primary care/reverse integration)

Current Development – Part of Harris County Health Exchange

EHF: Care Management Platform - & Primary care/Health Home Optimization

Compass Rose – EPIC EHR

Coordinated Care Management

Epic Overview

The comprehensive health and social care record in Epic moves healthcare beyond clinics and hospitals. Coordinated Care Management provides case management tools to roll out population health, social, and community related programs to improve a person's well-being through care management and outreach.

A Comprehensive View of Wellness

Coordinated Care Management can help your organization keep more people well. Use tools in Epic to address social determinants of health, map support networks, connect people to community services, and measure outreach and program effectiveness. If you're interested in installing Coordinated Care Management, talk to your Epic representative to discuss how these tools fit your needs.

Address Social Determinants of Health

With EpicCare, clinicians, social service providers, and community partners can capture a person's social determinants of health – such as isolation, depression, food insecurity, and barriers to reliable transportation. Social determinants can also be submitted directly in MyChart. Users have easy access to this information in the Epic chart and can use it, combined with medical information, to inform the care and services they provide.

With Epic's Coordinated Care Management license, you can use social determinants of health history to drive decision support, risk stratification, and analytics. These tools help you target outreach and program enrollment to the most vulnerable in your population, leading to improved health outcomes and reduced costs through prevention.

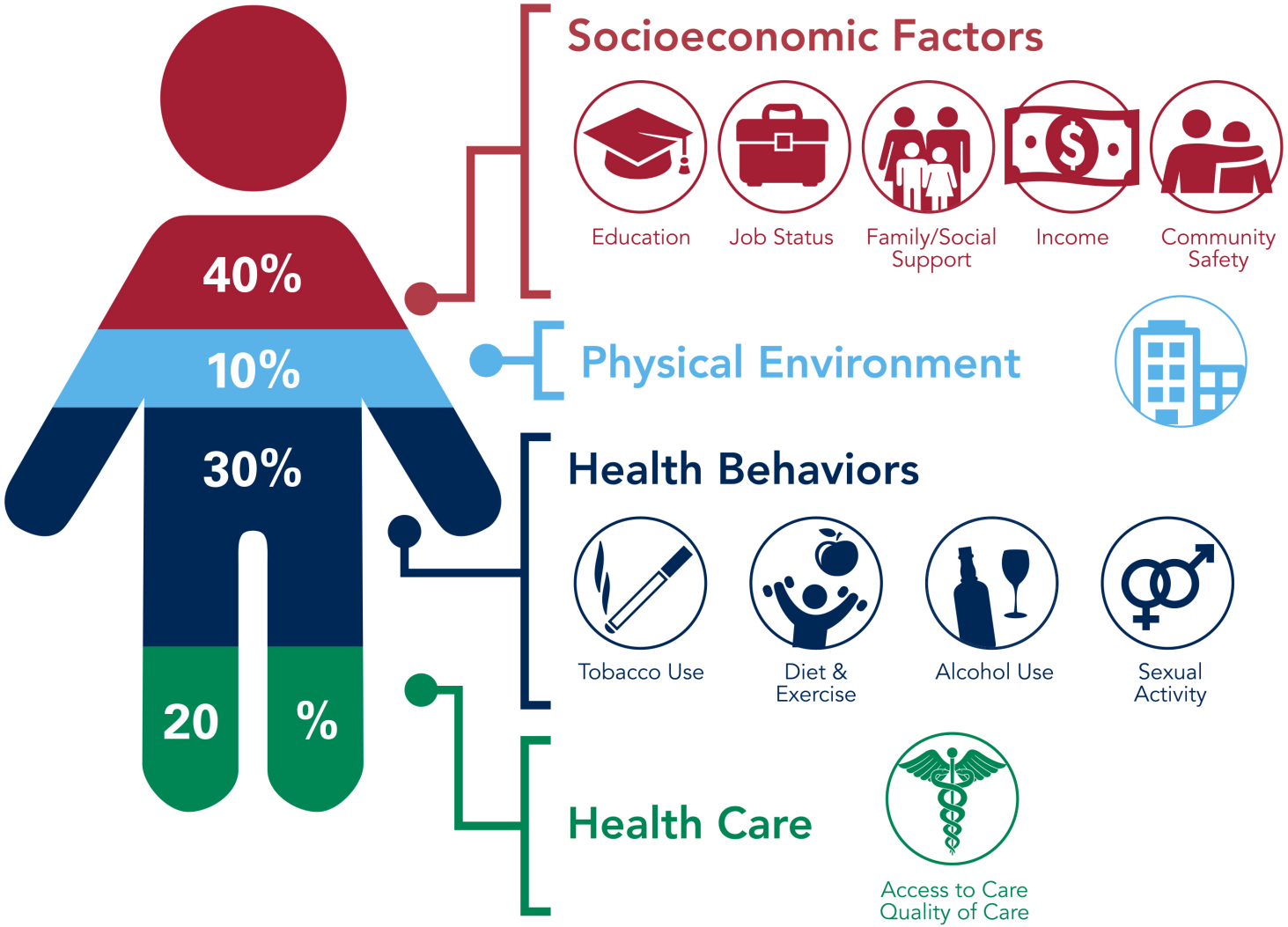
Coordinate Programs

With program management tools, you can organize and manage large-scale programs – like chronic care management and child welfare services – that benefit many different types of populations in your community. You can:

- Identify candidates for programs with decision support and reporting.
- Enroll program participants with referrals and applications, including a transparent application status visible in MyChart.
- Establish a program's targets and timelines in order to track the program's status relative to its goals.
- Track the services a person receives for each program he's enrolled in.
- Securely share a person's assessments and documents across multiple programs and provide confidential information specifically to program staff who need access.
- Manage staff workloads by visualizing program data like case load distribution by case manager and outstanding tasks by owner.
- Improve population health by enrolling consumers in structured programs, which include milestone tracking, integrated client plans, and actionable population reports with discrete, measurable outcomes.
- Providers bring care to people where they are with a mobile toolset for telehealth and home visits.

IMPACT OF SOCIAL DETERMINANTS OF HEALTH

Social determinants of health have tremendous affect on an individual's health regardless of age, race, or ethnicity.



SDOH Impact

- **20 percent** of a person's health and well-being is related to **access to care** and **quality of services**
- The **physical environment**, **social determinants** and **behavioral factors** drive **80 percent** of health outcomes

Source: Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems, 2014 Graphic designed by ProMedica.

IMPACT OF SOCIAL DETERMINANTS OF HEALTH

Social determinants of health have tremendous affect on an individual's health regardless of age, race, or ethnicity.

Economic Stabilty:
- » Employment
- » Income
- » Expenses
- » Debt
- » Medical Bills
- » Support

Neighborhood & Physical Environment:
- » Housing
- » Transportation
- » Safety
- » Parks
- » Playgrounds
- » Walkability

Education:
- » Literacy
- » Language
- » Higher Education
- » Vocational Training
- » Early Childhood Education

Food:
- » Hunger
- » Access to Healthy Options

Community & Social Context:
- » Social Integration
- » Community Engagement
- » Support Systems
- » Discrimination

Health Care Systems:
- » Health Coverage
- » Provider Availability
- » Provider Linguistic & Cultural Competency
- » Quality of Care

Health Outcomes:

» Mortality » Life Expectancy » Health Care Expenditures » Health Status » Functional Limitations

American Hospital Association™
Advancing Health in America

Source: Adapted from Kaiser Family Foundation. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. November 2015.

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Social Determinants of Health ~ ICD 10 Code Cross Walk

PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Social Intervention Response Categories

Code	Social Intervention Response
SI-RE	Racial/Ethnic Support Services
SI-FW	Farmworker Support Services
SI-VN	Veteran Support Services
SI-IN	Interpretation Services
SI-HS	Housing Support Services
SI-FC	Financial Counseling/Eligibility Assistance
SI-ED	Education Support Services
SI-EM	Employment Support Services
SI-FD	Food Support Services
SI-UT	Utilities Support Services
SI-CC	Child Care Support Services
SI-MH	Medicine or Health Care Support Services

Code	Social Intervention Response
SI-CL	Clothing Support Services
SI-PH	Phone Support Services
SI-OM	Other Material Security Support Services
SI-MT	Medical Transportation Services
SI-NMT	Non-Medical Transportation Services
SI-SI	Social Integration Support Services
SI-ST	Mental Health Support Services
SI-IN	Incarceration Support Services
SI-RF	Refugee Support Services
SI-ST	Safety Support Services
SI-DV	Domestic Violence Support Services

This tool is a crosswalk between the PRAPARE tool and its corresponding ICD-10 Z codes in the electronic medical record system (EMR); view the 2022 ICD-10-CM Release. In addition to social risk factor data, it is important to code for social complexities using ICD-10 Z codes and dummy CPT codes to track, monitor, and close the loop on the services provided to patients with identified social needs. CPT codes, or procedural codes, describe what kind of "procedure" a patient has received while ICD codes, or diagnostic codes, describe any diseases, illnesses, or conditions a patient may have. PRAPARE/SDOH data & Social Intervention documentation is needed to demonstrate value to payers/stewards and seek adequate financing to ensure interventions are sustainable while creating an integrated, value-driven delivery system to reduce total cost of care. PRAPARE Assessment Tool available at https://www.nachc.org/research-and-data/prapare/about-the-prapare-assessment-tool/

PRAPARE SDOH Domains/Constructs	PRAPARE Responses – Social Risk Factors	ICD-10 Z Codes	Z Code Description (New codes approved for publication on October 1, 2021)	Social Intervention (SI) for identified social need (these dummy CPT codes are optional):
Current Housing Situation	I have no housing	**Z59.0** **Z59.00** **Z59.01** **Z59.02**	Homelessness (new subcategory) Homelessness unspecified Sheltered Homelessness Unsheltered Homelessness	SI-HS Housing Support Services
Worried About Losing Housing	Yes	**Z59.81** **Z59.811** **Z59.812** **Z59.819**	Housing Instability, housed (new subcategory) Housing instability, housed, with risk of homelessness Housing Instability, housed, homelessness in the past 12 months Housing Instability housed unspecified	SI-FC Financial Counseling/Eligibility Assistance
Education	Less than high school	**Z55.5**	Less than high school diploma	SI-ED Education Support Services
Employment	Unemployed but seeking work	**Z56.0**	Unemployment, unspecified	SI-EM Employment Supportive Services
Other Needs/Financial Needs	Food, Clothing, Phone, Utilities, Childcare, Medicine or any health care, Other	**Z59.41** **Z59.6** **Z59.5** **Z63.6** **Z59.8**	Food Insecurity Low income Extreme poverty Dependent relative needing care at home Other problems related to housing/economic circumstances	SI-FD Food Supportive Services SI-CL Clothing Supportive Services SI-PH Phone Supportive Services SI-UT Utilities Supportive Services SI-CC Child Care Supportive Services SI-MH Medicine or Health Care Supportive Services SI-OM Other Materials Supportive Services
Transportation	Yes, Medical & Yes, Non-Medical	**Z75.3** Unavailability and inaccessibility of other helping agencies **Z75.4**	Unavailability and inaccessibility of health-care facilities	SI-MT Medical Transportation Services SI-NMT Non-Medical Transportation Services
Social Support	1-2 times per week and less than once	**Z60.8**	Other problems related to social environment	SI-SI Social Integration Supportive Services
Stress	Quite a bit and very much	**Z73.3**	Stress, not elsewhere classified	SI-ST Mental Health Supportive Services
Incarceration	Yes	**Z65.2**	Problems related to release from prison	SI-IN Incarceration Supportive Services
Safety	No	N/A	If the patient's response is a NO, that is a flag.	SI-ST Safety Supportive Services
Domestic Violence	Yes	**Z63.0**	Problems in relationship with spouse or partner	SI-DV Domestic Violence Support Services
Refugee Status	Yes	**Z65.3**	Problems related to other legal circumstances	SI-RF Refugee Supportive Services
Country of Origin	Other than USA	N/A	PRAPARE smart form in eClinicalWorks (eCW)	eCW Enterprise Business Optimizer (eBO) reporting

Member Eligibility & Attribution

Member Eligibility and Attribution:
Who qualifies for the program?

