AXON Digital Health

COLLABORATIVE PILOT CONCEPT

FREE Confidential Behavioral Health Screening and ADHD Assessment for Collegiate Fraternity Men

A proposed nine-month pilot for the North American Interfraternity Conference and participating member fraternities

PURPOSE **Proactive, free behavioral health screening to:** Help collegiate fraternity men recognize behavioral-health concerns early, obtain clinically appropriate answers and connect with care—without placing new clinical responsibilities on NIC, fraternity leaders, IFC officers or campus volunteers. The model complements existing wellness resources, campus counseling and disability services with a defined specialty pathway.

Why this matters

NIC has identified a persistent gap between men knowing support exists and taking action when they are struggling. **A private, voluntary pathway can move members from awareness to clinical clarification and care before academic or behavioral-health concerns escalate.**

PILOT FOOTPRINT	PARTICIPANTS	DURATION	DELIVERY
5-6 member fraternities **5-10 campuses**	**500–1000 adult undergraduate** fraternity members	**9-month implementation** plus outcomes review	**Virtual-first screening,** assessment and referral

The participant experience

01	**Invite**	Member fraternities and campus/IFC partners distribute approved outreach; no member roster is required.
02	**Screen**	Members independently consent and complete a confidential behavioral-health screener at no cost.
03	**Clarify**	Those meeting clinical thresholds may elect a separate comprehensive ADHD assessment.
04	**Connect**	Each participant receives results, recommendations and referral options; follow-up is available when appropriate.

What the pilot provides

- **No-cost screening** using validated measures for ADHD and selected behavioral-health concerns.
- **Comprehensive ADHD assessment when clinically indicated,** including diagnostic interview, developmental and functional history, validated measures, differential diagnosis and objective testing when appropriate.
- **Closed-loop results and referrals** for treatment, coaching, campus resources, accommodations review or other evaluation needs.
- **Deidentified pilot reporting** on reach, access, completion, participant experience and connection to care.

Built around autonomy, privacy and clinical integrity

Participation is voluntary and separate from fraternity membership, recruitment, leadership, standards, conduct or benefits. NIC, FFE, member fraternities, chapters, IFCs and campuses receive no identifiable screening or assessment information. Results are released only to the participant—or to a third party with the participant's specific authorization—except as required by law or necessary to address an imminent safety concern.

Partnership request

Designate an NIC/FFE liaison; identify one to three interested member fraternities and campus/IFC partners; and co-design a limited pilot in jurisdictions where services can be lawfully and safely delivered. **Screening is offered at no cost. Assessment funding—participant payment, insurance where applicable, sponsorship, foundation support or pilot subsidy—will be finalized before**

launch.

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CLINICAL GOVERNANCE APPENDIX

Proposed Governance Framework

For discussion with NIC, FFE, participating member fraternities, IFCs, campuses and counsel | Version 0.9 | July 2026

STATUS This appendix is a proposed operating framework, not a final clinical protocol, contract or legal opinion. Final requirements will be jurisdiction- and partner-specific and must be approved before enrollment begins.

1. Governance principles

- **Clinical independence.** Clinical eligibility, assessment, diagnosis, recommendations, referral and safety decisions remain with appropriately licensed clinicians.
- **Voluntary participation.** Participation cannot affect fraternity membership, recruitment, leadership eligibility, standards or conduct proceedings, housing or organizational benefits.
- **Member-fraternity autonomy.** NIC convenes and supports; each member fraternity independently determines whether to participate, consistent with its policies and relationships with host institutions.
- **Minimum necessary data.** The pilot does not require member rosters. Partners distribute approved outreach; participants self-enroll directly with the clinical operator.
- **No organizational access to results.** NIC, FFE, fraternities, chapters, IFCs, volunteers and campuses receive no participant-level clinical information without a participant-directed authorization or other lawful basis.
- **Transparent boundaries.** Participants are told what screening can and cannot establish, what services cost, where care is available and how emergencies are handled.