Eligibility and Attribution Methodology:

- Highest needs members with SMI, SED, and/or SUD are the focus of the IBHH
- 3 gateways to qualify (below)
- Based on claims history and geo-proximity
- Assures attributed members encompasses enough volume for enrollment
- Assumes ~50% engagement rate, with some currently engaged in care

Descriptors	Values
Medical Spend Thresholds	$120,000+
Behavioral IP/Residential Spend Thresholds	$12,000+
ER Visit Thresholds	12+
Attributed Members	**~1,545**

About 1500 have been attributed to us to date

Approximately 25% are Harris Center Clients

We are providing health literacy, tracking, wellness newsletter for all 1500

We are only serving about 10% of Harris Center patients in our primary care. We have been asked by United/Optum if we can provide primary care support to all the members in the project since they have struggles with their existing primary care doc (SDOH/barriers)

The Harris Center Health Home

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.

Review of Goals

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

Partnership Details:

- Per member per month (PMPM) payment structure
- Total cost of care shared savings
- Performance measures as part of shared savings bonus payout

Health Home Measures

- Follow-Up After Hospitalization for Mental Illness (HEDIS® - FUH): 7-day
- Comprehensive Diabetes Care HH - Composite 1 (HEDIS® - CDC): Eye exam
- Child and Adolescent Well-Care Visits (HEDIS® - WCV)
- Plan All-Cause Readmissions (HEDIS® - PCR)
- Ambulatory Care: AMB HH (CMS)
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (HEDIS® - SSD)
- Inpatient Utilization General Hospital/Acute Care HH (HEDIS® IPU)
- Rate of Inpatient Behavioral Health Admissions - TPI (Custom)
- Medication Adherence: Mood Stabilizers, Anti-Psychotics and Anti-Depressants- MA-MS, MA-AP, MA-AD (Custom)

Reporting Only Measures

- Follow-Up After Hospitalization for Mental Illness HH (HEDIS® - FUH): 30-day
- Behavioral Health Inpatient Days - TPI-DAYS (Custom)
- 7- and 30-Day Inpatient Behavioral Health & Residential Treatment Facility Readmission Rate TPR-7, TPR-30 (Custom)

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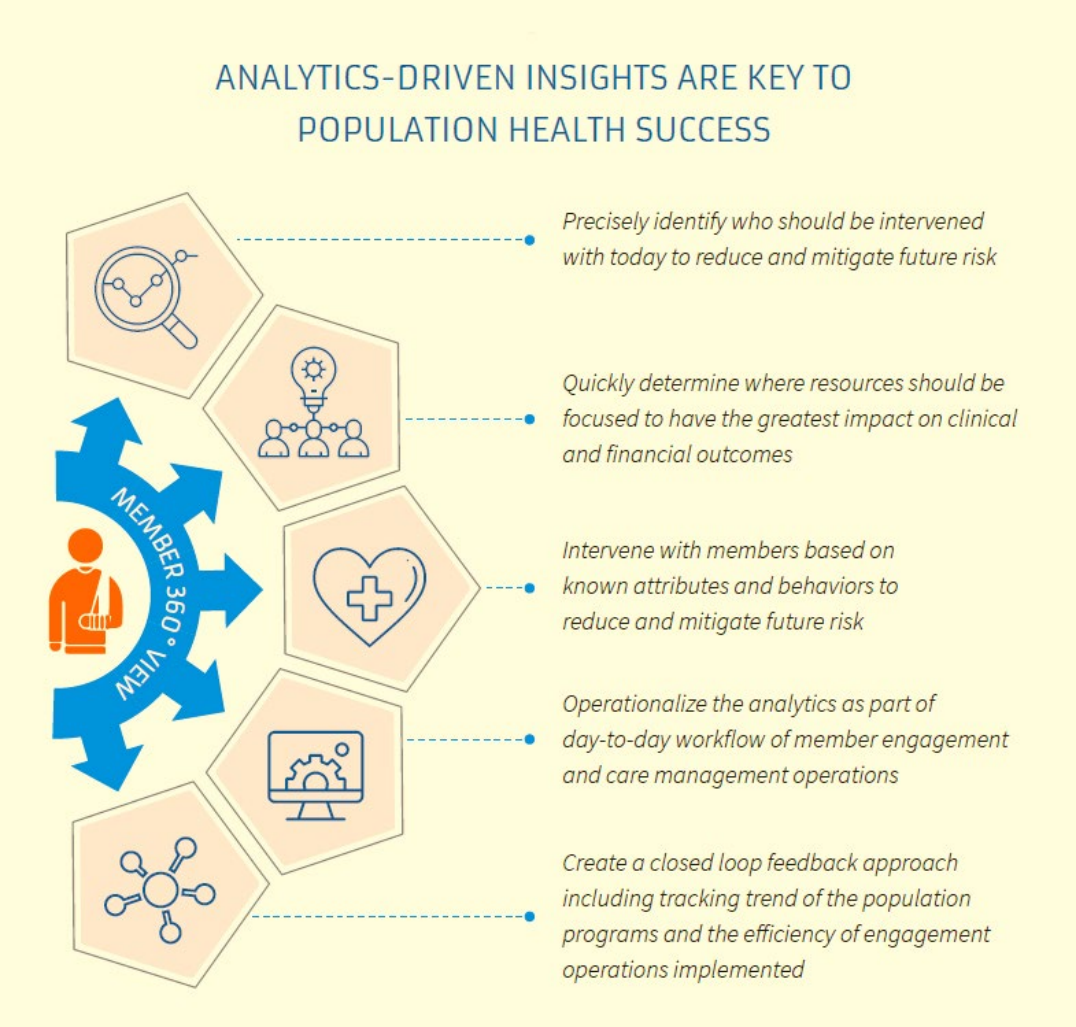


Utilizing Optum Portal – Data

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

Concierge Medical

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 -

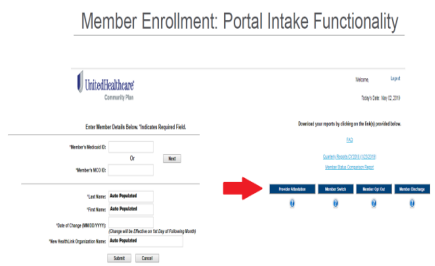
4. Integrative Behavioral Healthcare

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

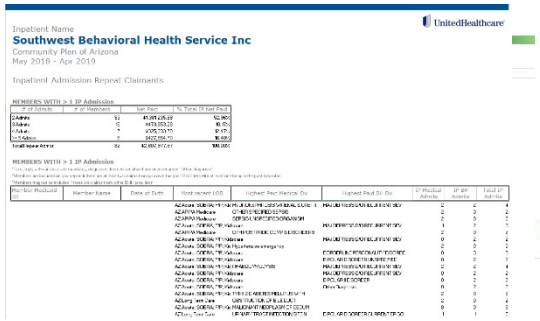
Health Home Reporting Capabilities

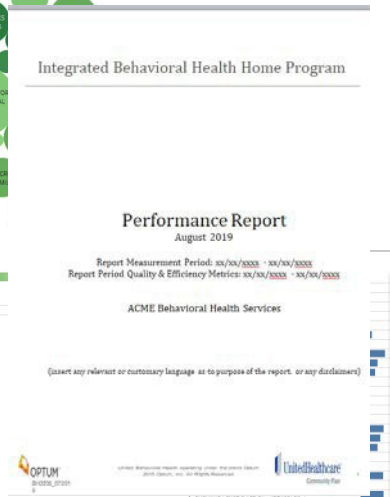
Member Identification & Attribution

Provider Attestation Portal

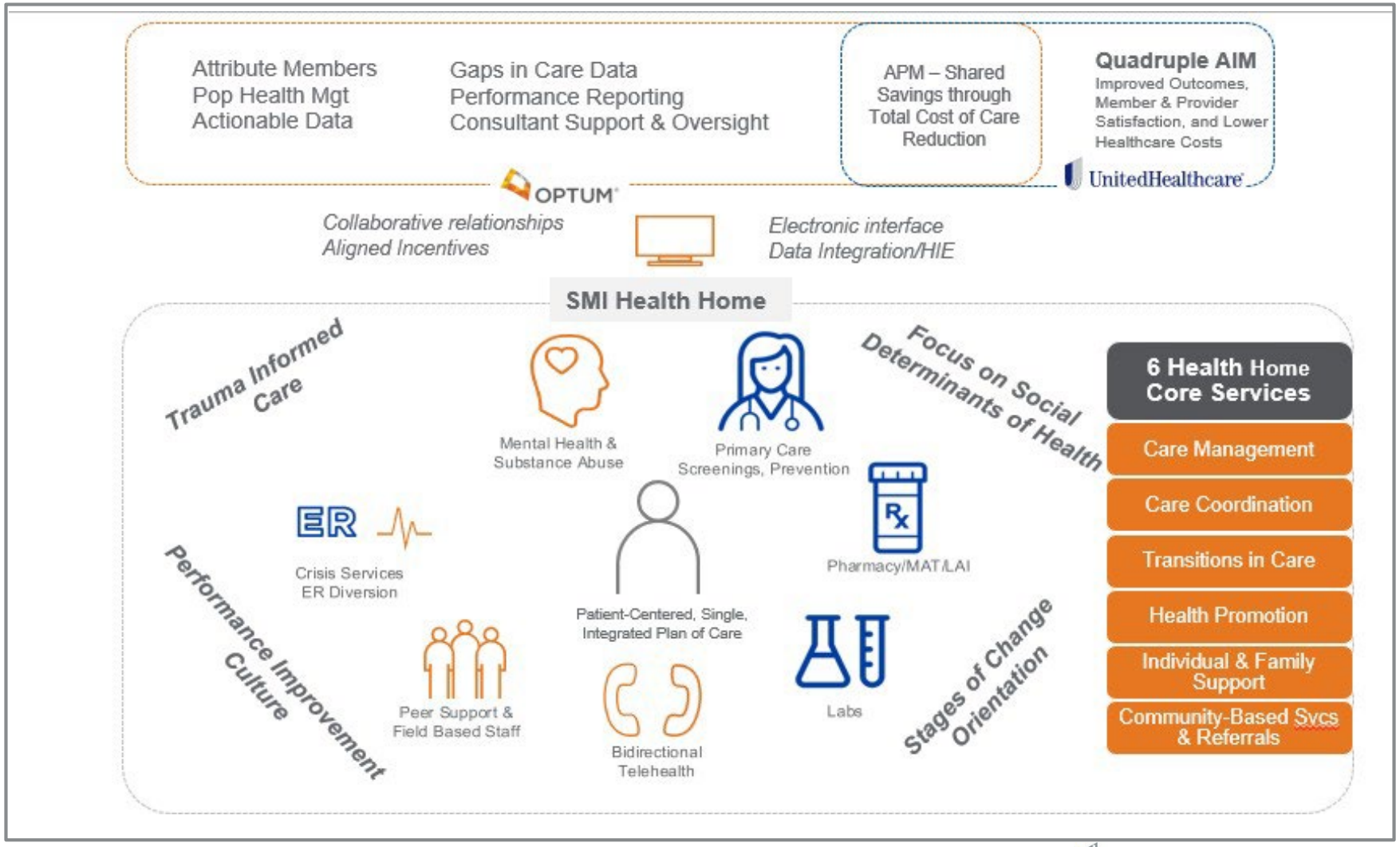


Reporting





Leveraging Partnership with Optum



United Behavioral Health operating under the brand Optum

Optum Reporting Suite, Roll-out Workflow and Decision-Making

Reporting Suite

Note: Reporting needs may change during the course of the pilot

Report Name	Frequency	Description	Delivery Mechanism
Daily Census Report	Daily	Report contains inpatient information for **all attributed members** on the roster, including admitting IP facility. Data contains a tab showing all admissions within the previous 30-day period	Provider Portal
Member Change Report	Weekly	Displays status changes for **all members** that occurred in the week since the previous Member Change Report was produced (new, enrolled, discharged, et al.)	Provider Portal
Pharmacy Refill Reminder Report	Weekly	Provides RX refill data for **enrolled** members 14 days before refill date, and 14 days overdue	Provider Portal
High-Cost Claimants and High Utilizers Report	Monthly	Identifies members based on medical/behavioral costs and utilization (counts) for frequent ER and IP utilization over a rolling 12 months	Provider Portal
Metric Performance Report with Member Adherence	Monthly	Gives HEDIS and other quality and utilization measures that are part of the VBP. Includes measurement **performance against targets** for the current reporting period **and member-level detail.**	Provider Portal
Provider Performance Reports	Quarterly – also serves as the Annual Report	Gives an overview of how providers are performing against metric targets and their current membership. Includes Total Cost of Care Summaries for medical and behavioral spend and tracks potential Outcome Payments.	Provider Portal
Invalid Billing Report	Monthly	Details all activity payments that were identified as having a potential billing error at the member level. Details remain on the report for 90 days.	Value-Based Practice Consultant – is not distributed

Team-based care -Daily Staff Huddle

- Review Optum Reporting Suite Portal
- Review daily & weekly reports
- Zero in on High utilizer list, admissions, assignments based upon risk stratification

23

Pro-active engagements based upon scripts used by staff for ER Diversion, Self-management, & On-going engagements

Sample Provider Checklist for Post-ED Follow-Up Visit Prior to the visit

• Review discharge summary
• If there are any outstanding questions, clarify with sending physician
• Initiate medication reconciliation with attention to the pre-hospital regimen
• Reminder call to patient or family/caregiver to: o Stress importance of the visit and address any barriers
o Remind patient/family/caregiver to bring medication lists and all prescribed and over-the-counter prescriptions
o Provide instructions for seeking emergency and non-emergency after-hours care

• Coordinate care with home health care nurses and case managers if appropriate

During the visit

• Say: Our clinic would like to be your medical home or home base helping you with all of your health care needs. We like to learn from our patients and families how we might improve the care we provide.
• Ask the patient/family/caregiver to share: o What would be helpful for you to get from today's visit?
o How did you decide the ED was the best choice in this situation?
o What medications he/she is taking and on what schedule?

• Perform medication reconciliation with attention to the pre-hospital regimen
• Determine the need to:
o Adjust medications or dosages;
o Follow-up on test results;
o Do monitoring or testing;
o Discuss advance directives;
o Discuss specific future treatments
• Instruct patient in self-management; have patient repeat back (offer the BP/weight Kit – for self-management
• Explain warning signs and how to respond; have patient repeat back
• Provide instructions for seeking emergency and non-emergency after-hours care; @ urgent care versus hospital if possible - have patient repeat back

Sample Conversation Starters for Encouraging Visits to Medical Home rather than the ED [For Patients with Recent ED Use]

Could be used for follow-up calls/visits for patients with recent ED use
• "I see that you have been in the Emergency Department recently. That must have been hard/scary for you. Would it be okay if we talked about this for a few minutes?"

If they say yes, continue...
• "Can you tell me a little more about this visit?"

Let them explain why they went to the ED. This will give you more information about what happened, etc. This will give you an "in" to find out why they went to the ED instead of your practice.
• *"How did you decide the ED was the best choice in this situation?"*
This gives the patient a chance to voice what they see as positive. It also may give you more information about what they might NOT know so you can fill in the blanks. Explain to the patient the benefits of being seen by their own provider.
• *"Could I share some information about how we handle urgent or after-hours calls?"*
If they say yes continue with:
• *"We hope you see us as your medical home or home base for your child's health care needs." [explain what a medical home is if needed].*
• *"As your medical home, we have an after-hours plan so you can reach us outside of business hours – you can start by calling the main number, it is XXX-XXX-XXXX."*
• *"What do you think about what we've talked about?"*

Preventative Call Script: General Practice Population Education

Provider and/or Nurse at end of visit and/or Front desk at check-out could use these to encourage all patients or parents to call the office, if needs come up in between planned visits.
• "Your next regular checkup/planned appointment is _____. If you need us before then, please call. We have our regular and our after-hours line, so you can get help whenever you need it."
• "Sometimes medication questions can come up after-hours, especially if you are feeling sick. If this happens, please don't hesitate to call us.
• Are you able to obtain weekly blood pressure readings or able to weight yourself as part of your healthcare monitoring?

Let them answer. Provide the brochure/information about calling the office first.
• "Could I share some information about how our practice handles after-hours calls?"

If they say yes, you can hand them the brochure and/or provide the after-hours information.
If they say they are unable to do health monitoring offer the weight scale/BP kits and set plan for self-monitoring

How Will We Track and Monitor

Optum | UnitedHealthcare Community Plan

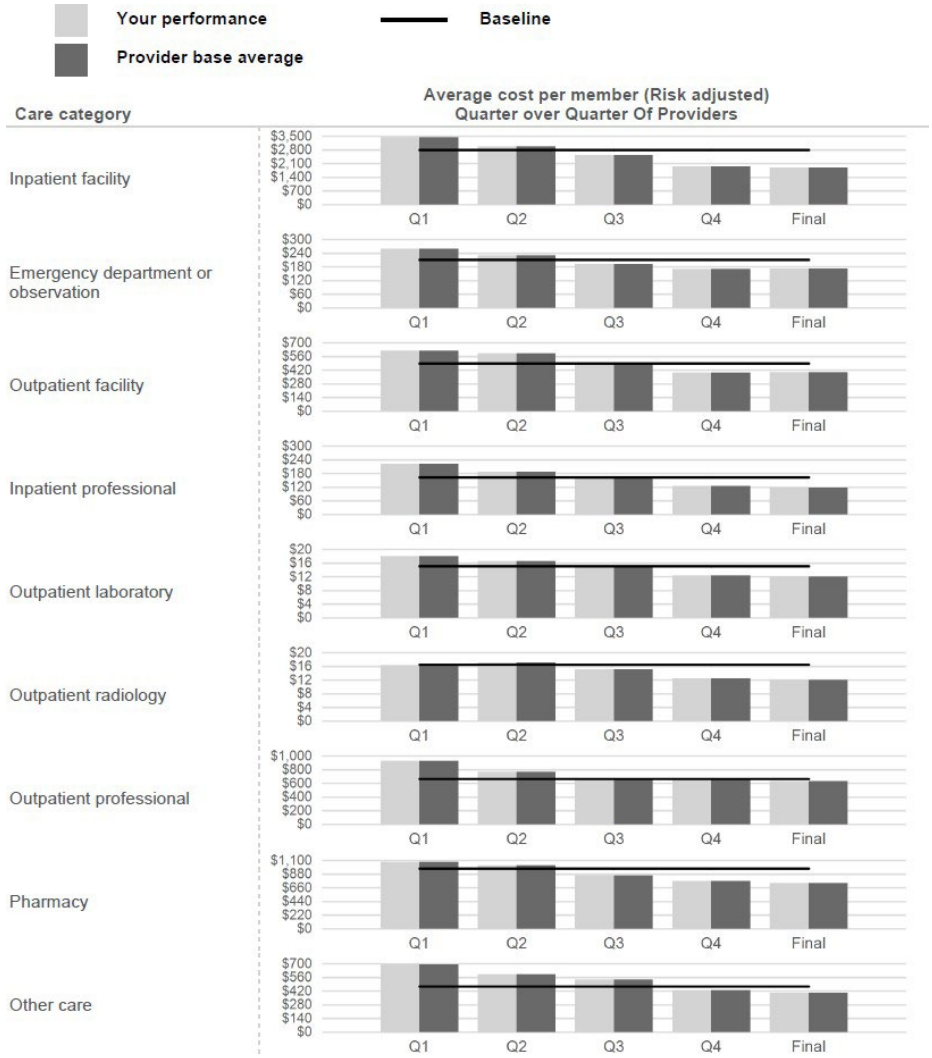
Integrated Behavioral Health Home Outcomes

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



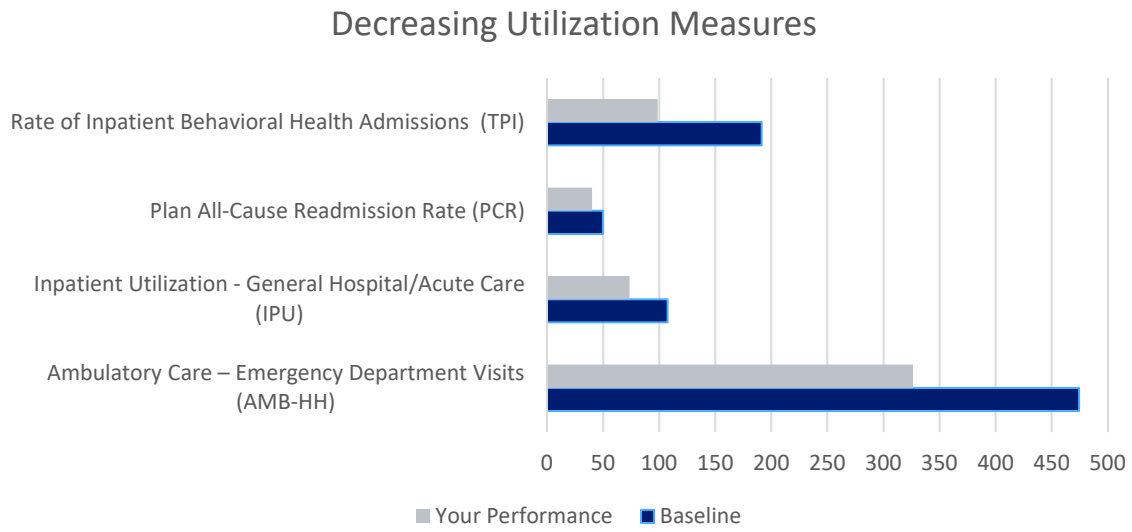
Behavioral Health Home Group Summary Report

Health Home TIN: 741603950
Health Home Name: Harris Center
Report Period: Jan 1, 2022 to May 31, 2022

Performance Measures:
The following data shows HEDIS and other standardized quality and utilization measures that are part of your value-based agreement for Health Homes and reflect measurement performance improvements against baselines for the current reporting period. Each measure requires at minimum of 30 observations to accurately measure your performance. Annual outcome payments are based on final measurement results and considers only those members who have been attributed to your program for a minimum of six (6) months during the measurement period. Each measure is worth a maximum of two points (.5 points for 3.00% - 4.99% improvement over baseline, 1 point for 5.00 - 7.99% improvement, and two points for 8.00% or more improvement

Utilization Measures	State	Denominator	Numerator	Baseline	Your Performance	Percentage Change from Baseline	Qualify for Points	Points
Ambulatory Care – Emergency Department Visits (AMB-HH)	TX_SEast	8,196	2,675	474.54	326.38	-31.22%	YES	2.0
Inpatient Utilization - General Hospital/Acute Care (IPU)	TX_SEast	8,196	603	107.54	73.57	-31.59%	YES	2.0
Plan All-Cause Readmission Rate (PCR)	TX_SEast	1,045	419	41.94%	40.10%	-4.39%	YES	0.5
Rate of Inpatient Behavioral Health Admissions (TPI)	TX_SEast	8,196	808	191.28	98.58	-48.46%	YES	2.0