2. Roles and decision rights

PARTY	PRIMARY ROLE	DECISION RIGHTS & RESPONSIBILITIES
NIC / FFE	Strategic convener	Names a liaison; helps identify interested member fraternities and campus/IFC partners; advises on alignment and communications. NIC and FFE receive no identifiable clinical information.
Member fraternities / IFCs / campuses	Invitation and local coordination	Opt in; approve outreach; identify local resources; coordinate campus counseling, student-affairs or disability-services contacts. They do not know who participates unless a participant independently chooses to disclose.
AXON / clinical entity	Clinical operator	Provides consent, screening, triage, assessment, clinical records, safety protocols, referrals, participant support and deidentified reporting.
Participant	Decision-maker	Chooses whether to enroll, what services to receive and whether any results may be released to another person or organization.

3. Pilot population and jurisdiction

- **Initial eligibility:** adult undergraduate fraternity members invited through participating organizations; the final protocol will define enrollment dates, exclusions and accessibility supports.
- **Location verification:** the participant's physical location is confirmed before clinical services. A clinician may proceed only when licensed or otherwise authorized in that jurisdiction.
- **Minors:** excluded from the initial pilot unless a separate consent, parental-permission and jurisdictional workflow is approved.

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CLINICAL DELIVERY

Participant Safeguards & Care Pathway

4. Consent and participant communications

- **Separate consent events.** Screening consent is distinct from assessment consent, releases of information, marketing preferences and any research consent.
- **Clear non-diagnostic language.** A screening result indicates that further evaluation may be useful; it is not an ADHD or other behavioral-health diagnosis.
- **No coercion.** Invitations avoid pressure from chapter officers, IFC leaders, alumni or peers. Choosing not to participate has no organizational consequence.
- **Cost disclosure.** Before assessment begins, participants receive the price, payment or insurance rules, cancellation terms, financial-assistance options and any costs associated with records or follow-up.
- **Release control.** Reports are delivered to the participant. Disclosure to a parent, primary-care clinician, campus disability office or another recipient requires a valid, specific authorization unless disclosure is otherwise permitted or required by law.
- **Conduct boundary.** Screening and assessment information is not collected for membership selection, chapter standards, conduct, insurance, event management or organizational risk-management decisions.

5. Stepped clinical pathway

1 VOLUNTARY SCREENING	A brief set of validated measures assesses ADHD symptoms and selected behavioral-health domains, which may include mood, anxiety and substance-use concerns. The platform explains limitations, return-of-results timing and emergency boundaries.
2 CLINICAL TRIAGE	Results are evaluated under a written protocol. Elevated results trigger appropriate education, follow-up or referral. Screening thresholds guide next steps but do not determine diagnosis.
3 COMPREHENSIVE ADHD ASSESSMENT	After separate consent, an appropriately licensed clinician evaluates current and childhood symptoms, functional impairment, developmental and clinical history, co-occurring conditions and reasonable alternatives. The clinician integrates interview findings, validated measures, relevant records or collateral information and objective attention/activity testing when clinically appropriate. No single instrument is treated as diagnostic.
4 RESULTS AND CARE CONNECTION	The participant receives a written report and consultation describing conclusions, limitations, recommendations and referral options. Possible next steps include psychotherapy, medication consultation, coaching, campus services, accommodations review, sleep or substance-use care, or other specialty evaluation.
5 FOLLOW-UP	When included in the pilot, follow-up monitors access to recommended care, participant experience and selected outcomes. New treatment requires its own consent and clinical relationship.

6. Safety and escalation

- **Not an emergency or event-safety service.** Every entry point explains how to contact emergency services and applicable local crisis resources. Screening and portal messages are not continuously monitored and do not replace chapter, campus, alcohol, hazing or event-response protocols.
- **Location-based response.** Current physical location and an emergency contact process are established as appropriate before synchronous clinical encounters.
- **Written risk protocol.** Positive suicide/self-harm, violence, abuse, intoxication or other acute-risk indicators prompt clinician review and escalation according to acuity, applicable law and professional standards.
- **Continuity and handoff.** The protocol defines local resource directories, warm handoffs where feasible, after-hours coverage, documentation, adverse-event review and unsuccessful-contact procedures.