***Decreasing "Utilization" measures are favorable**



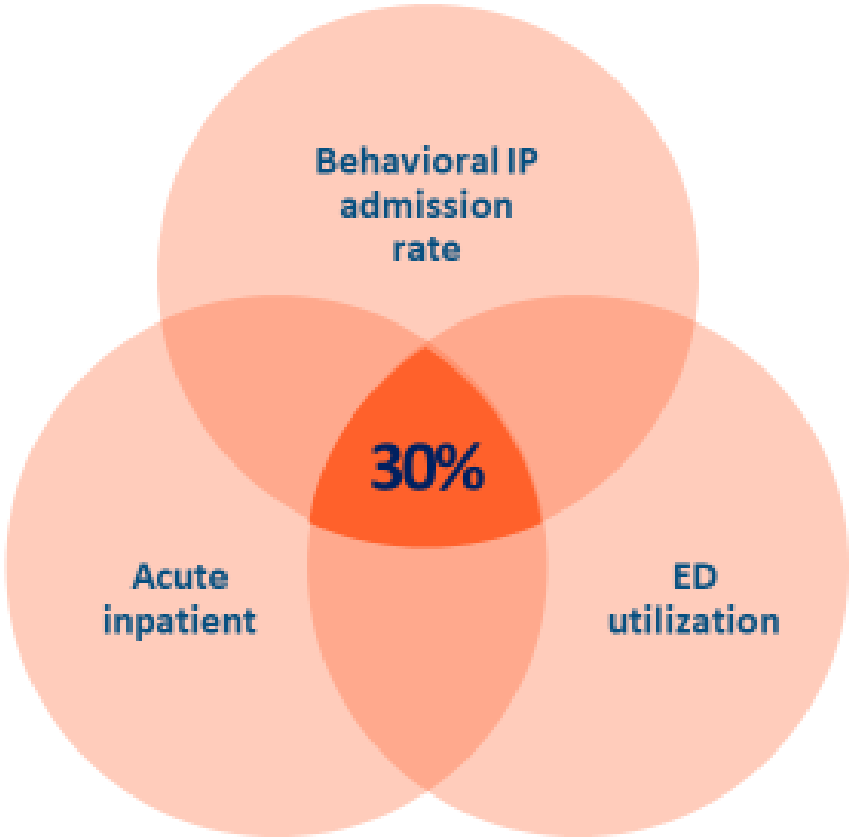
The HARRIS CENTER for Mental Health and IDD
Transforming Lives

Success indicators: The Harris Center IBHH Measurement Year 1*

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

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

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

Optum

The HARRIS CENTER for Mental Health and IDD

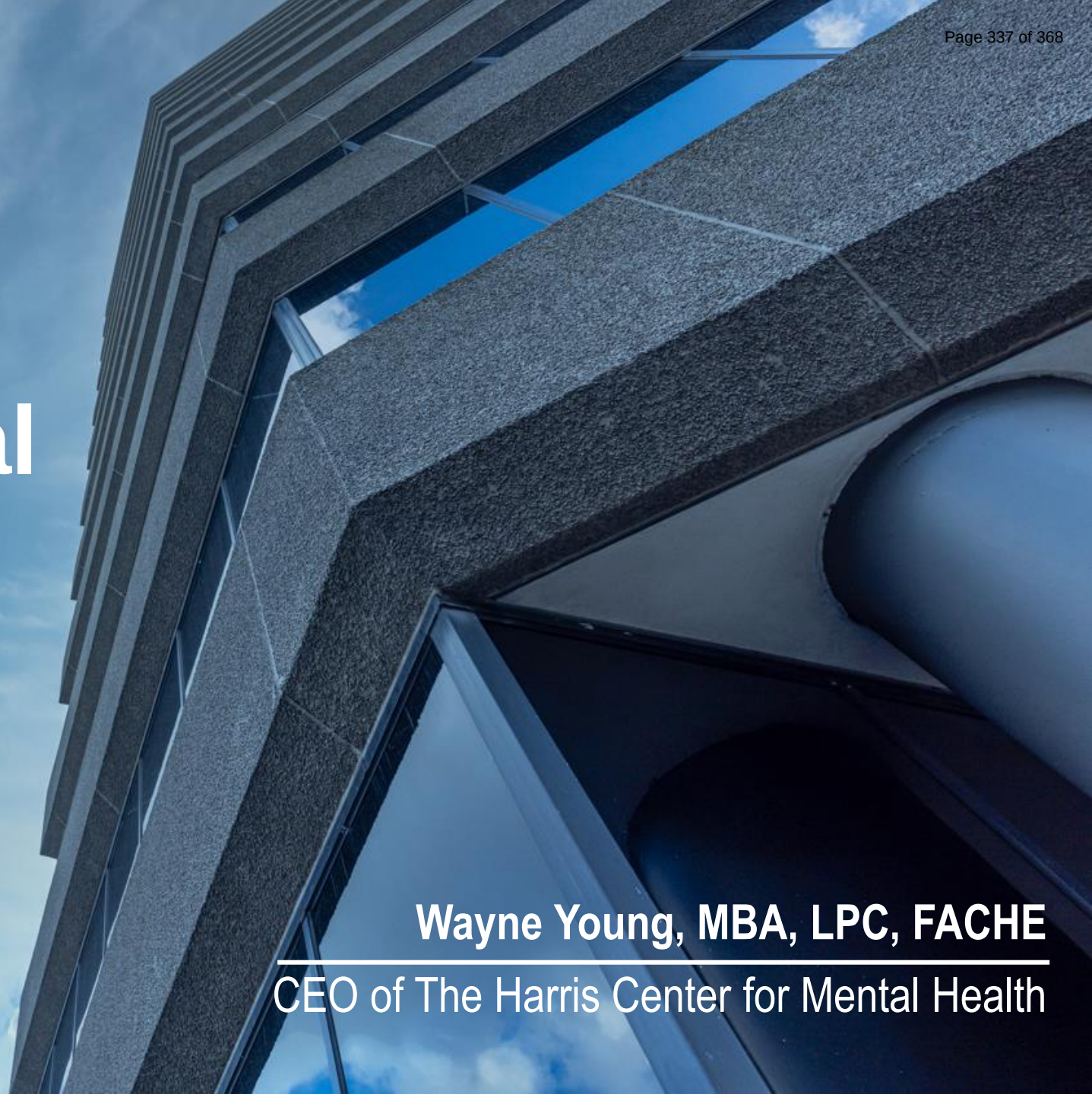
Transforming Lives

Thank You

EXHIBIT F-40

The HARRIS CENTER for Mental Health and IDD

Improving Mental and Behavioral Health Equity



Wayne Young, MBA, LPC, FACHE

CEO of The Harris Center for Mental Health

Harris County

The HARRIS CENTER for Mental Health and IDD

4.72+ MILLION
Total Population Estimate

3rd
Most Populous County in the U.S.

145
Languages Spoken

MOST DIVERSE
County in the U.S.

25.4%
Foreign Born

The Harris Center for Mental Health

HOUSTON BUSINESS JOURNAL BPTW BEST PLACES TO WORK

HOUSTON BUSINESS JOURNAL DIVERSITY IN BUSINESS AWARDS

About Us

The Harris Center is the largest provider of community-based behavioral health and IDD services in the State of Texas. Located in Houston, Texas, The Harris Center provides a full continuum of services to better serve one of the most diverse and multicultural communities in the nation.

Our Mission

To transform the lives of people with behavioral health and IDD needs.

Our Vision

To empower people with behavioral health and IDD needs to improve their lives through an accessible, integrated, and comprehensive recovery-oriented system of care.

multicultural

FY 2023

- **88K** people served
- **1.9M** services provided
- **2,650** dedicated employees
- **$343M** annual budget

Mental Health Treatment

Intellectual and Developmental Disabilities Services

Comprehensive Psychiatric Emergency Program

Justice Involved Services

Crisis and Access Line 24/7

iOS Apple – Mobile APP

Google Play – Mobile APP

Scope of Services

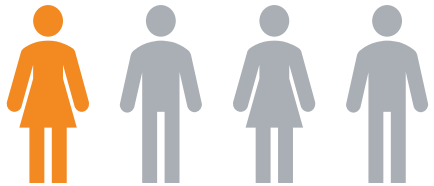
The HARRIS CENTER for Mental Health and IDD

Crisis and Residential Services	Criminal Justice Collaborations	Crisis Response	Outpatient Services	Integrated Healthcare
Psychiatric Emergency Center	Harris County Jail/ Juvenile Detention Center	Mobile Crisis Outreach Team MCOT Rapid Response	Assertive Community Treatment/ Forensic ACT	Offender/ Re-Entry Services
Inpatient Psychiatric Care (contract)	Jail Diversion Center	Clinician Office Remote Evaluation	Outpatient Clinics for Adults and Adolescents	IDD Services
Crisis Residential/ Crisis Stabilization/ P.E.E.R.S. House	Competency Restoration	Crisis Call Diversion (911 Clinicians)	School-based Co-locations	Substance Use Treatment
Respite, Rehabilitation, and Re-Entry Center	Crisis Intervention Response Team (Co-Responders)	Crisis Access Line/ 988 Hotline	IDD Day Habilitation	Primary Care Services
Dual Diagnosis Residential Program	Specialty Courts	Homeless Outreach Teams	Intellectual and Developmental Disability (IDD) Services	Dental Services
Permanent and Transitional Housing	Mental Health Services	Substance Use Disorder Outreach Program	Early Childhood Intervention (ECI) Services	ECI Services

Let's Not Forget...

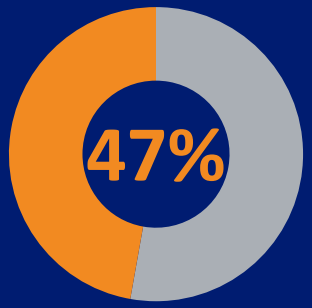
The HARRIS CENTER for Mental Health and IDD

1 in 4 Adults



Diagnosed with Any Mental Illness

Of the **57.8M** Adults with AMI,

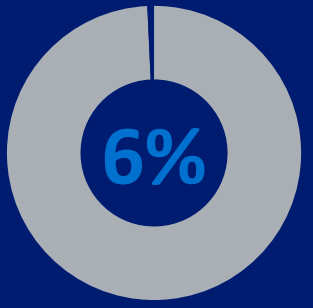


received treatment.

1 in 6 Adults

Met Criteria for Substance Use Disorder

Of the **46.3M** Adults with SUD,



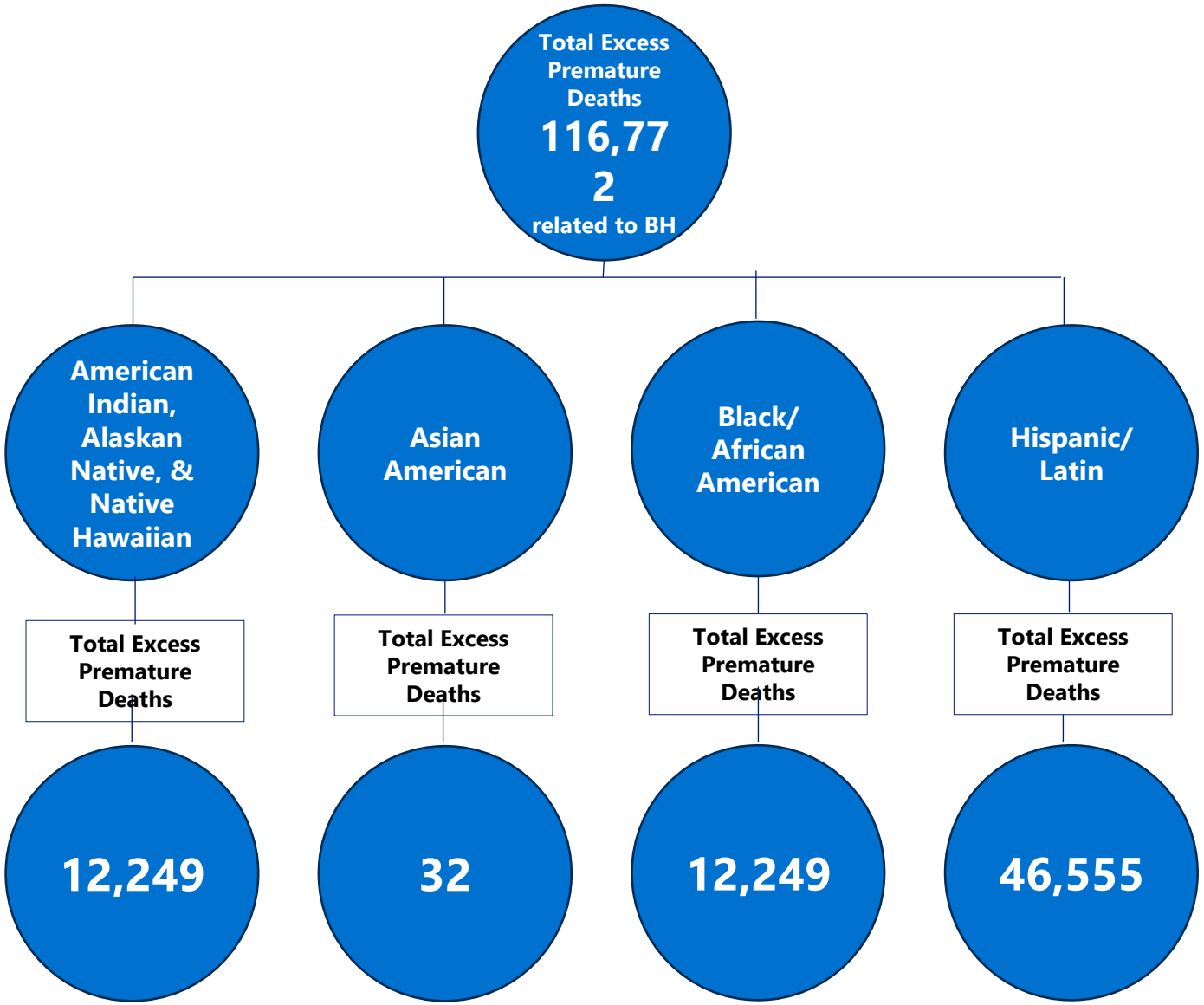
received treatment.

SAMHSA 2021 National Survey of Drug Use and Health

How many lives could be saved if mental health services were more equitable…

The Harris Center for Mental Health and IDD

Between 2016 and 2020, the total number of excess premature mental and behavioral health related deaths among indigenous populations and racial and ethnic minoritized groups was 116,722.

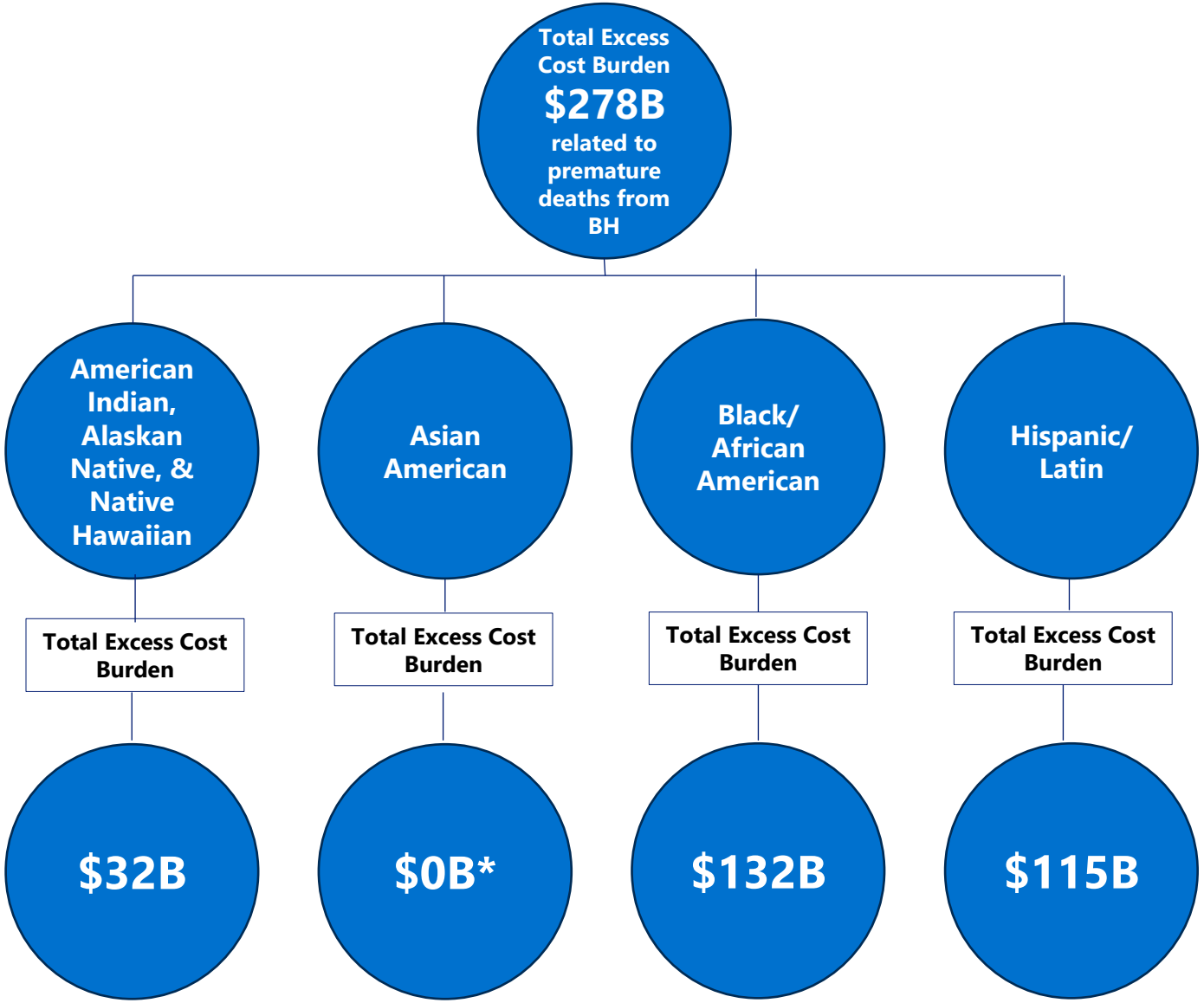


The Economic Burden of Mental Health Inequities in the US Report – Morehouse School of Medicine

How many dollars could be saved if mental health services were more equitable…

The HARRIS CENTER for Mental Health and IDD

Between 2016 and 2020, the total excess cost burden from premature mental and behavioral health-related deaths among indigenous populations and racial and ethnic minoritized groups due to mental illness, substance use, and suicide is $278 billion.

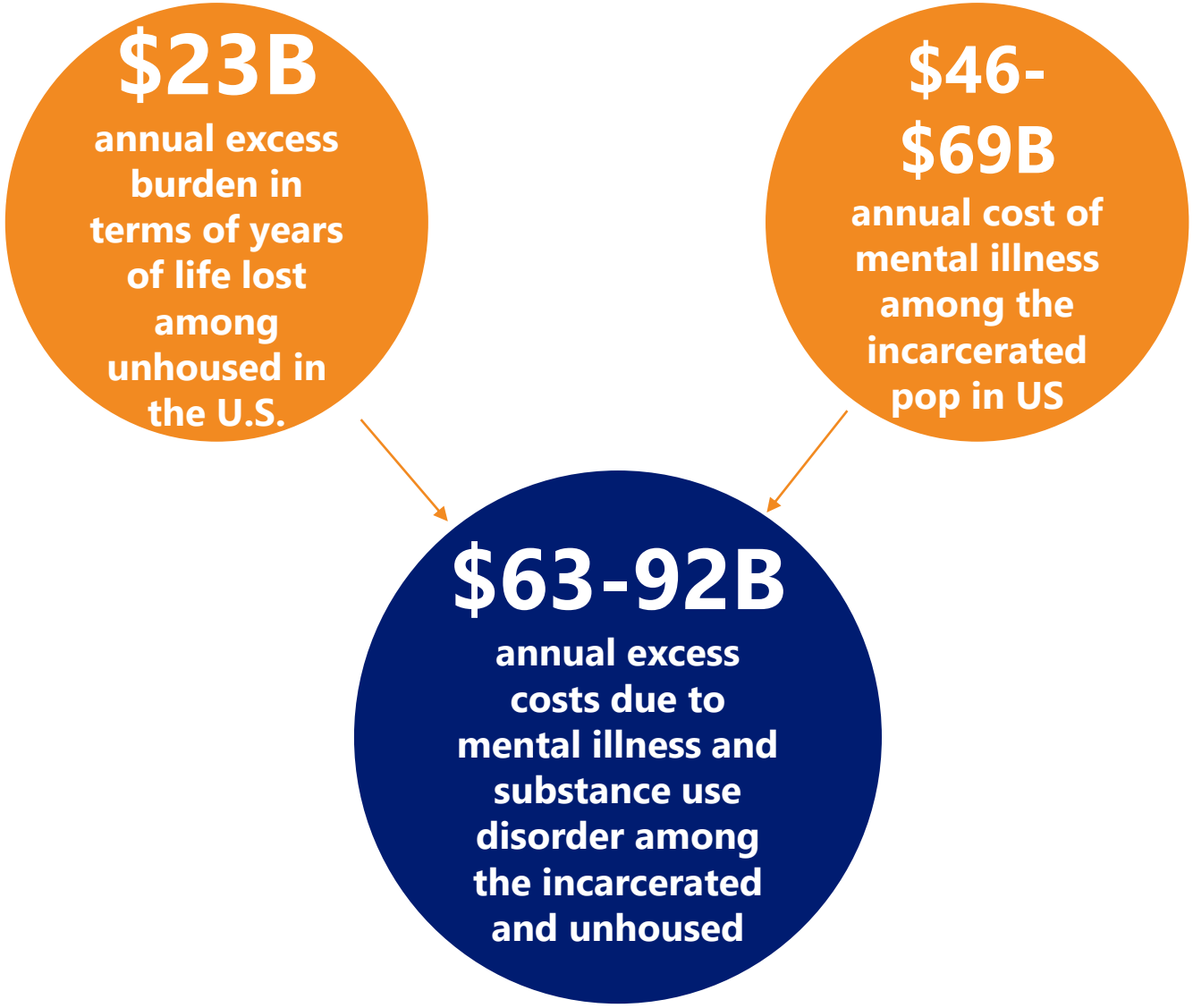


Oops… Homeless and Criminal Justice were not included…

The Harris Center for Mental Health and IDD

Excess cost burden of mental illness among the incarcerated population:

- **$15B - $44B** excess cost among those with substance use disorder
- **$19B** excess cost among those with mental illness
- **$6B** excess cost in potential averted crime



In other words…

Adequate treatment could save **$60-$90** billion dollars each year.