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DATA, QUALITY & LAUNCH READINESS

Privacy, Reporting & Implementation Controls

7. Privacy, security and records

- **Data map and legal classification.** Before launch, the parties document what information is collected, who controls it, where it is stored, applicable HIPAA/FERPA or state-law treatment, and whether any business-associate or data-use agreements are required.
- **Segregation.** Clinical records are maintained in the clinical operator's approved systems and are not stored in NIC, FFE, fraternity, chapter, IFC or campus platforms.
- **Access controls.** Role-based access, multifactor authentication, encryption, audit logging, workforce training and device/vendor controls are documented and tested.
- **Retention and destruction.** Records follow applicable clinical-record, payer, professional and state requirements. Outreach and pilot-evaluation data follow a documented minimization and deletion schedule.
- **Incident response.** The parties establish reporting, investigation, mitigation, notification and corrective-action responsibilities before data collection.
- **Substance-use information.** If the program creates or receives records subject to 42 C.F.R. Part 2, the operator applies the additional consent and disclosure requirements.

8. Reporting and evaluation

NIC, FFE and participating organizations receive an agreed aggregate dashboard only. Small-cell suppression and a documented HIPAA deidentification method are applied where relevant. Illustrative measures:

✓ Invitations delivered and unique screening starts/completions	✓ Percentage meeting protocol-defined follow-up thresholds
✓ Time from screening to clinical contact and assessment completion	✓ Connection to recommended care or campus resources
✓ Participant-reported clarity, satisfaction and access barriers	✓ Operational burden, safety events, complaints and equity indicators

Program evaluation remains distinct from research. If the parties intend to produce generalizable knowledge, publish findings or use identifiable data beyond care/operations, the protocol will undergo appropriate IRB and consent review before those activities begin.

9. Pre-launch approval gates

- Pilot charter, participating fraternities/IFCs/campuses, jurisdictions, timeline and success measures approved
- Clinician authority, malpractice coverage, telehealth workflow and emergency resources verified
- Screening battery, thresholds, clinical review, exclusions and escalation algorithm approved
- Consent forms, notices, participant communications and accessibility review completed
- Contracts, privacy/security review, data map, vendor inventory and incident plan completed
- Assessment funding, financial assistance, cancellation/refund terms and downstream referral capacity confirmed
- Staff training, dry run, participant-support workflow and launch/stop criteria documented

10. Items to resolve in pilot design

Participating organizations and AXON will finalize: eligible states and campuses; fraternity and IFC participation; assessment funding; instrument set; response-time commitments; local referral partners; reporting thresholds; accessibility supports; branding and outreach cadence; adverse-event oversight; and criteria for continuation, modification or scale.

Selected authorities and program sources

North American Interfraternity Conference. 2026–2027 Alliance Partner Benefits by Level. nicfraternity.org/wp-content/uploads/2026/03/NIC-Alliance-Partner-Benefits-by-Level-2026-2027-FINAL.pdf.
North American Interfraternity Conference. Partnerships with Host Institutions—Position Statement. nicfraternity.org/position-statement-partnerships-with-host-institutions/.
North American Interfraternity Conference. Supporting Fraternity Men When It Matters Most. nicfraternity.org/supporting-fraternity-men-when-it-matters-most/.
NICE. Attention deficit hyperactivity disorder—Quality statement 2: Identification and referral in adults. nice.org.uk/guidance/qs39.
U.S. HHS Office for Civil Rights. Guidance on De-identification of Protected Health Information. hhs.gov/hipaa/for-professionals/special-topics/de-identification/.
U.S. Departments of Education and HHS. Joint Guidance on FERPA and HIPAA (2019). hhs.gov/sites/default/files/2019-hipaa-ferpa-joint-guidance.pdf.
Psychology Interjurisdictional Compact Commission. Telepsychology authorization guidance. psypact.gov.