Increasing Access to High Quality Services

Clinic Access

Community Clinics:

- Same Day Access
- Walk In Availability Urgent Care Clinic
- Smart Pod
- Health Pod

Co-Located Clinics:

- Youth clinic located in 4 schools
- Community Centers

Youth Access Measures
- 1.86 Days to Professional
- 12.10 Days to Prescriber
- 10.3 Post Hospital F/U

Adult Access Measures
- 1.21 Days to Professional
- 13.66 Days to Prescriber
- 3.66 Post Hospital F/U

Mobile Access

The HARRIS CENTER for Mental Health and IDD

Community Clinics:

- Physical and Mental Health Screenings
- Integrated Care
- Vaccines
- Disaster Response

- Visits isolated segments of community
- Co-Deploy with other mobile services

Mobile Crisis Outreach Team

The Harris Center for Mental Health and IDD

- The Mobile Crisis Outreach Team (MCOT) is an interdisciplinary mobile team comprised of Psychiatrists, Registered Nurses, Licensed Master's Level Clinicians, Bachelor Level Clinicians, and Psychiatric Technicians specializing in crisis intervention.
- Community-based in Harris County, MCOT provides services to Children and Adults who are experiencing a mental health crisis.
- MCOT Services are provided 24 hours a day, seven days a week

2K Referrals Received

21K Services Provided

90 Days of Support

616 Urgent Dispatches

Community Initiate Care

The HARRIS CENTER for Mental Health and IDD

Healthy Minds, Healthy Communities

The HARRIS CENTER for Mental Health and IDD

Overview

Concept of democratizing and empowering individuals to learn how to respond to behavioral health issues and take helpful action in the moment

Task-Sharing Model

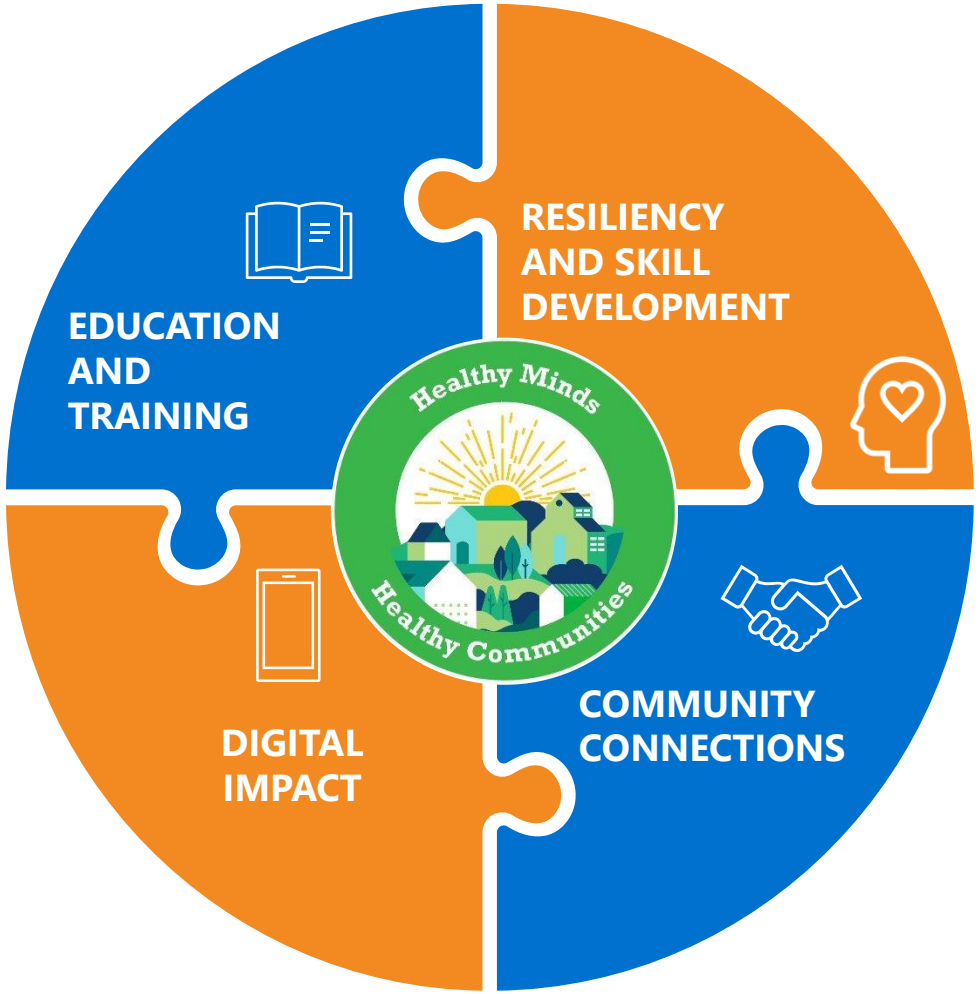
Allows delivery of evidence-based programs for prevention and early intervention of MH concerns by non-specialized members of the community

Application

Healthy Minds, Healthy Communities is the first large scale CIC-based program in the U.S., which targets 10 focused neighborhoods in Harris County (Houston, Texas), the 3rd most populous county in the nation.

HMHC Goals

- **Year 1**: Establish Community Learning Circles in all 10 communities to build trust, identify needs, and begin discussions around stigma
- **Year 2:** Grow youth engagement in the community by increasing social media presence across digital platforms



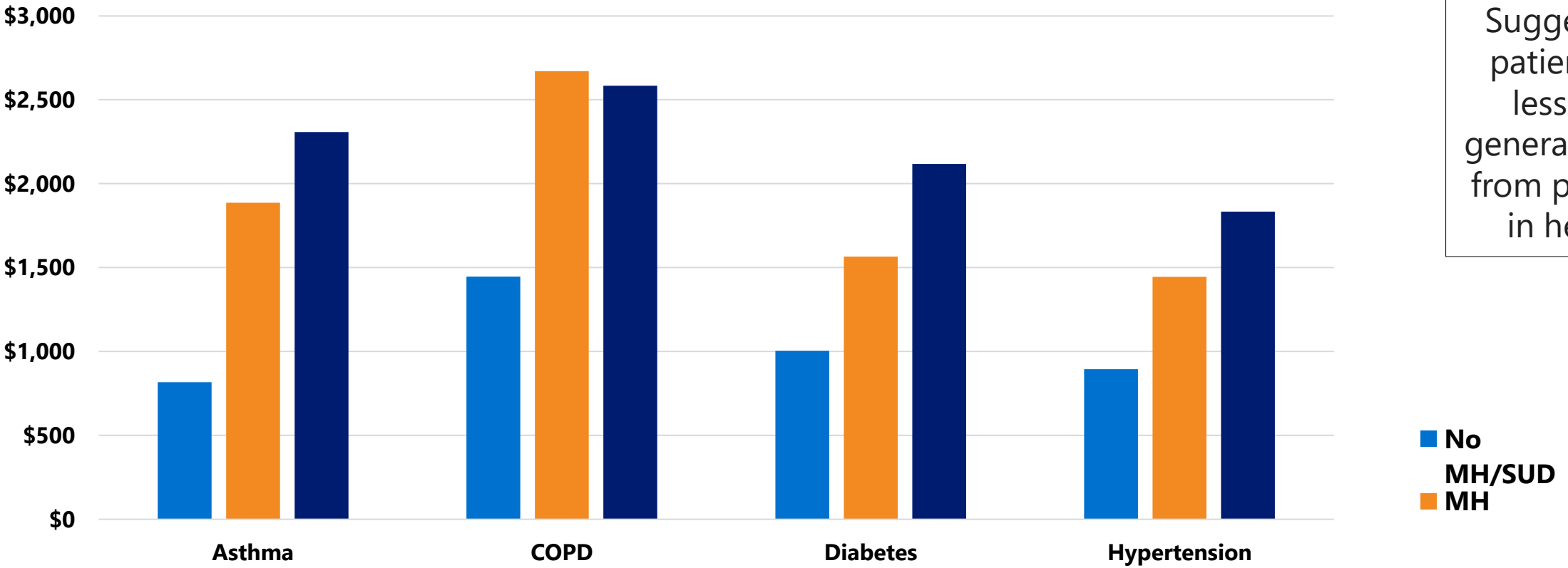
Behavioral Health Home

Physical Health Disparities

SMI patients die about **10–20 years earlier** than the general population mostly due to physical health conditions

There is also evidence that this **mortality gap has been increasing over time.** Suggesting, SMI patients benefit less than the general population from progressions in healthcare.

Impact of Behavioral Comorbidities on Overall Healthcare Costs, PMPM



Economic Impact of Integrated Medical Behavioral Healthcare.

Behavioral Health Home

Six locations provide integrated physical healthcare across our system

Includes:

- Primary Care services
- MH/SUD Screenings
- Combined treatment medications
- Interdisciplinary treatment team

With support of Episcopal Health Foundation Grant, we are actively pursuing FQHC Look-A-Like Status

Provides ONE treatment plan for:

- Chronic health conditions
- Mental illnesses
- Substance use disorders

houston foodbank

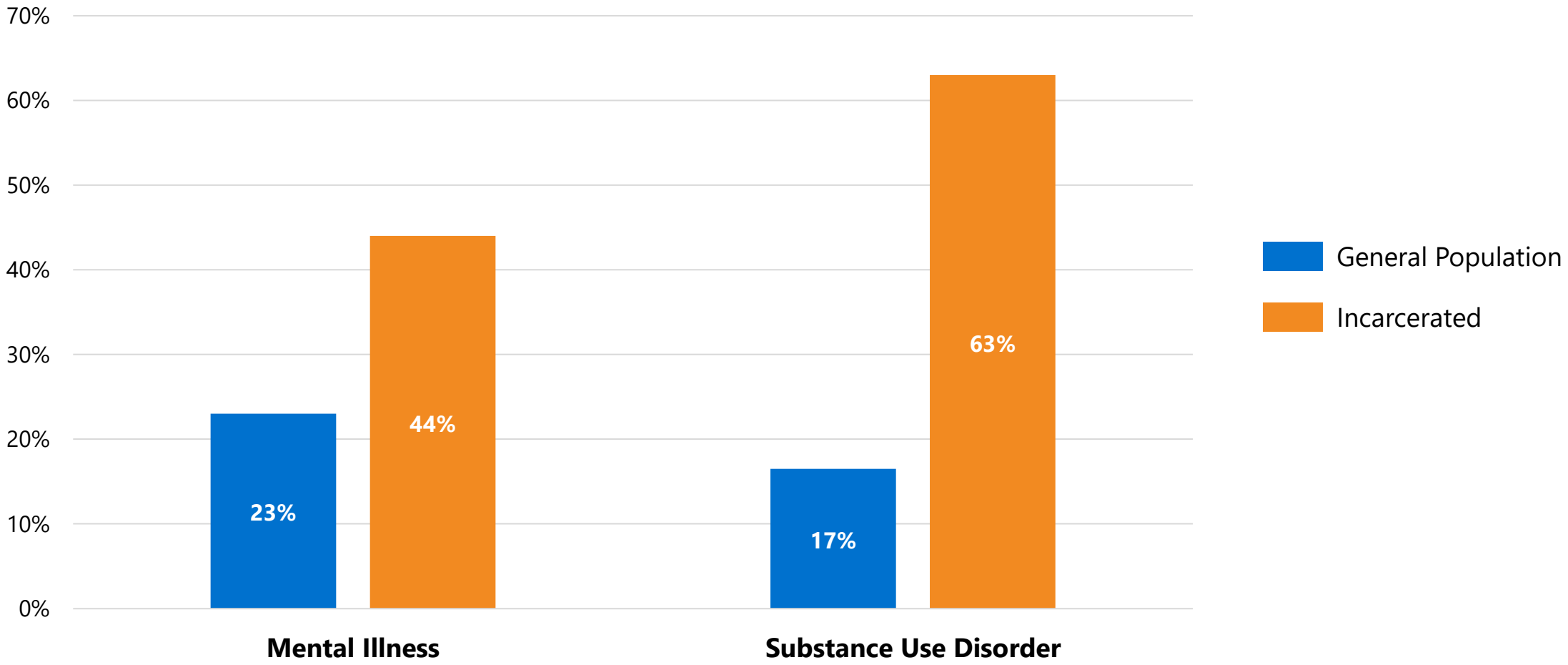
Food trucks will visit fours sites bringing 30 lbs of food every two weeks for roughly 400 of our clients meeting criteria

Partnership with University of Houston College of Medicine

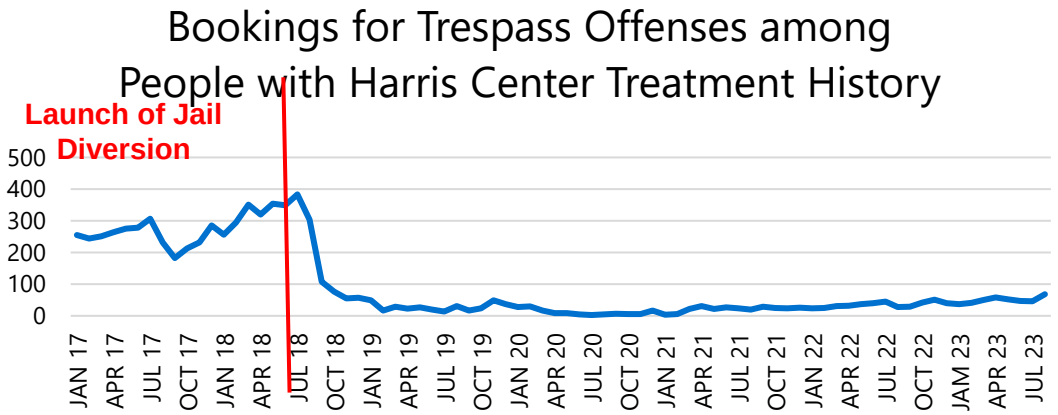
Reducing Criminal Justice Involvement

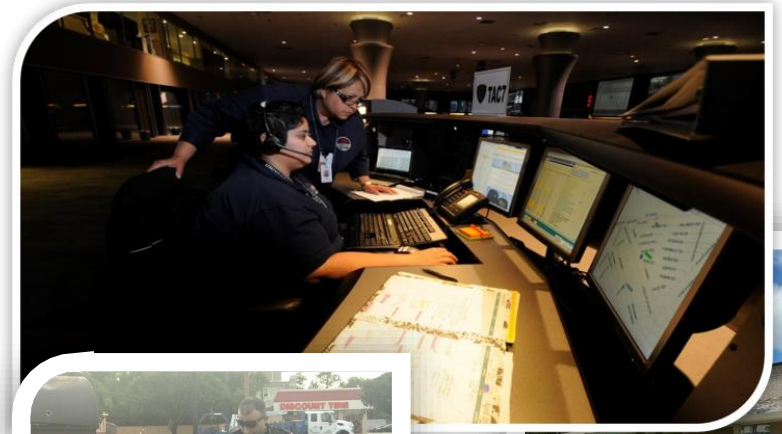
The HARRIS CENTER for Mental Health and IDD

By the Numbers



Criminal Justice Collaborations





Jail Diversion Program

Serves as an alternate location for law enforcement to drop off adults with severe mental illness that have been detained for low-level offenses (e.g., trespassing) prior to being charged

Youth Diversion Program

Serves as an alternate location for youth whom law enforcement has engaged due to low level, non-violent crimes, that temporarily need respite care due to a BH crisis

Crisis Call Diversion

Provides an integrated treatment program housed inside a correctional facility with 150 beds that serves those with a severe mental illness as an option for jail diversion

Houston Recovery Center

Includes a safe, short-term Sobering Center, links to community resources, and outreach services operated by the City of Houston that serves as an alternative to jail for public intoxication

Clinician Officer Remote Evaluation

Works to improve response to calls involving a person with mental illness, the CORE program connects a law enforcement first responder with a mental health clinician using a tablet and HIPAA-compliant technology.

MCOT Rapid Response

MCOT Rapid Response Teams is a non-law enforcement alternative response to non-violent, non-criminal, mental health 911 calls that CCD could not divert over the phone.

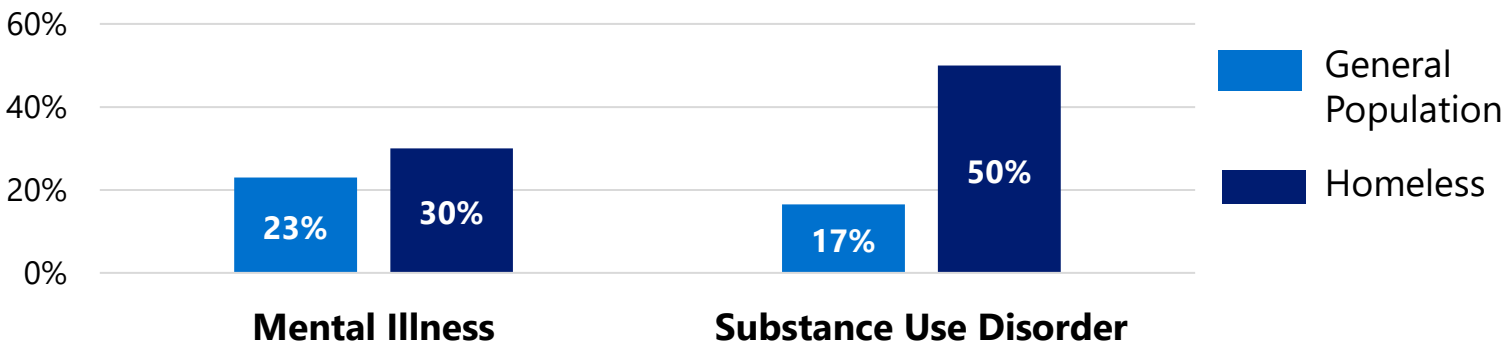
Housing

Emergency, Transitional and Permanent Housing

The HARRIS CENTER for Mental Health and IDD

Footprint:

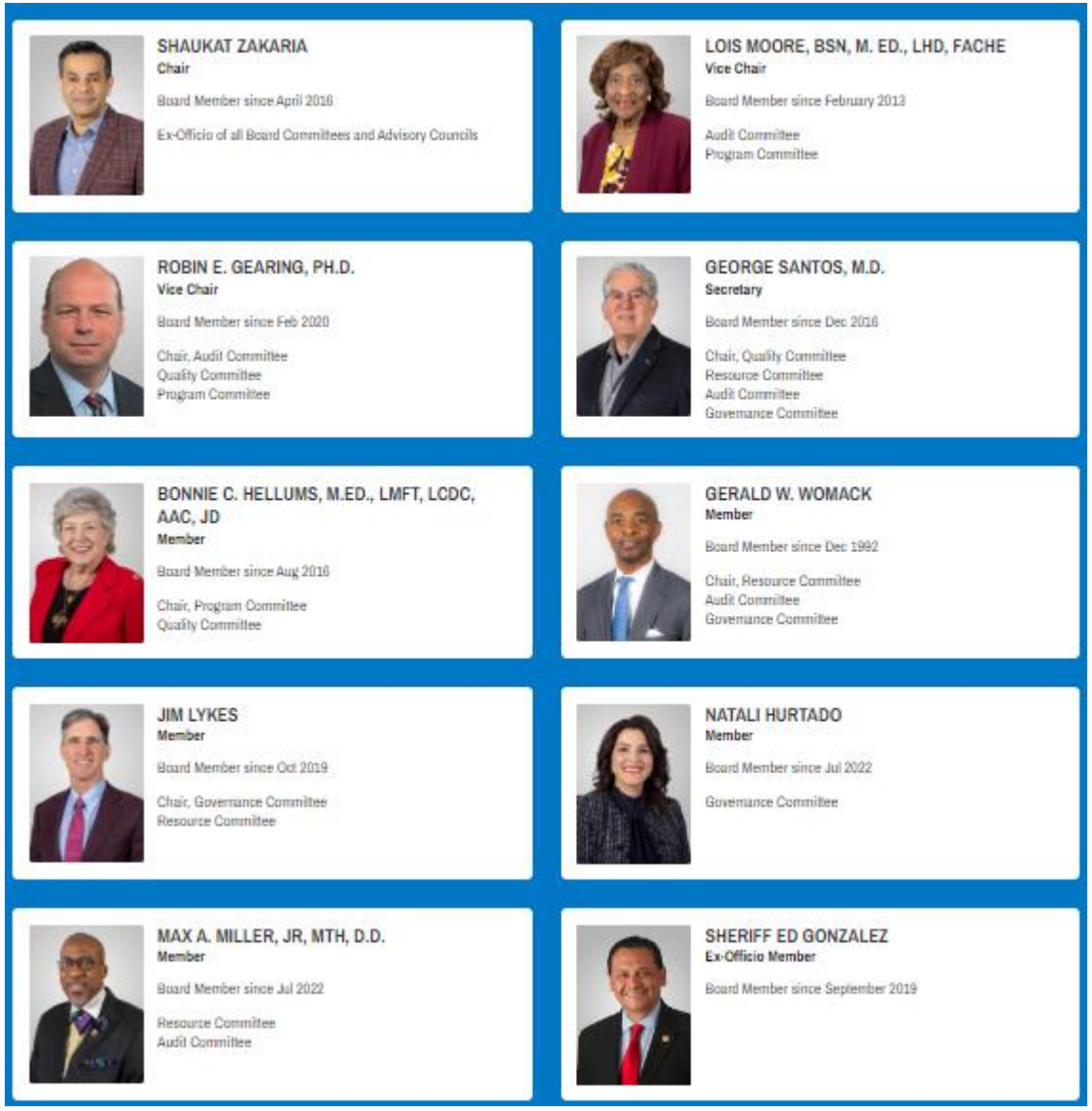
- MH Supportive Housing Center
- Apartments (100+ Units – 5 complexes)
  - Newest units – State/City/MCO
- Crisis Housing Contracts
- Hospital to Homes
- BHRT
- Jail Re-Entry Beds
- Embedded Staff in Housing Units
- IDD Cottages



Inclusion and Representation

The HARRIS CENTER for Mental Health and IDD

Harris Center Board



SHAUKAT ZAKARIA
Chair
Board Member since April 2016
Ex-Officio of all Board Committees and Advisory Councils

LOIS MOORE, BSN, M. ED., LHD, FACHE
Vice Chair
Board Member since February 2013
Audit Committee
Program Committee

ROBIN E. GEARING, PH.D.
Vice Chair
Board Member since Feb 2020
Chair, Audit Committee
Quality Committee
Program Committee

GEORGE SANTOS, M.D.
Secretary
Board Member since Dec 2016
Chair, Quality Committee
Resource Committee
Audit Committee
Governance Committee

BONNIE C. HELLUMS, M.ED., LMFT, LCDC, AAC, JD
Member
Board Member since Aug 2016
Chair, Program Committee
Quality Committee

GERALD W. WOMACK
Member
Board Member since Dec 1992
Chair, Resource Committee
Audit Committee
Governance Committee

JIM LYKES
Member
Board Member since Oct 2019
Chair, Governance Committee
Resource Committee

NATALI HURTADO
Member
Board Member since Jul 2022
Governance Committee

MAX A. MILLER, JR, MTH, D.D.
Member
Board Member since Jul 2022
Resource Committee
Audit Committee

SHERIFF ED GONZALEZ
Ex-Officio Member
Board Member since September 2019

Harris Center Executives

The HARRIS CENTER for Mental Health and IDD

MUSTAFA COCHINWALA
Chief Information Officer
+ Expand Bio

DR. LUMING LI, MD, MHS
Chief Medical Officer
+ Expand Bio

VANESSA MCKEOWN, CPA
Chief Financial Officer
+ Expand Bio

KEENA PACE, LCSW
Chief Operations Officer
+ Expand Bio

CARRIE RYS, MBA
Chief Administration Officer
+ Expand Bio

KENDRA THOMAS, JD, LPC
General Council
+ Expand Bio

KIA WALKER, RN, MSN
Chief Nursing Officer
+ Expand Bio

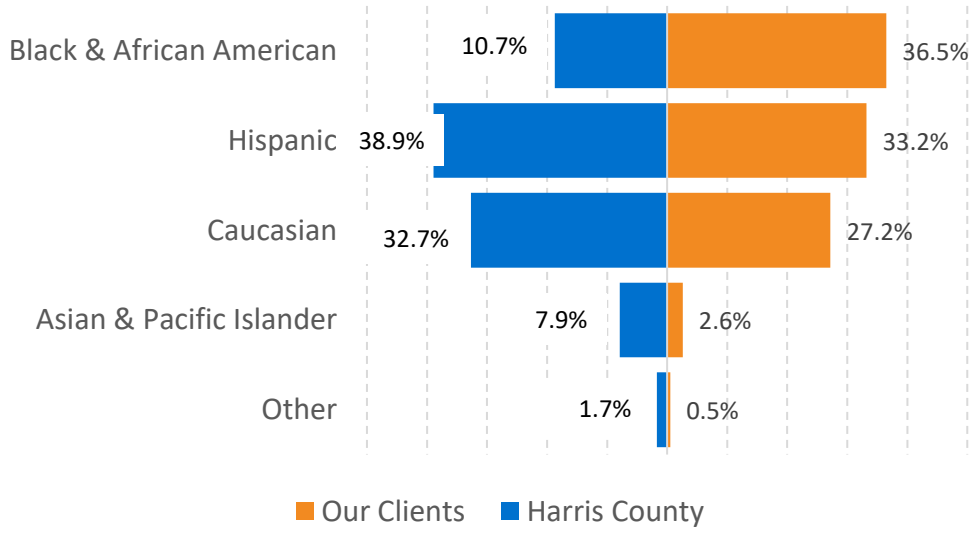
Inclusion and Representation

The Harris Center for Mental Health and IDD

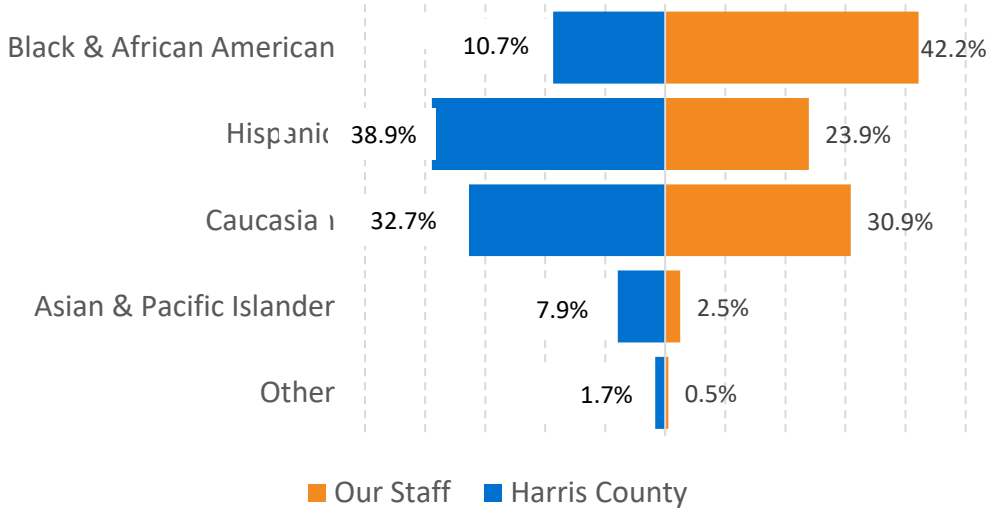
The Harris Center Efforts:

- ✓ Inclusion HUB
- ✓ IDD PAC
- ✓ 15% of staff receive language stipend
- ✓ Service Delivery in 30+ languages
- ✓ Oversight Committees
- ✓ BH Advisory Committee
- ✓ Diversity Spending
- ✓ Internal Translation Team

Harris County Demographics vs. Our Clients



Harris County Demographics vs. Our Staff



Questions

Contact Wayne Young, CEO

(713) 970 - 7160

Wayne.Young@TheHarrisCenter.org

Download The Harris Center App

The HARRIS CENTER for Mental Health and IDD

@TheHarrisCtr @TheHarrisCenterForMentalHealthandIDD @The-Harris-Center

EXHIBIT F-41

ABBREVIATION LIST

46B	Not Competent to stand trial HCJ

A

ACT	Assertive Community Treatment
ADL	Activities of Daily Living
AFDC	Aid to Families with Dependent Children
ALF	Assisted Living facility
ANSA	Adult Needs and Strengths Assessment
AOT	Assisted out- patient treatment
APS	Adult Protective Services
ARC	Association for Retarded Citizens
AUDIT-C	Alcohol Use Disorders Identification Test

B

BABY CANS	Baby Child Assessment needs (3-5 years)
BHO	Behavioral Health Organization
BDSS	Brief Bipolar Disorder Symptom Scale
BNSA	Brief Negative Symptom Assessment

C

CANS	Child and Adolescent Needs and Strengths
CAPES	Child and Adolescent Psychiatric Emergency Services
CAPS	Child and Adolescent Psychiatric Services
CARE	Client Assessment and Registration
CARF	Commission on Accreditation of Rehabilitation Facilities
CAS	Child and Adolescent Services
CBCL	Children's Behavioral Checklist
CBHN	Community Behavioral Health Network
CBT	Cognitive behavior therapy
CCBHC	Certified Community Behavioral Health Clinic
CCR	Clinical case review
CCSI	Chronic Consumer Stabilization Initiative
CCU	Crisis Counseling Unit
CHIP	Children's Health Insurance Plan
CIDC	Chronically Ill and Disabled Children
CIRT	Crisis Intervention Response Team
CIWA	Clinical Institute Withdrawal Assessment for Alcohol
CMAP	Children's Medication Algorithm Project
CMBHS	Clinical Management for Behavioral Health Services
CMS	Centers for Medicare and Medicaid
COC	Continuity of Care

COD	Co-Occurring Disorders Unit
COPSD	Co-occurring Psychiatric and Substance Abuse Disorders
COR	Council on Recovery
CPEP	Comprehensive Psychiatric Emergency Programs
CPOSS	Charleston Psychiatric Outpatient Satisfaction Scale
CPS	Children's Protective Services
CRCG	Community Resource Coordination Group
CRU	Crisis Residential Unit
CSC	Community Service Center
CSCD	Community Supervision and corrections department
CSP	Community Support plan
CSU	Crisis Stabilization Unit
CYS	Community Youth Services

D

DFPS	Department of Family and Protective Services
DHHS	Department of Health and Human Services
DID	Determination of Intellectual Disability
DLA-20	Daily Living Activities-20 Item Version
DRB	Dangerousness review board
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
DSRIP	Delivery System Reform Incentive Payment Program

E

ECI	Early Childhood Intervention
EO	Early Onset
EPSDT	Early Periodic Screening Diagnosis and Treatment

F

FACT	Forensic Assertive Community Team
FF	Flex Funds
FSIQ	Full Scale Intelligence Quotient
FSPA	Jail -Forensic Single Portal
FTND	Fagerstrom Test for Nicotine Dependence
FY	Fiscal Year

G

GAF	Global Assessment of Functioning
GR.	General Revenue

H

HAM-A	Hamilton Rating Scale for Anxiety
HCJPD	Harris County Juvenile Probation Department
HCPC	Harris County Psychiatric Center
HCPI	Harris County Psychiatric Intervention
HCPS	Harris County Protective Services for Children and Adults
HCS	Home and Community Services
HCS-O	Home and Community Services – OBRA
HCSO	Harris County Sheriff's Office
HH	Harris Health System
HHS	Health Human Services
HHSC	Health and Human Services Commission
HMO	Health Maintenance Organization
HOT	Homeless Outreach Team
HPD	Houston Police Department
HRC	Houston Recovery Center

I

ICAP	Inventory for Client and Agency Planning
ICC	Interim Care Clinic
ICF-ID	Intermediate Care Facility for Intellectual Disability
IEP	Individual Education Plan
IFSP	Individual Family Support Plan
IHR	In Home Respite
IRG	Innovative Resource Group
IRP	Individualized recovery plan

J

JDC	Juvenile Detention Center
JJAEP	Juvenile Justice Alternative Education Program
JSS	Job Satisfaction Scale

K

L

LAR	Legislative Appropriations Request
LIDDA	Local IDD Authority
LMHA	Local Mental Health Authority
LOC	Level of Care – LOC A= Authorized and LOC R= Calculated
LOS	Length of Stay
LPHA	Licensed Professional of the Healing Arts
LSA	Local Service Area

M

MACRA	Medicare Access and CHIP Reauthorization Act
MAPS	Mental Retardation Adult Psychiatric Services
MBOW	Medicaid Managed Care Report (Business Objects)
MCO	Managed Care Organization
MCOT	Mobil Crisis Outreach Team
MCAS	Multnomah Community Assessment Scale
MDU	Multiple Disabilities Unit
MHW	Mental Health Warrant
MMPI-2	Minnesota Multiphasic Personality Inventory 2nd Edition
MoCA	Montreal Cognitive Assessment
MSU	Maximum security unit

N

N	
NAMI	National Alliance for the Mentally Ill
NEO	New Employee Orientation
NGRI	Not Guilty for Reason of Insanity (46C)
NPC	Neuro-Psychiatric Center
NWCSC	Northwest Community Service Center

O

OSAR	Outreach Screening Assessment and Referral
OASS	Overt Agitation Severity Scale
OHR	Out of Home Respite
OVSOM	Office of Violent Sexual Offenders Management

P

PAP	Patient Assistance Program (for Prescriptions)
PASARR	Preadmission Screening and Annual Residential Review
PATH	Project to Assist in the Transition from Homelessness
PCH	Personal Care Home
PCM	Patient care monitoring
PDP	Person Directed Plan
PDSA	Plan-Do-Study-Act
PES	Psychiatric Emergency Services
PHCRU	Post Hospitalization Crisis Residential Unit
PHQ-9	Patient Health Questionnaire-9 Item Version
PHQ-A	Patient Health Questionnaire-9 Modified for Adolescents
PI	Performance Improvement
PIP	Performance Improvement Plan
PMAB	Prevention and Management of Aggressive Behavior
POC	Plan of Care

PoC-IP	Perceptions of Care-Inpatient
ProQOL	Professional Quality of Life Scale
PSRS	Positive Symptom Rating Scale
PSS	Parent Satisfaction Scale

Q

QAIS	Quality Assurance and Improvement System
QMHP	Qualified Mental Health Professional
QI	Quality Improvement
QIDS-C	Quick Inventory of Depressive Symptomology-Clinician Rated

R

RC	Rehab Coordination
ROI	Release of Information
RM	Recovery Manager
RTC	Residential Treatment Center

S

SAM	Service Authorization and Monitoring
SAMHSA	Substance Abuse and Mental Health Services Administration
SC	Service Coordination
SECSC	Southeast Community Service Center
SEFRC	Southeast Family Resource Center
SMAC	Sequential Multiple Analysis tests
SMHF	State mental health facility
SNF	Skilled Nursing Facility
SP	Service Package (SP1, etc)
SPA	Single portal authority
SSLC	State living facility
SWCSC	Southwest Community Service Center
SWFRC	Southwest Family Resource Center
SUD	Substance Use Disorder

T

TAC	Texas Administrative code
TANF	Temporary Assistance for Needy Families
TCOOMMI	Texas Correctional Office on Offenders with Medical or Mental Impairments
TDCJ	Texas Department of Criminal Justice
THKC	Texas Health Kids
THSteps	Texas Health Steps
TIC	Trauma informed Care
TMAP	Texas Medication Algorithm Project

TMHP	Texas Medicaid & Healthcare partnership
TJJD	Texas Juvenile Justice Department
TRR	Texas Resiliency and Recovery
TWC	Texas Workforce Commission

U

UR	Utilization Review

V

V-SSS	Visit-Specific Satisfaction Scale

W

X

Y